Amerigroup




Participating Provider Quick Reference Card

https://provider.amerigroup.com/WA

Washington Apple Health

WAAGP-CD-018486-23-CPN18476

Easy access to prior authorization/notification requirements and other important information

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

Prior authorization/notification instructions and definitions

- Request inpatient and outpatient prior authorization and inpatient admission notifications:
  - Phone: **800-454-3730**; Fax: **800-964-3627**
- Outpatient prior authorization (including physical therapy/occupational therapy/speech therapy (PT/OT/S), bariatrics, podiatry, and orthotics/prosthetics):
  - Phone: **855-323-4688**; Fax: **855-231-8664**
- Home health, home infusion, and durable medical equipment:
  - Phone: **855-323-4688**; Fax: **844-528-3681**
- For members assigned to Highline Medical Services Organization (HMSO):
  - Phone: **206-878-1985, option 3**; Fax: **206-878-1857**

Behavioral health and substance use disorder prior authorization/notification instructions

Requests should be submitted electronically using our preferred method at **https://provider.amerigroup.com/WA** through the Availity Essentials* secure website.

Requests can also be made:

- By phone: **800-454-3730**
- Outpatient fax requests: **844-442-8012**
- Inpatient fax requests: **844-430-6806**
- Psychological testing fax requests: **844-442-8012**
- Honor authorization fax: **844-430-6806**

Mental health

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

Prior authorization is required for most inpatient admissions, partial hospitalization programs, electroconvulsive therapy, transcranial magnetic stimulation, and psychological and neuropsychological testing. Out-of-network providers are required to request prior authorization for all services.

To assist primary care providers in meeting the needs of children with a mental health diagnosis, the Washington State Health Care Authority (HCA) provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL) at **866-599-7257**.

Substance use disorders

Prior authorization is not required for network providers requesting nonacute outpatient and intensive outpatient substance use disorder (SUD) services. You can call Provider Services at **800-454-3730** for clinical assistance if substance use disorders are suspected or identified. You may also contact any SUD provider directly. A referral from a PCP in not necessary.

Residential SUD treatment requires notification within 24 hours of admission. Additional clinical documentation (assessment and plan) must be submitted within 72 hours for consideration of additional, medically necessary care.

Screening, brief intervention and referral for treatment (SBIRT) services, substance use disorder services are covered when the provider is a certified SBIRT provider as reported by the HCA.

Medication-assisted therapy (MAT)

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

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

Hospital admissions

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

- Notification of census by fax: **855-323-4689**
- Individual notification of admission by phone: **800-454-3730**
- Individual notification of admission by fax: **800-964-3627**
- Admission and continued stay clinical fax: **855-225-9940**
- Discharge notification fax: **855-225-9940**
- For members assigned to HMSO:
  - By phone: **206-878-1985, option 4**
  - By fax: **206-878-1539**

Psychiatric notifications should be submitted electronically using our preferred method at **https://provider.amerigroup.com/WA** through the secure website.

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

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

- Notify us prior to rendering services requiring prior authorization, as outlined in this document.
- For emergency or urgent services, notify us within 24 hours or by the next business day if it results in an admission.
- Referring providers, PCPs, specialists, or those rendering the service may make the notification.

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

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

Network providers:
Requirements are listed below.

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

Acupuncture

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

Cardiac rehabilitation

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

Chemotherapy

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

- Offices
- Outpatient hospitals
- Ambulatory surgery centers

Many chemotherapy agents do require prior authorization. Prior authorization for oncology medications is managed through Amerigroup. Providers can contact Provider Services at **800-454-3730** or online at **http://www.CoverMyMeds.com**.*
Prior authorization is required for inpatient chemotherapy as part of inpatient admission.

Limitations and exclusions apply for experimental and investigational treatments.

Circumcision

Prior authorization is not required for CPT codes 54150, 54160, and 54161. Amerigroup pays contracted providers up to $150 for this service. This is a value-added benefit.

Dermatology

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

Cosmetic services or services related to previous cosmetic procedures are not covered.

Diagnostic testing

Prior authorization is not required for routine diagnostic testing.

Call Carelon Medical Benefits Management, Inc. at **833-775-1952** for prior authorization of computerized axial tomography (CAT), computerized tomography (CT), magnetic resonance angiogram (MRA), magnetic resonance imaging (MRI) and positron emission tomography (PET) scans; nuclear cardiology; and video electroencephalograms (EEGs).

Dialysis

Prior authorization may be required for dialysis services. Please refer to the provider website to check for prior authorization requirements.

Durable medical equipment (DME)

Prior authorization may be required for certain rental and purchased medical equipment and supplies.

