How to apply for participation
If you are interested in applying for participation with Amerigroup Community Care, please visit providers.amerigroupp.com or call a Provider Relations representative at 1-888-821-1108.
ADDITIONAL FORMS

Medical Forms
Referral and Claim Submission Forms
Precertification Forms
Provider Grievances and Appeals Forms
Medical Record Documentation Forms
Other Forms
Pharmacy Synagis Order Form
Behavioral Health Forms
Hysterectomy and Sterilization Forms
Cost Containment Form
INTRODUCTION

Amerigroup Community Care would like to welcome you to the Florida Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) provider network family. We are pleased you joined our network, which represents some of the finest providers in the country.

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 helping you provide quality care and services to our members. We believe hospitals, physicians 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, high-quality provider network. All network providers are contracted with Amerigroup through a participating provider agreement.

Note: This provider manual does not apply to members of the Medicare Advantage or the SMMC Long-Term Care (LTC) program. For more information about providing services to Medicare Advantage members, call 1-800-563-5581. For more information about providing services to LTC members, call 1-877-440-3738.
OVERVIEW

Who Is Amerigroup?
As a leader in managed health care services for the public sector, we provide health care coverage exclusively to low-income families, children, pregnant women, Medicare Advantage Plans and Medicare Special Needs Plans. We participate in Medicare, Florida Healthy Kids, SMMC-LTC and the SMMC-MMA programs.

Mission
Together, we are transforming health care with trusted and caring solutions.

Strategy
Our strategy is to:
- Improve access to preventive primary care services by ensuring the selection of a primary care physician who will serve as provider, care manager and coordinator for all basic medical services
- Improve the health status and outcomes of 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-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
The 2011 Florida Legislature passed House Bill 7107 (creating part IV of Chapter 409, F.S.) to establish the Florida Medicaid program as a statewide, integrated managed care program for all covered services, including long-term care services. This program is referred to as Statewide Medicaid Managed Care (SMMC) and includes two programs: one for Managed Medical Assistance (MMA) and one for long-term care (LTC) consistent with our mission.

The goals of the SMMC-MMA program are to provide:
- Coordinated health care across different health care settings
- A choice of the best-managed care plans to meet recipients’ needs
- The ability for health care plans to offer different, or more, services
- The opportunity for recipients to become more involved in their health care
QUICK REFERENCE INFORMATION

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

Amerigroup Phone Numbers

Provider Services at the National Customer Care department telephone: 1-800-454-3730

Provider Services at the National Customer Care department fax: 1-800-964-3627

AT&T Relay Service: 1-800-855-2880 (English); 1-800-855-2884 (Spanish)

Automated Provider Inquiry Line for Member Eligibility: 1-800-454-3730

Electronic Data Interchange (EDI) Hotline: 1-800-590-5745

Nurse HelpLine: 1-800-600-4441

Member Services: 1-800-600-4441

Pharmacy Services: 1-800-454-3730

Other Telephone Numbers

eyeQuest (vision): 1-888-696-9551

DentaQuest (dental): 1-877-468-5581

HearUSA (hearing): 1-877-664-9353

Vaccines for Children: 1-800-483-2543

Immunization Registry (SHOTS): 1-877-888-SHOT (1-877-888-7468)

It’s Great to Wait Pregnancy Prevention Program: 1-866-232-3309

Healthy Start Program: 1-800-541-BABY (toll free), 386-758-1135 (or the local health department)

Women, Infants, and Children and Nutritional Service: 1-800-342-3556

Florida Quitline (smoking cessation): 1-877-U-CAN-NOW (1-877-822-6669)

Chiro Alliance (chiropractic care): 727-319-6199

Express Scripts (pharmacy benefit manager): 1-800-824-0898

LabCorp: 1-800-877-5227

Quest: 1-800-377-8448
Amerigroup Website

Our website contains the full complement of online provider resources. The website features an online provider inquiry tool for real-time information about member eligibility, prior authorization requests, claims status, claims resubmission and claims disputes. You can also submit demographic changes and provider rosters. In addition, the website has other resources and materials to help you work with us, including provider forms, a preferred drug list, a list of drugs requiring prior authorization, provider manuals, referral directories, a provider newsletter, electronic remittance advice and electronic funds transfer information, updates, and clinical practice guidelines. Visit our website at providers.amerigroup.com/FL.

Provider Experience Program

To thank you for the quality of care you give our members, we work to continuously increase service quality for you. Our new Provider Experience Program, focused on claims payment and issue resolution, does just that!

Call 1-800-454-3730 with claims payment questions or issues.

The Provider Experience Program support model connects you with a dedicated resource team to ensure:
- Availability of helpful, knowledgeable representatives to assist you
- Increased first-contact and issue-resolution rates
- Significantly improved turnaround time of inquiry resolution
- Increased outreach communications to keep you informed of your inquiry status

Ongoing Provider Communications

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

The additional information below will help you in your day-to-day interaction with Amerigroup.

<table>
<thead>
<tr>
<th>Additional Information</th>
<th>Contact the Provider Inquiry Line at 1-800-454-3730 or visit our website at providers.amerigroup.com/FL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Eligibility</td>
<td>Medicaid Recipients can enroll in Amerigroup online at: <a href="http://www.flmedicaidmanagedcare.com">www.flmedicaidmanagedcare.com</a> or by contacting the numbers listed below:</td>
</tr>
<tr>
<td></td>
<td>• 1-877-711-3662 (Phone)</td>
</tr>
<tr>
<td></td>
<td>• 1-866-467-4970 (TTY)</td>
</tr>
<tr>
<td>Member Enrollment/Disenrollment</td>
<td>Florida Healthy Kids members should contact the Florida Healthy Kids Corporation at 1-800-821-5437</td>
</tr>
</tbody>
</table>
### Additional Information

#### Notification/Precertification

- Precertification requests may be telephoned, submitted online or faxed to Amerigroup:
  - Telephone: 1-800-454-3730
  - Fax: 1-800-964-3627
  - providers.amerigroup.com/FL
- The following data are required for complete notification/precertification:
  - Member ID
  - Legible name of referring provider
  - Legible name of individual referred to provider
  - National provider identifier and/or tax ID number
  - Number of visits/services
  - Date(s) of service
  - Diagnosis
- In addition, clinical information is required for precertification

Referral and authorization forms are available online at providers.amerigroup.com/FL.

#### Claims Information

- **Submit paper claims to:**
  Florida Claims
  Amerigroup Community Care
  P.O. Box 61010
  Virginia Beach, VA 23466-1010
- **Electronic claims payer ID:**
  - Emdeon (formerly WebMD) is 27514
  - Capario (formerly MedAvant) is 28804
  - Availity (formerly THIN) is 26375
- For EDI assistance, providers may call the EDI hotline at 1-800-590-5745.
- Timely filing is within 180 days of the date of service or per the terms of the provider agreement
- Amerigroup provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and authorization status. Visit our website at providers.amerigroup.com/FL.
- If you are unable to access the Internet, you may receive claims, eligibility and authorization status over the telephone at any time by calling our toll-free, automated Provider Services line at 1-800-454-3730.
<table>
<thead>
<tr>
<th>Additional Information</th>
</tr>
</thead>
</table>
| **Medical Appeal Information** | • Medical appeals may be initiated by the member or provider on behalf of the member and must be submitted within 30 calendar days from the date of an adverse determination  
• **Submit medical appeals to:**  
  Medical Appeals  
  Amerigroup Community Care  
  P.O. Box 62429  
  Virginia Beach, VA 23466-2429 |
| **Payment Dispute** | • Providers have 120 calendar days from receipt of an Explanation of Payment (EOP) or utilization denial letter to request a first-level appeal. Amerigroup will send a determination letter within 30 business days of receiving all necessary information. If the provider is dissatisfied with the resolution, the provider may submit an appeal of the resolution within 30 calendar days of the date on the resolution letter  
• Our Provider Experience program also helps you with claims payment and issue resolution. **Just call 1-800-454-3730 and select the Claims prompt within our voice portal.** The Provider Experience program connects you with a dedicated resource team to ensure:  
  • Availability of helpful, knowledgeable representatives to assist you  
  • Increased first-contact, issue resolution rates  
  • Significantly improved turnaround time of inquiry resolution  
  • Increased outreach communication to keep you informed of your inquiry status  
• **File a payment dispute to:**  
  Payment Disputes  
  Amerigroup Community Care  
  P.O. Box 61599  
  Virginia Beach, VA 23466-1599 |
| **Grievances** | **Provider grievances should be submitted to:**  
  Provider Relations  
  Amerigroup Community Care  
  4200 W. Cypress St., Suite 900  
  Tampa, FL 33607 |
| **Case Managers** | • **Amerigroup case managers are available during normal business hours from 8 a.m. to 5 p.m. Eastern time**  
• For urgent issues, assistance is available after normal business hours, on weekends and on holidays through the Provider Services line at 1-800-454-3730 |
| **Provider Services Representatives** | For more information, contact Provider Services at the National Customer Care department at 1-800-454-3730. |
PRIMARY CARE PHYSICIANS

Primary Care Physicians

The primary care physician (PCP) is a network physician 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 but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining continuity of care. The PCP’s responsibilities shall include at a minimum:

- Managing the medical and health care needs of members to ensure that all medically necessary services are made available in a timely manner
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service
- Providing the coordination necessary for the referral of patients to specialists and for the referral of patients for services that may be available through fee-for-service Medicaid
- Maintaining a medical record of all services rendered by the PCP and other referral providers
- Seeing newly enrolled pregnant members within 30 days of enrollment

A PCP must be a physician or network provider/subcontractor who provides or arranges for the delivery of medical services, including case management, to ensure that all medically necessary services 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 services to assigned members:

- 24 hours a day, 7 days a week in person or by an on-call physician
- By answering emergency telephone calls from members within 30 minutes
- By providing a minimum of 20 office hours per week of personal availability as a PCP

Provider Specialties

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

- Family practitioners
- General practitioners
- General pediatricians
- General internists
- Advanced registered nurses
- Nurse practitioners
- Practitioners certified as specialists in family practice/pediatrics
- FQHCs and RHCs
- Obstetricians/gynecologists (OB/GYNs) (for women when they are pregnant)
The provider must be enrolled in the Medicaid program at the service location where he or she wishes to practice as a PCP before contracting with Amerigroup.

A provider must be a board-certified pediatrician or family practitioner if he or she wishes to practice as a Florida Healthy Kids PCP (unless granted an exemption by the Florida Healthy Kids Corporation board of directors).

Our primary care network may also include PCPs who (1) have recently completed a residency program in pediatrics or family practice approved by the National Board for Certification of Training Administrators of Graduate Medical Education programs and (2) are eligible for but have not yet achieved board certification. If a PCP does not achieve board certification within the first three years of initial credentialing, we will remove that provider from our network and reassign members to a board-certified PCP.

All PCPs in our network must provide all covered immunizations to Amerigroup members and be enrolled in the Florida State Health Online Tracking System (SHOTS), the statewide immunization registry.

**Primary Care Physician Onsite Availability**

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

- PCPs must offer telephone access to member 24 hours a day, 7 days a week
- A 24-hour telephone service may be utilized. 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 30 minutes.
- The PCP or another physician/advanced registered nurse practitioner must be available to provide medically necessary services
- Covering physicians are required to follow the referral/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 participation 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 illness and/or death. A notice to affected members will be issued immediately upon the health plan becoming aware of the situation. Should a provider cease participation for a voluntary reason such as retirement, a written notice to the affected members will be issued no less than 90 calendar days prior to the effective date of the termination and no more than 10 calendar days after receipt or issuance of the termination notice.
If a member is in a preauthorized, ongoing course of treatment with the provider who ceases participation, Amerigroup will notify the member in writing within 10 calendar days from the date that Amerigroup becomes aware of the provider’s network status.

**Member Enrollment**

Members who meet the state’s eligibility requirements for participation in managed care are eligible to join the Amerigroup health care plan. Members are enrolled without regard to the applicant’s health status.

Members are enrolled for a period of 12 months, contingent upon continued eligibility. The member may request disenrollment without cause at any time during the 120 days following the date of the member’s initial enrollment with Amerigroup or upon enrollment reinstatement or agency approval. Unless the member loses eligibility or submits an oral or a written disenrollment request to change managed care plans for cause, the member remains enrolled in a health plan for the remainder of the 12-month period. Amerigroup will ensure that all written and oral disenrollment requests are promptly referred to Florida Statewide Medicaid Managed Care (SMMC).

Within three business days, Amerigroup will send notification of any written request received by Amerigroup to the member in the form of a letter advising the member to call enrollment and disenrollment services at SMMC at 1-877-771-3662 (phone)/1-866-467-4970 (TTY).

For member enrollment for Florida Healthy Kids, please call 1-800-821-KIDS (5437).

**Involuntary Disenrollment**

Involuntary disenrollment may occur under the following conditions:

- Member is deceased
- Member’s Medicaid ID card is fraudulently used
- Member relocates out of the service area
- Member loses Medicaid eligibility
- Member is admitted to a long-term facility or hospital
- Member enrolls in another Medicaid/Medicare Health Maintenance Organization (HMO)
- Member’s Medicaid eligibility has been determined through the medically needy program
- Member’s eligibility is under the Qualified Medicare Beneficiaries (QMBs) program
- Member has other major medical insurance (e.g., CHAMPUS, private HMO)
- Member takes part in disruptive and abusive behavior
- Member fails to follow a proposed plan of medical care

Action related to a request for involuntary disenrollment conditions must be clearly documented in the member’s records and submitted to the local Amerigroup Provider Operations department. The documentation must include attempts to bring the member into compliance. A member’s failure to comply with a written corrective action plan must be documented. The member must have at least one verbal and one written warning regarding the implications of his or her actions. Amerigroup must be notified before transferring a member out of a physician’s practice. The Agency for Health Care Administration (AHCA) will be responsible for processing disenrollments.
For any action to be taken, it is mandatory that copies of all supporting documentation from the member’s file be submitted with the request.

**Newborn Enrollment**

All Medicaid-eligible newborns of members are the responsibility of Amerigroup. We will be responsible for payment of medically necessary services and well-child care for the newborn from the date of his or her birth. Amerigroup must be notified by the Department of Children and Family Services (DCF) of the newborn’s Medicaid ID number, and activation of the ID number by Medicaid is necessary to complete the member’s enrollment. Once enrolled, Amerigroup will remain responsible for the newborn, regardless of the mother’s Medicaid eligibility or HMO enrollment status, for the birth month and the next two consecutive months unless the mother voluntarily disenrolls the newborn from the health plan, the newborn loses Medicaid eligibility or the newborn is enrolled by the mother in Children’s Medicaid Services.

Amerigroup and the hospital will follow the unborn/newborn activation process below for newborn enrollment:

1. Upon identification of an enrollee's pregnancy through medical history, examination, testing, claims, or otherwise, we will immediately notify DCF of the pregnancy and any relevant information known (for example, due date and gender). We must provide this notification by completing the DCF Excel spreadsheet and submitting it, via electronic mail, to the appropriate DCF Customer Call Center address and copied to MPI at email: mcobaby@ahca.myflorida.com. We shall indicate its name and number as the entity initiating the referral.
2. DCF will generate a Medicaid ID number for the unborn child. This information will be transmitted to the Medicaid fiscal agent. The Medicaid ID number will remain inactive until the child is born and DCF is notified of the birth.
3. Upon notification that a pregnant enrollee has presented to the hospital for delivery, Amerigroup shall inform the hospital, the pregnant enrollee's attending physician and the newborn's attending and consulting physicians that the newborn is an enrollee. At this time, Amerigroup or our designee shall complete and submit the Excel spreadsheet for unborn activation to DCF, and to MPI for its information.

**Members Eligibility Listing**

The PCP can review his or her panel of assigned members online; to receive a listing of assigned panel members by mail on the first day of each month, the PCP must request the list from his or her Provider Relations representative. The list will consist of Amerigroup members who have chosen the PCP’s office to provide services. 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 the membership listing. If a PCP does not receive the listing in a timely manner, he or she should contact a Provider Relations representative. For questions regarding a member’s eligibility, providers can access our provider website at providers.amerigroup.com/FL or call the automated Provider Inquiry Line at 1-800-454-3730.
Member ID Cards

Each Amerigroup member will be provided an ID card within 14 calendar days of notification of enrollment into Amerigroup or prior to the member’s enrollment effective date. The ID card identifies the member as a participant in the Amerigroup program. 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. The holder of the member ID card issued by Amerigroup is a member or guardian of the member. The ID card will include:

- The member’s ID number
- The member’s name (first and last names and middle initial)
- The member’s date of birth
- The member’s enrollment effective date
- Toll-free phone numbers for information and/or authorizations
- Toll-free Nurse HelpLine information; the line is accessible 24 hours a day, 7 days a week
- Descriptions of procedures to be followed to obtain emergency or specialty services
- Amerigroup address and telephone number
- The PCP’s name, address and telephone number

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
- An elevator or accessible ramp into facilities
- Access to a lavatory that accommodates a wheelchair
- Access to an examination room that accommodates a wheelchair
- Handicapped parking space(s) that are clearly marked, unless there is street-side parking

Medically Necessary Services

Medically necessary health services mean health services that are:

- Necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain
- Individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs
- Consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational
- Reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide
- Furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker or the provider
For services furnished in a hospital on an inpatient basis, medical necessity means appropriate medical care cannot be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical, allied, or long-term care goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

**Continuity of Care**

We will observe a 60-day continuity of care waiver for all MMA services. No service will be denied for absence of authorization in circumstances where care was in place prior to the transition date.

The continuity of care waiver applies to both participating and nonparticipating Amerigroup providers. The service is continued until we assess the member and reauthorize and/or transfer him or her to a participating provider. Once we assess the member, the new authorization will be observed and will drive future claims payment.
AMERIGROUP HEALTH CARE BENEFITS AND COPAYMENTS

Amerigroup Covered Services

Any modification to covered services will be distributed via a provider update by mail, fax, provider newsletter, provider manual addendum and/or contractual amendment. Covered services include the following list and may vary by product:

- Advanced registered nurse practitioner
- Ambulatory surgical center services
- Assistive care services
- Behavioral health services
- Birth center and licensed midwife services
- Clinic services
- Chiropractic services
- Dental services
- Child health check up
- Immunizations
- Emergency services
- Emergency behavioral health services
- Family planning services and supplies
- Healthy start services
- Hearing services
- Home health services and nursing care
- Hospice services
- Hospital services
- Laboratory and imaging services
- Medical supplies, equipment, prostheses and orthoses
- Optometric and vision services
- Physician assistant services
- Physician services
- Podiatric services
- Prescribed drug services
- Renal dialysis services
- Therapy service
- Transportation services

The scope of benefits is described in more detail in the quick reference card posted on the Amerigroup website at providers.amerigroup.com/FL.

Enhanced Benefits

Amerigroup has decided to offer a group of enhanced benefits. The expanded services identified below are additional benefits not included in the Florida MMA/Florida Healthy Kids (FKH) core benefits.

If copays are waived as an expanded benefit, you must not charge the member copays for covered services. If copays are not waived as an expanded benefit, the amount paid to you will be the contracted amount or, for fee-for-service providers, the Medicaid fee schedule amount less any applicable copays.

<table>
<thead>
<tr>
<th>Covered services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing services</td>
<td>MMA: Sixty (60) hearing aid batteries per year; includes battery size(s): 10, 13, 312 and 675; subject to medical necessity.</td>
</tr>
<tr>
<td>Healthy Families program</td>
<td>FHK: Six months of fitness and healthy behavior coaching is covered for members ages 7 to 13.</td>
</tr>
<tr>
<td>Hypoallergenic bedding</td>
<td>FHK: Covered services include up to $100 maximum per lifetime toward the purchase of hypoallergenic bedding. Coverage is limited to FKH members with a diagnosis of asthma or severe allergies. You will need to verify eligibility with Amerigroup by calling us at 1-800-454-3730. A Provider Services representative will provide additional instructions once eligibility is verified. The member will need to have a prescription to obtain the allergy bedding.</td>
</tr>
<tr>
<td>Covered services</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Mouth guards</td>
<td><strong>FHK:</strong> Mouth guards are free for members involved in contact sports.</td>
</tr>
</tbody>
</table>
| Amerigroup On Call | **MMA and FHK:** Members have access to a 24-hour Nurse HelpLine and physician consultations to answer their medical questions day and night. This service can help members:  
  - Find doctors when your office is closed, whether after-hours or on weekends  
  - Schedule appointments with you or other network doctors  
  - Get to urgent care centers or walk-in clinics  
  - Speak directly with an Amerigroup On Call doctor or a member of the doctor’s staff to talk about their health care needs  
  
We encourage you to tell your Amerigroup patients about this service and about the advantages of avoiding the ER when a trip there isn’t necessary, or the best alternative.  

Members can reach Amerigroup On Call at 1-866-864-2544 (TTY 1-800-855-2880). Language translation services are also available through the Amerigroup On Call line. |
| Primary care services | **MMA:** There is no copay to see a PCP and no limit to the number of primary care visits. |
| Home health care (nonpregnant adults) | **MMA:** Unlimited visits; subject to medical necessity and prior authorization. |
| Physician home visits | **MMA:** Unlimited visits; limited to adult, homebound enrollees who otherwise require ambulance transport to access primary care. |
| Prenatal/perinatal visits | **MMA:** Unlimited visits. |
| Outpatient services | **MMA:** No monetary limit on outpatient services; subject to medical necessity; subject to prior authorization with the exception of laboratory services. |
| Over-the-counter (OTC) medication and supplies | **MMA:** $25 per enrollee household per month.  
**FHK:** $10 per enrollee household per month. |
| Adult dental services | **MMA:** One exam every six months; one cleaning every six months.  
**For SSI non-Medicaid/Medicare dual-eligible enrollees:** One set of bitewings per year; unlimited fillings, limit one filling per tooth every 36 months; one fluoride treatment every six months. |
<p>| Waived copays | <strong>MMA:</strong> Enrollees shall not be subject to copay charges. |
| Vision services | <strong>MMA:</strong> $100 per year for contact lenses and contact lens services. Limited to adult |</p>
<table>
<thead>
<tr>
<th>Covered services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn circumcision</td>
<td><strong>MMA:</strong> Available for children up to 28 days of age; does not require prior authorization.</td>
</tr>
<tr>
<td>Adult pneumonia vaccine</td>
<td><strong>MMA:</strong> One vaccination per lifetime without prior authorization; one vaccine every five years subject to prior authorization.</td>
</tr>
<tr>
<td>Adult influenza vaccine</td>
<td><strong>MMA:</strong> One vaccination per year.</td>
</tr>
<tr>
<td>Adult shingles vaccine</td>
<td><strong>MMA:</strong> One vaccination per lifetime; limited to enrollees aged 60 and older.</td>
</tr>
<tr>
<td>Post-discharge meals</td>
<td><strong>MMA:</strong> Two meals per day for seven days; limited to adult enrollees following discharge from a surgical hospital stay of at least three days.</td>
</tr>
</tbody>
</table>

**Taking Care of Baby and Me Program**

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

**Prenatal Program**

A package will be sent upon enrollment into the Taking Care of Baby and Me program that includes a pregnancy book. Upon completing prenatal checks, members are eligible for a $10 gift card (e.g., Walmart, Target).

**Postpartum Program**

The member will also receive a Taking Care of Baby and Me postpartum book. Upon completing the postpartum check between 21 and 56 days post-delivery by her doctor, the member will be mailed an incentive gift for keeping her appointment.

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 member’s level of knowledge about her pregnancy
- Create systems that support the delivery of quality 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.
Quality Enhancement Program

Amerigroup offers quality-enhanced programs for the benefit of members and providers. These include:

1. Children’s programs — We provide regular general wellness programs for ages birth to 5 years, or we make a good faith effort to involve members in existing community children’s programs.
   a. We rely on providers seeing children to provide prevention and early intervention services for at-risk members. We approve claims for services recommended by the early intervention programs when they are covered services and medically necessary.
   b. We offer annual training to providers (through monthly provider agendas, the Amerigroup website, etc.) that promote proper nutrition, breast-feeding, immunizations, CHCUP, wellness, prevention and early intervention services.

2. Domestic violence programs — We require PCPs to screen members for signs of domestic violence and require PCPs to offer referral services to applicable domestic violence prevention community agencies.

3. Pregnancy prevention — We conduct pregnancy prevention programs or shall make a good faith effort to involve members in existing community pregnancy prevention programs. These programs will be targeted toward teen enrollees but be open to all ages.

4. Prenatal/postpartum pregnancy programs — We provide regular home visits by a home health nurse or aide and offer counseling and educational materials to pregnant and postpartum members who are not in compliance with the health plan’s prenatal and postpartum programs. We will coordinate our efforts with the local Healthy Start care coordinator to prevent duplication of services.

5. Smoking cessation — We provide smoking cessation counseling to members. We provide participating PCPs with a quick reference card to help identify tobacco users and support delivery of effective smoking cessation interventions. Please see the Smoking Cessation Program section below.

6. Substance abuse programs — We offer annual substance abuse screening training to our providers. In addition, several screening tools and other resources are available on our provider website to help providers identify substance abuse and make appropriate referrals.
   a. At a minimum, all PCPs are required to screen members for signs of substance abuse as part of prevention evaluation at the following times:
      i) During initial contact with a new member
      ii) During routine physical examinations
      iii) During initial prenatal contact
      iv) When the member displays serious overutilization of medical, surgical, trauma or emergency services
      v) When documentation of emergency room visits suggests the need
   b. Providers identifying patients with substance abuse needs should refer patients to community substance abuse programs
Well-child Visits/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Amerigroup members are encouraged to contact their physician within the first 90 days of enrollment to schedule a well-child visit and within 24 hours for newborns. Amerigroup members are eligible to receive these services from birth to age 20. The well-child program in Florida is known as Child Health Check-Ups (CHCUP) and provides the following:

- Comprehensive health and development history
- Physical and mental development assessment
- Comprehensive unclothed physical examination
- Age-appropriate immunizations
- Appropriate laboratory tests
- Health education

Newborn well-child services should be performed for newborns in the hospital and then at the following ages:

- Between 1 to 2 weeks
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

In the child’s second year of life, he or she should see a PCP at 15 months, 18 months and 24 months of age. During the span of a child’s third year of life until age 20, the child should be seen by his or her PCP at least on an annual basis. Amerigroup educates our members about these guidelines and monitors encounter data for compliance.

Amerigroup recommends that participating providers who treat children under the age of 21 to utilize the American Academy of Pediatrics Bright Futures Well-Child Forms to ensure all aspects of an EPSDT visit are captured. The forms can be found at http://brightfutures.aap.org (Tools and Resources) or under Appendix A of this manual.

Amerigroup requires providers to:

- Participate in the CHCUP program if they treat children under the age of 21
- Provide all needed initial, periodic and interperiodic EPSDT health assessments, diagnosis and treatment to all eligible members in accordance with the Florida Agency for Health Care Administration’s approved Medicaid administrative regulation Sect. III C.9.b and the periodicity schedule provided by the American Academy of Pediatrics (AAP)
- Refer members to an out-of-network provider for treatment if the service is not available within our network
- Provide vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines
- Provide vaccinations in conjunction with EPSDT/well-child visits; providers are required to use vaccines available without charge under the Vaccine for Children (VFC) program for Medicaid children 18 years of age and younger
- Address unresolved problems, referrals and results from diagnostic tests, including results from previous EPSDT visits
• Request a prior authorization for a medically necessary EPSDT special service in the event other health care, diagnostic, preventive or rehabilitative services or treatment or other measures described in 42 U.S.C. 1396d(a) are not otherwise covered under the Florida Medicaid program

• Monitor, track and follow up with members:
  – Who have not had a health assessment screening
  – Who miss appointments to assist them in obtaining an appointment

• Ensure members receive the proper referrals to treat any conditions or problems identified during the health assessment, including tracking, monitoring and following up with members to ensure they receive the necessary medical services

• Assist members with transition to other appropriate care for children who age-out of EPSDT services

Amerigroup recommends that participating providers who administer immunizations to children under the age of 18 to utilize the Centers for Disease Control (CDC) Immunization Schedule for Persons Aged 0 through 18. This schedule can be found at http://www.cdc.gov/vaccines/schedules/index.html or under Appendix A of this manual.

