Important Contact Information Continued

If you're unable to accept or schedule a P2P discussion within a 10-business-day time frame, you'll need to follow the formal medical necessity appeal process.

The medical director will make two attempts to connect with the provider at the providers' specified contact number. If the provider fails to return the contact to the health plan medical director, the request for a P2P will be closed, and the provider's next course of action will be to follow the formal medical necessity appeal process.

Medical Appeals

Medical appeals, or medical administrative reviews, can be initiated by members or providers on behalf of members with the member's written consent and must be submitted within 30 calendar days from the dates of the notices of proposed actions.

A provider submitting on behalf of a member can write a letter or use the Provider Appeals Form on our provider self-service website. Submit in writing to:
Central Appeals and Grievance Processing
Amerigroup Louisiana, Inc.
P.O. Box 62429, Virginia Beach, VA 23466-2429

Health Services

Care Management Services • 1-800-454-3730
We offer care management services to members who are likely to have extensive health care needs. Our nurse care managers work with you 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 • 1-888-830-4300
DMCCU services include educational information like local community support agencies and events in your local area. Services are available for members with the following medical conditions: asthma, bipolar disorder, COPD, CHF, CAD, diabetes, HIV/AIDS, hypertension, obesity, major depressive disorder, schizophrenia, substance use disorder and transplants.

Quality Management Program • 1-800-454-3730
We have a comprehensive Quality Management (QM) program to monitor the demographic and epidemiological needs of the populations we serve. We evaluate the needs of our Louisiana member populations annually, including age/sex distribution and inpatient, emergent/urgent care and office visits by type, cost and volume. In this way, we can define high-volume, high-risk and problem-prone conditions.

You have opportunities to make recommendations for areas of improvement. To contact the QM department about quality concerns or to make recommendations, please call 1-800-454-3730.

Amerigroup On Call
1-866-864-2544 (Spanish 1-866-864-2545)
Amerigroup On Call is a telephonic, 24-hour triage service your Amerigroup patients can call to speak with a registered nurse who can help them:

- 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
- Obtain a virtual physician visit directly with a Louisiana-licensed online physician through LiveHealth Online (www.livehealthonline.com) beginning in early 2016

We encourage you to tell your Amerigroup patients about this service and share with them the advantages of avoiding the ER when a trip there isn't necessary or the best alternative. Members can call our 24-hour Nurse HelpLine for health advice 24 hours a day, 7 days a week, 365 days a year.

TTY services are available for the hearing impaired, and language translation services are also available.

Member Services • 1-800-600-4441
Behavioral Health Member Services • **1-844-227-8350**
Pharmacy Services • 1-800-454-3730

providers.amerigroup.com/LA

Provider Quick Reference Card

Louisiana

BAYOU HEALTH and LaCHIP

LAPEC-0815-15 QRC 12.15

providers.amerigroup.com/LA

Easy access to **precertification/notification requirements** and other important information

For more information about requirements, benefits and services, visit our provider website to get the most recent, full version of our provider manual. If you have questions about this document or recommendations to improve it, call your local Provider Relations representative: New Orleans and Metairie, call 504-834-1271, Baton Rouge, call 225-819-4893, Shreveport, call 318-795-2130.

We want to hear from you and improve our service so you can focus on serving your patients!

Precertification/Notification instructions and definitions

Request precertifications and give us notifications:

- **Online:** providers.amerigroup.com/LA
- **By phone:** 1-800-454-3730
- **By fax:** 1-800-964-3627
  - Durable medical equipment, home health and infusion services: 1-844-528-3684
  - Speech, physical and occupational therapy: 1-844-365-9036 (OrthoNet)
  - Spinal surgery: 1-844-207-4145 (OrthoNet)
  - Behavioral health inpatient: 1-877-434-7578
  - Behavioral health outpatient: 1-866-877-5229

Precertification – 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 us of your intent to render covered medical services to a member.