Providers may use the Amerigroup *Prior Authorization Request* form. Attach a complete prescription for the services and any clinical support documentation.

Amerigroup must agree on the HCPCS values and/or other codes and appropriate modifiers for billing.

Ear, nose, and throat services (otolaryngology)

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

Prior authorization is required for:

- Tonsillectomy and/or adenoidectomy.
- Nasal/sinus surgeries.
- Cochlear implant surgeries and services.

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

Prior authorization is not required.

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

Members may self-refer for services.

Use the EPSDT schedule and document all screenings and visits.

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

Educational consultation

Prior authorization is not required.

Emergency room (ER)

Prior authorization is not required.

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

Family planning/sexually transmitted disease (STD) care

Prior authorization is not required.

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

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

Flu shots

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

Gastroenterology services

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

Prior authorization is required for:

- Bariatric program/bariatric surgery.
- Insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components.

For code-specific requirements, visit our provider website.

Gynecology

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

Habilitative services

See *Therapy*.

Hearing aids and cochlear implants

Prior authorization is required. The covered benefit is as follows:

Children (age 20 and under):

- **Hearing aids**:
  - Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair
  - **Replacement**: Hearing aid(s), which includes the ear mold, when all warranties are expired and the hearing aid(s) are one of the following:
    - Lost beyond repair.
    - Not sufficient for the client's hearing loss.
    - Earmold(s) when the client's existing ear mold is damaged or no longer fits the client's ear.
    - Batteries with a valid prescription from an audiologist.
  - **Repair**: Maximum of two repairs, per hearing aid, per year, when the repair is less than 50% of the cost of a new hearing aid. To receive payment, all the following must be met:
    - All warranties are expired. The repair is under warranty for a minimum of 90 days.
- **Cochlear implants**:
  - Bilateral cochlear implants, including implants, parts, accessories, batteries, chargers, and repairs.
  - Bone-anchored hearing aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts, and batteries.
  - No limit on the number of batteries or repairs.

Adults (age 21 and older):

- **Hearing aids**:
  - One new nonrefurbished monoaural hearing aid, which includes the ear mold, every five years.
  - Binaural hearing aids.
  - **Hearing aids**: Nonrefurbished, monaural hearing aids and binaural hearing aids, including replacement and repair.
  - **Repairs**: Two repairs per hearing aid per year when the cost of the repair is less than 50% of the cost of a new hearing aid.
- **Cochlear implants**:
  - Repair or replacement of external parts of cochlear devices and bone-anchored hearing aids (BAHA).
  - Repair or replacement of external parts of bone conduction hearing aids, whether implanted or worn with a headband. If the client has bilateral bone conduction hearing aids, both devices are eligible for repair and replacement of external parts.

Hearing aids and cochlear implants (cont.)

Prior authorization may be required for digital hearing aids. For code-specific requirements, visit our provider website.

Hearing screening

Prior authorization is required for digital hearing aids.

Prior authorization is not required for:

- Diagnostic and screening tests.
- Hearing aid evaluations.
- Counseling services.

Home healthcare

Prior authorization is required.

Covered services include:

- Skilled nursing.
- Physical, occupational, and speech therapy services (yearly coverage limitations apply regardless of setting).
- Private duty nursing (for members 17 years old and under).

Prior authorization is not reuries for Home Health Aid.

Drugs and DME require separate prior authorization.

Hospital admissions

Prior authorization is required for:

- Elective admissions.
- Some same-day/ambulatory surgeries.

Hospitals must notify Amerigroup within 24 hours or by the next business day of all member admissions, including those through the ER.

Notification by faxing daily census is acceptable. See **https://provider.amerigroup.com/WA** for required data elements. Actual emergency services will not be denied solely for the lack of notification.

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

Amerigroup does not cover:

- Rest cures.
- Personal comfort and convenience items.
- Services and supplies not directly related to patient care (such as, telephone chargers, take home supplies, etc.)

Laboratory services (outpatient)

All laboratory tests must be submitted to LabCorp,* PACLAB,* PAML,* or TriCities Laboratory,* the preferred lab vendors for our members, or to other network laboratories.

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

For more information or to receive a specimen drop box, testing solutions and services, or set up an account, contact one of the following:

- LabCorp: **800-345-4363**
- PACLAB/PAML/TriCities Lab: **800-541-7891**

Medical supplies

Prior authorization is required for certain supplies. Updated physician prescriptions for ongoing orders for supplies and services are required annually.

All prescriptions for medical equipment and supplies provided in the home is required.