**Well-child Visits Reminder Program**

Based on Amerigroup claims data, we send a list of members who may not have received wellness services according to schedule to the members’ PCPs each quarter. Additionally, we mail information to these members encouraging them to contact their PCPs’ offices to set up appointments for needed services.

Please note:

• The specific service(s) needed for each member is listed in the report; reports are based only on services received during the time the member is enrolled with Amerigroup

• Services must be rendered on or after the due date in accordance with federal EPSDT and state Department of Health guidelines; in accordance with these guidelines, services received prior to the specified schedule date do not fulfill EPSDT requirements

• This list is generated 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 the Amerigroup Claims department at:

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

**Blood Lead Testing Requirements**

During every well-child visit for children between the ages of 6 months and 6 years, the PCP should screen each child for lead poisoning. Amerigroup requires all PCPs to test for high blood lead levels in accordance with Centers for Medicare & Medicaid Services (CMS) requirements. These requirements state that all Medicaid enrollees must have a blood lead test performed at 12 months and 24 months of age to determine lead exposure and toxicity. In addition, children over the age of 24 months, up to
72 months, should receive a blood lead test if there is no past record of a test. Please see blood lead risk forms located in Appendix A — Forms.

We encourage providers to contact Medtox to receive supplies to test children’s blood lead levels in their offices. With a simple finger prick and a drop of blood on the filter paper from Medtox, the member will not have to go to another provider/lab to have the services done. Once you return the sample by mail, Medtox will send you the results and bill Amerigroup for the test.

For those children who have a blood level greater than or equal to 10, continued testing is required until the blood level is below 10.

**Vaccines for Children for Medicaid Recipients**

The VFC program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of an inability to pay. VFC was created by the Omnibus Budget Reconciliation Act of 1993 as an entitlement program to be a required part of each state’s Medicaid plan. The program was officially implemented in October 1994.

Funding for the VFC program is approved by the Office of Management and Budget and allocated through CMS to the Centers for Disease Control and Prevention (CDC). CDC buys vaccines at a discount and distributes them to grantees (i.e., state health departments and certain local and territorial public health agencies) that then distribute them at no charge to those private physicians’ offices and public health clinics registered as VFC providers.

Children who are eligible for VFC vaccines are entitled to receive pediatric vaccines recommended by the ACIP.

Amerigroup requires our providers to participate in the VFC program and have sufficient vaccine supplies. For additional information on the VFC program, visit cdc.gov/vaccines/programs/vfc/default.htm.

**Family Planning Services**

Members have direct access to both network and non-network providers for all family planning services, including exams, assessments and traditional contraceptive devices. Services are not covered for members under the age of 18 unless they are married, a parent, pregnant or will suffer health hazards if services are not provided. FHK coverage of family planning is limited to one annual visit and one visit for a supplier every 90 days.

**Smoking Cessation Program**

Amerigroup requires all providers to discuss smoking cessation options with their patients who smoke. Our Smoking Cessation program is designed to help members find the best way for them to quit smoking and stay smoke-free. We offer members a variety of resources and services free of charge. The program has many options to choose from, including:

- Community classes — A listing of classes taught in the community
• Phone counseling — Free phone counseling in which trained health coaches work with members over the phone to identify a personalized cessation method that focuses on behavior and lifestyle issues
• Prescription benefits

Resources and Tools
The Florida Quitline is a toll-free telephone-based tobacco use cessation service. Any person living in Florida who wants to try to quit smoking can use the Quitline. The following services are available through the Quitline:
• Counseling sessions
• Self-help materials
• Counseling and materials in English and Spanish
• Translation service for other languages
• Pharmacotherapy assistance
• TDD service for the deaf or hard of hearing

Online Resources
• A cravings journal, medicines to help members quit and other resources are available at smokefree.gov
• Pathways to Freedom for African Americans is online at smokefree.gov
• Guía para Dejar de Fumar is a Spanish resource at smokefree.gov
• The American Lung Association’s Freedom from Smoking Program is offered online at ffsonline.org
• More quitting resources are online at quitnet.com
• Support to quit is offered through quitsmokingsupport.com
• Information about why to quit and how to get help can be found at cancer.gov/cancertopics/factsheet/tobacco/cessation

Online Continuing Education for Physicians
Providers can receive continuing education training online through these resources:
• MAHP Oral Health and Tobacco Cessation Educational Program for Primary Care Providers
• Treating Tobacco Use and Dependence through the Wisconsin Medical School
• www.medscape.com
• Tobaccocme.com, which offers programs for general medicine, pediatrics and OB/GYN providers
• www.tobaccofreepatients.com
• Tobacco Cessation Podcasts for Physicians

Printed Resources for Members
We offer the following printed resources you can share with members:
• You Can Quit Smoking flier
• Tobacco Use — Breaking the Habit Ameritip
• Tobacco Use – Reasons to Quit Ameritip

Printed Resources for Providers
• Quick Reference Guide: Treating Tobacco Use and Dependence
All member materials are available on the member website, and provider materials can be accessed through the provider website.

**Audiology Services**

Amerigroup provides the following audiology services:

<table>
<thead>
<tr>
<th>Code/Mod</th>
<th>Description</th>
<th>Unit</th>
<th>Length</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5090</td>
<td>Dispensing fee, unspecified hearing aid</td>
<td>1 handling</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92557</td>
<td>Comprehensive audiology threshold evaluation and speech recognition (92553 and 92556 combined)</td>
<td>1 evaluation</td>
<td>1 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92590</td>
<td>Hearing aid examination and selection; monaural</td>
<td>1 evaluation</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>V5011</td>
<td>Fitting/orientation/checking of hearing aid</td>
<td>1 orientation</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>V5275/RT</td>
<td>Ear impression, each — right</td>
<td>1 ear mold</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>V5275/LT</td>
<td>Ear impression, each — left</td>
<td>1 ear mold</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92557/52</td>
<td>Comprehensive audiology threshold evaluation and speech recognition (92553 and 92556 combined)</td>
<td>1 re-evaluation</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92592</td>
<td>Hearing aid check; monaural</td>
<td>1 analysis</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92592/52</td>
<td>Hearing aid recheck; monaural</td>
<td>1 recheck</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92552</td>
<td>Pure tone audiometry (threshold); air only</td>
<td>1 test</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92567</td>
<td>Tympanometry (impedance testing)</td>
<td>1 test</td>
<td>6 every 12 months</td>
<td></td>
</tr>
<tr>
<td>92587</td>
<td>Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)</td>
<td>1 test</td>
<td>No limit</td>
<td></td>
</tr>
<tr>
<td>92588</td>
<td>Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)</td>
<td>1 test</td>
<td>No limit</td>
<td></td>
</tr>
<tr>
<td>92585</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</td>
<td>1 test</td>
<td>No limit</td>
<td></td>
</tr>
<tr>
<td>92585/52</td>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</td>
<td>1 test</td>
<td>No limit</td>
<td></td>
</tr>
<tr>
<td>92584</td>
<td>Electrocochleography</td>
<td>1 test</td>
<td>1 per implant</td>
<td></td>
</tr>
<tr>
<td>92626</td>
<td>Evaluation of auditory rehabilitation status; first hour</td>
<td>1 test</td>
<td>10 per year</td>
<td></td>
</tr>
</tbody>
</table>

**Outpatient Laboratory and Radiology Services**

All outpatient laboratory tests should be performed at a network facility outpatient lab or at one of the Amerigroup preferred network labs (LabCorp or Quest Diagnostics) unless the test is a Clinical Laboratory Improvement Amendments (CLIA)-approved office test. Visit the CMS website at cms.hhs.gov for a complete list of approved accreditation organizations under CLIA. MedSolutions provides diagnostic radiology management services and will precertify CAT scans, MRA, MRI, nuclear cardiology and PET scans. Contact MedSolutions at 1-888-693-3211 or www.medsolutionsonline.com for more information.

**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.

**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. To prescribe medications that do not appear on the PDL, please contact Pharmacy Services at 1-800-454-3730. Please refer to the PDL on our website at providers.amerigroup.com/FL.

**Prior Authorization Drugs**
Providers are strongly encouraged to write prescriptions for preferred products as listed on the PDL. If a member cannot use a preferred product as a result of a medical condition, 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. 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.)

**Over-The-Counter Drugs**
Amerigroup provides coverage of several OTC drugs when accompanied by a prescription. The following are examples of covered OTC medication classes:

- Analgesics/antipyretics
- Antacids
- Antibacterials, topical
- Antidiarrheals
- Antiemetics
- Antifungals, topical
- Antifungals, vaginal
- Antihistamines
- Contraceptives
- Cough and cold preparations
- Decongestants
- Laxatives
- Pediculocides
- Respiratory agents (including spacing devices)
- Topical anti-inflammatories

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

- Weight control
- 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

**Informed Consent for Psychotherapeutic Medications for Children**
Pursuant to F.S.A. 409.912(51), the Agency for Health Care Administration (ACHA) may not pay for a psychotropic medication prescribed for a child in the Medicaid program without the express and informed consent of the child's parent or legal guardian. The physician shall document the consent in the child’s medical record and provide the pharmacy with a signed attestation of this documentation with the prescription.
The psychotherapeutic drugs affected are antipsychotics, antidepressants, anti-anxiety medications and mood stabilizers. Anti-convulsants and ADHD medications (i.e., stimulants and nonstimulants) are not included at this time. Consent forms are available at ahca.myflorida.com/medicaid/prescribed_drug/med_resource.shtml.

**Behavioral Health Services**

**Overview**
Pursuant to the Amerigroup contract with AHCA and the state MMA plan, Amerigroup will provide coverage for a full range of behavioral health care services (i.e., treatment for psychiatric and emotional disorders), including community mental health services and mental health targeted case management services to all members in contracted counties. Amerigroup will provide coverage of mental health and alcohol and drug treatment for Florida Healthy Kids members residing in the counties in which Amerigroup participates as part of the member’s behavioral health benefit.

**Primary and Specialty Services**
PCPs are encouraged to screen members for behavioral health and alcohol and drug abuse conditions as a part of the initial assessment or whenever there is a suspicion that a member may have a behavioral health condition.

A PCP can offer covered behavioral health and/or alcohol and drug abuse services when:
- Services are within the scope of the PCP’s license
- The member’s current condition is not so severe, confounding or complex as to warrant a referral to a mental health and alcohol and drug abuse provider
- The member is willing to be treated by the PCP
- Services are within the scope of the benefit plan

PCPs are encouraged to educate members with behavioral health and/or alcohol and drug abuse conditions about the nature of the condition and its treatment. As appropriate, PCPs are also encouraged to educate members about the relationship between physical and behavioral health and alcohol and drug abuse conditions.

**Referral for Mental Health and Alcohol and Drug Abuse Conditions**
Members may self-refer, or providers may direct members to the Amerigroup network of behavioral health care providers.

Experienced behavioral health care clinicians are available 24 hours a day, 7 days a week by calling the Provider Inquiry Line (1-800-454-3730) to assist with identifying the closest and most appropriate behavioral health service.
Behavioral Health Claims
Paper behavioral health claims can be submitted to the following address:

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

Electronic behavioral health claims may be submitted through the Amerigroup contracted clearinghouses. To initiate the electronic claims submission process or obtain additional information, please contact the Amerigroup Electronic Data Interchange (EDI) Hotline at 1-800-590-5745.

Behavioral Health Emergency Services
Behavioral health emergency services are those services that are required to meet the needs of an individual who is experiencing an acute crisis resulting from a mental illness, which is at a level of severity that would meet the requirements for involuntary examination pursuant to Section 394.463, F.S., and who, in the absence of a suitable alternative or psychiatric medication, would require hospitalization.

Examples of behavioral health and alcohol and drug abuse emergency medical conditions are when:
- The member is suicidal
- The member is homicidal
- The member is violent with objects
- The member has suffered a precipitous decline in functional impairment and is unable to take care of his or her activities of daily living
- The member is alcohol- or drug-dependent and there are signs of severe withdrawal

In the event of a behavioral health and/or alcohol and drug abuse emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or behavioral health and alcohol and drug abuse crisis service facility. An emergency dispatch service or 911 should be contacted in the event that the member is a danger to self or others and is unable to go to an emergency setting.

Behavioral Health Medically Necessary Services
Amerigroup defines medically necessary behavioral health services as those that are:
- Reasonably expected to prevent the onset of an illness, condition or disability; reduce or ameliorate the physical, behavioral or developmental effects of an illness, condition, injury or disability; and assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the member and those functional capacities appropriate for members of the same age
- Reasonably expected to provide an accessible and cost-effective course of treatment or site of service that is equally effective in comparison to other available, appropriate and substantial alternatives and is no more intrusive or restrictive than necessary
- Sufficient in amount, duration and scope to reasonably achieve their purpose as defined in federal law
- Of a quality that meet standards of medical practice and/or health care generally accepted at the time services are rendered
Behavioral Health Coordination of Care
Amerigroup, through its contracted providers and case management services, will be responsible for the coordination and active provision of continuity of care for all members. Appropriate and timely sharing of information is essential when the member is receiving psychotropic medications or has a new or ongoing medical condition. Additionally, if applicable, Amerigroup will coordinate medical and behavioral health services.

The exchange of medical information facilitates behavioral and medical health care collaboration. For example, if the PCP obtains the member’s consent via the authorization for release of information form, the form is completed and sent to the behavioral health care provider. The behavioral health care provider may use the release, as necessary, for the administration and provision of care.

Amerigroup providers are mandated to utilize the Functional Assessment Rating Scale (FARS) and Children’s Functional Assessment Rating Scale (CFARS), which are the outcome measures used by the state of Florida for Medicaid providers. CFARS are administered for patients ages 6 to 17 and FARS are administered for patients ages 18 and older. FARS/CFARS assessments are required to be completed at admission, every 6 months after admission (as long as the member remains a patient) and at discharge.

A FARS/CFARS should not be completed for members who (1) only receive a one-time assessment service and are immediately discharged or (2) are served in medication-only settings. Additionally, FARS is not required when a member is admitted and discharged from a crisis stabilization unit. Changes to any other level of service will require administration of the FARS.

Free Training and Certification Websites
Note that only staff with certification should be providing assessment services. Free trainings are available online:
- CFARS: https://samh-fars.dcf.state.fl.us/cfars/cfars_home.aspx
- FARS: https://samh-fars.dcf.state.fl.us/fars/fars_home.aspx

The behavioral health care provider should note contacts and collaboration efforts in the member’s chart as well as determine whether referral assistance is needed for the member for noncovered services.

When the member has seen a behavioral health care provider, that provider should send a copy of a completed coordination of care and treatment summary form to both Amerigroup and the member’s PCP. This form is available on our website at providers.amerigroup.com/FL.

If a PCP refers a member to a contracted behavioral health care provider, the PCP will fax a copy of a completed coordination of care and treatment summary form to the designated behavioral health care fax number at 1-800-505-1193 and to the behavioral health care provider.

The behavioral health care provider will send initial and quarterly (or more frequently if clinically indicated) summary reports of the member’s behavioral health status to the member’s PCP. The PCP will be contacted if there is a change in the behavioral health treatment plan. The PCP will contact the behavioral health care provider and document the information on the coordination of care and treatment summary form if the member’s medical condition could reasonably be expected to affect the member’s mental health treatment planning or outcome.
Self-referral Services

The following services do not need a referral from a PCP:

- Emergent care (regardless of network status with Amerigroup)
- Family planning (regardless of network status with Amerigroup)
- Behavioral health assessments (nonparticipating providers must seek prior approval from Amerigroup)
- OB care (nonparticipating providers must seek prior approval from Amerigroup)
- Well-woman/GYN care (nonparticipating providers must seek prior approval from Amerigroup)
- EPSDT/Well-child services (nonparticipating providers must seek prior approval from Amerigroup)
- Tuberculosis, STD, HIV/AIDS testing and counseling services (regardless of network status with Amerigroup)

Member Rights and Responsibilities

Florida law requires that providers or health care facilities recognize the rights of members while they are receiving medical care and that members respect the health care provider’s or health care facility’s right to expect certain behavior on the part of members. Members may request a copy of the full text of this law from their health care provider or health care facility. The following is a summary of the member’s rights and responsibilities. See Section 381.026, Florida Statutes

Patients’ Rights

Patients have a right to:

- Be treated with respect and with due consideration for dignity and privacy
- A prompt and reasonable response to questions and requests
- Know who is providing medical services and who is responsible for their care; know what member support services are available, including whether an interpreter is available if they don’t speak English
- Know what rules and regulations apply to their conduct
- Receive information on available treatment options and alternatives, presented in a manner appropriate to their conditions and ability to understand; members are given the opportunity to be involved in decisions involving their health care, except when such participation is contraindicated (not recommended) for medical reasons
- Participate in decisions regarding their health care, including the right to refuse treatment
- Be given health care services in line with federal and state regulations
- Be given, upon request, full information and necessary advice of available financial help for their care
- Receive, upon request, before treatment, a reasonable estimate of charges for medical care
- Receive a copy of a reasonably clear and easy-to-understand itemized bill and, upon request, to have the charges explained
- Impartial access to medical treatment or accommodations, no matter of race, national origin, religion, physical handicap or source of payment
- Treatment for any emergency medical condition that will get worse from not getting the proper treatment
- Know if medical treatment is for experimental research and to give your or refusal to be involved in that research
• File grievances regarding any violation of their rights, as states in Florida law, through the grievance procedure to the health care provider or health care facility that served them and to the appropriate state licensing agency
• Be free from any form of restraint (control) or seclusion used as coercion (force), discipline, convenience or retaliation (revenge)
• Ask for and get a copy of their medical records and ask that those records be updated or corrected

Also, the state must make sure you’re able to use your rights and those rights do not change the way Amerigroup and its providers or the state agency treat you

Patients’ Responsibilities
Patients have the responsibility to:
• Provide their health care provider, to the best of their knowledge, correct and complete information about present complaints, past illnesses, hospitalizations, medications (including over-the-counter products), dietary supplements, any allergies or sensitivities, and other matters relating to their health
• Report unexpected changes in their conditions to their health care providers
• Report to their health care providers whether they understand a planned action and what is expected of them
• Follow the treatment plan recommended by the health care provider
• Keep appointments and, when not able to for any reason, tell the health care provider or health care facility
• Understand their actions if they refuse treatment or don’t follow the health care provider’s instructions
• Inform their providers about any living wills, medical powers of attorney or other directives that could change their care
• Make sure the needs of their health care are met as quickly as possible
• Follow health care facility rules and regulations about member care and conduct
• Behave in a way that is respectful of all health care providers and staff, as well as of other members

First Line of Defense Against Fraud
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 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.

Amerigroup policy on 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 amerigroup.com/about-amerigroup/ethics.

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 online at
amerigroup.silentwhistle.com. In addition to anonymous reporting, suspected fraud, waste and abuse may also be sent via email to corpinvest@amerigroup.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 (CCO) at 757-473-2711 or via email to ethics.integry@amerigroup.com.

To report suspected fraud or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx. If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Inspector General’s Fraud Rewards Program. You can call the Inspector General’s office at 850-414-3990 or toll free at 1-866-866-7226. The reward may be up to 25 percent of the amount recovered or a maximum of $500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General’s office about keeping your identity confidential and protected.

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 member or contractor who works 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 CCO.

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 crackdown 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, waste 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 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 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 ID 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 ID.

Providers should take measure 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 at all times, and report any lost or stolen cards 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 or abuse and working with members to protect their Amerigroup ID cards 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, emailing corpinvest@amerigroup.com or contacting the Amerigroup Chief Compliance Officer. An anonymous report also can be made by visiting amerigroup.silentwhistle.com. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and 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 providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Contracted providers must have the following procedures implemented to demonstrate compliance with the HIPAA privacy regulations.

We recognize our 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 an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

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

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, post office box or department at Amerigroup.

The Amerigroup voicemail system is secure and password-protected. When leaving messages for Amerigroup associates, 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, national provider identifier or Amerigroup provider ID.
MEMBER MANAGEMENT SUPPORT

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

Amerigroup, through our participating providers, 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 Primary Care Provider (PCP) should make every effort to schedule Amerigroup members for appointments using the guidelines outlined in the PCP Access and Availability section.

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 1-866-864-2544 (English)/1-866-864-2545 (Spanish) and is 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 based upon nationally recognized and accepted guidelines
- Free translation services for 150 different languages and for members that are deaf or hard of hearing
- Education for members regarding appropriate alternatives for handling nonemergent medical conditions
- Faxing of the member’s assessment report by a nurse to the provider’s office within 24 hours of receipt of a call

Interpreter Services

Interpreter services are available if needed. Contact the Amerigroup Provider Services department at the National Customer Care department at 1-800-454-3730.
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, and health education classes are available through Amerigroup-contracted community organizations and network providers that are contracted with Amerigroup.

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

- A newsletter to members at least once a year
- Creation and distribution of Ameritips, an Amerigroup health education tool used to inform members of health promotion issues and topics
- Health Tips on Hold, which are educational telephone messages that play 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 to enhance opportunities for members
- Available community resources via the Amerigroup website at www.myamerigroup.com/FL

Case Management

Case Management is designed to proactively respond to a member’s needs when conditions or diagnoses require care and treatment for long periods of time. When a member is identified (usually through precertification, admission review, and/or provider or member request), the Amerigroup nurse helps to identify medically appropriate alternative methods or settings in which care may be delivered.

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

- Intensity level of case 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 the member and PCP)

The Amerigroup clinician will assist the member, utilization review team, and PCP and/or 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.

Please note, an Amerigroup case manager cannot perform services that are limited to providers such as overriding the need to prior authorize prescription medications.
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 include but are not limited to:

- 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

- Uses proactive population identification processes
- Based on evidence-based national practice guidelines
- Based on collaborative practice models to include physician and support-service providers in treatment planning for members
- Offers 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
- Offers ongoing process and outcomes measurement, evaluation and management
- Offers ongoing communication with providers regarding patient status

Amerigroup DM programs are based on nationally approved clinical practice guidelines located at providers.amerigroup.com/FL. Simply access the Florida website and log in to the secure site by entering your login name and password. At the top of the page, select Clinical Policy & Guidelines and then Clinical Practice Guidelines. A copy of the guidelines can be printed from the website, or you can contact Provider Services at 1-800-454-3730 to receive a printed copy.

Who is Eligible?

All members with the above conditions/diagnoses are eligible for DMCCU services. Members are identified through continuous case finding efforts that include but are not limited to continuous case finding, welcome calls, claims mining and referrals.
**DMCCU Provider Rights and Responsibilities**
The provider has the right to:

- Have information about Amerigroup, including provided programs and services, our staff, and our staff’s qualifications and any contractual relationships
- Decline to participate in or work with the Amerigroup programs and services for his or her patients, depending on contractual requirements
- Be informed of how Amerigroup coordinates our interventions with treatment plans for individual patients
- Know how to contact the person responsible for managing and communicating with the provider’s patients
- Be supported by the organization to make decisions interactively with patients regarding their health care
- Receive courteous and respectful treatment from Amerigroup staff
- Communicate complaints regarding DMCCU as outlined in the Amerigroup Provider Complaint and Grievance Procedure

**Hours of Operation**
Amerigroup 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.

**Contact Information**
Please call 1-888-830-4300 to reach a care manager. Additional information about disease management can be obtained by visiting providers.amerigroup.com/FL. Select Patient & Medical Support and then click on the link for Disease Management (DMCCU). Members can obtain information about our DMCCU by visiting www.myamerigroup.com or calling 1-888-830-4300.

**Health Education Advisory Committee**
The Health Education Advisory Committee provides advice to Amerigroup regarding health education and outreach program 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
- Assist the health plan in decision-making in the areas of member grievances, marketing, member services, case management, outreach, health needs and cultural competency
- 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
WIC Program
The Women, Infants and Children (WIC) program impacts the health of mothers and children in the medically needy population. Optimal nutritional status during pregnancy and early childhood provides the best chance for the future of Floridians.

Medicaid recipients eligible for WIC benefits include the following classifications:
- Pregnant women
- Women who are breast-feeding infant(s) up to one year postpartum
- Women who are not breast-feeding up to six months postpartum
- Infants under the age of 1
- Children under the age of 5

Network providers are expected to coordinate with the WIC program. Coordination includes referral to the local WIC office for all infants and children up to age 5 and pregnant, breast-feeding and postpartum women.

WIC Referrals
Amerigroup providers are required to refer all infants and children up to age 5 and pregnant, breast-feeding and postpartum women to the local WIC office. Providers are required to send WIC:
- A completed Florida WIC program medical referral form (located in the form section of Appendix A) with the current height or length and weight (taken within 60 calendar days of the WIC appointment)
- Hemoglobin or hematocrit
- Any identified medical and/or nutritional problems

For each subsequent WIC certification, providers are required to coordinate with the local WIC office to provide the above referral data from the most recent Child Health Check-Up (CHCUP). Each time you complete the WIC referral form, providers are required to give a copy to the enrollee and keep a copy in the patient’s medical record.

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. For more information, please visit doh.state.fl.us/family/wic.

Pregnancy-related Requirements
Prenatal Risk Screening
Providers seeing Amerigroup members for pregnancy-related diagnoses must:
- See the pregnant member within 30 days of enrollment
- Complete Florida’s Healthy Start prenatal risk screening to each pregnant member as part of her first prenatal visit as required by Section 383.14, F.S., Section 381.004, F.S., and 64C-7.009, F.A.C.
  - Use the Department of Health prenatal risk form (DH Form 3134), which can be obtained from the local County Health Department (CHD)
  - Retain a copy of all documentation of Healthy Start screenings, assessments, findings and referrals in the enrollees’ medical records
  - Submit the completed DH Form 3134 to the CHD in the county in which the prenatal screen was completed within 10 business days of completion
• Collaborate with the Healthy Start care coordinator within the member’s county of residence to assure risk-appropriate care is delivered

• Pregnant members or infants who do not score high enough to be eligible for Healthy Start care coordination may be referred for services, regardless of their score on the Healthy Start risk screen, in the following ways:
  − If the referral is to be made at the same time the Healthy Start risk screen is administered, the provider may indicate on the risk screening form that the member or infant is invited to participate based on factors other than score
  − If the determination is made subsequent to risk screening, the provider may refer the enrollee or infant directly to the Healthy Start care coordinator based on assessment of actual or potential factors associated with high risk, such as HIV, hepatitis B, substance abuse or domestic violence

Infant Risk Screening
Providers must complete the Florida Healthy Start infant (postnatal) risk screening instrument (DH Form 3135) with the certificate of live birth and transmit the documents to the CHD in the county in which the infant was born within 10 business days of the birth. Providers must retain a copy of the completed DH Form 3135 in the patient’s medical record and provide a copy to the patient.

HIV Testing
Providers are required to give all women of childbearing age HIV counseling and offer them HIV testing. See Chapter 381, F.S.