- Provide notification prior to rendering services outlined in this document.
- For emergency or urgent services, provide notification within 24 hours or the next business day.
- There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.
- It is our policy to cover two routine prenatal ultrasounds for fetal anatomic survey per member per pregnancy (CPT codes 76801 +76802 and 76805 +76810). For CPT codes 76811 (+76812), 76815, 76816 and 76817, additional ultrasound studies are covered when medically necessary and supported by the appropriate diagnosis code for the ultrasound study being requested. CPT code 76811 (and +76812) is only reimbursable to Maternal Fetal Medicine specialists.

  The policy does not apply to the following specialists:
  - Maternal fetal medicine specialists (S142, S083, S055 and S088)
  - Radiology specialists (S164 and S232)

The policy also does not apply to ultrasounds performed in place of service code 23 – emergency department.

For code-specific requirements for all services, visit our provider self-service website and select Precertification Lookup from our Quick Tools menu.

Requirements listed are for network providers. In many cases, out-of-network providers may be required to request precertification for services when network providers do not.

Air Ambulance Services

Precertification is required for all services. Providers have 30 days from the date of transportation to provide medical necessity documentation and request authorization of services.

Behavioral Health/Substance Abuse Services

No precertification is required for basic behavioral health services provided in a primary care provider (PCP) or medical office, or routine outpatient behavioral health services provided by behavioral health specialists. Precertification is required for the following specialty behavioral health services:

- Anesthesia for electroconvulsive therapy
- Inpatient psychiatric sub-acute
- Electroconvulsive therapy
- Psychological testing with interpret face to face
- Psychological testing with interpret technician
- Psychological testing with interpret computer
- Neurobehavioral status examination
- Psychological testing with interpret face to face
- Psychological testing with interpret technician
- Psychological testing with interpret computer
- Initial hospital inpatient care, low complexity
- Initial hospital inpatient care, moderate complexity
- Initial hospital inpatient care, high complexity
- Subsequent hospital inpatient care, low
- Subsequent hospital inpatient care, moderate
- Subsequent hospital inpatient care, high
- Hospital discharge day management
- Hospital discharge day
- Alcohol and/or drug services – intensive outpatient ii.1 Individual
- Alcohol and/or drug services – intensive outpatient ii.1 Group, ages 0-20
- Alcohol and/or drug services – intensive outpatient ii.1 Group, ages 21+
- Therapeutic group home per diem, ages 0-20
- Community psychiatric supportive treatment individual office
- Community psychiatric supportive treatment individual community
- Community psychiatric supportive treatment – homebuilders, ages 0-20
- Community psychiatric supportive treatment – functional family therapy, ages 0-20
- Community psychiatric supportive treatment – psh individual office
- Community psychiatric supportive treatment – psh individual community
- Assertive community treatment – non physician per diem, ages 18-20
- Assertive community treatment – physician per diem, ages 18-20
- Assertive community treatment – 1st month if enrolled 1-10th day of month, ages 21+
- Assertive community treatment – 1st month if enrolled 11-20th day of month, ages 21+
- Assertive community treatment – 1st month if enrolled 21-31st day of month, ages 21+
- Assertive community treatment – subsequent months,* ages 21+
- Psychiatric health facility service per diem – prtf, ages 0-20
- Psychosocial rehabilitation individual office
- Psychosocial rehabilitation individual community
- Psychosocial rehabilitation group office, ages 0-20
- Psychosocial rehabilitation group community, ages 0-20
- Psychosocial rehabilitation group office, ages 21+
- Psychosocial rehabilitation group community, ages 21+
- Multi systemic therapy – 12-17 year old target population, ages 0-20

Cardiac Rehabilitation

Precertification is required for all services.

Chemotherapy

- Precertification is required for inpatient chemotherapy, as part of inpatient admission, and for oncology drugs and adjunctive agents.
- Precertification is required for outpatient chemotherapy drugs.
- Precertification is not required for procedures performed in the following outpatient settings:
  - Office
  - Outpatient hospital
  - Ambulatory surgery center

For information on coverage and precertification requirements on chemotherapy drugs, please refer to the Precertification Lookup tool on our provider website. Limitations and exclusions apply for experimental and investigational treatments.