Medical injectables

Below are examples of the most commonly prescribed injectables that require prior authorization:

- Botox
- Erythropoiesis stimulating agents (ESAs), such as Epogen, Procrit, and Aranesp
- Makena
- Zolendronic acid
- Colony stimulating factors (CSFs), such as Neupogen and Neulasta
- IVIG
- Biologic response modifiers, such as Remicade

For a complete list, visit our provider website. You may also call Amerigroup Provider Services for assistance.

Neurology

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

Prior authorization is required for:

- Neurosurgery.
- Spinal fusion.
- Artificial intervertebral disc surgery.

Observation

Prior authorization is not required for in-network observation. If an observation results in admission, hospitals must notify Amerigroup within 24 hours or the next business day.

Obstetrical (OB) care

Prior authorization is not required for:

- OB services.
- Certain diagnostic tests and lab services by participating providers.
- Labor and deliveries for newborns up to 12 weeks in age.
- Ultrasounds — Two routine (CPT codes 76801, 76805) ultrasounds are allowed per pregnancy without authorization. Diagnosis codes on claims must reflect medical necessity for all additional nonroutine ultrasound services.
- Refer to **https://provider.amerigroup.com/WA** for codes deemed medically necessary.

OB practitioners must notify Amerigroup after the **first** prenatal visit.

Hospitals and midwives must notify Amerigroup within 24 hours of delivery with newborn information (include baby's weight, gestational age, and disposition at birth).

We request notification but will not deny claims payment based solely on lack of notification for OB care (at first visit) and OB admissions exceeding 48 hours after vaginal delivery and 96 hours after cesarean section delivery. Review of newborn stay beyond the mother's inpatient stay does require notification and admission/concurrent reviews to ensure payment.

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

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

Ophthalmology

See *Vision care*.

Oral maxillofacial

See *Plastic/cosmetic/reconstructive surgery*.

Out-of-area/out-of-network care

Prior authorization is required except for out-of-area emergency care and out-of-network:

- EPSDT screenings;
- Family planning, STD screenings and treatment at local health departments and family planning agencies;
- Immunizations, HIV screenings, tuberculosis screenings, and follow-up by local health departments;
- Immunizations, STD screenings, family planning, and mental health services through school-based health centers
- Tribal-provided healthcare services for tribal members.

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

Outpatient/ambulatory surgery

Prior authorization requirements are based on the procedures performed. For code-specific requirement, visit our provider website.

Pain management/physiatry/physical medicine and rehabilitation

Prior authorization is required for non-E&M-level testing and procedures. For code-specific requirement, visit our provider website.

Pharmacy

To check member eligibility or for prior authorization of nonpreferred and other drugs requiring prior authorization, call Provider Services at **800-454-3730**.

Formulary and *Preferred Drug List* (*PDL*) are available on our provider website at **https://provider.amerigroup.com/WA**. Amerigroup uses the HCA *Single PDL* for Apple Health.

Pharmacy providers can call the CarelonRx, Inc. Help Desk at **833-253-4453** for assistance.

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

Pharmacy (cont.)

Most specialty injectable drugs require prior authorization when administered in outpatient settings. For further details on prior authorizations, visit the provider website.

Plastic/cosmetic/reconstructive surgery (including oral maxillofacial services)

Prior authorization is not required for E&M services and consultations.

Prior authorization is required for other services such as:

- Trauma to the teeth.
- Oral maxillofacial medical and surgical conditions.
- Temporomandibular joint and muscle disorders (TMJ).
- Reducation mammoplasty.

We do not cover services:

- Considered to be cosmetic in nature.
- Related to previous cosmetic procedures.

Podiatry/foot care

Prior authorization is not required. For code-specific requirements, visit our provider website.

Psychiatric hospital admission

Prior authorization is required for elective/voluntary psychiatric admissions. Emergency admissions require notification initially, followed by clinical information within 24 business hours.

Psychiatric notifications should be submitted electronically using our preferred method at **https://provider.amerigroup.com/WA** through the secure website.

Refer to the *Hospital admissions* (medical and behavioral Health) section for more information.

Radiology

See *Diagnostic testing*.

Rehabilitation therapy (short-term outpatient): occupational, physical, and speech therapy

See *Therapy*.

Skilled nursing facility

Prior authorization is required.

Sleep studies

Prior authorization is required for certain sleep study tests.

Studies are allowed at Washington State HCA Centers of Excellence and member homes. For code-specific requirements, visit our provider website.

Smoking cessation

All members ages 18 years and older may enroll in Quit for Life, the state's tobacco cessation program. Members enroll by phone at **866-QUIT-4-LIFE (866-784-8454)** or online at **https://www.warecoveryhelpline.org**.