• Providers, in accordance with Florida law, must offer all pregnant women counseling and HIV testing at the initial prenatal care visit and again at 28 to 32 weeks of pregnancy
• Providers must attempt to obtain a signed objection if a pregnant woman declines an HIV test. See Section 384.31, F.S. and 64D-3.019, F.A.C.
• For those women who are infected with HIV, providers are to offer and provide counseling about the latest antiretroviral regimen recommended by the U.S. Department of Health & Human Services (per the U.S. Department of Health & Human Services, Public Health Service Task Force Report titled Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States; to receive a copy of the guidelines, contact the Department of Health, Bureau of HIV/AIDS, at 850-245-4334 or visit aidsinfo.nih.gov/guidelines)

Hepatitis B Screenings
Providers are required to:

• Screen all pregnant members receiving prenatal care for the Hepatitis B surface antigen (HBsAg) during the first prenatal visit
• Perform a second HBsAg test between 28 and 32 weeks of pregnancy for all pregnant members who tested negative at the first prenatal visit and are considered high-risk for Hepatitis B infection; this test shall be performed at the same time that the other routine prenatal screenings are ordered
• Report all HBsAg-positive women to the local CHD and to Healthy Start, regardless of their Healthy Start screening score
Hepatitis B and Hepatitis B Immune Globulin Vaccines

- Infants born to HBsAg-positive members must receive Hepatitis B immune globulin and the Hepatitis B vaccine once they are physiologically stable, preferably within 12 hours of birth, and complete the Hepatitis B Maxine vaccine series according to the recommended vaccine schedule established by the Recommended Childhood Immunization Schedule for the United States.
- Providers must test infants born to HBsAg-positive members for HBsAg and Hepatitis B surface antibodies (anti-HBs) six months after the completion of the vaccine series to monitor the success or failure of the therapy.
- Providers must report to the local CHD a positive HBsAg result in any child 24 months or younger within 24 hours of receipt of the positive test results.
- Providers must refer infants born to members who are HBsAg-positive to Healthy Start regardless of their Healthy Start screening scores.

Testing Positive for Hepatitis B

Providers are required to:

- Report to the perinatal Hepatitis B prevention coordinator at the local CHD all prenatal or postpartum patients who test HBsAg-positive.
- Report said patients’ infants and contacts to the perinatal Hepatitis B prevention coordinator at the local CHD.
- Report the following information: name, date of birth, race, ethnicity, address, infants, contacts, laboratory test performed, date the sample was collected, the due date or EDC, whether or not the enrollee received prenatal care, and immunization dates for infants and contacts.
- Use the perinatal Hepatitis B case and contact report (DH Form 1876) for reporting purposes.

Providers are required to provide the most appropriate and highest level of quality care for pregnant members, including but not limited to the following:

- Prenatal care
  - Complete a pregnancy test and a nursing assessment with referrals to a physician, physician assistant or advanced registered nurse practitioner for comprehensive evaluation.
  - Complete case management through the gestational period according to the needs of the member.
  - Ensure any necessary referrals and follow-up.
  - Schedule return prenatal visits at least every four weeks until week 32, every two weeks until week 36 and every week thereafter until delivery unless the member’s condition requires more frequent visits.
  - Contact those members who fail to keep their prenatal appointments as soon as possible and arrange for their continued prenatal care.
  - Assist members in making delivery arrangements if necessary.
  - Screen all pregnant members for tobacco use and make available to pregnant members smoking cessation counseling and appropriate treatment as needed.

- Nutritional assessment/counseling — Providers are required to:
  - Supply nutritional assessment and counseling to all pregnant members.
  - Ensure the provision of safe and adequate nutrition for infants by promoting breast-feeding and the use of breast milk substitutes.
  - Offer a mid-level nutrition assessment.
- Provide individualized diet counseling and a nutrition care plan by a public health nutritionist, a nurse or a physician following the nutrition assessment
- Keep documentation of the nutrition care plan in the medical record by the person providing counseling

**Obstetrical delivery** — Amerigroup has developed and uses generally accepted and approved protocols for both low-risk and high-risk deliveries, which reflect the highest standards of the medical profession, including Healthy Start and prenatal screening; and requires all providers use these protocols:
- Providers must document preterm delivery risk assessments in the enrollee’s medical record by the 28th week
- If the provider determines that the member’s pregnancy is high-risk, the provider’s obstetrical care during labor and delivery must include preparation by all attendants for symptomatic evaluation and as the member progresses through the final stages of labor and immediate postpartum care

**Newborn care** — Providers are required to supply the highest level of care for the newborn beginning immediately after birth. Such level of care shall include but not be limited to the following:
- Instilling prophylactic eye medications into each eye of the newborn
- When the mother is Rh-negative, securing a cord blood sample for type Rh determination and direct Coombs testing
- Weighing and measuring the newborn
- Examining the newborn for abnormalities and/or complications
- Administering 0.5 mg of vitamin K
- Calculating an Apgar score
- Assessing any other necessary and immediate need for referral in consultation with a specialty physician, such as the Healthy Start (postnatal) infant screen
- Administering any necessary newborn and infant hearing screenings, must be conducted by a licensed audiologist pursuant to Chapter 468, F.S.; a physician licensed under Chapters 458 or 459, F.S.; or an individual who has completed documented training specifically for newborn hearing screenings and who is directly or indirectly supervised by a licensed physician or a licensed audiologist

**Postpartum care** — The provider is required to:
- Administer a postpartum examination for the member between 21 and 56 days post delivery
- Supply voluntary family planning, including a discussion of all methods of contraception as appropriate
- Ensure eligible newborns are enrolled with Amerigroup and that continuing care of the newborn is provided through the CHCUP program component
Healthy Start Program

Healthy Start is a national program that provides comprehensive developmental services for pregnant women, infants and preschool children ages 3 to 5. We collaborate with community Healthy Start programs to provide timely and age-appropriate health screening and referrals for routine health services.

- Amerigroup provides each member with a community-based PCP
- Amerigroup encourages Healthy Start staff to refer 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
- Amerigroup encourages physical exams in accordance with the CHCUP 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 managers and Health Promotion staff coordinate the delivery of services for children and work with their caretakers to eliminate barriers to timely health care

Local Health Department

Amerigroup work collaboratively with local health departments. Members have access to any county health department without authorization for the following services:

- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases, such as tuberculosis and HIV
- Immunizations
- Family planning services and related pharmaceuticals
- School health services listed above and services rendered on an urgent basis by such providers
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 and family’s initial contact point when accessing health care. The PCP 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 and family’s special and 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 for 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.

Providers’ Bill of Rights

Each health care provider who contracts with the Florida Agency for Health Care Administration (AHCA) and/or Florida Healthy Kids or subcontracts with Amerigroup to furnish services to members will be assured of the following rights:

- To advise or advocate (within the lawful scope of practice) on behalf of a member who is his or her patient, for the following:
  - The member’s health status, medical care or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs in order to decide among all relevant treatment options
  - The risks, benefits and consequences of treatment or nontreatment
  - The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions
- To receive information on the grievance, appeal and fair hearing procedures
- To have access to the Amerigroup policies and procedures covering the authorization of services
- To be notified of any decision by Amerigroup to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested
- To challenge, on behalf of Medicaid members, the denial of coverage of or payment for medical assistance
- To be free from provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- To be free from discrimination for participation, reimbursement or indemnification when acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification
Responsibilities of the PCP

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing it himself or herself or by referral to the appropriate provider of care within the network. FQHCs health and RHCs may be included as PCPs. Some of the PCP’s responsibilities are listed below:

- All Florida Healthy Kids PCPs must be board-certified pediatricians or family practice physicians.
- All PCPs must provide coverage 24 hours a day, 7 days a week, and regular hours of operation must be clearly defined and communicated to members.
- All PCPs must provide services ethically and legally in a culturally competent manner and meet the unique needs of members with special health care requirements.
- The PCP is the coordinator of all care. Therefore, the PCP agrees to ensure continuity of care to Amerigroup members and arrange for the provision of services when the PCP’s office is not open. Documentation of emergency room visits, hospital discharge summaries or operative reports are to be obtained by the PCP and maintained in the medical record.
- The PCP agrees to practice in his or her profession ethically and legally, provide all services in a culturally competent manner, accommodate those with disabilities, and not discriminate against anyone based on his or her health status.
- The PCP must conduct a health assessment of all new enrollees within 90 days of the effective date of enrollment.
- When clinically indicated, the PCP agrees to contact Amerigroup members regarding appropriate follow-up of identified problems and abnormal laboratory, radiological or other diagnostic findings.
- The PCP must establish office procedures to facilitate the follow-up of member referrals and consultations. The PCP is responsible for obtaining and maintaining in the medical record the results or findings of consultant referrals. If findings were communicated through telephonic consultation, a summary of the findings and name of the specialist must be documented.
- The PCP must participate in any system established by Amerigroup to facilitate the sharing of medical records (subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor’s consultation, examination and drugs for STDs in accordance with Section 384.30 (2), F.S.).
- The PCP agrees, when the need arises, to contact Amerigroup regarding interpretive services via AT&T or other service for members who may require language assistance.
- If a new PCP is added to a group, Amerigroup must approve and credential the provider before the provider may treat members. Notification of changes in the provider staff is the responsibility of the provider’s office and must be communicated to Amerigroup in writing.
- The PCP agrees to participate and cooperate with Amerigroup in quality management, utilization review, continuing education and other similar programs established by Amerigroup.
- The PCP agrees to participate in and cooperate with the Amerigroup grievance and appeal procedures when Amerigroup notifies the PCP of any member complaints or grievances.
- Balance billing for a covered service is not permitted. A member can only be billed for applicable copayments if the copayment was not collected at the time the service was rendered.
• In the event that a PCP agreement with Amerigroup is terminated, the PCP must continue care in progress during and after the termination period for up to six months until a provision is made by Amerigroup for the reassignment of members. Pregnant members can continue receiving services through postpartum care. Payment for covered services under this continuity of care period will be made in accordance with the rates effective in the provider’s participating agreement at the time of termination.

• The PCP may opt to go bare but must follow the requirements under the Florida Statute 458.320.

• The PCP must comply with all applicable federal and state laws regarding the confidentiality of member records.

• The PCP must certify to Amerigroup whether his or her active member load exceeds 3,000 during the recredentialing process.

• The PCP agrees to develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.

• The PCP agrees to establish appropriate policies and procedures to fulfill obligations under the Americans with Disabilities Act (ADA).

• The PCP agrees to support and cooperate with the Amerigroup Quality Management Program to provide quality care in a responsible and cost-effective manner.

• The PCP agrees to provide HIV counseling and offer HIV testing to all members of childbearing age.

• The PCP agrees to refer pregnant women or infants to Healthy Start and WIC Children programs within 30 days of enrollment.

• The PCP agrees to provide counseling and education in support of Medicaid quality and benefit enhancement (QBE) services, which include children’s programs, domestic violence, pregnancy prevention (including abstinence), prenatal/postpartum care, smoking cessation and substance abuse programs. The PCP agrees to include information on the programs and community resources encouraged by Amerigroup.

• The PCP agrees to provide counseling and offer the recommended antiretroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs, regardless of their screening scores.

• The PCP agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the PCP agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.

• The PCP agrees to inform Amerigroup if he or she objects to the provision of any counseling, treatments or referral services on religious grounds.

• The PCP agrees to treat all members with respect and dignity, provide them with appropriate privacy, and treat members’ disclosures and records confidentially, giving members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws.

• The PCP agrees to provide members with complete information concerning their diagnosis, evaluation, treatment and prognosis and give members the opportunity to participate in decisions involving their health care, regardless of whether members have completed an advance directive, except when contraindicated for medical reasons.

• The PCP agrees to an adequate and timely communication among providers and the transfer of information when members are transferred to other health care providers. The PCP agrees to obtain a signed and dated release allowing for the release of information to Amerigroup and other providers involved in the member’s care.
The PCP agrees to physically screen members taken into the protective custody, emergency shelter or foster care programs by the Department of Children and Families (DCF) within 72 hours or immediately if required.

The PCP must ensure food snacks or services provided to members meet their clinical needs and are prepared, stored, secured and disposed of in compliance with local health department requirements.

The PCP agrees that provisions will be made to minimize sources and transmission of infection in the office.

The PCP agrees to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality member care.

The PCP agrees that any notation in a member’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research will be clearly contrasted with entries regarding the provision of nonresearch-related care.

The PCP is required to participate with Florida’s Immunization Registry (SHOTS).

The PCP agrees to provide immunization information to the DCF upon receipt of members’ written permission and DCF’s request for members requesting temporary cash assistance from the DCF.

The PCP agrees to attempt to obtain medical records on any member(s) receiving services from a non-network provider with the proper release specific to any diagnosis signed by the member. These services include, but are not limited to, family planning, preventive services and sexually transmitted diseases.

The PCP agrees to maintain vaccines safely and in accordance with specific guidelines, to provide member immunizations according to professional standards, and to maintain up-to-date member immunization records.

The PCP for Medikids members must bill Amerigroup for reimbursement of the vaccine administration fee on the administration code(s). The PCP must also bill the serum code(s) along with the administration code(s). To obtain reimbursement for the vaccine serum, Medicaid fee-for-service should be billed.

The PCP seeing Medicaid members must participate in the Vaccines for Children (VFC) program.

The PCP for Medicaid members must use the VFC supply and bill Amerigroup for the administrative fee only. The VFC program covers children from birth to 18 years of age. Florida Medicaid requires vaccines for Medicaid children from birth through 20 years of age. Members 19 through 20 years of age should receive their vaccinations from their PCP.

The PCP for Florida Healthy Kids members should use his or her own vaccine supply and bill Amerigroup for the vaccine and administrative fee. PCPs for FHK will be enrolled in the Florida State Health Online Tracking System (SHOTS) statewide registry. Providers should bill Medicaid fee-for-service directly for immunizations provided to Title XXI MediKids participants.

It is important that PCPs avoid sending Amerigroup members to local health departments for immunizations. Amerigroup Florida Healthy Kids members are required to receive their immunizations from their PCPs to ensure continuity of care, timeliness and accurate recordkeeping.

Role of the PCP

Each Medicaid and Healthy Kids member will select or be assigned a PCP at the time of enrollment. Medicaid membership is limited to 1,500 members per full-time PCP and may be increased by 750 members for each Advanced Registered Nurse Practitioner (ARNP) or physician extender affiliated
with the physician, with a maximum of 3,000 active Amerigroup members. The PCP coordinates the member’s health care needs through a comprehensive network of specialty, ancillary and hospital providers.

- For new members, the provider will contact each new member within 90 days of enrollment to perform an initial health risk assessment. The provider will notify Amerigroup if he or she is unable to contact the member within the 90-day enrollment period. Amerigroup will send a release form to Medicaid members for the purpose of Amerigroup and state agency review. Once a release has been signed, the PCP will request records from previous care providers. The PCP will use the previous medical records and the health risk assessments to identify members who have not received age-appropriate preventive health screenings (Child Health Check-Ups) for children from birth through 20 years of age according to the standards established by the American Academy of Pediatrics and endorsed by AHCA. Health screenings for adults will meet Amerigroup standards, including those standards established by the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force. When external regulating agencies impose more stringent health screening standards, the PCP is required to comply with those standards.

- The PCP is responsible 24 hours a day, 7 days a week for providing or arranging all covered services, including prescribing, directing and obtaining appropriate authorizations of all care for members who have been assigned to the PCP.

- To the extent necessary, the PCP is responsible for coordinating coverage for members with an alternate Amerigroup network physician. All financial arrangements must be made between the PCP and covering physician. The PCP is also responsible for notifying Amerigroup in writing two weeks prior to his or her absence of the duration of the absence and the physician who will be providing the coverage. The covering physician must be an Amerigroup network physician.

- All PCPs and physician extenders (ARNPs, PA) must be credentialed by Amerigroup or one of the Amerigroup delegated credentialing entities. All personnel assisting in the provision of health care services to members are to be appropriately trained, qualified and supervised in the care provided.

- PCPs must notify their Provider Relations representative when a new provider joins the practice.

- Anytime a new provider joins a practice, that individual must be credentialed with the plan and cannot see members until the credentialing process is completed. Nonemergent services must not be provided by a noncredentialed physician, and such services will not be covered by Amerigroup. The PCP is responsible for the direct training and supervision of medical assistants. Duties of the medical assistant will be strictly limited to those identified in the Florida Statutes, Section 458.3485.

- All PCP facilities must have handicap accessibility, adequate space, supplies, good sanitation and fire safety procedures in operation.

- The PCP will only collect copayments from members when applicable and permitted under Florida’s Medicaid law. The PCP must not charge any member for missed appointments.

- PAs and ARNPs may not be assigned as the PCP for Amerigroup members.

**Physician Extenders**

Physician extenders (e.g., ARNPs, PAs) must be credentialed prior to seeing Amerigroup members. They must clearly and appropriately identify themselves as an ARNP or PA to the member. Office staff must appropriately refer to and identify physician extenders as ARNPs or PAs.

Supervising physicians must review, sign and date PA medical record entries within seven days in accordance with F.A.C. 64B8-30.012 (3). Record entries of ARNPs do not require cosigning.
Background Checks
Providers must complete a Level 2 criminal history background screening to determine whether their subcontractors or any employees or volunteers of their subcontractors who meet the definition of “direct service provider” have disqualifying offenses as provided for in s. 430.0402 F.S. as created and s. 435.04, F.S. Any subcontractor, employee or volunteer of a subcontractor meeting the definition of a “direct service provider” who has a disqualifying offense is prohibited from providing services to the elderly as set forth in s. 430.0402, F.S.

Abuse, Neglect and Exploitation
Report elder abuse, neglect and exploitation to the statewide Elder Abuse Hotline at 1-800-96ABUSE (1-800-962-2873).

Abuse means any willful act or threatened act by a caregiver that causes or is likely to cause significant impairment to an enrollee’s physical, mental, or emotional health. Abuse includes acts and omissions.

Exploitation of a vulnerable adult means a person who:
1. Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use a vulnerable adult’s funds, assets or property for the benefit of someone other than the vulnerable adult
2. Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult’s funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit or possession of the funds, assets or property for the benefit of someone other than the vulnerable adult

Neglect of an adult means the failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and behavioral health of the vulnerable adult, including but not limited to food, clothing, medicine, shelter, supervision and medical services that a prudent person would consider essential for the well-being of the vulnerable adult. The term neglect also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect or exploitation by others. Neglect is repeated conduct or a single incident of carelessness that produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

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. The ability of Amerigroup to provide quality access depends upon the accessibility of network providers. Providers are required to adhere to the following access standards:
<table>
<thead>
<tr>
<th>Service</th>
<th>Access Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergent or emergency visits</td>
<td>Immediately upon presentation</td>
</tr>
<tr>
<td>Urgent, nonemergency visits</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Routine visits</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Waiting time</td>
<td>Should not exceed 45 minutes for scheduled appointment of routine nature</td>
</tr>
<tr>
<td>Walk-in patients (nonurgent)</td>
<td>Seen if possible or scheduled, consistent with standards</td>
</tr>
<tr>
<td>Walk-in patients (urgent)</td>
<td>Within 48 hours</td>
</tr>
</tbody>
</table>

Providers may not use discriminatory practices such as preference to other insured or private-pay patients, separate waiting rooms, or appointment days.

Amerigroup will routinely monitor providers’ adherence to the access care standards.

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after hours by an answering service, which can contact the PCP or another designated network medical practitioner; all calls answered by an answering service must be returned within 30 minutes
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP or another provider designated by the PCP; someone must be available to answer the designated provider’s telephone; another recording is not acceptable
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Amerigroup network medical practitioner, who can return the call within 30 minutes

The following telephone answering procedures are not acceptable:

- Only answering office telephone during office hours
- Only answering office telephone after hours by a recording that tells members to leave a message
- Answering office telephone after hours by a recording that directs members to go to an emergency room for any services needed
- Returning after-hours calls outside of 30 minutes

**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. Members who miss three consecutive appointments within a six-month period may be
considered for disenrollment from a provider’s panel. Such requests must be submitted at least 60 calendar days prior to the requested effective date. 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 management as appropriate. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP. Please note that the provider agrees not to charge a member for missed appointments.

**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 of treatment, and/or making or appearing for appointments, please contact our National Customer Care department at 1-800-454-3730.

**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 National Customer Care 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 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 reason(s) for the denial of the request within one day of the decision. Specialists serving as PCPs will continue to be paid fee-for-service while serving as the member’s PCP. The designation cannot be retroactive. For further information, see the specialist as PCP request form located in the Appendix A — Forms section of this manual.

**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.

The provider can request an extended authorization by contacting the member’s PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP to complete the authorization review.

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 the PCP. 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). Should the need arise for a secondary referral, the specialist physician or other health care provider must contact Amerigroup for a coverage determination.

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 appeal process.

**Second Opinions**

A member, parent, and/or legally appointed representative or the member’s PCP may request a second opinion in any situation where 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 with
precertification from a non-network provider if there is not a network provider with the expertise
required for the condition. Once approved, the PCP will notify the member of the date and time of the
appointment and forward copies of all relevant records to the consulting provider. The PCP will notify
the member of the outcome of the second opinion.

Amerigroup may also request a second opinion at our 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 the
  plan 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 recommendation(s)
regarding further action.

Specialty Care Providers

To participate in the Medicaid managed care model, the provider must have applied for enrollment in
the Florida Medicaid and Florida Healthy Kids program and 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 specialized care for members, usually upon
appropriate referral from a PCP within the network (see Role and Responsibility of the Specialty Care
Provider section). 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 and clinical social workers (i.e., behavioral health)
- Critical care medical services
- Dermatology services
- Endocrinology services
- Gastroenterology services
- General surgery
- Hematology/oncology services
- Neonatal services
- Nephrology services
- Neurology services
- Neurosurgery services
- Ophthalmology services
- Orthopedic surgery services
- Otolaryngology services
- Perinatal services
- Pediatric services
- Psychiatry (adult) assessment services
- Psychiatry (child and adolescent) assessment services
- Trauma services
- Urology services

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

Members may self-refer to a participating specialist provider, including mental health and substance abuse providers. Obligations of the specialist include, but are not limited to, the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all Amerigroup members who self-refer or are directed to the specialist provider for care
- Submitting required claims information
- 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
- 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 will:

- 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 Fee-For-Service (FFS) basis; provide coordination necessary for referrals 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 hours 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 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
• Make reasonable efforts to communicate, coordinate and collaborate with other specialty care providers, including behavioral health providers, involved in delivering care and services to members
• 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
• Continue care in progress during and after termination of his or her contract for up to 60 days 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 regarding blood-borne pathogens in compliance with OSHA standards
• Make best efforts to fulfill the obligations under the ADA applicable to his or her practice location
• Support, cooperate and comply with the Amerigroup Quality Management 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 or 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
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</td>
</tr>
<tr>
<td>Routine visits</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Maternity care – 1st Trimester</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Maternity care – 2nd Trimester</td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Maternity care – 3rd Trimester</td>
<td>Within 3 business days</td>
</tr>
<tr>
<td>High-risk pregnancies</td>
<td>Within 3 business days</td>
</tr>
</tbody>
</table>

Open-Access Specialist Providers

Members may self-refer to the network providers listed below without a PCP referral. Providers should establish processes for the identification of the member’s PCP and forward information concerning the member’s evaluation and treatment to the PCP after obtaining consent from the member as appropriate under legal requirements.

- Chiropractors
- Podiatrists
- Dermatologists
- OB/GYN

Cultural Competency

Cultural competency refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of individuals, and protects and preserves the dignity of each.

Amerigroup promotes cultural competency. We collect information regarding the cultural differences of our members and provide training opportunities to staff and network providers, helping them learn ways to interact effectively with members. Staff and provider cultural competency is monitored as part of the Quality Improvement process.

Amerigroup has a comprehensive written Cultural Competency Plan (CCP) describing the health plan’s program to ensure that services are provided in a culturally competent manner to all enrollees. The CCP is updated yearly and can be accessed via the provider website, or you can call and request a copy at no cost to you by calling 1-800-454-3730.

Marketing

When it comes to marketing, you need to be aware of and comply with the following:

- Providers are permitted to make available and/or distribute Amerigroup marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all Managed Care Plans with which the provider participates. Providers are also permitted to display posters or other materials in common areas such as the provider’s waiting room. Additionally, long-
term care facilities are permitted to provide materials in admission packets announcing all Managed Care Plan contractual relationships.

- We will provide education, outreach and monitoring to ensure you are aware of and comply with the following:
  1. To the extent a provider can assist a recipient in an objective assessment of his or her needs and potential options to meet those needs, the provider may do so. Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
  2. Providers may not:
     a. Offer marketing/appointment forms
     b. Make phone calls or direct, urge or attempt to persuade recipients to enroll in a Managed Care Plan based on financial or any other interests of the provider
     c. Mail marketing materials on behalf of a Managed Care Plan
     d. Offer anything of value to induce recipients/enrollees to select them as their provider
     e. Offer inducements to persuade recipients to enroll in the Managed Care Plan
     f. Conduct health screening as a marketing activity
     g. Accept compensation directly or indirectly from the Managed Care Plan for marketing activities
     h. Distribute marketing materials within an exam room setting
     i. Furnish to the Managed Care Plan lists of their Medicaid patients or the membership of any Managed Care Plan
  3. Providers may:
     a. Provide the names of the Managed Care Plans with which they participate
     b. Make available and/or distribute Managed Care Plan marketing materials
     c. Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office
     d. Share information with patients from the Agency’s website or the CMS website

- Provider Affiliation Information
  1. Providers may announce new or continuing affiliations with the Managed Care Plan through general advertising (e.g., radio, television, websites).
  2. Providers may make new affiliation announcements within the first 30 calendar days of the new provider agreement.
  3. Providers may make one announcement to patients of a new affiliation that names only the Managed Care Plan when such announcement is conveyed through direct mail, email or phone.
  4. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all Managed Care Plans with which the provider contracts.
  5. Any affiliation communication materials that include Managed Care Plan-specific information (e.g., benefits, formularies) must be prior approved by the Agency.

- Providers may distribute printed information provided by the Managed Care Plan to their patients comparing the benefits of all of the different Managed Care Plans with which the providers contract.
Member Records

Providers are required to maintain medical records for each patient in accordance with the medical record requirements below and with 42 CFR 431 and 42 CFR 456. A permanent medical record will be maintained at the primary care site for every member and be available to the PCP and other physicians. Medical records shall include the quality, quantity, appropriateness and timeliness of services performed.

Providers are required to have a designated person in charge of medical records. This person’s responsibilities include, but are not limited to:

1. The confidentiality, security and physical safety of records
2. The timely retrieval of individual records upon request
3. The unique identification of each patient’s record
4. The supervision of the collection, processing, maintenance, storage and appropriate access to the usage of records
5. The maintenance of a predetermined, organized and secured record format

Medical Record Standards

Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.

All patient medical records are to reflect all aspects of patient care, including ancillary services.