Circumcision

- Routine circumcisions are covered within the first 30 days of life.
- Medically necessary circumcisions are covered with no age limit.

Dermatology

- No precertification is required for a network provider for Evaluation and Management (E&M), testing and procedures.
- Cosmetic services or services related to previous cosmetic procedures are not covered.

Diagnostic Testing

- No precertification is required for routine diagnostic testing.
- Precertification is required for MRAs, MRIs, CAT scans, nuclear cardiology and video EEGs.

Durable Medical Equipment (DME)

No precertification is required for:

- Glucometers and nebulizers
- Dialysis
- Gradient pressure stockings
- Light therapy/bili-lights for jaundice babies
- Sphygmomanometers
- Standard walkers
- Orthotics for arch support
- Heels, lifts, shoe inserts and wedges

Precertification is required for:

- All routine rentals and purchased DME equipment other than what is included above
- Breastfeeding pumps
- Certain prosthetics and orthotics
- Heavy Duty Walkers
- Specialized Wheelchairs
- Oxygen Concentrators
- Insulin Pumps and supplies
- Continuous Glucose Monitoring Systems
- Hospital Beds
- Ventilators
- CPAP, BIPAP and APAP
- Parenteral and Enteral Nutrition
- Lymphedema Pumps
- Hoyer Lifts
- Support Surfaces
- POVs and Motorized Wheelchairs
- Osteogenesis stimulators
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Seat Lift Mechanism

For DME code-specific precertification requirements, visit our provider self-service website at www.amerigroup.com/providers. Select Quick Tools and then choose precertification look up tool (PLUTO). Enter codes to determine authorization requirement.

To request precertification, please submit a physician's order and fill out our precertification form which can be found on providers.amerigroup.com/LA.

We must agree on HCPCS and/or other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment).

Our policy for rent to purchase on most items is limited to 10 months. For additional questions regarding rent to purchase items, please contact 1-800-454-3730.

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

- Members may self-refer for these visits.
- Use the EPSDT schedule and document visits.

Note: Vaccine serum is received under the Vaccines for Children (VFC) program. For questions about the VFC program, please call 504-838-5300.

Educational Consultation

No precertification is required.

Elective Termination of Pregnancy

Precertification is required. Termination is only covered when either:

- A woman suffers from a physical disorder, physical injury or physical illness – including a life-endangering physical condition caused by or arising from the pregnancy itself – that would, as certified by a physician, place the woman in danger of death unless an abortion is performed
- The pregnancy is the result of an act of rape or incest

Emergency Room

No precertification is required. We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the ER.

ENT Services (Otolaryngology)

No precertification is required for a network provider for E&M, testing and certain procedures.

Precertification is required for:

- Tonsillectomy and/or adenoidectomy
- Nasal/Sinus surgery
- Cochlear implant surgery and services

Family Planning/Sexually Transmitted Infection (STI) Care

Members may self-refer to any in-network or out-of-network provider. Encourage patients to receive family planning services in network to ensure continuity of service.

Gastroenterology Services

No precertification is required for a network provider for E&M, testing and certain procedures.

Precertification is required for:

- Bariatric surgery
- Insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components
- Upper endoscopy

Gynecology

No precertification is required for a network provider for E&M, testing and certain procedures.

Hearing Aids

Precertification is required for digital hearing aids.

Hearing Screening

Precertification is required for digital hearing aids.

No precertification is required for:

- Diagnostic and screening tests
- Hearing aid evaluations
- Counseling

Home Health Care and Home IV Infusion

Precertification is required for:

- Skilled nursing
- Private duty nursing
- Extended home health services
- IV infusion services
- Home health aide
- Physical, occupational and speech therapy services
- Physician-ordered supplies
- IV medications for in home therapy

Notes:

- Home health visits are limited to 50 skilled nursing visits per calendar year for each recipient based on medical necessity for members ages 21 and older
- Drugs and DME require separate precertification

Hospice Care

A recipient must be terminally ill in order to receive hospice care. An individual is considered terminally ill if he or she has a physician certified medical **prognosis** that the individual's life expectancy is six months or less if the illness runs its normal course. Precertification is required.