Amerigroup is covering the cost of the EX by Truth Initiative Program, a digital quit-tobacco program, for eligible members who smoke, vape, or chew. Nicotine patches, gum or lozenges at no extra cost, as well as custom quit plans, and expert support.

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

Amerigroup also pays PCPs for smoking cessation referral evaluations, smoking cessation prescription evaluations, and face-to-face counseling for all members ages 18 years and older:

- Intensive smoking cessation counseling (procedure 99407 for greater than 10 minutes) is limited to one per day.
- Two cessation counseling attempts (or up to eight sessions) are allowed every 12 months. An attempt is defined as up to four cessation counseling sessions.

Sports physicals

Prior authorization is not required for sports physicals, and they are eligible for reimbursement once every 12 months.

Amerigroup will pay for both a sports physical and an EPSDT visit performed on the same day. To receive payment, use CPT code 99212 with DX Z02.5 and include the modifier 25.

Sterilization

Prior authorization is not required for men and women ages 21 and older:

- Sterilizations.
- Tubal ligations.
- Vasectomies.

For members 18 to 20 years of age, sterilization is covered by Washington State Health Care Authority fee-for-service.

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

Therapy: Occupational therapy, physical therapy, and speech therapy

Habilitative/rehabilitative

Covered services include the following:

- Children: unlimited benefit
- Adults:
  - 24, 15-minute units of physical therapy visits
  - 24, 15-minute units of occupational therapy visits
  - Six, 60-minute speech therapy visits

We approve up to one evaluation and six visits for adults when authorization is requested without clinical evaluation. With evaluation, an additional six visits may be approved. Up to six visits of speech therapy may be approved with or without evaluation. Therapies for rehabilitative care are covered as medically necessary.

Vision care

Includes vision services from a licensed ophthalmologist or optometrist.

EyeQuest:*

- Phone: **855-230-4656**
- Online: **www.eye-quest.com**

Providers must be contracted directly with EyeQuest to render services. EyeQuest manages all vision and medical eye services provided by an ophthalmologist or optometrist in a clinic or ambulatory surgery center. Services provided in other settings are covered by Amerigroup and should be billed to Amerigroup directly.

Vision care (cont.)

Eyeglass frames, lenses, fabrication services, and associated fitting and dispensing services are covered under the Washington State Health Care Authority's fee-for-service program through Correctional Industries Optical. Orders should be placed by the member's optical provider.

Eye examinations, refractions and fitting services are covered with the following limitations:

- Once every 24 months for asymptomatic members 21 years of age or older
- Once every 12 months for asymptomatic members 20 years of age or younger

Fitting of contact lenses for treatment of ocular surface diseases (92071) is limited to:

- Once every 24 months for members ages 21 and older.
- Once every 12 months for members ages 20 and younger.

Fitting of contact lenses for management of keratoconus: the initial fitting (92072) is limited to a diagnosis range of 371.60 to 371.62, and is limited to:

- Two every 24 months for members ages 21 and older.
- Two every 12 months for members ages 20 and younger.

Repair and adjustment of spectacles (92370 and 92371) is limited to clients 20 years of age and younger. Scanning, computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report, unilateral or bilateral, for the optic nerve (92133) is limited to one per calendar year.

Scanning, computerized ophthalmic diagnostic imaging, posterior segment with interpretation and report, unilateral or bilateral, for the retina (92134) is limited to two times per calendar year but may be expanded to up to 12 times per calendar year with prior authorization.

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

Well-woman exams

Prior authorization is not required. Amerigroup covers one well-woman exam per member, per year when performed by a PCP or network women's healthcare provider. Exams include:

- Examinations.
- Routine lab work.
- Sexually transmitted infection (STI) screenings, including human papillomavirus (HPV).
- Mammograms for members 40 years of age or older.
- Pap smears.

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

Revenue (RV) codes)

Prior authorization is required for services billed with RV codes for:

- Inpatient care.
- OB.
- Home health care.
- Hospice care.
- CT, MRI, and PET scans, and nuclear cardiology.
- Chemotherapeutic agents.
- Pain management.
- Rehabilitation (physical/occupational/respiratory therapy).
- Short-term rehabilitation (speech therapy).
- Specialty pharmacy agents.

For a complete list of specific RV codes, visit our website.