Providers shall follow the medical record standards set forth below for each member’s medical records, as appropriate:

- Include the enrollee’s identifying information, including name, enrollee identification number, date of birth, gender, and legal guardianship or responsible party, if applicable
- Maintain each record legibly and in detail
- Include a summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications and any other health conditions
- Record the presence or absence of allergies and untoward reactions to drugs, current medications and/or materials in a prominent and consistent location in all clinical records; this information should be verified at each patient encounter and updated whenever new allergies or sensitivities are identified
- Ensure all entries are dated and signed by the appropriate party
- Indicate in all entries the chief complaint or purpose of the visit, the objective, diagnoses, and medical findings or impression of the provider
- Indicate in all entries the studies ordered (e.g., laboratory, X-ray, electrocardiogram) and referral reports
- Indicate in all entries the therapies administered and prescribed
- Record all medications prescribed and documentation or medication reconciliation, including any changes in prescription and nonprescription medication with name and dosage when available
- Include in all entries the name and profession of the provider rendering services (e.g., M.D., D.O.), including the provider’s signature or initials
• Include in all entries the disposition, recommendations, instructions to member, evidence of follow-up and outcome of services
• Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for children under age of thirteen (13)
• Ensure all records contain an immunization history and documentation of body mass index
• Ensure all records contain information relating to the member’s use of tobacco products and alcohol and/or substance abuse
• Ensure all records contain summaries of all emergency services and care and hospital discharges with appropriate and medically indicated follow-up
• Document referral services in all members’ medical records
• Include all services provided such has family planning services, preventive services and services for the treatment of sexually transmitted diseases
• Ensure all records reflect the primary language spoken by the member and any translation needs of the member
• Ensure all records identify members needing communication assistance in the delivery of health care services
• Ensure all records contain documentation of the member being provided with written information concerning his or her rights regarding advance directives (i.e., written instructions for living will or power of attorney) and whether or not he or she has executed an advance directive (Note: neither the health plan nor any of its providers shall require, as a condition of treatment, the member to execute or waive an advance directive. The health plan must maintain written policies and procedures for advance directives)
• Maintain copies of any advance directives executed by the member
• Enter in the patient’s clinical record and appropriately sign or initial significant medical advice given to a patient by telephone or online, including medical advice provided after hours
• Clearly contrast any notation in a patient’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research with entries regarding the provision of nonresearch-related care
• Review and incorporate into the record in a timely manner all reports, histories, physicals, progress notes and other patient information such as laboratory reports, X-ray readings, operative reports and consultations
• Document a summary of past and current diagnoses or problems, including past procedures if a patient has had multiple visits/admissions or the clinical record is complex and lengthy
• Include a notation concerning cigarettes if present for patients ages 12 and older; abbreviations and symbols may be appropriate
• Screen patients for substance abuse and document in the medical record as part of a prevention evaluation during the following times:
  1. Initial contact with a new member
  2. Routine physical examinations
  3. Initial prenatal contact
  4. When the member evidences serious overutilization of medical surgical, trauma or emergency services
  5. When documentation of emergency room visits suggests the need
• Provide health education to the member
The following requirements must also be met regarding the patient’s medical records:

1. **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, including timely notification with patient or responsible party (adult).

2. **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.

3. **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.

4. **Security** — Providers must maintain a written policy and are required to ensure that medical records are safeguarded against loss, tampering, alteration, destruction, or unauthorized use or inadvertent use.

5. **Storage** — Providers must maintain a system for the proper collection, processing, maintenance, storage, retrieval and distribution of patient’s records. Also, the records must be easily accessible to personnel in the provider’s office and readily available to authorized personnel any time the organization is open to patients.

6. **Release of information** — Written procedures are required for releasing information and obtaining consent for treatment.

7. **Documentation** — Documentation is required setting forth the results of medical, preventive and behavioral health screenings as well as all treatment provided and the outcome of such treatment, including significant medical advice given to a patient by telephone.

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

9. **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/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 when a patient with disabilities or chronic or complex physical or developmental conditions has a co-occurring behavioral disorder

10. **Domestic violence** — Documentation of screening and referral to applicable domestic violence prevention community agencies is required.

11. **Consent for psychotherapeutic medications** — Pursuant to Statute F.S. 409.912(51), providers must document in the medical record informed consent from the parent or legal guardian of members...
younger than 13 who are prescribed psychotherapeutic medications and must provide the pharmacy with a signed attestation of this documentation. Pharmacies are required to obtain and keep these consents on file prior to filing a psychotherapeutic medication.

12. Behavioral health services provided through telemedicine – Documentation of behavioral health services provided through telemedicine is required. Such documentation must include:
   – A brief explanation of the use of telemedicine in each progress note
   – Documentation of telemedicine equipment used for the particular covered services provided
   – A signed statement from the enrollee or the enrollee’s representative indicating the choice to receive services through telemedicine. This statement may be for a set period of treatment or for a one-time visit, as applicable to the service(s) provided; and
   – For telepsychiatry the results of the assessment, findings and practitioner(s) plan for next steps.

Amerigroup will periodically review medical records to ensure compliance with these standards. Amerigroup will institute actions, including corrective actions for improvement, when standards are not met.

Patient Visit Data

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

1. Date of service; name, signature and profession (e.g., M.D., O.D., RN) of the person(s) providing the service; type of service provided; department of facility (if applicable); chief complaint; changes in medications with name and dosage; disposition; recommendations or instructions provided; and documentation of missed or cancelled appointments

2. A history and physical exam that includes appropriate subjective and objective information obtained for the presenting complaints

3. For patients receiving behavioral health treatment, documentation that includes at-risk factors such as danger to self and/or others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social health

4. An admission or initial assessment that includes current support systems or lack of support systems

5. For patients receiving behavioral health treatment, a documented assessment that is done with each visit relating to client status/symptoms and that may indicate initial symptoms of the behavioral health condition as decreased, increased or unchanged during the treatment period, along with the type and units of service provided

6. A plan of treatment that includes activities/therapies to be carried out and goals to be met

7. For patients receiving behavioral health treatment, a treatment plan that includes the member and/or parent or guardian’s preferences for treatment, identifies reasonable and appropriate objectives, provides the necessary services to meet the objectives, and includes a retrospective review to confirm that care provided and its outcomes were consistent with the approved treatment and member’s needs

8. Diagnostic tests

9. Documented therapies and other prescribed regimens for patients who receive behavioral health treatment and show evidence of family involvement as applicable and include evidence that the family was included in therapy sessions when appropriate
10. For 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 PRN (as needed) the specific time to return with unresolved problems from any previous visits being addressed in subsequent visits

11. Referrals and results, including all other aspects of patient care, such as ancillary services

Amerigroup will systematically review medical records to ensure compliance with these standards. We will share the results of our audits and institute actions for improvement when standards are not met.

We maintain 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, which states that records must be retained for seven years from the date of service.

**Misrouted Protected Health Information**

Providers and facilities are required to review all member information received from Amerigroup to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately destroy misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call our Provider Services team at 1-800-454-3730 for help.

**Clinical Practice Guidelines**

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

Amerigroup select at least four evidence-based clinical practice guidelines that are relevant to the member population. We then 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.

Amerigroup uses the following clinical practice guidelines:
- Asthma over age 5 per the National Heart, Lung and Blood Institute
- Asthma under age 5
- Attention deficit hyperactivity disorder
- Bipolar disorder
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Coronary artery disease
- Diabetes mellitus
- HIV/AIDS
- Hypertension
- Immunization schedules
- Major depressive disorder
- Obesity
- Obstetrical care
- Preventive health – adult comparison grid
- Preventive pediatric care
- Schizophrenia
- Synagis criteria
- Family planning preventive health
- Gestational diabetes mellitus and pregnancy-induced hypertension
- Florida Synagis algorithm

The clinical practice guidelines are developed based on the recommendations of industry specialty associations and organizations, including the following:
- American Academy of Child and Adolescent Psychiatry
- American Academy of Family Physicians
- American Academy of Pediatrics
- American Cancer Society
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians
- American Diabetes Association
- American Lung Association
- American Medical Association
- Centers for Disease Control and Prevention
- Department of Health and Human Services Commission
- National Institutes of Health
- U.S. Preventive Services Task Force

Visit our provider website at providers.amerigroup.com/FL to review the clinical practice guidelines.

**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 (i.e., 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 forms are located in Appendix A — Forms.

Telemedicine

If you have been approved by us to provide services through telemedicine, you must implement telemedicine fraud and abuse protocols that address:

- Authentication and authorization of users
- Authentication of the origin of the information
- The prevention of unauthorized access to the system or information
- System security, including the integrity of information that is collected, program integrity and system integrity
- Maintenance of documentation about system and information usage

If approved to provide dental services through telemedicine, only the following medically necessary dental services may be provided:
1. Oral prophylaxis
2. Topical fluoride application
3. Oral hygiene instructions.

The services listed above performed via telemedicine must be provided by a Florida-licensed dental hygienist at a spoke site with a supervising Florida-licensed dentist located at a hub site. For such dental services, mobile dental units as defined in the Dental Services Coverage and Limitations Handbook may be used as a spoke site.
MEDICAL MANAGEMENT

Medical Review Criteria

On December 24, 2012, WellPoint, Inc. (WellPoint) acquired Amerigroup Corporation and its subsidiaries. WellPoint has its own nationally recognized medical policy process for all of its subsidiary entities.

Effective March 1, 2014, WellPoint medical policies, which are publicly accessible from its UniCare subsidiary website, became the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Amerigroup subsidiaries.

A list of the specific UniCare Clinical UM Guidelines used is posted and maintained on the Amerigroup provider self-service websites and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical-appropriateness claims edits and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or Centers for Medicare & Medicaid Services (CMS) requirements will supersede UniCare medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

McKesson InterQual is used for nonbehavioral health concurrent review determinations only through March 1, 2014. Effective March 1, 2014, Amerigroup Corporation and its health plan subsidiaries no longer use McKesson InterQual Care Planning and Behavioral Health criteria to determine medical necessity for non-behavioral health and behavioral health inpatient and outpatient precertification reviews. Except in cases where superseded by state Medicaid or Centers for Medicare & Medicaid Services (CMS) requirements, all non-behavioral health, and behavioral health inpatient and outpatient precertification requests and Behavioral Health concurrent reviews will be determined using WellPoint’s UniCare medical policies and clinical utilization management guidelines.

McKesson InterQual will continue to be used for non-behavioral health concurrent review determinations after March 1, 2014.

We work with network providers to develop clinical guidelines of care for our membership. The Medical Advisory Committee assists us in formalizing and monitoring guidelines.

If we utilize 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.

**UM Decision Making**

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

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

**Clinical Criteria**

Amerigroup utilizes nationally recognized standards of care 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.

**Precertification/Notification Process**

Amerigroup may require members to seek a referral from their PCP prior to accessing nonemergency specialty physical health services. **Precertification** is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered and a member’s severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided. **Notification** is defined as telephonic, facsimile or electronic communication received from a provider informing Amerigroup of the intent to render covered medical services to a member. There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified. Notification should be provided prior to rendering services as referenced in the Quick Reference Card. For services that are emergent or urgent, notification should be given within 24 hours or the next business day.
HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Amerigroup requires precertification of all inpatient elective admissions. The referring primary care provider (PCP) 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 medical necessity 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 UniCare Clinical UM 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 precert nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Two requests for additional information will be made over a 48-hour period. If information is not received within the specified time period, the request will be denied.

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, the member’s PCP and the 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 Milliman criteria, an Amerigroup reference number will be issued to the hospital. Two requests for additional information will be made over a 48-hour period. If information is not received within the specified time period, the request will be denied.

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

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

Nonemergent Outpatient and Ancillary Services: Precertification and Notification Requirements

Amerigroup requires precertification for coverage of selected nonemergent outpatient and ancillary services (see chart below). 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>Amerigroup Precertification/Notification Coverage Guidelines Florida MMA/MediKids Program and Florida Healthy Kids (FHK) Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SERVICE</strong></td>
</tr>
<tr>
<td>Behavioral Health/Substance Abuse</td>
</tr>
<tr>
<td>SERVICE</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
</tr>
<tr>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Child Health Check-Up</td>
</tr>
<tr>
<td>Chiropractic Services</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Dermatology Services</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Disposable Medical Supplies</td>
</tr>
<tr>
<td>Educational Consultation</td>
</tr>
<tr>
<td>Emergency Room (ER)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis</td>
</tr>
<tr>
<td>and Treatment (EPSDT)</td>
</tr>
<tr>
<td>ENT Services (Otolaryngology)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Family Planning/STD</td>
</tr>
</tbody>
</table>
### Amerigroup Precertification/Notification Coverage Guidelines

**Florida MMA/MediKids Program and Florida Healthy Kids (FHK) Program**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>REQUIREMENT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care</strong></td>
<td></td>
<td>services include information and referral for learning and counseling, diagnostic procedures, contraceptive drugs and supplies, and medically needed sterilization and follow-up care. Services are not covered for a member under the age of 18 unless married, a parent, pregnant or will suffer health hazards if services are not provided.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> Coverage of family planning is limited to one annual visit and one supply visit per 90 days.</td>
</tr>
<tr>
<td><strong>Gastroenterology Services</strong></td>
<td>No precertification required for network provider for E&amp;M, testing and most procedures.</td>
<td>• Precertification is required for bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components and upper endoscopy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See Diagnostic Testing.</td>
</tr>
<tr>
<td><strong>Gynecology</strong></td>
<td>No precertification required for network provider in office for E&amp;M, testing and most procedures.</td>
<td>Self-referral to network provider.</td>
</tr>
<tr>
<td><strong>Hearing Services</strong></td>
<td></td>
<td>• Precertification for services is not required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Members should contact HearUSA at 1-877-664-9353 or see a participating ENT or audiologist. Covered services include up to 60 hearing aid batteries per year; subject to medical necessity. Coverage of newborn screenings for members from birth to 12 months is limited to a maximum of two screenings. Routine maintenance, batteries, cord or wire replacement, or cleaning is not covered. There is no age limit for hearing services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> No copay is required.</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>Precertification</td>
<td>• Precertification is required for coverage of all services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> $5 copay per visit is required. Coverage is limited to skilled nursing services.</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
<td>• Hospice is a covered benefit for MMA and does not require precertification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Notification is required for coverage of inpatient hospice services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> Precertification is required for coverage of inpatient hospice services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See Home Health Care.</td>
</tr>
<tr>
<td>SERVICE</td>
<td>REQUIREMENT</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Hospital Admission              | Precertification | • Precertification is required for coverage of an elective admission.  
• Notification is required for coverage of emergency and obstetric admissions within 24 hours or the next business day.  
• To be covered, preadmission testing must be performed by an Amerigroup-preferred lab vendor or network facility outpatient department. See provider referral directory for a complete listing of participating vendors.  
**MMA:** Non-pregnant members age 21 and older are covered for up to 45 inpatient days and up to 365 days of emergency inpatient care. Members under age 21 are covered for up to 365 days of health-related inpatient care. Twenty-eight inpatient hospital days in an inpatient hospital substance abuse treatment program for pregnant substance abusers who meet ISD Criteria with Florida Medicaid modifications, as specified in InterQual Level of Care Acute Criteria-Pediatric and/or InterQual Level of Acute Criteria-Adult for use in screening cases admitted to rehabilitative hospitals and CON-approved rehabilitative units in acute care hospitals.  
• **FKH:** Amerigroup case managers will coordinate services that are medically necessary. Covered services include 15 days per contract year for preapproved rehabilitation and physical therapy stays. No copay is required. |
| Laboratory Services (Outpatient) | Precertification | • Precertification is required for all laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition.  
• All laboratory tests must be submitted to Quest Diagnostics or LabCorp, the preferred lab providers for all Amerigroup members. Contact Quest or LabCorp at the numbers below to receive a Quest or LabCorp specimen drop box.  
• For more information, testing solutions and services or to set up an account, contact either:  
  – Quest Diagnostics: 1-866-MY-QUEST (1-866-697-8378)  
  – LabCorp: 1-800-345-4363 |
<p>| Neurology                       | No precertification | • Precertification is required for neurosurgery, spinal |</p>
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>REQUIREMENT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>required for network provider for E&amp;M and most testing</td>
<td>fusion and artificial intervertebral disc surgery. • See Diagnostic Testing.</td>
<td></td>
</tr>
<tr>
<td>Observation</td>
<td>• No precertification or notification required for in-network observation. • If observation results in admission, notification to Amerigroup is required within 24 hours or the next business day. • If admission occurs, all charges for observation services roll up into the admission.</td>
<td></td>
</tr>
<tr>
<td>Obstetrical Care</td>
<td>• Member may self-refer to a network OB/GYN provider. • No precertification/PCP referral is required for coverage of obstetrical services, including obstetrical visits, diagnostic tests and laboratory services when performed by a participating provider. This includes prenatal office visits (10 for normal pregnancy or 14 for high-risk pregnancy), postpartum office visits, routine ultrasounds and lab work. • No precertification is required for coverage of labor and delivery. • Notification to Amerigroup is required at the FIRST prenatal visit. • Notification is required for coverage of emergency and obstetric admissions within 24 hours or the next business day. • FHK: Notification is required. We cover 48 hours post-delivery for vaginal births and 96 hours post-delivery for C-section deliveries.</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>See comments</td>
<td>• Precertification must be obtained through eyeQuest (1-888-696-9551) from a participating eyeQuest optometrist. See Vision Care. There is no age limit for vision services. • Examination, diagnosis, treatment, and management of ocular and adnexal pathology • Visual examinations to determine the need for eyeglasses • Members age 21 years and older are covered for an extra $100 for contact lenses and contact lens services, as medically necessary. • Visual services include the medically necessary</td>
</tr>
<tr>
<td>SERVICE</td>
<td>REQUIREMENT</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>provision of optical services and supplies such as eyeglasses,</td>
<td></td>
<td>The fitting, dispensing, and adjusting of eyeglasses, and eyeglass repair services are also covered.</td>
</tr>
<tr>
<td>prosthetic eyes, and contact lenses. The fitting, dispensing, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>adjusting of eyeglasses, and eyeglass repair services are also</td>
<td></td>
<td></td>
</tr>
<tr>
<td>covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Area/Out-of-Network Care</td>
<td>Precertification</td>
<td>Precertification is required for any out-of-area/out-of-network care except for coverage of emergency care (including self-referral) and OB care.</td>
</tr>
<tr>
<td>Outpatient/ Ambulatory Surgery</td>
<td>Precertification</td>
<td>Precertification requirements based on the service performed.</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Precertification</td>
<td>• No precertification is required for E&amp;M services.</td>
</tr>
<tr>
<td>• Precertification is required for all other services.</td>
<td></td>
<td>• See Diagnostic Testing.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>• The pharmacy benefit covers medically necessary prescriptions prescribed by a licensed provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exceptions and restrictions exist as the benefit is provided under a closed formulary/Preferred Drug List (PDL). Please refer to the PDL on our provider website for the preferred products within therapeutic categories and requirements around generics, prior authorization step therapy, quantity edits and the prior authorization process. Quantity and day supply limits apply.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>MMA</strong>: Covered prescription drugs at no cost. Non Reform: OTC drug benefit is subject to $25 per household per month.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK</strong>: $5 per prescription for up to a 31-day supply. OTC drug benefit does not exceed $10 per family per month.</td>
</tr>
<tr>
<td>Physiatry</td>
<td>Precertification</td>
<td>• Precertification is required for coverage of all services and procedures related to pain management.</td>
</tr>
<tr>
<td>• See Diagnostic Testing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td>Precertification</td>
<td>• Precertification is required for coverage of all services and procedures related to pain management.</td>
</tr>
<tr>
<td>• See Diagnostic Testing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic/Cosmetic/Reconstructive Surgery (including Oral Maxillofacial</td>
<td>No precertification required for network provider for E&amp;M</td>
<td>• All other services require precertification for coverage.</td>
</tr>
<tr>
<td>Services)</td>
<td></td>
<td>• Services considered cosmetic in nature are not covered.</td>
</tr>
<tr>
<td>• Services related to previous cosmetic procedures are not covered (e.g., scar revision, keloid removal)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Amerigroup Precertification/Notification Coverage Guidelines  
Florida MMA/MediKids Program and Florida Healthy Kids (FHK) Program

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>REQUIREMENT</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| Podiatry                              | No precertification required for network provider in office for E&M, testing and most procedures | Coverage includes:  
  - Open access  
  - One podiatrist-recipient contact per day, not to exceed two per month except for emergencies  
  - One long-term care facility service per month per recipient except for emergencies  
  - One new patient E&M service per recipient every three years  
  See Diagnostic Testing                                                                                                                                                                                                 |
| Primary Care Provider (PCP) Services  | Self-referral                       |  
  - **MMA and FHK:** Covered services include preventive, diagnostic, therapeutic palliative care or treatment of an illness or disease. Provider services do not include nonclinically proven procedures or cosmetic surgery.                                                                                   |
| Radiation Therapy                     |                                    | No precertification is required for coverage of radiation therapy procedures when performed in the following outpatient settings by a network facility or provider: office, outpatient hospital and ambulatory surgery center.                                                                                       |
| Radiology                             |                                    | See Diagnostic Testing.                                                                                                                                                                                                                                                                                                                    |
| Rehabilitation Therapy (Short-term): OT, PT, RT and ST | Precertification                 |  
  - **MMA:** No precertification is required for initial evaluation. Covered services include evaluation and treatment to prevent or correct physical deficits.  
  Coverage limitations:  
    - One initial evaluation per member per provider  
    - One re-evaluation every six months per member per provider  
    - Medically necessary therapy services are covered for members under age 21 and for members over 21 only if services are provided in an outpatient hospital setting  
    - ST: Refer members to an in-network provider.  
    - **MMA:** For members over 21 years of age, limitations apply  
    - **FHK:** Outpatient coverage is limited to 24 sessions |

resulting from pierced ears).  
- Reduction mammoplasty requires medical director’s review and approval.  
- No precertification is required for coverage of oral maxillofacial E&M services.  
- Precertification is required for coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions including TMJ.
### Amerigroup Precertification/Notification Coverage Guidelines

**Florida MMA/MediKids Program and Florida Healthy Kids (FHK) Program**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>REQUIREMENT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>within a 60-day period per incident. The 60-day coverage period begins with the first visit. A $5 copay is required for each office visit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Please call Amerigroup for precertification at 1-800-454-3730.</td>
</tr>
<tr>
<td>Respite Care Services</td>
<td>Precertification</td>
<td>If medically needed, members can get an initial home health visit by a registered nurse and eight follow-up visits (each lasting four hours) by an aide. This benefit includes a maximum of 16 hours per month and 32 hours per year.</td>
</tr>
<tr>
<td>Sleep Study</td>
<td>Precertification</td>
<td>Precertification is required for sleep studies.</td>
</tr>
<tr>
<td>Sterilization</td>
<td></td>
<td>• Sterilization services are a covered benefit for members 21 and older.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No precertification or notification is required for coverage of sterilization procedures, including tubal ligation and vasectomy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>Sterilization consent form is required for claims submission.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reversal of sterilization is not a covered benefit.</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Precertification</td>
<td>Precertification is required for coverage.</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>• <strong>MMA:</strong> Members may contact LogistiCare (1-866-372-9794) for nonemergent transportation or reference their member handbooks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> Precertification is required for fixed-wing transportation. A $10 copay is required per trip for emergency services only. Nonemergent transportation services are not covered.</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td></td>
<td>• No notification or precertification is required for a network facility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> The $10 copay should only be charged:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If the urgent care service is taking place in a <strong>hospital ER</strong> and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- If the urgent care service is inappropriate (i.e., the member’s situation did not meet the definition of urgent)</td>
</tr>
<tr>
<td>Vision Care (Medical)</td>
<td>Precertification</td>
<td>• See Ophthalmology.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> $5 copay per specialist visit is required.</td>
</tr>
<tr>
<td>Vision Care (Routine)</td>
<td>Self-referral</td>
<td>• Services include eye exams plus certain glasses and contact lenses, if medically needed. Contact eyeQuest at 1-888-696-9551. There is no age limit for vision services.</td>
</tr>
</tbody>
</table>
Amerigroup Precertification/Notification Coverage Guidelines
Florida MMA/MediKids Program and Florida Healthy Kids (FHK) Program

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>REQUIREMENT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• <strong>MMA (TANF and SSI):</strong> Members ages 21 years and older are covered for an extra $100 for contact lenses and contact lens services, as medically necessary.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <strong>FHK:</strong> Covered services include an eye exam plus corrective lenses and frames if medically needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No copay is required for routine eye exams provided by the PCP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $5 copay per specialist visit is required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• $10 copay for corrective lenses is required.</td>
</tr>
</tbody>
</table>

| Well-woman Exam        | Self-referral        | • Well-woman exams are covered once every 365 days by either PCP or a network GYN. Services include exam, physical, blood work, routine lab, STD screening and Pap smear, and mammogram (one baseline at age 35 or older, one per year at age 40 and older). |
|                        |                      | • **FHK:** No copay is required by member.                                                                                             |

| Revenue (RV) Codes     |                      | To the extent the following services are covered benefits, precertification or notification is required for all services billed with the following revenue codes: |
|                        |                      | • All Inpatient and Behavioral Health Accommodations                                                                                   |
|                        |                      | • 0023 – Home Health Prospective Payment System                                                                                       |
|                        |                      | • 0240 through 0249 – All-inclusive Ancillary Psychiatric                                                                                |
|                        |                      | • 0570 through 0572, 0579 – Home Health Aide                                                                                          |
|                        |                      | • 0632 – Pharmacy Multiple Source                                                                                                     |
|                        |                      | • 0901, 0905 through 0907, 0913, 0917 – Behavioral Health Treatment Services                                                          |
|                        |                      | • 0944 through 0945 – Other Therapeutic Services                                                                                      |
|                        |                      | • 0961 – Psychiatric Professional Fees                                                                                               |
|                        |                      | • 3101 through 3109 – Adult day care and foster care                                                                                  |

For services that require precertification, Amerigroup uses Interqual, Florida Medicaid Guidelines, WellPoint Medical Policies, and WellPoint Clinical UM Guidelines.

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 by fax, the precertification assistant will verify eligibility and benefits, which will then be forwarded 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.

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 (i.e., expedited service authorizations), the decision will be made within two business days.

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. Two requests for additional information will be made over a 48-hour period. If information is not received within the specified time period, the request will be denied.

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 Review**

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within 24 hours. The 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 Utilization Management (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 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 will be communicated to the hospital for the continued stay. The request for the clinical information needed will be communicated to the designated department within the hospital. Amerigroup asks that the hospital reviewer provide only the necessary information being requested and not provide the entire medical record.

If the discharge is approved, the Amerigroup UM clinician will help coordinate discharge planning needs with the hospital utilization 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 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 is likely to be several days or is 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, the member’s PCP and the member.

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of the member’s discharge when acute care (i.e., 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 a:

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

When the provider identifies medically necessary and appropriate services for the member, we 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 UniCare Clinical UM Guidelines. Authorizations include, but are not limited to, home health, durable medical equipment, pharmacy, follow-up visits to practitioners or outpatient procedures.

Confidentiality of Information

Utilization Management (UM), case 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 the 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 UM and related processes.

Emergency Services

Amerigroup provides a 24 hours a day, 7 days 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 system 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.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services, including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency, 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 assist the health care provider in determining whether or not the patient’s condition is an emergency medical condition.

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

If the member is admitted, the Amerigroup 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

Quality Management Program

Overview
Amerigroup maintains a comprehensive Quality Management (QM) 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 QM Program goals and outcomes are available, upon request, to providers and members. 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 plan’s 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.

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

Quality of Care
All physicians, advanced registered nurse practitioners and physician assistants are evaluated for compliance with pre-established standards as described in the Amerigroup credentialing program.

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

Reviews are accomplished by 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.

The Amerigroup quality program includes review of quality-of-care issues identified for all care settings. QM staff use member complaints, reported adverse events and other information to evaluate the quality of service and care provided to our members.

Use of performance data
Practitioners and providers must allow Amerigroup to use performance data in cooperation with our quality improvement program and activities.
Quality Management Committee

The purpose of the 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 QM Program
- Establish processes and structure that ensure accreditation compliance
- Analyze, review and make recommendations regarding the planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Address and resolve any problems/issues identified but not included in a process improvement program
- Coordinate communication of QM activities throughout the health plans
- Review and analyze Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems data and action plans for improvement
- Review, monitor and evaluate program compliance against Amerigroup, state, federal and accreditation standards
- Review and approve the annual QM Program description and work plan
- Provide oversight and review of delegated services
- Provide oversight and review of operational indicators
- Assure interdepartmental collaboration, coordination and communication of quality improvement activities
- Measure compliance to medical and behavioral health practice guidelines
- Monitor continuity of care between medical and behavioral health services
- Monitor accessibility and availability with cultural assessment
- Make information publicly available to members and practitioners about our actions to improve patient safety
- Make information available about our quality improvement program to members and practitioners; members and providers can request the program by calling Customer Service
- Assure practitioner involvement through direct input from our MAC or other mechanisms that allow practitioner involvement

Medical Advisory Committee

The 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 health plan administration in any aspect of health plan policy or operation affecting network providers or members. The MAC approves and provides oversight of the peer review process, the QM Program and the Utilization Review Program. It oversees and makes recommendations regarding health promotion activities.
The MAC’s responsibilities are to:
- Utilize an ongoing peer review system to assess levels of care and quality of care provided
- Monitor practice patterns in order to identify risk prevention activities and the appropriateness of care
- Review, provide input and approve evidence-based clinical protocols and guidelines to facilitate the delivery of quality care and appropriate resource utilization
- Review clinical study designs and results
- Develop and approve action plans and recommendations regarding clinical quality improvement studies
- Consider and act in regard to physician sanctions
- Review, provide input for, and approve policies and procedures for credentialing/recredentialing, QM, utilization management and disease/case management
- Review and provide feedback regarding new technologies
- Oversee the compliance of delegated services

Provider Orientation and Education
QM coordinators are available to provide a thorough orientation to Amerigroup review standards. Educational sessions can be scheduled at a provider’s convenience. The QM staff is also available to furnish providers with a thorough explanation of review findings during an exit conference on the day of the review. If a provider’s schedule does not allow for sufficient time on the day of the review, a follow-up appointment can be scheduled. Experience has taught that provider participation in orientation and education sessions helps improve standards’ compliance and, therefore, decreases the frequency for required reviews.