Hospital Admission

- Precertification is required for elective and nonemergent admissions and some same-day/ambulatory surgeries.
- Notification is required within 24 hours or the next business day if a member is admitted into the hospital through the ER. This includes normal vaginal and Cesarean deliveries. Preadmission testing must be performed by an Amerigroup Louisiana, Inc.-preferred lab vendor or network facility outpatient department. Please see our provider directory for a complete listing.
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.) are not covered.
- We request notification of inpatient emergency admissions within one business day of admission. Failure of admission notification after one business day may result in claim denial.

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:

- At the hospital
- By telephone or fax

It is the hospital's responsibility to submit clinical information for review by the specified next review date and time determined by the health plan at the time of admission and for continued length of stay.

The clinical submission deadline for Amerigroup is 3 p.m. Central time. We will implement a 10-minute grace period to alleviate time discrepancies on fax machines. A fax confirmation for the transmittal of documentation prior to a specified time will be accepted by the plan as meeting the deadline.

If the clinical information is not submitted within the required time frame, the case will be administratively denied (reason: **lack of timely submission of clinical**). The receipt of an administrative denial is based on the timely notification and/or submission of clinical information and is not based on medical necessity.

Administrative denials are not subject to our informal reconsideration or peer-to-peer process.

We will communicate to hospitals all approved days, denied days and bed-level coverage to the hospital for any continued stay.

Your Utilization Management Resources Hospital Precertification/Admission Notification: Precertification request and notification of intent to render covered medical services	Fax: **1-800-964-3627** Call: **1-800-454-3730** Web: Log in to providers. amerigroup.com/LA
Inpatient Utilization Management: Emergent inpatient admission required review for medical necessity and clinical information submitted	Fax: **1-888-822-5595** Call: **1-800-454-3730**

Laboratory Services (Outpatient)

Precertification is required for:

- Genetic testing
- All laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition

If your office has limited or no lab facilities, please refer tests to one of our preferred lab providers. See our provider referral directory for a complete listing.

Medical Supplies

No precertification is required for disposable medical supplies.

Neurology

- No precertification is required for a network provider for E&M, testing and certain other procedures.
- Precertification is required for neurosurgery, spinal fusion and artificial intervertebral disc surgery.

Observation

No precertification is required for in-network observation up to 30 hours. If your observation results in an admission, you must notify us within 24 hours or on the next business day.

Obstetrical (OB) Care

Notification to our Provider Services team at 1-800-454-3730 for the first prenatal visit is required.

No precertification is required for:

- OB services and diagnostic testing
- OB visits
- Certain diagnostic tests and lab services by a participating provider
- Prenatal ultrasounds (clinical guideline for medical necessity applies)
- Normal vaginal and Cesarean deliveries
- Amerigroup will authorize up to 48 hours for a normal vaginal delivery and 96 hours for normal Cesarean delivery. The hospital is required to notify Amerigroup of the discharge date of the mother. Please fax Maternal Discharge Notifications to 1-888-822-5595 within one business day of discharge.
- For deliveries where the inpatient confinement exceeds 48 hours for vaginal delivery and 96 hours for a Cesarean delivery, the hospital is required to provide:
  - Notification to our Provider Services team by phone or fax to 1-800-964-3627
  - Initial hospital medical records and subsequent medical justification directly to the local health plan by fax to 1-888-822-5595
- The health plan is allowed to deny a portion of a claim for payment based solely on the lack of notification by the provider of an obstetrical admission exceeding 48 hours after a vaginal delivery and 96 hours after a Cesarean section. In these cases, the health plan is allowed to deny only the portion of the claim related to the inpatient stay.
- If a member is admitted for an induction or labor and fails to deliver by day two of the admission, the hospital is required to submit inpatient medical records via fax for the first two days of admission for medical necessity review.