Important contact information

Our service partners

Vendor	Service	Contact information
Carelon Medical Benefits Management, Inc.	Complex imaging management	**Phone: 833-775-1952** Fax is not available. **www.carelon.com**
Availity Essentials	Online eligibility, claims, authorizations, claim payment disputes	**Phone: 800-282-4548** **https://www.availity.com**
CoverMyMeds	Pharmacy prior authorizations	**Phone: 833-293-0659** **www.covermymeds.com**
Clinical lab services	Clinical laboratories	**Call one of the following:** ■ **LabCorp: 800-345-4363** ■ **PACLAB/PAML/TriCities Lab: 800-541-7891**
CarelonRx, Inc.	Pharmacy	**Prior authorization requests:** **Phone: 800-454-3730** **Retail pharmacy fax: 844-493-9207** **Medical injectables fax: 844-493-9209** **CarelonRx, Inc. Help Desk: 833-253-4453**
EyeQuest*	Medical eye care and routine vision services Providers should reach out to EyeQuest directly to contract for services rendered within the above scenarios.	**Provider line: 855-230-4656** **Member line: 855-225-2640**
Highline Medical Services Organization* (HMSO)	Provider group delegated for utilization management and claims	**Main line: 206-724-0869** **Claims: 206-878-1985, ext. 3** **http://hmsoinc.com**
Edgepark	Electric breast pumps	**Edgepark website: https://www.edgeparkbreast-pumps.com/order** **Phone assistance: 855-504-2099**
Sleep studies	Home sleep studies	**Prior authorization requests:** **Phone: 800-454-3730** **Fax: 800-964-3627**
OrthoNet*	Back pain medical management/prior authorization	**Phone: 844-887-8388** **Fax: 844-492-8927**

Important contact information (cont.)

Provider Services program

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

The provider website and interactive voice response (IVR) are available 24 hours a day, 7 days a week, 365 days a year:

- To verify eligibility and check claims and referral authorization status, visit **https://www.availity.com** and choose **Amerigroup**.
- To look up prior authorization/notification requirements and find many other provider reference tools, go to **https://provider.amerigroup.com/WA**.

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

Claims services

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

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

Electronic data interchange (EDI)

Call our EDI hotline at **800-590-5745** to get started. We accept claims through Availity (payer 26375) as our preferred clearinghouse for EDI transactions.

Paper claims

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

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

For members assigned to HMSO:
Highline Medical Services Organization
P.O. Box 48319
Burien, WA 98148

HMSO Payer ID: 91164

Payment disputes

Claims payment disputes, where the provider believes the claim was incorrectly adjudicated, must be filed within 24 months of the adjudication date on your *Explanation of Payment*. Forms for provider appeals are available on our website. Providers can submit claim payment disputes through the Availity Portal at **https://www.availity.com**, which offers healthcare providers and professionals free access to real-time information and instant responses in a consistent format. The Availity Portal has a quicker response time and more reliable tracking of disputes and appeals.

Medical necessity appeals

Appeals of medical necessity denials must be filed within 60 calendar days of the date of denial notification. Provider submit the appeal on behalf of a member with written consent from the member. Please be sure to include the member's written consent so we may proceed with the request. We cannot process a request without the member's written consent.

Important contact information (cont.)

Medical necessity appeals (cont.)

Submit medical necessity appeals to:
Appeals Department
Amerigroup Washington, Inc.
705 5th Ave., Suite 300
Seattle, WA 98104

Fax: **844-759-5953**

Information needed to submit an appeal: reference numbers if possible such as authorization number, Member ID, DOB, provider information. Please include what the appeal is for; why the provider feels we should review the prior decision; all clinical information the provider is requesting to be considered when making a decision on the appeal.

Appeals of **administrative denials** (for untimely notification of inpatient admissions or for untimely submission of clinical information) must be filed within 60 days of the date of the denial letter, unless extension clauses apply.

Submit medical necessity appeals to:
Appeals Department
Amerigroup Washington, Inc.
705 5th Ave., Suite 300
Seattle, WA 98104

Health services

Care Management services — 800-454-3730

We offer care management services to members who are likely to have extensive health care needs. Our nurse care managers work with providers to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

Disease Management Centralized Care Unit (DMCCU) services — 888-830-4300

DMCCU services include educational information like local community support agencies and events in the Amerigroup service area. Services are available for members with the following medical conditions: asthma, bipolar disorder, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, HIV/AIDS, hypertension, obesity, major depressive disorder, schizophrenia, and transplants.

24-hour Nurse HelpLine — 866-864-2544/ Spanish 866-864-2545

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

Member Services — 800-600-4441

Primary care provider changes:
The fastest way to make PCP assignment changes for members is by calling Member Services at **800-600-4441**.

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

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

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

Note: For non-participating providers, please refer to the Digital Provider Enrollment tool on our provider website to become contracted with us.


Amerigroup