Medical Record Documentation Review Standards

Administrative Component

MEDICAL RECORD DOCUMENTATION STANDARDS
For Primary Care Providers

<table>
<thead>
<tr>
<th>ELEMENTS &amp; REFERENCES</th>
<th>GUIDELINES</th>
</tr>
</thead>
</table>
| **1. Record is organized and legible**  
AAAHC, Std 6, G, M  
AHCA, 20.13, a (2) | Records are fastened and maintained in detail with contents organized in a logical, consistent manner to facilitate information retrieval.  
- There is an individual record for each member.  
- The record must be legible.  
Record legibility is determined by the Amerigroup reviewer; a record is scored as illegible when the reviewer cannot decipher documentation sufficiently to score the record. |
| **2. Member identification on file**  
AHCA, 20.13, a (1) | A copy of the Amerigroup membership card on file or in the medical record or a written office policy regarding verification of member eligibility before rendering service. Use of the current Amerigroup membership list is acceptable for eligibility verification. |
<table>
<thead>
<tr>
<th>ELEMENTS &amp; REFERENCES</th>
<th>GUIDELINES</th>
</tr>
</thead>
</table>
| **3. Personal biographical data**  
AHCA, 20.13, a (1) | Required information: name, member identification number, date of birth, sex, address and telephone number. For pediatric members (under 21 years old), the name of a parent or a legal guardian is required. |
| **4. Primary language and translation**  
AAAHC Std 4, H  
AHCA, 20.13, a (13), (14) | • All records must reflect the member’s primary spoken language and translation needs to include services for the deaf or hard of hearing. Records must identify members needing communication assistance in the delivery of health care service.  
• Documentation may be by the member (i.e., included on a patient history form or by the provider or office staff).  
• When the member is an infant or young child, documentation of the primary language spoken by others in the home is required.  
• If English is the primary language, this must be documented. |
| **5. Advance directives advisement**  
AHCA, 20.13, a (15)  
FL Statute 765.110 | All records for members 21 years and older must contain:  
• Documentation that the member was provided written information concerning the member’s rights regarding advanced directives (written instructions for living will or durable power of attorney).  
• Documentation whether or not the member has executed an advance directive. When an advance directive exists, a copy must be maintained in the record. |
| **6. Patient identification on each page**  
Amerigroup Florida | Patient first and last name and/or an identification number are on ALL pages, reports and documents in the record. Pages that are used on both sides require identification on each side. |
| **7. Entries dated and signed**  
AAAHC, Std 6, K1, 8  
AHCA, 20.13, a (4), (8)  
FL Regulation 64B8-30.012 | • All entries must be signed and dated with month, day and year. This applies to all clinical entries such as history forms, progress notes, triage documentation, immunization administration, referral forms, etc.  
• All entries must contain author identification. Signatures must include professional status when applicable (M.D., D.O., ARNP, P.A., R.N., LPN and M.A.). Applies to both licensed and nonlicensed personnel.  
• All physician assistant signatures must be reviewed, cosigned and dated by a supervising physician within seven days. ARNP notes do not require cosigning. |
| **8. Requested tests accomplished and filed**  
AAAHC, Std 4, D5, 7, 8; Std 6H  
AHCA 20.13, a (5) | Evidence is in the record to support that ordered tests and referrals were accomplished. Acceptable documentation includes test results/consult reports filed in record and telephone results documented in progress notes or on an office form designed for that purpose. Attempts to obtain reports should be documented. |
<table>
<thead>
<tr>
<th>ELEMENTS &amp; REFERENCES</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>•</strong> Patient noncompliance and associated risks must be documented when applicable.</td>
<td></td>
</tr>
<tr>
<td><strong>•</strong> Results are to be filed in the record:</td>
<td></td>
</tr>
<tr>
<td>- Consults: within six weeks of the date the PCP initiated the request or four weeks from the date of the consult. It is the PCP’s responsibility to obtain consultant reports.</td>
<td></td>
</tr>
<tr>
<td>- Laboratory tests: Routine — within two weeks of the date ordered/planned in the PCP records. Nonroutine — (endocrine studies, genetic mapping, tuberculosis cultures, fungal cultures, etc.) — within two weeks of the date ordered/planned in the PCP progress notes.</td>
<td></td>
</tr>
<tr>
<td>- Radiographic studies: within two weeks of the date noted in the PCP plan.</td>
<td></td>
</tr>
</tbody>
</table>

Processes are in place to obtain and follow up on consultant visits and diagnostic studies (e.g., tickler files, logbook, computer log, etc.).

| 9. Follow-up of missed and cancelled appointments | Documentation of follow-up for missed and cancelled appointments is required. |
| AAAHC, Std 6, K(9) | |

### General Medical Care

#### MEDICAL RECORD DOCUMENTATION REVIEW STANDARDS

**For Primary Care Providers**

<table>
<thead>
<tr>
<th>ELEMENTS &amp; REFERENCES</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Allergies noted</strong></td>
<td>All patient allergies are <strong>prominently and uniformly</strong> noted in the record. When there are no known allergies, this is noted prominently and uniformly in the record.</td>
</tr>
<tr>
<td>AAAHC, Std 6J AHCA, 20.13, a (3)</td>
<td></td>
</tr>
<tr>
<td><strong>2. Problem list maintained</strong></td>
<td>A problem list is maintained for each patient. The list identifies chronic and significant illnesses, diagnoses, medical conditions and significant surgical procedures based on the history and physical. If a summary of significant surgical procedures is found elsewhere (i.e., the H&amp;P and is prominently and uniformly displayed), it is not required to repeat on the problems list. Documentation of the problem list in the progress notes alone meets standards only if the complete list is documented at each visit.</td>
</tr>
<tr>
<td>AAAHC, Std 6I AHCA, 20.13, a (3)</td>
<td></td>
</tr>
<tr>
<td><strong>3. Medication profile is maintained</strong></td>
<td>A medication profile for all chronic medications is clearly documented on a medication list; <strong>dosage is required.</strong> Documentation of medications for acute illnesses may be documented in the progress notes alone; they must reflect the start and stop dates.</td>
</tr>
<tr>
<td>AHCA, 20.13, a (3)</td>
<td></td>
</tr>
<tr>
<td>ELEMENTS &amp; REFERENCES</td>
<td>GUIDELINES</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| **4. Health history documented**  
AAAHC, Std 4, D3; Std 6I  
AAP Recommendations  
AHCA, 20.13, a (3)  
AHCA CLH, pages 2-5, 2-6  
AHCA CH CLH, pages 2-2, 2-6 | • A thorough health history must be documented in the record at least once. This should be accomplished during the first visit.  
• A periodic interval history or update is required with each preventive health visit as a minimum.  
• Components of the health history include:  
  - Current medications  
  - Chronic/past illnesses/diagnoses/problems (including childhood diseases)  
  - Hospitalizations and significant surgical procedures  
  - Transfusion of blood products  
  - Family history  
  - Social/behavioral history  
  - Review/inventory of systems  
  - Required for infants 2 months and younger: a prenatal, delivery and neonatal history (recommended for all children) |
| **5. Tobacco/alcohol/drug use**  
AAP Recommendations  
AHCA, 20.13, a (11)  
AHCA CH CLH, pages 2-7 | Records for members ages 8 years old or older must contain documentation regarding the member’s:  
• Tobacco use and exposure to secondhand smoke  
• Alcohol use  
• Drug use/abuse (street drugs, inhalants, prescription drug abuse)  
This requires assessment of the member’s actual use/abuse of these substances. Education regarding the risks associated with such use is addressed with age-specific preventive health standards and anticipatory guidance. |
| **6. Subjective complaint recorded**  
AAAHC, Std 6K, 2  
AHCA, 20.13, a (5) | The chief complaint or reason for the visit, as told by the patient or family member, must be recorded. |
| **7. Objective findings**  
AAAHC, 6K, 3  
AHCA, 20.13, a (5) | Objective findings include at least the physical findings relative to the subjective complaint.  
Anytime patient refusal is documented. Education regarding the risk associated with the refusal must be documented. |
| **7. Vital signs recorded**  
Amerigroup | Vital signs are required as appropriate for the chief complaint. |
| **9. Working diagnosis**  
AAAHC, Std 4, D3; Std 6, K4  
AHCA, 20.13, a (5)  
AHCA CH CLH, pages 2-2 | The rationale for which a plan is formulated and the diagnosis or clinical impression is required. Appropriateness is based on the findings in the history and physical. |
| **10. Plan of care documented**  
AAAHC, Std 4, D4; Std 6K5,6,7  
AHCA, 20.13, a (6), (7), (9) | All entries must indicate diagnostic tests, consultations and treatments administered or prescribed. Dispositions, recommendations, evidence of follow-up and outcomes of
**GUIDELINES**

<table>
<thead>
<tr>
<th>ELEMENTS &amp; REFERENCES</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCA CH CLH, pages 2-2</td>
<td>services must be documented. The plan is consistent with the working diagnosis. When treatment is for a chronic condition, there is evidence of continued care.</td>
</tr>
</tbody>
</table>

11. **Follow up of acute or chronic problems and high-risk issues addressed in subsequent visits**  
   AAAHC, Std 4, D8  
   Documentation of follow-up care is present for:  
   - Unresolved problems from previous visits that are addressed in subsequent visits.  
   - Follow-up of high-risk issues that are identified in the history and physical or at subsequent visits.  

12. **Patient teaching/instructions**  
   AAAHC, Std 4, D1; Std 6Q  
   AHCA, 20.13, a (9)  
   Documentation of patient education and counseling pertinent to the subjective complaint, personal and family history, newly prescribed medications, treatment and/or therapy, diagnosis, and plan is required.  
   Patient noncompliance and/or refusal to follow diagnostic or treatment plans must be accompanied by documented instruction regarding the risk associated with the noncompliance.  

13. **Follow-up requirements documented**  
   AHCA, 20.13, a (9)  
   Amerigroup Florida  
   A specific time for return (i.e., the next patient visit) is noted in days, weeks, months, PRN, etc.  

14. **Emergency care documented**  
   AHCA, 20.13.a (12)  
   AAAHC, Std 6, O  
   Information regarding emergency care is recorded in the record. A copy of the emergency room record or a progress note reflecting the PCP’s discussion with the hospital or treating provider is required.  

15. **Hospital care documented**  
   AHCA, 20.13.a (12)  
   AAAHC, Std 6, O  
   Information regarding hospitalizations is recorded in the record. A copy of the discharge summary or a progress note reflecting the PCP’s discussion with the hospital or treating physician is acceptable.  

16. **All reports initialed and dated by PCP**  
   AAAHC, Std 4, D8; Std 6H  
   Consultation, lab and imaging reports filed in the record are initialed and dated by a provider to signify review.  
   Processes must be in place for patient notification and follow-up of abnormal diagnostic studies.  

**Adult**

**MEDICAL RECORD DOCUMENTATION REVIEW STANDARDS**

*For Primary Care Providers*

PCPs are responsible for contacting new members and conducting preventive health care within 90 days of enrollment. Member contacts and attempted contacts must be documented.
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Risk screening</td>
<td>Screening to identify high-risk individuals and assessing family, medical and social history is required. Screening for the following risks are required as a minimum: cardiovascular disease, hepatitis, HIV/AIDS, STDs other than HIV/AIDS, and TB. Appropriate interventions and follow-up for high-risk patients, or the rationale for no intervention, must be documented.</td>
</tr>
<tr>
<td>AHCA CLH, pages 2-6</td>
<td>USPSTF</td>
</tr>
<tr>
<td>2. Interval history</td>
<td>Interval histories are required with preventive health care. Changes in medical, emotional and social status are documented.</td>
</tr>
<tr>
<td>AHCA CLH, pages 2-5, 2-6</td>
<td>USPSTF</td>
</tr>
<tr>
<td>3. Immunizations</td>
<td>Age-appropriate immunizations are documented and current. If immunization status is not current, this is documented with a catch-up plan. It is not sufficient to document up to date, documentation of a date or year is necessary.</td>
</tr>
<tr>
<td>AHCA, 20.13 a (10)</td>
<td>USPSTF</td>
</tr>
<tr>
<td>a. Influenza</td>
<td>a. Influenza: annually beginning at age 65 and all pregnant women</td>
</tr>
<tr>
<td>b. Tetanus (TD booster)</td>
<td>b. TD booster: every 10 years if completed five-dose series in childhood beginning at age 18</td>
</tr>
<tr>
<td>c. Pneumococcal</td>
<td>c. Pneumococcal: age 65 and older at once</td>
</tr>
<tr>
<td></td>
<td>If vaccinated with pneumococcal vaccine when under 65 and it has been five years since the vaccination, revaccinate at 65 or after five years</td>
</tr>
<tr>
<td>4. Height and weight</td>
<td>Documented height and weight required for all preventive health care visits and at least:</td>
</tr>
<tr>
<td>AHCA CLH, pages 2-6</td>
<td>USPSTF</td>
</tr>
<tr>
<td></td>
<td>• Every five years for ages 21 to 40</td>
</tr>
<tr>
<td></td>
<td>• Every two years beginning at age 41</td>
</tr>
<tr>
<td>5. Vital signs</td>
<td>Pulse and blood pressure are required for all preventive health care visits and at least:</td>
</tr>
<tr>
<td>AHCA CLH, pages 2-6</td>
<td>USPSTF</td>
</tr>
<tr>
<td></td>
<td>• Every five years for ages 21 to 40</td>
</tr>
<tr>
<td></td>
<td>• Every two years beginning at age 41</td>
</tr>
<tr>
<td>ELEMENTS</td>
<td>GUIDELINES</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 6. Physical exam               | **Baseline physical examination** of an asymptomatic adult are:  
| AHCA CLH, pages 2-6            | • General appearance  
|                                | • Skin  
|                                | • Gums/dental/oral  
|                                | • Eyes/ears/nose/throat  
|                                | • Neck/thyroid  
|                                | • Chest/lungs  
|                                | • Cardiovascular  
|                                | • Breasts  
|                                | • Abdomen/GI  
|                                | • Pelvic  
|                                | • Genital/urinary  
|                                | • Rectal  
|                                | • Extremities  
|                                | • Musculoskeletal  
|                                | • Neurological  
|                                | • Lymphatic  
|                                | If noncompliance or refusal is documented, the risk associated with the noncompliance must be documented.                                |
| 7. Urinalysis testing          | Urinalysis documented; as a minimum, dipstick for blood, sugar and acetone. Required per adult health screening guidelines.  
| AHCA CLH, pages 2-6            | • Every five years for ages 21 to 40  
|                                | • Every two years beginning at age 41 |
12. Colorectal cancer screening
ACS
AHCA CLH, pages 2-7
USPSTF
Colorectal cancer screening beginning at age 50 may be accomplished by any of the following:
- Colonoscopy, every 10 years
- Flexible sigmoidoscopy, every five years
- Double-contrast barium enema, every five years
- Annual Fecal Occult Blood Test (FOBT)

13. Cervical cancer screening
AHCA CLH, pages 2-7
USPSTF
Annual Pap smears for cervical cancer screening are required for all sexually active females, regardless of age, and all females ages 18 and older.

14. Chlamydia screening
AHCA CLH, pages 2-7
USPSTF
Screening for chlamydia for all sexually active females under age 26 is required.

15. Mammography
AHCA CLH, pages 2-7
USPSTF
Required for females as appropriate for age:
- Baseline between ages 35 and 40
- Annually after age 40

16. Prostate cancer screening
AHCA CLH, pages 2-7
USPSTF
Documentation of a biannual prostate exam and Prostate-Specific Antigen (PSA) testing beginning at age 50 for all males.

17. Education/anticipatory guidance
Preventive Services Task Force
Health education and guidance must be documented. Educational needs are based on risk factors identified through personal and family medical history and social history and current practices.

Adolescent Wellness Care

MEDICAL RECORD DOCUMENTATION REVIEW STANDARDS
For Primary Care Providers

1. Well-child screening schedule maintained
AAP
AHCA, 10.8.1a
AHCA CH CLH, pages 2-2, 2-4, 2-5
Provider Manual
Periodic comprehensive, preventive health exam visits are accomplished in accordance with the American Academy of Pediatrics and Agency for Health Care Administration. For adolescents, well-child exams are required annually from ages 11 through 20.

PCPs are responsible for contacting and scheduling or conducting preventive health screenings for members within 90 days of assignment to their panel. Member contacts and attempted contacts are documented in the medical record.

2. Interval history
AAP
AHCA, 10.8.1a
AHCA CH CLH, pages 2-6
An interval history is required at each well visit. Changes in medical, emotional and social status are documented.
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Risk screening</strong>&lt;br&gt;AHAC CH CLH, pages 2-6, 2-7, 2-15&lt;br&gt;USPSTF</td>
<td>Screening to identify high-risk individuals and assessing family, medical and social history is required. If high-risk indicators are present, appropriate follow-up or a rationale for no intervention is documented. See Amerigroup Florida's High-Risk Intervention Guide as a summary of some of the U.S. Preventive Services Task Force recommendations.</td>
</tr>
<tr>
<td><strong>4. TB risk screening</strong>&lt;br&gt;AAP&lt;br&gt;AHCA CH CLH, pages 2-15, 2-16&lt;br&gt;Pediatric Red Book</td>
<td>Screening for TB risk factors is required.&lt;br&gt;• Adolescents who have no risk factors and live in low-TB-prevalent communities do not need skin (Mantoux) testing. But the record must reflect an assessment of the risk factors to meet standards.&lt;br&gt;• Adolescents who have no individual risk factors and live in high-TB-prevalent communities and those with incomplete or unreliable risk histories or assessment are to be tested, using the Mantoux test, once between the ages of 11 and 16.</td>
</tr>
<tr>
<td><strong>5. Hemoglobin and/or hematocrit testing</strong>&lt;br&gt;AAP Recommendations 2000&lt;br&gt;AHCA, 10.8.1a&lt;br&gt;AHCA CH CLH, 2-13</td>
<td>All menstruating adolescents are screened annually with a hemoglobin and/or hematocrit.</td>
</tr>
<tr>
<td><strong>6. Urinalysis</strong>&lt;br&gt;AAP&lt;br&gt;AHCA CH CLH, pages 2-16</td>
<td>Dipstick urinalysis for leukocytes at age 16 and annually for sexually active adolescents, males and females. Must screen for sexual activity.</td>
</tr>
<tr>
<td><strong>7. Immunizations current</strong>&lt;br&gt;AAP Immunizations&lt;br&gt;AHCA, 10.8.1a, 10.8.9a, 10.8.11a, 20.13 a (10)&lt;br&gt;AHCA CH CLH, pages 2-17</td>
<td>Documentation of immunization status:&lt;br&gt;• An immunization record is present&lt;br&gt;• Immunizations are current in accordance with the recommendations of the AAP&lt;br&gt;• If immunizations (MMR, TD, varicella, hepatitis B) are not current, it is noted by the provider and a catch-up plan is documented; there is evidence the plan is being followed for new patients; it is documented that immunization records have been requested and indicate whether they are reported to be up-to-date for patients with documentation of a previous request for immunization records; the immunization record and/or a catch-up plan is noted in the record within six months or at the next well-child visit, whichever is sooner.</td>
</tr>
<tr>
<td><strong>8. Vital signs</strong>&lt;br&gt;AAP&lt;br&gt;AHCA CH CLH, pages 2-9</td>
<td>Pulse, respirations and blood pressure are required at each well visit.</td>
</tr>
<tr>
<td><strong>9. Nutritional assessment</strong>&lt;br&gt;AAP&lt;br&gt;AHCA, 10.8.1.a&lt;br&gt;AHCA CH CLH, pages 2-2, 2-7</td>
<td>Assessment incorporates dietary intake, eating habits and physical growth. The following must be documented for each well-child visit:&lt;br&gt;• Height</td>
</tr>
<tr>
<td>ELEMENTS</td>
<td>GUIDELINES</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| 10. Vision screening | Vision screening, by physical exam, history and standardized testing, must be documented. The following minimum standards are required:  
- Ages 12, 15 and 18: objective, standardized testing  
- Ages 11, 13, 14, 16, 17, 19 and 20: subjective assessment |
| AAP, AHCA, 10.8.1.a, AHCA CH CLH, pages 2-2, 2-10, 2-11 |

| 11. Hearing screening | Hearing screening, by physical exam, history and standardized testing, must be documented. The following minimum standards are required:  
- Ages 12, 15 and 18: objective, standardized testing  
- Ages 11, 13, 14, 16, 17, 19 and 20: subjective assessment |
| AAP, AHCA, 10.8.1.a, AHCA CH CLH, pages 2-2, 2-11, 2-12 |

| 12. Physical exam | Appropriate evaluation for inclusion in the physical examination of an asymptomatic adolescent are:  
- General appearance  
- Skin  
- Head  
- Gums/dental/oral  
- Eyes/ears/nose/throat  
- Neck/thyroid  
- Chest/lungs  
- Cardiovascular  
- Breasts  
- Abdomen/GI  
- Genital/urinary  
- Extremities  
- Musculoskeletal  
- Neurological  
- Lymphatic |
| AAP, AHCA, 10.8.1.a, AHCA CH CLH, pages 2-2, 2-9, 2-11 |

If noncompliance or refusal for all or portions of the exam, documentation of noncompliance and associated risks are required.

| 13. Dental screening | Dental screening consists of a documented oral exam, and documentation of PCP recommendation/referral to a dentist is required. |
| AAP, AHCA, 10.8.1.a, AHCA CH CLH, pages 2-2, 2-10 |

| 14. Annual Pap smear | Annual Pap smears for cervical cancer screening are required for all sexually active females, regardless of age, and all females 18 and older. Documentation for females ages 15 through 20 must address sexual activity. |
| AAP, AHCA CH CLH, pages 2-11, 2-17 USPSTF |

| 15. Chlamydia screening | Screening for chlamydia for all sexually active females younger than 21 is required. Documentation for females ages 15 through 20 must address sexual activity. |
| AHCA CH CLH, pages 2-15 USPSTF |

| 16. Physical and mental health developmental assessment | Required for each wellness visit. The focus of the assessment is on areas of special concern for adolescents (e.g., physical development, potential learning disabilities, social/emotional development, peer relations, psychological/psychiatric problems and vocational skills). |
| AAP, AHCA, 10.8.1.a, AHCA CH CLH, pages 2-2, 2-6, 2-8, 2-9 |

| 17. Anticipatory guidance/health | Age-appropriate health education and guidance must be |
| | |
### ELEMENTS

<table>
<thead>
<tr>
<th>education</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
</tr>
<tr>
<td>AHCA, 10.8.1.a</td>
</tr>
<tr>
<td>AHCA CH CLH, pages 2-18</td>
</tr>
</tbody>
</table>

### GUIDELINES

documented for each well-child visit. The following topics are to be addressed and documented:

- Injury prevention
- Importance of physical activity
- Nutritional counseling
- Puberty and general sex education, age appropriate
- Pregnancy prevention and STDs, as appropriate for age and history
- School performance and absenteeism
- Tobacco/alcohol/drug use and abuse
- Violence prevention

Other topics important to adolescents:

- The Amerigroup Nurse HelpLine
- The Amerigroup website community resources:
  - Pregnancy prevention and abstinence programs
  - Smoking cessation programs
  - Substance abuse programs/resources
  - Support groups

---

### Infant, Young and Middle Childhood

**MEDICAL RECORD DOCUMENTATION REVIEW STANDARDS**

**For Primary Care Providers**

<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Well-child screening schedule maintained</strong></td>
<td></td>
</tr>
<tr>
<td>AAP</td>
<td></td>
</tr>
<tr>
<td>AHCA 10.8.1.a</td>
<td></td>
</tr>
<tr>
<td>AHCA CH CLH pages 2-4, 2-5</td>
<td></td>
</tr>
<tr>
<td>Provider Manual</td>
<td></td>
</tr>
<tr>
<td>Periodic comprehensive, preventive health exam visits are accomplished in accordance with the AAP and AHCA.</td>
<td></td>
</tr>
<tr>
<td>• Within two to four days following discharge, within 48 hours after delivery or if breastfeeding</td>
<td></td>
</tr>
<tr>
<td>• By 1 month of age</td>
<td></td>
</tr>
<tr>
<td>• At ages 2, 4, 6, 9, 12, 15, 18 and 24 months</td>
<td></td>
</tr>
<tr>
<td>• Annually from ages 2 through 20 years</td>
<td></td>
</tr>
<tr>
<td>PCPs are responsible for contacting new members and scheduling or conducting preventive health for members within 90 days of assignment to their panel.</td>
<td></td>
</tr>
</tbody>
</table>

| **2. Interval history** |
| AAP |
| AHCA 10.8.1.a |
| AHCA CH CLH pages 2-6 |
| An interval history is required at each wellness visit. Changes in medical, emotional and social status are documented. |

<p>| <strong>3. Developmental history</strong> |
| AAP |
| AHCA 10.8.1.a |
| A developmental history that provides information regarding the infant’s/child’s physical, cognitive and emotional development must be documented. |</p>
<table>
<thead>
<tr>
<th><strong>ELEMENTS</strong></th>
<th><strong>GUIDELINES</strong></th>
</tr>
</thead>
</table>
| **AHCA CH CLH pages 2-2, 2-6** | **Risk screening**  
AHCA CH CLH pages 2-6  
USPSTF  
Screening to identify high-risk individuals, assessing family, medical and social history, is required. If high-risk indicators are present, appropriate follow-up or a rationale for no intervention is documented. See Amerigroup Florida’s High-risk Intervention Guide for a summary of the U.S. Preventive Services Task Force recommendations. |
| **TB risk screening**  
AAP  
AHCA CH CLH pages 2-15, 2-16  
USPSTF | **TB risk screening**  
AAP  
AHCA CH CLH pages 2-15, 2-16  
USPSTF  
Screening for TB risk factors is required beginning at 12 months.  
Infants/children who have no risk factors and live in low-TB-prevalent communities do not need routine Mantoux testing, but the record must reflect an assessment of risk factors.  
Infants/children who have no individual risk factors and live in high-TB-prevalent communities and those with incomplete/unreliable risk histories are to be tested, using the Mantoux test, once between ages 4 and 6 years. |
| **Lead testing**  
AAP  
AHCA 10.8.1.a  
AHCA CH CLH, pages 2-2, 2-13, 2-14  
USPSTF | **Lead testing**  
AAP  
AHCA 10.8.1.a  
AHCA CH CLH, pages 2-2, 2-13, 2-14  
USPSTF  
Blood lead levels are required as follows:  
- Age 12 months  
- Age 24 months  
- Members who are between the ages of 36 and 72 months when there is no previously documented lead level  
- Any time a member is identified as high risk to lead exposure as indicated by a yes answer to one or more questions on a lead risk assessment survey |
| **Hemoglobin or hematocrit testing**  
AAP  
AHCA 10.8.1.a  
AHCA CH CLH pages 2-2, 2-15 | **Hemoglobin or hematocrit testing**  
AAP  
AHCA 10.8.1.a  
AHCA CH CLH pages 2-2, 2-15  
Hemoglobin and/or hematocrit testing are required at 18 months and 24 months of age. |
| **Urinalysis testing**  
AAP  
AHCA 10.8.1.a  
AHCA CH CLH pages 2-16 | **Urinalysis testing**  
AAP  
AHCA 10.8.1.a  
AHCA CH CLH pages 2-16  
Urinalysis testing at age 5. |
| **Immunizations current**  
AAP Immunizations  
AHCA 10.8.1a, 10.8.9a, 10.8.11a, 20.13.a (10)  
AHCA CH CLH pages 2-18, 2-19 | **Immunizations current**  
AAP Immunizations  
AHCA 10.8.1a, 10.8.9a, 10.8.11a, 20.13.a (10)  
AHCA CH CLH pages 2-18, 2-19  
To meet standards:  
- An immunization record is present  
- Immunizations are current in accordance with AAP recommendations  
- If immunizations are not current, it is noted by the provider and a catch-up plan is addressed; there is evidence the plan is being followed *(Catch-up plans are evaluated using American Academy of Pediatrics, Committee on Infectious Diseases catch-up)* |
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELEMENTS</td>
<td><strong>GUIDELINES</strong></td>
</tr>
<tr>
<td>-</td>
<td><em>recommendations)</em></td>
</tr>
<tr>
<td>-</td>
<td>• For new patients, it is documented that immunization records have been requested</td>
</tr>
<tr>
<td>-</td>
<td>• For patients with documentation of a previous request for immunization records, the immunization record and/or a catch-up plan is noted in the record within six months or at the next well-child visit (whichever is sooner)</td>
</tr>
<tr>
<td>-</td>
<td>• A history of chickenpox is documented in place of the varicella vaccine when appropriate</td>
</tr>
<tr>
<td>10. Vital signs</td>
<td>Pulse and respirations are required for infants and children of all ages. Blood pressure is required at each well-child visit, beginning at age 3.</td>
</tr>
<tr>
<td>AAP</td>
<td><em>AHCA CH CLH pages 2-9</em></td>
</tr>
<tr>
<td>11. Nutritional assessment</td>
<td>Assessment incorporates dietary intake, eating habits and physical growth. The following must be documented for each well-child visit:</td>
</tr>
<tr>
<td>AAP</td>
<td>• Height</td>
</tr>
<tr>
<td>AHCA 10.8.1.a</td>
<td>• Weight</td>
</tr>
<tr>
<td>AHCA CH CLH pages 2-2, 2-7</td>
<td>• Head circumference (age 24 months and younger)</td>
</tr>
<tr>
<td>-</td>
<td>• Dietary intake or an overall nutritional assessment are specifically addressed</td>
</tr>
<tr>
<td>12. Growth chart maintained</td>
<td>A growth chart is plotted with height and weight for infants and children. Head circumference is documented for infants and children 24 months and younger.</td>
</tr>
<tr>
<td>AHCA CH CLH pages 2-7</td>
<td>Since the growth chart is intended to help make comparative assessments, a separate growth chart for each visit does not meet the intent; values for exams on various dates are to be plotted on the same chart.</td>
</tr>
<tr>
<td>13. WIC screening</td>
<td>Documentation of participation in or a needs/eligibility assessment for the Supplemental Nutrition Program for Women, Infants and Children (WIC) is present for all children birth to age 5.</td>
</tr>
<tr>
<td>AHCA CH CLH pages 2-7</td>
<td>Infants and children up to age 5 identified as at risk or potentially at risk for poor nutrition must be referred to WIC for a nutritional and eligibility evaluation. Exception: documentation that this child is not eligible for WIC and there is patient/family education regarding nutritional needs.</td>
</tr>
<tr>
<td>14. Vision screening</td>
<td>Vision screening by physical exam, history and standardized testing must be documented. The following minimum standards are required:</td>
</tr>
<tr>
<td>AAP</td>
<td>• Infancy through 2 years; 7 and 9 years: subjective assessment</td>
</tr>
<tr>
<td>AHCA, 10.8.1.a</td>
<td>• Ages 3, 4, 5, 6, 8 and 10: objective, standardized testing</td>
</tr>
<tr>
<td>AHCA CH CLH pages 2-2, 2-10, 2-11</td>
<td>If a child is found to be too uncooperative to accomplish</td>
</tr>
<tr>
<td>ELEMENTS</td>
<td>GUIDELINES</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 15. Hearing screening                         | Hearing screening by physical exam, history and standardized testing must be documented. The following minimum standards are required:  
- Infancy through 2 years; 3, 7 and 9 years: subjective assessment  
- Ages 4, 5, 6, 8 and 10: objective, standardized testing  
If a child is found to be too uncooperative to accomplish standardized testing, this must be documented with plans to rescreen. |
| Hearing by physical exam, history and standardized testing must be documented. The following minimum standards are required:  
- Infancy through 2 years; 3, 7 and 9 years: subjective assessment  
- Ages 4, 5, 6, 8 and 10: objective, standardized testing  
If a child is found to be too uncooperative to accomplish standardized testing, this must be documented with plans to rescreen. |
| 16. Physical exam                             | **Appropriate evaluation for inclusion in the physical examination of an asymptomatic infant/child are:**  
- General appearance  
- Skin  
- Head/facial features  
- Gums/dental/oral  
- Eyes/ears/nose/throat  
- Neck/thyroid  
- Chest/thyroid  
- Cardiovascular  
- Abdomen/GI  
- Genital/urinary  
- Extremities  
- Musculoskeletal  
- Neurological  
- Lymphatic  

Physicals are performed on unclothed infants and appropriately draped children.  
Deferred does **not** meet documentation standards.  
Documentation of noncompliance or refusal for portions of the exam must be documented with the associated risk of the noncompliance or referral. |
| 17. Dental screening                          | Dental screening consists of a visual and tactile examination of the intra-oral hard and soft tissues and teeth to check for obvious abnormalities. Beginning at age 3, an annual recommendation or referral to a dentist must accompany the PCP screening. |
| 18. Physical and mental health developmental assessment | A developmental assessment must be documented at each well-child visit. Assessments include specific evaluations of gross/fine motor skills, communication/language development, visual motor integration, auditory processing skills, attention skills, and cognitive and social/emotional mental health status. |
| 19. Anticipatory guidance/health education   | Age-appropriate health education and guidance must be documented for each well-child visit. As a minimum, three of the following must be addressed for compliance:  
- Injury prevention  
- Nutritional counseling |
ELEMENTS | GUIDELINES
--- | ---
Risk of lead poisoning, ages 6 to 72 months  
- Sleep positioning counseling, birth through 6 months of age (required for infants under 6 months of age)  
- Sun protection  
- Tobacco, alcohol, drug use/abuse (school-age children)  
- Violence prevention

Other issues important to infants and children:  
- The Amerigroup Nurse HelpLine  
- Awareness of community children’s programs  
- Importance of staying on schedule with child health checkups and immunizations  
- Appropriate expectations for use of antibiotics/risk of overutilization of antibiotics  
- Appropriate use of health care providers; when to use PCP, urgent care and emergency rooms

### High-risk Intervention Guide

<table>
<thead>
<tr>
<th>HIGH-RISK INTERVENTION GUIDE</th>
<th>AGE GROUP</th>
<th>INTERVENTION</th>
</tr>
</thead>
</table>
| **RISK** | **RISK FACTORS** | **Lifestyle counseling/ prevention:**  
- Smoking cessation  
- Diet and exercise  
- Stress reduction  
- Screening for high cholesterol, 2 years and older  
- Nonfasting total cholesterol for children/ adolescents with parental history of premature cardiovascular disease  
- Fasting lipid profile for children/ adolescents with parental history of premature cardiovascular disease |
| Coronary artery disease | Smoking  
- Hypertension  
- High cholesterol  
- Family history  
- Obesity  
- Diabetes  
- Men over 50 years  
- Women, post-menopausal  
- Women over 50 years  
- Children/adolescents* whose parents or grandparents younger than 55 years of age had:  
  - Diagnosed coronary atherosclerosis by arteriography, balloon angioplasty or coronary artery bypass surgery  
  - Documented myocardial infarction, angina pectoris, peripheral vascular disease  
  - Disease, cerebrovascular disease or sudden cardiac death  
- Children/adolescents whose parents | All ages with multiple risk factors |
## HIGH-RISK INTERVENTION GUIDE

<table>
<thead>
<tr>
<th>RISK</th>
<th>RISK FACTORS</th>
<th>AGE GROUP</th>
<th>INTERVENTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis</td>
<td>• Intravenous (IV)/street drug use</td>
<td>All ages</td>
<td>• Counseling regarding high-risk behaviors</td>
</tr>
<tr>
<td></td>
<td>• High-risk sexual behavior</td>
<td></td>
<td>• Hepatitis B vaccine (if series not documented)</td>
</tr>
<tr>
<td></td>
<td>• Current or past HIV-positive partners</td>
<td></td>
<td>• Hepatitis A vaccine (consider, if not previously vaccinated)</td>
</tr>
<tr>
<td></td>
<td>• Person/partner exchange sex for money or drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bisexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Men who have sex with men</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Partners with history of IV drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Multiple partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Partners with multiple partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unprotected sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Person/partners with history of STDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Health care/lab workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Have an elevated blood cholesterol level of 240 mg/dL or higher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>• High-risk sexual behavior (see Hepatitis above)</td>
<td>• All ages</td>
<td>• Counseling regarding high-risk behaviors</td>
</tr>
<tr>
<td></td>
<td>• Current or past history of IV/street drug use</td>
<td>• *Birth to 2 months</td>
<td>• Counseling regarding high-risk behaviors</td>
</tr>
<tr>
<td></td>
<td>• Blood product transfusion between 1978 and 1985</td>
<td></td>
<td>• Counseling/recommendation for HIV testing</td>
</tr>
<tr>
<td></td>
<td>• Infants born to high-risk mothers whose HIV status is unknown*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>• Residents of chronic care facilities*</td>
<td>• *6 months or older</td>
<td>• Risk counseling</td>
</tr>
<tr>
<td></td>
<td>• Suffer chronic cardiopulmonary disorders, metabolic diseases, hemoglobinopathies, immunosuppression, renal dysfunction*</td>
<td>• 65 or older</td>
<td>• Influenza vaccine, annually</td>
</tr>
<tr>
<td></td>
<td>• Health care workers for patients at risk*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neural tube</td>
<td>• History of pregnancy with neural tube defect and planning a pregnancy</td>
<td>Women of childbearing age</td>
<td>Offer treatment with folic acid prior to conception</td>
</tr>
<tr>
<td>defects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>• Young immunocompromised children (ages 24 to 59 months) at high risk of pneumococcal infections*</td>
<td>*24 to 59 months</td>
<td>Risk counseling</td>
</tr>
<tr>
<td>disease</td>
<td>• Immunocompetent adolescents; children and adults with chronic cardiac or pulmonary disease, diabetes mellitus, anatomic asplenia**</td>
<td>**4 years or older</td>
<td>* Prevnar, two doses per administration guidelines (ages 24 to 59 months)</td>
</tr>
<tr>
<td></td>
<td>• HIV-positive</td>
<td>• 65 and older</td>
<td>** Pneumococcal vaccine × 1 (revacci-</td>
</tr>
<tr>
<td>RISK</td>
<td>RISK FACTORS</td>
<td>AGE GROUP</td>
<td>INTERVENTION</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| High-risk intervention      | • Immunocompetent institutionalized individuals  
                              • Adults 65 years of age and older                                      | nation after five years at provider discretion for those with severe chronic disease  
                              • Revaccination after five years at provider discretion for adults 75 years and older |
| STDs other than HIV         | • High-risk sexual behavior (see Hepatitis above)  
                              • Current or past history of IV/street drug use                        | All ages, sexually active | • Counseling regarding high-risk behaviors  
                              • Counseling/recommendation for HIV testing  
                              • RPR  
                              • Screen for gonorrhea (females)  
                              • Screen for chlamydia (females)  
                              • Hepatitis B vaccine (if series not documented)  
                              • Hepatitis A vaccine (consider, if not previously vaccinated) |
| Tuberculosis                | • Contact with persons with confirmed or suspected TB infection            | 12 months and older | Risk counseling Mantoux testing:  
                              • I: Immediate testing using Mantoux test  
                              • A: Annual testing using Mantoux test  
                              • Every two to three years: Mantoux test every two to three years  
                              • *Children: Mantoux testing once between ages 4 to 6 years  
                              • Adolescents, once |
|                             | • Contact with persons in jail/prison in past five years  
                              • Clinical or radiographic findings suggesting TB  
                              • Are from have parents from or travel histories to regions of the world with high prevalence of TB infection (most countries in Africa, Asia, Latin America and Middle East)  
                              • Parent recently converted from negative to positive  
                              • HIV-positive  
                              • Incarcerated individuals |
### HIGH-RISK INTERVENTION GUIDE

<table>
<thead>
<tr>
<th>RISK</th>
<th>RISK FACTORS</th>
<th>AGE GROUP</th>
<th>INTERVENTION</th>
</tr>
</thead>
</table>
|      | - Frequently exposed to the following:  
- HIV-positive individuals  
- Homeless populations  
- Residents of nursing homes  
- Institutionalized persons  
- Migrant farm workers  
- IV/street drug users | | between 11 and 16 years |

Children and adolescents who have no risk factors and live in high-TB-prevalent communities and those with incomplete/unreliable risk histories or assessments* |

### Diabetes

### MEDICAL RECORD DOCUMENTATION REVIEW STANDARDS
For Primary Care Physicians

<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
</table>
| 1. Baseline medical history  
ADA, Standards of Medical Care in Diabetes, 2005, Table 5 | Elements of the baseline medical history are:  
- Current symptoms  
- History of glucose control (results of prior A1C records and lab studies related to the diagnosis of diabetes)  
- Results of glucose self-monitoring  
- Exercise history  
- Eating patterns, nutritional status, weight history; growth and development in children and adolescents  
- Previous treatment programs and diabetic education  
- All current medications, including over-the-counter  
- Frequency, severity of acute complications such as ketoacidosis and hypoglycemia  
- Symptoms and treatment of chronic eye, kidney, nerve, foot, GI, GU, heart and vascular complications  
- Risk factors to include smoking, alcohol use, hypertension, obesity, dyslipidemia and family history  
- Lifestyle, cultural, psychological and economic factors that might affect management of diabetes |

| 2. Baseline physical exam  
ADA, Standards of Medical Care in Diabetes, 2005, Table 5 | A baseline physical examination includes the following assessments:  
- Height and weight (and comparison to norms in children and adolescents)  
- Sexual maturation (during the peripubertal period) |
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td></td>
</tr>
<tr>
<td>Fundoscopic examination</td>
<td></td>
</tr>
<tr>
<td>Oral, dental</td>
<td></td>
</tr>
<tr>
<td>Thyroid palpation</td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td></td>
</tr>
<tr>
<td>Abdominal</td>
<td></td>
</tr>
<tr>
<td>Evaluation of pulses</td>
<td></td>
</tr>
<tr>
<td>Extremities/hand/fingers/feet</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
</tr>
</tbody>
</table>

A comprehensive baseline physical exam is required:

- For diabetics newly assigned to the PCP’s panel (within three months)
- Upon diagnosis for diabetics (newly diagnosed members already established with the PCP’s practice)

* For diabetics younger than 21 years, comparisons to normal growth, development and sexual maturation can be documented as plotted growth charts, tanner maturation staging or in narrative descriptions

3. **Interim history**  
   ADA, Standards of Medical Care in Diabetes, 2005  
   An interim history must be obtained at each diabetic visit and should include the following:
   - Frequency, causes and severity of hypo- or hyperglycemia
   - Results of blood glucose self-monitoring
   - Changes patient made to the therapeutic regime
   - Problems with adherence
   - Symptoms suggesting complications of diabetes
   - Other medical illnesses
   - Psychosocial issues
   - Lifestyle changes
   - Continuation of tobacco or alcohol use

4. **Follow-up examination**  
   ADA, Standards of Medical Care in Diabetes, 2005  
   Routine follow-up diabetic examinations are indicated at least every **three months** for diabetics who are not meeting treatment goals and at least every **six months** for those who are meeting goals. The following must be addressed:
   - Blood pressure
   - Follow-up on abnormalities on previous visits
   - Visual inspection of the feet
   - Weight
   - Sexual maturation (in peripubertal patients)

5. **A1C measurement**  
   ADA, Standards of Medical Care in Diabetes, 2005, Tables  
   A1C levels are required every three months in patients who are not meeting treatment goals and every six months if treatment goals are being met.
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 and 9</td>
<td>Treatment goals:</td>
</tr>
<tr>
<td></td>
<td>• 20 years and older, A1C &lt; 7 percent</td>
</tr>
<tr>
<td></td>
<td>• Adolescents 13 to 19 years &lt; 7.5 percent</td>
</tr>
<tr>
<td></td>
<td>• Children 6 to 12 years &lt; 8 percent</td>
</tr>
<tr>
<td></td>
<td>• Children younger than 6 years 7.5 percent to 8.5 percent</td>
</tr>
</tbody>
</table>

6. **Lipid measurement**  
ADA, Standards of Medical Care in Diabetes, 2005  
Fasting lipid profiles are indicated at least annually for adults and per guidelines below for children.

Treatment goals are:  
• 20 years and older:  
  - LDL <100 mg/dl (<2.6 mmol/l)  
  - Triglycerides <150 (<1.7 mmol/l)  
  - HDL > 40 (>1.1 mmol/l)  
• Adolescents:  
  - Measure once at puberty (>12 years), LDL  
  - < 100 mg/dl measure in 5 years  
  - If abnormal LDL, >100 mg/dl, continue annual monitoring  
  - Children ages 2 years to puberty, monitor per high-risk guidelines

7. **Microalbumin**  
ADA, Standards of Medical Care in Diabetes, 2005  
Annual screening for albuminuria.

Screening can be performed by the following methods:  
• Albumin-to-creatinine ratio in a random, spot urine  
• 24-hour urine collection with creatinine, allowing for the simultaneous measurement of creatinine clearance  
• Timed (e.g., four-hour or overnight) urine collection  
• If reagent tablets or dipsticks for microalbumin are used, all positive results should be confirmed by more specific methods  
  - Microalbumin, spot urine

8. **Annual foot exam**  
ADA, Standards of Medical Care in Diabetes, 2005  
A comprehensive foot exam is required annually for all individuals with diabetes. Exams are to include assessment of:  
• Structure and biomechanics  
• Vascular status (including pulses)  
• Skin integrity  
• Neurological status/protective sensation (Semmes-Weinstein monofilament test and tuning fork)

If a podiatry referral is used, documentation of the exam must be obtained by the PCP and maintained in the record.  
Providing a written referral, with request and instructions for
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>return, will facilitate the prompt return findings.</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **9. Dilated eye exam**  
ADA, Standards of Medical Care in Diabetes, 2005 | A dilated eye exam for retinopathy by an ophthalmologist or optometrist is required annually. |
| **10. Documentation of results of dilated eye exams**  
Medicaid Contract 2004-2006, 20.13.a (9)  
AAAHC, Ch. 6, C, H | Results of the dilated eye exam must be present in the record. Providing a written referral, with request and instructions for return, will facilitate the prompt return of findings. |
| **11. Documentation of results of dilated eye exams**  
Medicaid Contract 2004-2006, 20.13.a (9)  
AAAHC, Ch. 6, C, H | The influenza vaccine is indicated annually for patients age 6 months and older who have diabetes.  
The CDC recommends a vaccination period from September 1 through December 30 (ideally prior to November 30 for high-risk individuals). |
| **12. Pneumococcal vaccination**  
ADA, Standards of Medical Care in Diabetes, 2005  
U.S. Preventive Services Task Force, 3rd Edition | The one-time pneumococcal vaccine is indicated for all patients with diabetes.  
**Exception:** A one-time revaccination is recommended for patients older than 64 who were previously immunized when younger than 65 years and the vaccine was administered over five years ago. |
| **13. Diabetic education and nutrition counseling**  
ADA, Standards of Medical Care in Diabetes, 2005 | Appropriate diabetic and nutritional education and counseling, as defined by the ADA will be addressed at each diabetic visit. Educational goals are to increase understanding of diabetes and the patient’s role in self-management and ultimately to reduce or prevent diabetes-related complications. |
| **14. Appropriate referral and follow-up**  
ADA, Standards of Medical Care in Diabetes, 2005  
Medicaid Contract 2004-2006, 20.13.a(9)  
Amerigroup FL, Medical Record Documentation Review Standards, General Medical Care, standard #11 | Complications or high-risk issues are addressed. Consultations for specialized services, such as podiatry, endocrinology, cardiology, neurology, etc., are ordered when the patient’s condition warrants. |
| **15. Requested tests/consults accomplished/filed**  
AAAHC, Std 4, D5, 7, 8; Std 6H Medicaid Contract 2004-2006, 20. 13, a (5) | Results of the consults and diagnostic tests are available in the record in a timely manner. |
| **16. Treatment plan**  
ADA, Standards of Medical | Visits for continuing care of diabetes (every three to six months) must have treatment plans that address the following: |
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>GUIDELINES</th>
</tr>
</thead>
</table>
| Care in Diabetes, 2005 Medicaid Contract 2004-2006, 20.13.9 | • Treatment goals  
• Progress towards attaining treatment goals (e.g., glycemic, and lipid control, weight management, physical activity, blood pressure) |

References

MEDICAL RECORD REVIEW DOCUMENTATION STANDARDS REFERENCES

<table>
<thead>
<tr>
<th>AAAHC</th>
<th>Accreditation Association for Ambulatory Health Care, Accreditation Guidebook for Managed Care Organizations, 2009 Edition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, Recommendations for Preventive Pediatric Health Care, March 2000</td>
</tr>
<tr>
<td>AAP Immunizations</td>
<td>American Academy of Pediatrics, Committee on Infectious Diseases, Recommended Childhood and Adolescent Immunization Schedule: United States, 2005</td>
</tr>
<tr>
<td>ACS</td>
<td>American Cancer Society, Guidelines for Colorectal Cancer Screening for Individuals at Average Risk, Reviewed 2003</td>
</tr>
<tr>
<td>AHCA</td>
<td>Florida Agency for Health Care Administration, Medicaid Contract 2004–2006</td>
</tr>
<tr>
<td>AHCA CH CLH</td>
<td>Florida Agency for Health Care Administration, Medicaid Child Health Check-Up Coverage and Limitations Handbook, October 2003</td>
</tr>
<tr>
<td>AHCA CLH</td>
<td>Florida Agency for Health Care Administration, Medicaid Physician Services Coverage and Limitations Handbook, January 2007</td>
</tr>
<tr>
<td>Provider Manual</td>
<td>Amerigroup Florida Provider Manual</td>
</tr>
<tr>
<td>USPSTF</td>
<td>U.S. Preventive Services Task Force, Guide to Clinical Preventive Services, 3rd Edition</td>
</tr>
</tbody>
</table>

Infection Prevention

In order for our providers to ensure members are treated in a safe and sanitary environment, you must implement nationally recognized Infection Control guidelines, such as those through the CDC. The infection prevention program’s purpose is to identify and prevent infections and maintain a sanitary practice environment.

Your office staff must be educated on:

• A process for identifying and preventing infections through activities such as proper hand hygiene and safe injection practices
• A process for the management of identified hazards, potential threats, near misses, and other safety concerns; this includes monitoring of products including medications, reagents and solutions that carry an expiration date
• Being aware of and a process for the reporting of known adverse incidents to the appropriate state and federal agencies when required by law to do so
• A process to reduce and avoid medication errors
• Prevention of falls or physical injuries involving patients, staff and all others

You must have a written emergency and disaster preparedness plan to address internal and external emergencies to ensure member safety and includes an evacuation plan.

You must provide for accessible and available health services, ensuring information about services when provider practices are not open.

Amerigroup and our providers must comply with applicable state and local building codes and regulations; applicable state and local fire prevention regulations, such as the NFPA 1010 Life Safety Code, 2000 edition, published by the National Fire Protection Association, Inc.; and applicable federal regulations.

Provider practice sites must:
• Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire
• Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall
• Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of member and staff, in case of an emergency
• Have stairwells protected by fire doors, when applicable
• Provide examination rooms, dressing rooms and reception areas that are constructed and maintained in a manner ensuring member privacy during interviews, examinations, treatment and consultation
• Operate in a safe and secure manner
• Have provisions to reasonably accommodate disabled individuals

Ensure you have the necessary personnel, equipment, supplies and procedures to deliver safe care and handle medical and other emergencies that may arise. Have periodic instruction of all staff in the proper use of safety, emergency, and fire-extinguishing equipment and hold periodic drills.

These items will be reviewed during site review for each cycle of credentialing and recredentialing. All items will be scored using the Practitioner Site Office tool.

**Risk Management**

Risk Management is defined as the identification, investigation, analysis and evaluation of risks and the selection of the most advantageous method of correcting, reducing or eliminating identifiable risks.

The Risk Management Program at Amerigroup is intended to protect and conserve the human and financial assets, public image and reputation of the provider of care and/or the organization from the consequences of risks associated with members, visitors and employees at the lowest reasonable cost:
• To minimize the incidents of legal claims against the provider of care and/or organization
• To enhance the quality of care provided to members
• To control the cost of losses
• To maintain patient satisfaction with the provider of care and the organization

The scope of the Risk Management Program is organization-wide. Each member of the medical care team has an equally important role to play in minimizing the occurrence of incidents. All providers of care, agents and employees of Amerigroup have the affirmative duty to report adverse or untoward incidents (potential or actual) on an incident report and to send the report to specific personnel for necessary follow-up.

The activities of the risk manager will contribute to the quality of care and a safer environment for members, employees, visitors and property, as well as to reduce the cost of risk to the provider of care and the organization.

These activities are categorized as those directed toward loss prevention (pre-loss) and those for loss reduction (post-loss).

The primary goal of pre-loss activity is to correct, reduce, modify or eliminate all identifiable risk situations, which could result in claims and litigation for injury or loss.

This can be accomplished through:
• Providing ongoing education and training programs in risk management and risk prevention
• Participating in safety, utilization review, quality assessment and improvement activities
• Interfacing with the medical staff to ensure communication and cooperation in risk management
• Exchanging information with professional organizations, peers and other resources to improve and update the program
• Analyzing member grievances that relate to member care and the quality of medical services for trends and patterns

The primary goal of post-loss activity is the selection of the most advantageous methods of correcting identifiable risks and claim control. This can be accomplished through an effective and efficient incident reporting system.

All employees of Amerigroup will be given education on the Internal Incident Reporting System, which outlines the incident reporting responsibilities and includes the definition of adverse or untoward incidents, a copy of the plan inquiry form, appropriate routing and the required time frame for reporting incidents to the risk manager.

Provider input and participation in the QM process further emphasizes the identification of potential risks in the clinical aspects of member care.

Internal Incident Reporting System
The Internal Incident Reporting System establishes the policy and procedure for reporting adverse or untoward incidents that occur.
Definitions

Adverse or untoward incident — an event over which health care personnel could exercise control and:

- Is more probably associated in whole or in part with medical intervention rather than the condition for which such intervention occurred
- Is not consistent with or expected to be a consequence of such medical interventions
- Occurs as a result of medical intervention to which the member has not given his or her informed consent
- Occurs as a result of any other action or lack thereof on the part of the facility or personnel of the facility
- Results in a surgical procedure being performed on the wrong member
- Results in a surgical procedure unrelated to the member’s diagnosis or medical needs being performed on any member
- Causes injury to a member as defined below

Injury — any of the following outcomes when caused by an adverse incident:

- Death
- Fetal death
- Brain damage
- Spinal damage
- Surgical procedure performed on the wrong site
- Surgical procedure performed on the wrong patient
- Wrong surgical procedure
- Surgical procedure unrelated to the patient’s diagnosis
- Surgical procedure to remove foreign objects remaining from a surgical procedure

These issues are applicable with all Amerigroup members:

- Abuse/neglect
- Altercations
- Elopement
- Escape
- Exploitation
- Homicide
- Injury or illness
- Medication errors
- Sexual battery
- Suicide
- Suicide attempt

Reporting Responsibilities

- All incidents involving members must be reported to the risk manager or risk manager designee within three calendar days. If the incident has resulted in serious or potentially serious member
harm (Code 15), the risk manager must be contacted immediately if during the day, and the medical director must be contacted immediately if during the night.

- The organization must report Code 15 incidents to the Agency for Health Care Administration (AHCA) within three calendar days after its occurrence. A more detailed follow-up report must be submitted to AHCA within 10 days after the first report. AHCA may require an additional final report.

- All participating and direct service providers are required to report adverse incidents to the Managed Care Plans within twenty-four (24) hours of the incident. The Managed Care Plan must ensure that all participating and direct service providers are required to report adverse incidents to the Agency immediately but not more than twenty-four (24) hours of the incident. Reporting will include information including the enrollee’s identity, description of the incident and outcomes including current status of the enrollee.

- Amerigroup shall report suspected adult abuse, neglect and exploitation of enrollees immediately, in accordance with Chapter 415, F.S. Suspected cases of abuse, neglect and/or exploitation must be reported to the state’s Adult Protective Services Unit. The Florida Adult Protective Services has the responsibility for investigating allegations of abuse, neglect and exploitation of elders and individuals with disabilities.

- Additionally, Amerigroup reports any related behavioral health clinical incidents to AHCA monthly.

Procedural Responsibilities

- The provider staff member involved in observing or first discovering the unusual incident or an Amerigroup staff member who becomes aware of an incident is responsible for initiating the incident report before the end of the working day. Reports will be fully completed on the incident report form and will provide a clear, concise, objective description of the incident. The director of the department involved in observing the risk situation will assist in the completion of the form, if necessary.

- The director of the department involved will forward all incident reports to the risk manager or risk manager designee within three calendar days. Upon being logged and date-stamped by the risk manager, the QM department will solicit information from other departments and/or providers. All incident reports resulting in serious or potentially serious member harm will be forwarded to the risk manager or risk manager designee immediately for consideration of Code 15 reporting.

- The National Customer Care department associate is responsible for initiating incident reports for member grievances that relate to an adverse or untoward incident.

- The QM Committee will review all pertinent safety-related reports.

- The QM Committee, MAC and/or Peer Review Committee will review pertinent member-related reports.

- Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be kept in a file, separate from the enrollee’s case file, that is designated as confidential. Such file shall be made available to the Agency upon request.

- The only copy of a member incident report will be kept in the office of the risk manager, and reports will not be photocopies or carbon copies. Employees, providers and agents are prohibited from placing copies of an incident report in the medical record. Employees, providers and agents are prohibited from making a notation in the medical record referencing the filing of an incident report.
• The risk manager will communicate with department directors and managers to provide follow-up, as appropriate. If corrective action is needed on the part of an Amerigroup associate, the Human Resources department will execute.
• The risk manager will follow up on all incidents pertinent to quality to determine causes and possible preventive interventions.
• The risk manager will keep statistical data of incidents for analysis purposes.
• Original incident reports will be maintained in the office of the risk manager for a minimum of six months.

Incident Report Review and Analysis
• The risk manager will review all incident reports and analyze them for trends and patterns. This includes the frequency, cause and severity of incidents by location, practitioner and type of incident.
• The risk manager will have free access to all health maintenance organization or provider medical records.
• The incident reports will be utilized to develop categories of incidents that identify problems.
• Once problems become evident, the risk manager will make recommendations for corrective actions, such as procedure revisions.
• Should definitive injuries occur, cases will be categorized using the ICD-CM coding classification.

An incident report is an official record of incident and is privileged and confidential in all regards. No copies will be made of any incident report for any reason, other than those situations authorized by applicable law.

Credentialing
Amerigroup credentialing policies and procedures incorporate the current National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Managed Care Organizations as well as the Florida Department of Health (FDOH) requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom we contract.

Amerigroup will accept the provider’s copy of the Council for Affordable Quality Healthcare (CAQH) applications in lieu of an Amerigroup application form.

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 our policies, procedures and rules.

Credentialing Requirements
Each provider, applicable ancillary/facility and hospital will remain in full compliance with the Amerigroup credentialing criteria as set forth in our credentialing policies and procedures and all applicable laws and regulations. Each provider, applicable ancillary/facility and hospital will complete the Amerigroup application form upon request. Each provider will comply with other such credentialing criteria as may be established by Amerigroup. We are authorized to take whatever steps necessary to ensure each provider is recognized by the state Medicaid program, including its choice
counseling/enrollment broker contractor(s) as a participating provider of Amerigroup, and the
provider’s submission of encounter data is accepted by the Florida Medicaid Management Information
Systems and/or the state’s encounter data warehouse. Each provider must supply us with his or her
Medicaid information number or complete the managed care treating provider registration form prior
to participation.

Each provider must have a unique Florida Medicaid provider number, Medicaid provider registration
number or documentation of submission of the Medicaid provider registration form.

Amerigroup requires each provider to have a National Provider Identifier (NPI) in accordance with s.
1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997.

Credentialing Procedures
We are committed to operating an effective, high-quality credentialing program. We credential the
following provider types: medical doctors, doctors of osteopathy, doctors of dental surgery, doctors of
dental medicine, doctors of podiatric medicine, doctors of chiropractic, physician assistants,
optometrists, dentists, nurse practitioners, certified nurse midwives, licensed professional
counselors/social workers, psychologists, physical/occupational therapists, 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.

We will establish a Credentialing Committee and a MAC 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 MAC.

The Amerigroup credentialing policy is revised periodically based on input from several sources,
including but not limited to, the Credentialing Committees, the health plan 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. We are responsible for externally verifying
specific items attested to on the application. Any discrepancies between information included with 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.

All providers have the right to inquire about the status of their applications. They may do so by the
following methods: (1) telephone, (2) facsimile, (3) contact through their 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 health plan 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. **Verification of enrollment** — If group enrollment, verification that provider is linked appropriately to the group and that the provider is enrolled at the appropriate service locations.

2. **Board certification** — Verification by referencing the American Medical Association 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.

3. **Verification of education and training** — Verification by referencing board certification or the appropriate state-licensing agency.

4. **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 written format and brought to the attention of the medical director and Credentialing Committee as applicable.

5. **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 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.

6. **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.

7. **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.

8. **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.

9. **Professional liability claims history** — Verification of an applicant’s history of professional liability claims, if any, reviewed by the Health Plan 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.

10. **CMS sanctions** — Verification that the practitioner’s record is clear of any sanctions by CMS. This information is verified by accessing the NPDB.

11. **Disclosures – attestation and release of information** — The Amerigroup provider application will require responses to the following:
   - Reasons for the inability to perform the essential functions of the position with or without accommodation
   - Any history or current problems with chemical dependency or 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 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 CMS sanctions
   - Attestation by the applicant of the correctness and completeness of the application
   - Written explanation of any issue identified; these explanations are presented with the provider’s application to the Credentialing Committee

12. **NPDB** — The NPDB is queried against applicants and the 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 doctors of medicine, doctors of osteopathy and physician assistants is queried to verify any restrictions/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 the health plan’s decision to accept or deny the applicant’s participation in the network.
13. **Office location review** — At the time of initial credentialing, an Amerigroup representative will complete a site visit for each office location of all providers to determine whether the provider’s office can accommodate the members and meets all requirements.

14. **Recredentialing** — At the time of recredentialing (every three years), information for PCPs from quality improvement activities and member complaints is presented for Credentialing Committee 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 provider. 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. The provider’s signature also serves as a release of information to verify credentials externally.

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.

We contract 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 Health Care Organizations (JCAHO), Health Care Facilities Accreditation Program (HFAP) or the American Osteopathic Association (AOA). The Commission on Accreditation of Rehabilitation Facilities (CARF) may accredit rehabilitation facilities. Home health agencies should be accredited by JCAHO or the Community Health Accreditation Program (CHAP). Nursing homes should be accredited by JCAHO. JCAHO or the Accreditation Association for Ambulatory Health Care (AAAHC) 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.

- We will track a facility’s/ancillary’s reassessment date and reassess every 36 months as applicable. Requirement for recredentialing of organizational providers are the same for reassessment as they are for the initial assessment.

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**

We will ensure the quality of our 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, we may evaluate a delegation of credentialing and recredentialing. The provider group must have a minimum of 150 participating providers.

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

We will perform a predelegation audit of the group’s credentialing practices. A passing score is considered to be an overall average of 90 percent compliance. The group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results.

If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.

We may, at our discretion, 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:
- To participate in the implementation of the established peer review system
- To review and make recommendations regarding individual provider peer review cases
- To 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 MAC 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 QM Committee.

The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.
MEMBER APPEAL AND GRIEVANCE PROCEDURES

Amerigroup has a formal appeal and grievance process for the handling of disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see the Provider Payment Disputes section.

The appeal process is the procedure for addressing member appeals, which are requests for review of an action. Actions are defined as the following:
- The denial or limited authorization of a requested service, including the type or level of service pursuant to 42 CFR 438 400(b)
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or part, of a payment for a service
- The failure to provide services in a timely manner as defined by the state
- The failure of the plan to act within the time frames provided in Sec. 438.408(b)

Members have the right to tell Amerigroup if they are not happy with their care or the coverage of their health care needs. These are called “Grievances and Appeals.”

A grievance is when a member is unhappy about something besides his or her health benefits. A grievance could be about a doctor’s behavior or about information the member should have received but did not.

An appeal is when a member feels he or she should be getting a service covered and is not, or when a service has been discontinued or stopped.

Complaints and Grievances

Amerigroup has a process to solve complaints and grievances. If a member has a concern that is easy to solve and can be resolved within 24 hours, Member Services can help.

If the concern cannot be handled within 24 hours and needs to be looked at by our grievance coordinator, the concern is noted and turned over to the grievance coordinator.

A complaint or grievance must be given orally or in writing within one year of the occurrence.

To file a complaint or grievance, the member can:
1. Call Member Services at 1-800-600-4441. If you are deaf or hard of hearing, call the toll-free AT&T Relay Service at 1-800-855-2880.
2. Write us a letter regarding the concern and mail it to:
   Grievance Coordinator
   Amerigroup Community Care
   4200 West Cypress St., Suite 900
   Tampa, FL 33607-4173

Members can have someone else help them with the grievance process. This person can be:
- A family member
- A friend
- A doctor
• A lawyer

The member must give written permission in order for someone else to file a grievance or an appeal on his or her behalf.

If a member needs help filing the complaint, Amerigroup can help. Call Member Services at 1-800-600-4441. If you are deaf or hard of hearing, call the toll-free AT&T Relay Service at 1-800-855-2880.

If the member or member’s representative would like to speak with the grievance coordinator to give more information, tell Member Services when the complaint is filed or put it in a letter.

Once Amerigroup gets the grievance (oral or written), we send the member a letter within five working days telling them the date we received the grievance.

What happens next?

1. The grievance coordinator reviews the concern.
2. If more information is needed or you have asked to talk to the coordinator, the coordinator will call the member or the designated representative.
3. If you have more information to give us, you can bring it to us in person or mail it to:
   
   Grievance Coordinator
   
   Amerigroup Community Care
   
   4200 West Cypress St., Suite 1000
   
   Tampa, FL 33607-4173

4. Medical concerns are looked at by medical staff.
5. Amerigroup will tell the member the decision of the grievance within 30 calendar days from the date we received the grievance.

What can a member do if he or she is unhappy with the decision?

Members have the right to file a state fair hearing. The member must do so no later than 90 days from the date he or she received notice that coverage of a service has been denied, stopped, reduced or delayed.

The Office of Appeal Hearings is not part of Amerigroup. They look at grievances of Medicaid members who live in Florida. If you contact the Office of Appeal Hearings, we will give them information about your case, including the information you have given us.

To ask for a state fair hearing contact:
Department of Children and Families
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Blvd.
Tallahassee, FL 32399-0700
Phone: 850-488-1429
Fax: 850-487-0662
Email: Appeal_Hearings@dcf.state.fl.us
Note: Members cannot ask for a Medicaid fair hearing if they have MediKids.

Members have the right to ask to receive benefits while the hearing is pending by calling Member Services toll free at 1-800-600-4441. If you are deaf or hard of hearing, please call the AT&T Relay Service toll free at 1-800-855-2880.

**Medical Appeals**

There may be times when Amerigroup says it will not pay, in whole or in part, for care that a member’s doctor recommended. If we do this, a member or someone on behalf of a member (with the member’s written consent) can appeal the decision. A medical appeal is when Amerigroup is asked to look again at the care being asked for that we said we will not pay for. Members must file for an appeal within 30 days from the date on the letter that says Amerigroup has denied, limited, reduced, suspended or terminated services. Amerigroup will not hold it against the member or the doctor for filling an appeal.

The member can have someone else help them with the appeal process. This person can be a family member, a friend, your doctor or a lawyer. Write this person’s name on the appeal form and fill out a request to designate a personal representative form.

Members can ask us to send you more information to help them understand why we would not pay for the service you requested.

**I want to ask for an appeal. How do I do it?**

An appeal may be filed verbally or in writing within 30 calendar days of when the member gets the notice of action. Except when expedited resolution is required, an oral notice must be followed by a written notice within 10 calendar days of the oral notice. The date of the oral notice will be the date Amerigroup received the notice.

There are two ways to file an appeal:
1. Write us and ask to appeal
2. Call Member Services at 1-800-600-4441 and ask to appeal. If you are deaf or hard of hearing, please call the AT&T Relay Service toll free at 1-800-855-2880.

**What else do I need to know?**

If a member or the member’s representative calls Amerigroup, we will send the member an appeal form. If the member wants someone else to help you with the appeal process, let us know, and we will send the member a form for that. Fill out the form. Mail it back to us. The member must mail it back to us within 10 days of the oral notification. We need the appeal in writing to continue. We can help the member fill out the form when we talk on the phone.

When Amerigroup receives the appeal letter or form, we will send the member a letter within five business days notifying them of the receipt of the appeal request.

The member or the representative may talk to the doctor who looks at the appeal to give more information. We can arrange for the member to talk to this person. Or you can mail it to us.
Members may ask for a free copy of the guidelines, records or other information used to make the denial and/or appeal decision.

We will notify the member of the decision within 30 calendar days of getting the appeal request.

If we reduce coverage for a service a member is receiving and the member wants to continue to get the service during the appeal, the member can call Amerigroup to ask for continuation of benefits. The member must call within 10 days of the date of the letter that tells him or her that Amerigroup will not pay for the service.

If you or the member has more information to give us, you can bring it in person or mail it to the address below. Also, the member can look at your medical records and information on this decision before and during the appeal process.

The time frame for an appeal may be extended up to 14 calendar days if:
• The member asks for an extension
• Amerigroup finds additional information is needed, and the delay is in the member’s interest

If the time frame of the appeal is extended other than at the member’s request, Amerigroup will notify the member in writing within five business days of when the decision is made.

If a member has a special need, Amerigroup will give additional help to file the appeal. Please call Member Services at 1-800-600-4441, Monday through Friday from 8:00 a.m. to 7:00 p.m. Eastern time. If you are deaf or hard of hearing, please call the AT&T Relay Service at 1-800-855-2880.

\textbf{Where do I mail my letter?}

Mail all medical information and medical necessity appeals to:
Medical Appeals
Amerigroup Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

\textbf{What can I do if Amerigroup still will not pay?}

The member or representative on the member’s behalf with the member’s written consent has a right to ask for a state fair hearing. Members do not need to file an appeal before they request a fair hearing. If the member would like to request a fair hearing, he or she must do so no later than 90 days from the date of the letter.

The Office of Appeal Hearings is not part of Amerigroup. They look at appeals of Medicaid members who live in Florida.

If you contact the Office of Appeal Hearings, we will give them information about your case, including the information you have given us.
Members have the right to ask to receive benefits while the hearing is pending by calling Member Services toll free at 1-800-600-4441. If you are deaf or hard of hearing, please call the AT&T Relay Service toll free at 1-800-855-2880.

Note: Members cannot ask for a Medicaid fair hearing if they have MediKids.

How do I contact the state for a state fair hearing?

You can contact the Office of Appeal Hearings at any time during the Amerigroup appeals process at:

DCF/Office of Appeal Hearings, Building 5, Room 255,
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

What can I do if I think I need an urgent or expedited appeal?

Members can ask for an urgent or expedited appeal if they or their physician thinks the time frame for a standard appeal process could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function.

Members can also ask for an expedited appeal by calling Member Services toll free at 1-800-600-4441, Monday through Friday from 8:00 a.m. to 7:00 p.m. Eastern time. If you are deaf or hard of hearing, please call the AT&T Relay Service toll free at 1-800-855-2880.

We must respond to the expedited request within three business days (72 hours) after we receive the appeal request, whether the appeal was made verbally or in writing.

If the request for an expedited appeal is denied, the appeal will be transferred to the time frame for standard resolution, and the member will be notified within three business days (72 hours).

If you have any questions or need help, please call Member Services toll free at 1-800-600-4441, Monday through Friday from 8:00 a.m. to 7:00 p.m. Eastern time. If you are deaf or hard of hearing, please call the AT&T Relay Service toll free at 1-800-855-2880.

How do I ask for an external appeal review?

After receiving a final determination from Amerigroup, you can call or write the Beneficiary Assistance Program (BAP):

Agency for Health Care Administration
Beneficiary Assistance Program
2727 Mahan Drive, Building 1, M.S. 26
Tallahassee, FL 32308
1-888-419-3456 or 1-850-412-4502

Before filing with the BAP, you must finish the Amerigroup appeals process.

You must ask for the appeal to the BAP within one year after receipt of the final decision letter from Amerigroup.

The BAP will not handle an appeal that has already been to a Medicaid fair hearing.
The BAP will finish its review and make a decision.

CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

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

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 providers.amerigroup.com/FL. 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 the Amerigroup EDI Hotline at 1-800-590-5745.

Paper Claims Submission

Providers also have the option of submitting paper claims. Amerigroup uses Optical Character Reading (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Amerigroup 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) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed 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/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third party documents resolution of the claim.
**Paper claims** must be submitted **within 180 days** of the date of service and submitted to the following address:

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

**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) claim form unless other arrangements are approved by Amerigroup. Data will be submitted in a timely manner, but no later than 180 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 ID
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider tax ID number and state Medicaid ID number

**Encounter data** should be submitted to the following address:

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

Through claims and encounter data submissions, HEDIS® information is collected. This includes, but is not limited to, the following:
- Preventive services (e.g., childhood immunization, mammography, Pap smears)
- Prenatal care (e.g., LBW, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by the Amerigroup utilization and quality improvement staff, coordinated with the medical director and reported to the Quality Management Committee on a quarterly basis. The Primary Care Provider (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 from the network.
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 Manuals. Institutional claims should be submitted using EDI submission methods or a UB-04 CMS-1450 or successor forms; provider services should be submitted 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 services are 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 date the service is rendered; for inpatient claims filed by a hospital, submit claims within 120 days from the date of discharge
- In the case of other insurance, submit claims within 180 days of receiving a response from the third-party payer
- Claims for members whose eligibility has not been added to the state’s eligibility system must be received within 180 days from the date the eligibility is added and Amerigroup is notified of the eligibility/enrollment. Claims submitted after the 180-day filing deadline will be denied

After filing a claim with Amerigroup, review the 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 using the Amerigroup provider website at providers.amerigroup.com/FL 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.

International Classification of Diseases, 10th Revision (ICD-10) Description

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with HIPAA requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9) which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:
Clinical modification (CM): ICD-10-CM is used for diagnosis coding
Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

Clean Claims Payment

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

- Is submitted by the provider in a timely manner
- Is accurate
- Is submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS-1450, or successor forms thereto, or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by the 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, we will pay all applicable interest as required by law.

We produce and mail an EOP on a biweekly basis, which delineates the status of each claim that has been adjudicated during the previous week. Upon receipt of the requested information from the provider, we 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 that are determined to be unclean will be returned to the Amerigroup contracted clearinghouse that submitted the claim.

In accordance with state requirements, we will pay at least 90 percent of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 30 days of the date of receipt. We will pay at least 99 percent of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within 120 days of the date of receipt. 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

You can visit the Amerigroup website located at providers.amerigroup.com/FL or call the automated Provider Inquiry Line at 1-800-454-3730 to check claims status.

High-dollar claims may be placed in a prepayment pending status, to enable third party vendor (Equian) claims review. An itemized bill may be requested for claims review, only if otherwise indicated in your contract.
Provider Reimbursement

Increased Medicaid Payments for Primary Care Physicians and Eligible Providers

In compliance with the Patient Protection and Affordable Care Act (PPACA), as amended by Section 1202 of the Health Care and Education Reconciliation Act, Amerigroup reimburses eligible Medicaid Primary Care Providers (PCPs) at parity with Medicare rates for qualified services in calendar years 2013 and 2014.

If you meet the requirements for the PPACA enhanced physician reimbursement and haven’t yet submitted a completed attestation, you should do so as soon as possible to qualify for enhanced payments. Visit https://providers.amerigroup.com/pages/nv-2012.aspx and look in our News & Announcements section for links to information and instructions to follow or https://dhcfp.nv.gov/Index.htm.

Amerigroup process for supporting enhanced payments to eligible providers

As set forth in Section 1202 of the PPACA:

- Conditioned upon the state of Florida requiring and providing funding to Amerigroup, Amerigroup will provide increased reimbursement to Medicare levels or some other federal or state-mandated level for specified CPT-4 codes for primary care services furnished with dates of service in 2013 and 2014 by providers who have attested to their eligibility to receive such increased reimbursement as set forth in the Section 1202 of the PPACA.
- Such CPT-4 codes will be paid in accordance with the requirements of PPACA and the State and will not be subject to any further enhancements from Amerigroup or any other source.

Provider responsibilities with regard to payments

If you completed the attestation process as required by the state, the following procedures and guidelines apply to you regarding payments received from Amerigroup:

- If you are a group provider, entity or any person other than the eligible provider who performed the service, you acknowledge and agree you will direct any and all increased reimbursements to such eligible providers or otherwise ensure such eligible providers receive direct and full benefit of the increased reimbursement in accordance with the final rule implementing PPACA. You also acknowledge and agree you will provide Amerigroup with evidence of your compliance with this requirement upon request.

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 accounts. In addition, providers can select from a variety of remittance information options, including:

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

To register for ERA/EFT, please visit our website at providers.amerigroup.com/FL.

**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 and receipt of the required claims and encounter information to Amerigroup.

**Overpayment Process**
Refund notifications may be identified by two entities, Amerigroup and its contracted vendors or the Providers. Amerigroup 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, Amerigroup will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

If a provider identifies an overpayment and submits a refund, a completed Refund Notification Form specifying the reason for the return must be included. This form can be found on the provider website at providers.amerigroup.com. The submission of the Refund Notification Form will allow Cost Containment to process and reconcile the overpayment in a timely manner. For questions regarding the refund notification procedure, please call Provider Services at 1-800-454-3730 and select the appropriate prompt.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.
Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled “Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments,” codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

**Provider Payment Disputes**

Providers may access a timely payment dispute resolution process. A payment dispute is any dispute between the health care provider and Amerigroup for reason(s) including, but not limited to:
- Denials for timely filing
- Amerigroup failure to pay timely
- Contractual payment issues
- Lost or incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment rendered by a provider
- Inappropriate or unapproved referrals initiated by providers (e.g., a provider payment dispute may arise if a provider was required to get authorization for a service, did not request the authorization, provided the service and then submitted the claim)
- Provider appeals without the member’s consent
- Retrospective review after a claim denial or partial payment
- Request for supporting documentation

Responses to itemized bill requests, submission of corrected claims and submission of coordination of benefits/third-party liability information are not considered payment disputes. These are considered correspondence and should be addressed to Claims Correspondence.

No action is required by the member. Payment disputes do not include medical appeals.

Providers will not be penalized for filing a payment dispute. All information will be confidential. The Payment Dispute Unit will receive, distribute and coordinate all payment disputes. To submit a payment dispute, please complete the payment dispute form located in Appendix A — Forms or online at providers.amerigroup.com/FL and submit to:
The network provider should file a payment dispute within 120 calendar days of the paid date of the EOP by submitting a written request with a written explanation of what is in dispute and why. Include supporting documentation, such as an EOP, a copy of the claim, medical records or contract page.

Non-network providers should file a payment dispute within 120 calendar days of the paid date of the EOP by submitting a written request with supporting documentation, such as an EOP, a copy of the claim or medical records.

The Payment Dispute Unit will research and determine the current status of a payment dispute. A determination will be made based on the available documentation submitted with the dispute and a review of Amerigroup systems, policies and contracts. Any payment dispute received with supporting clinical documentation will be retrospectively reviewed by a registered nurse. Established clinical criteria will be applied to the payment dispute. After retrospective review, the payment dispute may be approved or forwarded to the plan medical director for further review and resolution.

A Level I determination letter will be sent to the provider within 30 calendar days from receipt of complete payment dispute information. The response will include the following information:

- Provider name and Amerigroup ID
- Date of initial filing of concern
- Written description of the concern
- The decision
- Further dispute options

If a provider is dissatisfied with the Level I payment dispute resolution, the provider may file a Level II payment dispute. This should be a written dispute and submitted within 30 days of receipt of the Level I determination letter.

If a provider is dissatisfied with the Level II payment dispute resolution, the provider may appeal the Amerigroup decision to Maximus (the vendor for ACHA for provider disputes).

Application forms and instructions on how to file claims are available from Maximus directly. For information updates, call Maximus at 1-800-356-8151 and ask for the Florida Appeals Process department.

**Coordination of Benefits**

State-specific guidelines will be followed when Coordination of Benefits (COB) procedures are necessary. Amerigroup agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the Amerigroup plan.

Amerigroup and our providers agree that the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members. When Amerigroup is aware of these resources prior to paying for a medical service, we will
avoid payment by either rejecting a provider’s claim and redirecting the provider to bill the appropriate insurance carrier or, if Amerigroup does not become aware of the resource until sometime after payment for the service was rendered, by pursuing postpayment recovery of the expenditure. Providers must not seek recovery in excess of the Medicaid payable amount.

Amerigroup will avoid payment of trauma-related claims where third-party resources are identified prior to payment. Otherwise, we will follow a pay-and-pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched postpayment to determine likely cases with multiple letters and phone calls being made to document the appropriate details. The filing of liens and settlement negotiations are handled internally and externally via our subrogation vendor, ACS Recovery Services.

We will require members to cooperate in the identification of any and all other potential sources of payment for services.

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 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 that which is paid by Amerigroup for covered services.

In addition, providers may not bill a member if any of the following occurs:
- Failure to submit a claim timely, including claims not received by Amerigroup
- Failure to submit a claim to Amerigroup for initial processing within the six-month filing deadline
- Failure to submit a corrected claim within the 120-day filing resubmission period
- Failure to appeal a claim within the 45-day administrative appeal period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process
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 may not be 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 are not a covered benefit.”

Signature: ________________________________
Date: ________________________________

Amerigroup Website and the Provider Inquiry Line
Amerigroup recognizes that in order for you to provide the best service to our members, we must share with you accurate, up-to-date information. We offer the following methods of accessing claim status, member eligibility and authorization determination (24 hours a day, 365 days a year):

- Amerigroup website
- Toll-free, automated Provider Inquiry Line

The Amerigroup website provides a host of online resources at providers.amerigroup.com/FL, featuring our online provider inquiry tool for real-time claim status, eligibility verification and precertification status. You can also submit a claim or precertification, print referral forms or directories, or obtain a member panel listing. Detailed instructions for use of the online provider inquiry tool can be found on our website.

The toll-free, automated Provider Inquiry Line can be reached at 1-800-454-3730 for real-time member status, claim status and precertification status. This option also offers the ability to be transferred to the appropriate department for other needs, such as seeking advice in case/care management.
Medical Record Forms

The rest of this page intentionally left blank. Form displayed on subsequent pages.
# Specialist as PCP Request Form

<table>
<thead>
<tr>
<th>Date:</th>
<th>______________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Name:</td>
<td>______________________________________________________</td>
</tr>
<tr>
<td>Member’s ID:</td>
<td>_________________ ______________________</td>
</tr>
<tr>
<td>PCP’s Name (if applicable):</td>
<td>______________________________________________________</td>
</tr>
<tr>
<td>Specialist/Specialty:</td>
<td>______________________________________________________</td>
</tr>
<tr>
<td>Member’s Diagnosis:</td>
<td>______________________________________________________</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Specialist’s Signature:</th>
<th>________________________________</th>
<th>Date: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Director’s Signature:</td>
<td>________________________________</td>
<td>Date: ________________</td>
</tr>
<tr>
<td>Member’s Signature:</td>
<td>________________________________</td>
<td>Date: ________________</td>
</tr>
</tbody>
</table>
## Precertification Request Form

<table>
<thead>
<tr>
<th>Precertification Request</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phone:</strong> 1-800-454-3730</td>
</tr>
<tr>
<td>To avoid delay, please print clearly</td>
</tr>
<tr>
<td><strong>TODAY'S DATE:</strong></td>
</tr>
</tbody>
</table>

### MEMBER INFORMATION

| NAME: (Last Name, First Name) | AMERIGROUP #: |
| ADDRESS: | DOB: |
| MEDICAID #: | OTHER INSURANCE/WORKER’S COMP: |

### REFERRING PROVIDER INFORMATION

| NAME: | OFFICE CONTACT NAME: |
| MEDICAID PROVIDER #: | AMERIGROUP #: |
| PHONE #: | GROUP PRACTICE #: NPI #: |
| PHONE #: | OTHER PHONE #: |

### SPECIALIST CONSULT

| CONSULTANT: (Last Name, First Name, Provider Specialty) |

### AMERIGROUP PROVIDER:

| ADDRESS: | PHONE #: | FAX #: |
| ICD-9 CODE/DIAGNOSIS/REASON FOR REFERRAL: |
| PMH/PREVIOUS STUDIES/TREATMENT: |

### # OF VISITS REQUIRED:

### MATERNITY CARE

For initial notification of pregnancy, please use the Maternity Notification form.

For all other services related to pregnancy, please use this form (e.g., ultrasound, fetal nonstress test).

### DIAGNOSTIC STUDY

| FACILITY NAME: | DOS: |
| DIAGNOSIS/REASON FOR REFERRAL: |
| PROCEDURE/CPT-4 CODE: |
| PMH/PREVIOUS STUDIES/TREATMENTS: |

### SURGERY REQUEST

| SURGEON’S FULL NAME: (Last Name, First Name) |
| DOS: | Inpt | Outpt | Ext Stay |

### OTHER - CLINICAL INFORMATION NEEDED

- DME
- Home Health
- Hospice
- Other

| REFERRED TO PROVIDER: (Last Name, First Name) | AMERIGROUP PROVIDER #: |
| NPI #: |

### DIAGNOSIS/REASON FOR SURGERY:

| PROCEDURE/CPT-4 CODE: |
| PMH/PREVIOUS STUDIES/TREATMENTS: |

### PLACE OF SERVICE:

- OFFICE
- HOME
- OUTPATIENT HOSPITAL
- INPATIENT HOSPITAL
- OTHER

** PLEASE ATTACH CLINICAL INFORMATION TO SUPPORT MEDICAL NECESSITY **

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.

To be completed by Amerigroup: **DATE APPROVED:**

**DATE SPAN:**

| REFERENCE #: |
| INITIALS OF APPROVER: |
Pharmacy Prior Authorization Request Form

INSTRUCTIONS:
- PLEASE PHONE OR FAX THE COMPLETED PRIOR AUTHORIZATION/NON-FORMULARY REQUEST TO: PHONE: (800) 454-3730 FAX: (800)-359-5781.
- NOTE: ANY MEMBER OF THE PHYSICIAN’S STAFF MAY COMMUNICATE THIS INFORMATION TO AMERIGROUP.

PATIENT INFORMATION:
LAST NAME: __________________________ FIRST NAME: __________________________ MI: __________________________
AMERIGROUP PATIENT ID NUMBER: __________________________
DATE OF BIRTH: __________________________
PHARMACY: __________________________ PHARMACY PHONE: __________________________

DRUG REQUESTED:
STRENGTH: __________________________ QUANTITY: __________________________ DURATION: __________________________

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG? □ YES □ NO
   IF YES, HOW LONG HAS PATIENT BEEN ON THIS DRUG? __________________________

2. HAS THIS PATIENT HAD A DOCUMENTED ALLERGY TO THE FORMULARY MEDICATION?
   □ YES □ NO □ N/A

3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS:
   __________________________

4. PATIENT DIAGNOSIS:
   __________________________
   __________________________
   __________________________

5. MEDICAL RATIONALE:
   __________________________
   __________________________
   __________________________

PHYSICIAN NAME: __________________________ PHYSICIAN PHONE #: __________________________
SPECIALTY: __________________________
ADDRESS: __________________________
DATE: __________________________
PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): __________________________
OFFICE CONTACT: __________________________
INCIDENT REPORT FORM

REPORT NUMBER (to be completed by Risk Manager only): ______________________

NAME: ___________________________ Social Security #: ___/___/______

ADDRESS: __________________________ PHONE #: ______________________

DOB: ___/___/______ MARRIED: ☐ Yes ☐ No SEX: ☐ Male ☐ Female

GUARDIAN (if applicable): __________________________

PRIMARY CARE PHYSICIAN: __________________________

INCIDENT (brief, objective description): __________________________

DESCRIPTION OF INCIDENT

TIME: __________________________ DATE: ___/___/______

EXACT LOCATION: __________________________

ICD-9-CM CODING INFORMATION (to be filled out by the Risk Manager):

________________________

PHYSICIAN CALLED: ☐ Yes ☐ No IF YES, NAME OF PHYSICIAN: __________

PHYSICAL FINDINGS AND DIAGNOSIS: __________________________

MEDICAL RECOMMENDATIONS GIVEN: __________________________
# Medical Record Review Checklist

<table>
<thead>
<tr>
<th>CRITERIA (Critical indicators are in bold type)</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
<th>Y</th>
<th>N</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient identification on each page</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Biographical/personal data documented</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medical record entries are legible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. All entries dated and signed by provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Medication log</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Immunization log up to date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Immunization log complete (route, dose, lot number, expiration date)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Immunization log signed by appropriate provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Allergies and adverse reactions flagged</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Completed problem list</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Past medical history</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Follow-up on past visit problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Mental health screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. EtOH/substance/smoking screen counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. HIV education, counseling and screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Domestic violence/child abuse screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Pertinent history and physical exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Working diagnosis consistent with findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Tx plan appropriate and consistent with Dx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Return date and follow-up plan on encounter with time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Labs and other studies as appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Labs and other studies reviewed and initialed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Appropriate use of specialist/consultants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Continuity and coordination of care with specialist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Consultative reports reviewed and initialed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Preventive services rendered appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Age-appropriate education provided</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Appropriate reporting of communicable disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medical Documentation Forms

2-5 Days Documentation
1 Month Documentation
2 Month Documentation
4 Month Documentation
6 Month Documentation
9 Month Documentation
12 Month Documentation
15 Month Documentation
18 Month Documentation
2 Year Documentation
2.5 Year Documentation
3 Year Documentation
4 Year Documentation
5-6 Year Documentation
7-8 Year Documentation
9-10 Year Documentation
11-14 Year Documentation
15-21 Year Documentation
Pediatric Periodicity Forms

The rest of this page intentionally left blank. Form displayed on subsequent pages.
### American Academy of Pediatrics – Bright Futures Periodicity Schedule

#### Recommendations for Preventive Pediatric Health Care

<table>
<thead>
<tr>
<th>AGE</th>
<th>HISTORY</th>
<th>HEARING</th>
<th>EYES</th>
<th>NOSE</th>
<th>MOUTH</th>
<th>EAR</th>
<th>IMMUNIZATION</th>
<th>DEVELOPMENTAL ASSESSMENT</th>
<th>DENTAL</th>
<th>PYLORIC</th>
<th>BOWEL</th>
<th>urinary</th>
<th>genitourinary</th>
<th>ANTECUBITAL VENIPUNCTURE</th>
<th>HIV SCREENING</th>
<th>PATHOLOGY</th>
<th>OBSTETRIC</th>
<th>ORAL HEALTH</th>
<th>ANTECUBITAL SUBCUTANEOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFANT</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
<td>0-6 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
<td>7-12 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
<td>24-35 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
<td>36-47 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
<td>60-71 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
<td>72-83 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
<td>84-95 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
<td>96-107 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
<td>120-131 mo</td>
</tr>
<tr>
<td>INFANT</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
<td>132-143 mo</td>
</tr>
</tbody>
</table>

**KEY**
- **y** = to be performed, **-** = test not recommended or test performed, with appropriate cutoff in italics, **+** = result during initial a year may be provided, with the option including the recommended age range.

**Note:** The American Academy of Pediatrics and the American Academy of Family Physicians recommend that the 2001 edition of the Bright Futures Periodicity Schedule be used in providing comprehensive preventive care for children and adolescents aged 0-20 years. The 2001 edition is available online at www.brightfutures.org. The recommendations in the statement are intended to be a guide to practice and should not replace the judgment of the health care provider. The American Academy of Pediatrics is not responsible for the quality of care provided by health care providers who use the periodicity schedule.
Centers for Disease Control Immunizations Schedule for Persons Aged 0-18
[Insert CDC Immunization Schedule Forms (6 pages)]
Centers for Disease Control Immunizations Schedule for Persons Aged 0-18
[Insert CDC Immunization Schedule Forms (6 pages)]
Centers for Disease Control Immunizations Schedule for Persons Aged 0-18
[Insert CDC Immunization Schedule Forms (6 pages)]
Centers for Disease Control Immunizations Schedule for Persons Aged 0-18
[Insert CDC Immunization Schedule Forms (6 pages)]
Centers for Disease Control Immunizations Schedule for Persons Aged 0-18
[Insert CDC Immunization Schedule Forms (6 pages)]
Centers for Disease Control Immunizations Schedule for Persons Aged 0-18
[Insert CDC Immunization Schedule Forms (6 pages)]
HIV Antibody Blood Forms

The rest of this page intentionally left blank. Form displayed on subsequent pages.
Counsel for HIV Antibody Blood Test

___________________________________________________________

use patient imprint

Name: _______________________________________________________________________

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

I acknowledge that _____________________________________
(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 (Name or title of person who is to receive results) 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

This form must be in at least eight-point type.
Hysterectomy and Sterilization Forms

Visit the U.S. Department of Health & Human Services located at www.hhs.gov/forms to access the hysterectomy and sterilization forms.
STERILIZATION CONSENT FORM

STATE OF FLORIDA

STERILIZATION 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

I have asked for and received information about sterilization from ____________________________ (DOCTOR OR CLINIC). 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 health benefits from programs receiving Federal funds, such as A.F.D.C. 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 these 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 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)

by a method called ____________________________. My consent expires 100 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 and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

________________________________ ________________
SIGNATURE DATE MONTH/DATE/YEAR

You are requested to supply the following information but it is not required:

Race and ethnicity designation (please check)

☐ American Indian
☐ Black (not of Hispanic origin)
☐ Asian or Pacific Islander
☐ Hispanic
☐ White (not of Hispanic origin)

INTERPRETER’S STATEMENT

If an interpreter is provided to assist an 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.

________________________________ ________________
SIGNATURE DATE

STATEMENT OF PERSON OBTAINING CONSENT

Before ____________________________ signed the consent 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 this 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 consequences of the procedure.

________________________________ ________________
SIGNATURE DATE

PHYSICIAN’S STATEMENT

Shortly before I performed a sterilization operation upon ____________________________

NAME OF INDIVIDUAL TO BE STERILIZED

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.

________________________________ ________________
DATE OF STERILIZATION

DATE OF STERILIZATION

Nature of the sterilization operation ____________________________

(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 forms. In these cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

1. At least thirty 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 requested)

☐ Premature delivery
☐ Individual’s expected date of delivery
☐ Emergency abdominal surgery:

(Describe circumstances)

________________________________ ________________
PHYSICIAN SIGNATURE DATE OF SURGERY
STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Hysterectomy Information

PART I - PHYSICIAN’S STATEMENT (To be completed by the physician’s office)

____________________________________________  ___________________________________
Physician’s Name (Print)                      Provider Identification Number

I understand the Florida Medicaid program will not reimburse for a hysterectomy service unless it is performed in accordance with the federal requirements as specified in Title 42, Code of Federal Regulations, Section 441, Subpart F. The hysterectomy to be performed is not solely for the purpose of rendering the below named recipient permanently incapable of reproducing, nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The non-elective hysterectomy is therefore being performed for the following medical reasons (include any applicable diagnosis):

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

____________________________________________     _________________________________
Physician’s Signature     Date

PART II- RECIPIENT’S STATEMENT (To be completed by the Florida Medicaid recipient)

____________________________________________  ___________________________________
Recipient Name (Print)                      Florida Medicaid Identification Number

I was told verbally, and in writing, that I will not be able to have children after this surgery.

____________________________________________     _________________________________
Recipient’s Signature     Date

_________________________________ ____________________________________________
Interpreter’s Signature (If necessary)    Date

NOTE: A copy of this form must be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.
State of Florida
Abortion
Certification Form

SECTION I

1. Recipient’s Name:___________________________________________________________________

2. Address:___________________________________________________________________________

3. Medicaid Identification Number________________________________________________________

SECTION II

4. On the basis of my professional judgement, I have performed an abortion on the above named recipient for the following reason:
   - The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
   - Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
   - Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

I have documented in the recipient’s medical record the reason for performing the abortion; and I understand that Medicaid reimbursement to me for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. ___________________________________ 6. _____________________________________
   Physician’s Name                           Physician’s Signature

7. ___________________________________ 8. _____________________________________
   Physician’s Provider Number                Date of Signature

AHCA MedServ Form 011, (JUN 2016), incorporated by reference in Rule 59G-1.045, F.A.C
Durable Power of Attorney (English)

In the event that my physician determines that I am incompetent or so incapacitated as to provide expressed and informed consent for medical treatment, surgical intervention or diagnostic procedures, I, ____________________________, wish to designate the following person to make those decisions for me.

**DESIGNEE**

<table>
<thead>
<tr>
<th>NAME</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>RELATIONSHIP (If any)</td>
</tr>
</tbody>
</table>

**ALTERNATE DESIGNEE**

If the person that I have named is unable to act on my behalf, I authorize the following person to act on my behalf.

<table>
<thead>
<tr>
<th>NAME</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS</td>
<td>RELATIONSHIP (If any)</td>
</tr>
</tbody>
</table>

I fully understand that this document will permit the above identified designee to support, withhold or withdraw consent for intended treatment, and to do so on my behalf. That individual may also apply for public benefits to defray the cost of health care and authorize for my transfer to or from a health care facility.

I further reaffirm that this designation is not being made as a condition of treatment or admission to a health care facility. I understand, should my judgmental incapacitation or incompetence be reversed such that I am once again considered competent to make my own decisions, such decisions will once again be mine.

I understand that I may rescind this declaration at any time so long as I am judged to be competent and capable to make such judgements.

ADDITIONAL INSTRUCTIONS:

- [ ] Yes
- [ ] No

**SIGNATURE**

[ ] Date:

**WITNESS #1:**

[ ] Date:

**WITNESS #2:**

[ ] Date:

**NOTE:** One witness should not be a spouse, blood relative, nor the estate of the designee or responsible for paying health care costs for that individual.
Gooble Power of Attorney (Spanish)

Designación De Sustituto Para Decisiones Médicas

(PODER PARA DECISIONES DE ATENCIÓN MÉDICA)

En el caso de que mi médico determine que me encuentre incompetente o incapacitado al punto de no poder expresar e informar consentimiento para tratamientos médicos, intervenciones quirúrgicas o procedimientos de diagnóstico. Yo, __________________________, deseo designar a la siguiente persona para tomar estas decisiones por mi:

**DESIGNADO**

NOMBRE: __________________________
TELEFONO: __________________________
DIRECCIÓN: __________________________
RELACIÓN: __________________________

**DESIGNADO ALTERNO** Si la persona que he designado (nombrado) es incapaz de actuar en mi nombre, yo autorizo a la siguiente persona para así hacerlo:

NOMBRE: __________________________
TELEFONO: __________________________
DIRECCIÓN: __________________________
RELACIÓN: __________________________

Yo entiendo perfectamente que este documento permitirá a la persona arriba identificada a aceptar, evitar o retirar consentimiento del tratamiento propuesto y de hacerlo en mi nombre. Esta designación puede aplicarse para beneficios públicos para defi nir los costos de atención de salud y autorizar mi transferencia hacia o desde una facilidad de atención de salud.

Yo reafirmo más aún que esta designación no se ha tomado como condición de una facilidad de atención médica para recibir tratamiento o ser admitido. Entiendo que si mi incapacidad de juicio o de incompetencia se revoco será considerado inmediatamente competente para tomar mis propias decisiones, estas decisiones serán otra vez mías.

Yo entiendo que puedo cancelar esta designación en cualquier momento en que se determine que soy competente y capaz de decidir por mi mismo.

**INSTRUCCIONES ADICIONALES:**

________________________
________________________
________________________
________________________

¿TIENE USTED UNA DECLARACIÓN DE TESTAMENTO EN VIDA?

SI o No

**FIRMA FECHA**

________________________
________________________

**TESTIGO #1 FECHA**

________________________
________________________

**TESTIGO #2 FECHA**

________________________
________________________

**NOTA:** De los testigos no deben ser cónyuges, ni parientes consanguíneos, ni heredero único de las propiedades del designado e responsable de pagar costo de atención de salud para con individuos.
Living Will (Florida Declaration)

On this ___ day of _____, 20__, I, _________________________________________________,

of my own free will, make known my desire that my dying not be artificially prolonged under any of the circumstances set out below, and I do hereby declare that:

Should I develop a terminal condition, and if my attending physician determines there can be no reasonable expectation of recovery from such a condition and my death is imminent, I hereby direct that life-prolonging procedures be withheld or withdrawn when such procedures serve only to artificially prolong the process of my dying. Under such circumstances, it is my desire that I be permitted to die naturally, with only the administration of such medication or the performance of any such medical procedure judged necessary to provide me with comfort and pain relief.

Relating to the administration of nutrition and hydration (food and fluids), I do __/I do not __ (check one) desire that such be withheld or withdrawn when such procedures serve to only prolong in an artificial way the process of my dying. It is my intent that, should I be unable to give directions regarding the use of life-prolonging procedures, this represents the declaration of my intent and will be honored by my physicians, as well as by my family, as a valid representation of my legal right to refuse medical and/or surgical treatment and to accept the consequences as such.

I fully understand the important and consequences of this declaration. I am competent to make such declaration, and it is my desire to do so. I make this declaration without coercion and of my own free will.

If I am diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall not be in effect during the course of my pregnancy.

Check one:  ☐ I want to donate my organs.  ☐ I do not want to donate my organs.

Signature: ___________________________ Date: ___________________________

Declaration of Witness:
The above is known to me, and it is my judgment that he/she is of sound mind and is making the above declaration of his/her free will.

Witness 1: ___________________________ Relationship: ___________________________

Witness 2: ___________________________ Relationship: ___________________________

Note: One witness should neither be a spouse nor a blood relative of the declarant, in compliance with Florida Statute 765, amended effective 10/1/90.
Testamento Médico en Vida (Declaración de Florida)

En este día ___ de _____ de 20__, Yo, ______________________________________________,
por voluntad propia quiero manifestar (por escrito) mi deseo, de que mi vida no sea prolongada artificialmente bajo ninguna de las circunstancias dispuestas a continuación en este documento y por consiguiente declaro:

Si desarrolló una condición terminal y el médico que me atiende considera que no hay expectativa razonable de recuperación debido a esta condición y mi muerte es inminente, declaro directamente que los procedimientos para prolongar mi vida sean evitados o retirados cuando dichos procedimientos sirvan solamente para prolongar artificialmente el proceso de mi muerte. Bajo éstas circunstancias, es mi deseo el que se me permita morir naturalmente, que solamente se me administren medicamentos o se ejecuten procedimientos que se juzguen necesarios para proveerme comodidad y aliviar el dolor. Con relación a la nutrición e hidratación (alimentos y fluidos) Yo deseo ____/Yo no deseo (marque una de las dos opciones) que éstos procedimientos me sean negados o reservados cuando éstos solamente sirvan para prolongar de forma artificial el proceso de mi muerte.

Es mi intención que si de alguna forma quedo impedido de dar las direcciones referentes a procedimientos de prolongar la vida, sea esta declaración la representación de mi intención que será honrada por mis médicos, así como mi familia como representación de mis derechos legales de rehusar tratamientos médicos y/o quirúrgicos y aceptar las consecuencias como tales.

Es de mi absoluto entendimiento la importancia y consecuencias de ésta declaración y es mi deseo de que así sea. Hago esta declaración sin coacción y por voluntad propia.

Si llega a haber un diagnóstico de embarazo y mi médico tiene conocimiento del mismo, esta declaración no se hará efectiva durante el curso de mi embarazo.

Marque una de las dos opciones: □ Yo deseo donar mis órganos. □ Yo no deseo donar mis órganos.

Firma: ___________________________________________ Fecha: ______________________

Declaración de Testigos:
Lo arriba escrito es de mi conocimiento y a mi juicio el/ella está en su sano juicio y está haciendo esta declaración voluntariamente.

Testigo 1: _______________________________ Relación: _______________________________

Testigo 2: _______________________________ Relación: _______________________________

Nota: Uno de los testigos no debe ser cónyuge o pariente consanguíneo del declarante de acuerdo con el Estatuto 765 de la Florida, enmienda efectiva 10/1/90.
Advance Directive (English)

DATE: __________________________

I, ____________________________, have discussed the Living Will and

(Physician’s Name)

Durable Power of Attorney with ____________________________

(Member’s Name)

_____ Yes, the member has completed the Living Will and a copy will remain in his/her medical file.

_____ Yes, the member has completed the Durable Power of Attorney and a copy will remain in his/her medical file.

_____ No, the member declines to complete a Living Will.

_____ No, the member declines to complete a Durable Power of Attorney.

PHYSICIAN’S SIGNATURE: ____________________________

MEMBER’S SIGNATURE: ____________________________
Advance Directive (Spanish)

Fecha:

Yo, ____________________________________________,
(Name del Medico)

he hablado con ____________________________________________,
(Name del Miembro)
sobre lo que es un Testamento en Vida y un Potestad para Cuidado De Salud.

____ Si, el miembro ha completado un Testamento en Vida y una copia
se mantendrá en su archivo médico.

____ Si, el miembro ha completado un Potestad para Cuidado De Salud
y una copia se mantendrá en su archivo médico.

____ No, el miembro rechaza completar un Testamento en Vida.

____ No, el miembro rechaza completar un Potestad para Cuidado De Salud.

Firma del Medico:

Firma del Miembro:
Provider Payment Dispute and Correspondence Form

Provider Payment Dispute and Correspondence – Submission Form

This form should be completed by providers for payment disputes and claim correspondence only.

Member First and Last Name_________________________________________ Member DOB ______________
Member Amerigroup, Medicaid or Medicare ID (circle one)___________________________________________

Provider First and Last Name________________________ National Provider Identifier (NPI)__________________

[ ] Participating [ ] Nonparticipating*

*If filing for a Medicare member and the member has potential financial liability, you must include a completed CMS Waiver of Liability form.

Provider Contact First and Last Name________________________ Contact Phone (____) _____________
Provider Street Address_________________________________________________________________________
City_______________________ State______ ZIP_____________ Phone (_______) ______________________

Claim Number________________________ Billed Amount $____________ Amount Received $____________
Start Date of Service _________________ End Date of Service _________________ Auth Number ____________

To ensure timely and accurate processing of your request, please complete the payment dispute or claim correspondence section below by checking (✓) the applicable determination or request reason that was provided on the Amerigroup determination letter or Explanation of Payment (EOP).

PAYMENT DISPUTE: Check (✓) One → [ ] First-level Dispute [ ] Second-level Dispute
A payment dispute is defined as a dispute between the provider and Amerigroup in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must follow the applicable appeals process. Please refer to the EOP to ensure you are following the correct process.

Clearly and completely indicate the payment dispute reason(s). You may attach an additional sheet if necessary.

Please include appropriate medical records.

________________________________________________________________________________________

CLAIM CORRESPONDENCE: Check (✓) appropriate box below.
Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

[ ] Itemized Bill/Medical Records (In response to an Amerigroup claim denial or request)
[ ] Corrected Claim [ ] Other Insurance/Third-Party Liability Information [ ] Other Correspondence

Clearly and completely indicate the reason(s) for your correspondence. You may attach an additional sheet if necessary.

___________________________________________________________________________________

Mail this form and supporting documentation to:

Payment Disputes
Amerigroup Community Care
P.O. Box 61599
Virginia Beach, VA 23466-1599
APPENDIX B — CLINICAL PRACTICE GUIDELINES

Visit our website at providers.amerigroup.com/FL for the clinical practice guidelines.
ADDITIONAL FORMS

The following forms are also available on our website at providers.amerigroup.com/FL. You may also download them for your use as needed.

Medicare Forms
- CMS Waiver of Liability Statement
- Medicare Advantage Health Risk Assessment Form

Referral and Claim Submission Forms
- Authorization Request Form
- Maternity Notification Form
- Child Health Check-Up 221 Form and Claim Instructions — This form and instructions are available at www.fdhc.state.fl.us/medicaid or by calling 1-800-289-7799
- Specialist as a PCP Request Form
- CMS-1500 (08-05) Claim Form
- UB-04-Claim Form

Precertification Forms
- Precertification Information Required for Hysterectomy
- Precertification Information Required for Gastroplasty
- Precertification Information Required for Tonsillectomy, Adenoidectomy, Adenotonsillectomy

Provider Grievances and Appeals Forms
- Provider Payment Dispute and Correspondence Submission
- Provider Medical Necessity Appeal Form
- Grievance Form

Medical Record Documentation Forms
- Adult Health Form
- Oral Lead Risk Form – English
- Oral Lead Risk Form – Spanish
- Incident Report Form
- Inpatient Medical Review Form
- Advance Directive – English
- Advance Directive – Spanish
- Durable Power of Attorney – English/Spanish
- Living Will – English/Spanish
- Site Review Form

Other Forms
- Florida Assisted Living Facility Form
- Authorization Request Form
- Pharmacy Prior Authorization Form
- Incident Report Form
- Sterilization Consent Form
- Hysterectomy Acknowledgement Form
- Abortion Certificate Form
- Provider Payment Dispute Form

**Pharmacy Synagis Order Form**
- Express Scripts Enrollment Form

**Behavioral Health Forms**
- Behavioral Health Outpatient Treatment Form
- Behavioral Health Outpatient Treatment Report C Form
- Request for Authorization – Psychological Testing Authorization Form
- Behavioral Health Neuropsychological Testing Form

**Hysterectomy and Sterilization Forms**
- Acknowledgement of Receipt of Hysterectomy Information
- Consent to Sterilization Form

**Cost Containment Form**
- Refund Notification Form