Birth Notification:

- Within 24 hours of the birth of a newborn (or within one business day of delivery), the hospital is required to submit clinical birth information to the health plan. Please fax Newborn Delivery Notification to 1-800-964-3627.
- The clinical information required is outlined as follows:
  - Indicate whether it is a live birth
  - Newborn's birth weight
  - Gestational age at birth
  - Apgar scores
  - Disposition at birth
  - Type of delivery (vaginal or Cesarean*)
  - Date of birth
  - Gender
  - Single/Multiple birth
  - Gravida/Para/Ab for mother
  - EDC and if NICU admission was required
- You may use the standard reporting form specific to your hospital, as long as the required information outlined above is included.
- If a newborn requires admission to the NICU, the hospital must provide notification to our Provider Services team and send initial inpatient medical records directly to the local health plan via fax to 1-888-822-5595.
- Well babies are covered under the mother's hospitalization authorization. If a newborn requires hospitalization as a boarder baby beyond the mother's discharge date, the hospital must provide notification as directed for NICU admissions.
- Free maternal child case management programs are available.

*If delivery is by Cesarean, the reason must be given.

Ophthalmology

- No precertification is required for a network provider for E&M, testing and certain other procedures.
- Precertification is required for repair of eyelid defects.
- We do not cover services that are considered cosmetic.

Oral Maxillofacial

See Plastic/Cosmetic/Reconstructive Surgery.

Out-of-Area/Out-of-Network Care

Precertification is required except for emergency care, EPSDT screening, family planning and OB care.

Outpatient/Ambulatory Surgery

Precertification is required based on the procedure performed; visit our provider website for more details.

Pain Management/Physiatry/Physical Medicine and Rehabilitation

Precertification is required for non-E&M-level testing and procedures.

Pediatric Day Health Care

Precertification is required for the following services and codes:

- T1025
- T1026
- T2002

Personal Care Services

- Provided by attendants when physical limitations due to illness or injury require assistance with eating, bathing, dressing and personal hygiene. Does not include medical tasks such as medication administration, tracheostomy care, feeding tubes or catheters.
- Covered for members aged 0-20 and excluded for members > 21 years of age
- Requires prior authorization

Pharmacy Services

- The pharmacy benefit covers medically necessary prescription and over-the-counter drugs prescribed by a licensed provider. Please refer to the Preferred Drug List (PDL) for the preferred products within therapeutic categories, as well as requirements around generics, prior authorization, step therapy, quantity edits and the prior authorization process. Quantity and day supply limits apply.
- Requests for nonformulary or nonpreferred drugs will require prior authorization by calling the Amerigroup Pharmacy department at 1-800-454-3730 or by faxing a request to 1-888-346-0102.
- Pharmacy providers can call the Express Scripts Pharmacy Help Desk at 1-844-367-6111 for technical assistance.
- Pharmacy providers who need to check pharmacy eligibility can call Amerigroup Provider Services at 1-800-454-3730.
- Members can call Amerigroup Member Services at 1-800-600-4441.
- Our Medicaid formulary and PDL are available on our provider self-service website.
- Most biotechnology injectable drugs require precertification by the Amerigroup Pharmacy department at 1-800-454-3730 when administered in any outpatient setting. Examples include Epogen, Procrit, Aranesp, Neupogen, Neulasta, Leukine, IVIG, Enbrel, Remicade, Kineret, Amevive, Raptiva, Synvisc, Hyalgan, Erbitux, Avastin, Rituxan, Tasigna, growth hormones, Herceptin, Makena and Orthovisc.

Plastic/Cosmetic/Reconstructive Surgery (including Oral Maxillofacial Services)

- No precertification is required for E&M services, including oral maxillofacial E&M services.
- Precertification is required for:
  - All other services
  - Trauma to the teeth
  - Oral maxillofacial medical and surgical conditions
  - Temporomandibular joint and muscle disorders (TMJ)
- We do not cover services considered cosmetic in nature or related to previous cosmetic procedures.
- Reduction mammoplasty requires our medical director's review.

Podiatry

No precertification is required for E&M, testing and most procedures.

Radiology

See Diagnostic Testing.

Rehabilitation Therapy (Short-Term): Speech, Physical and Occupational Therapy

- No precertification is required for evaluation or initial visit.
- Precertification is required for treatments.
- Therapy to improve a child's ability to learn and participate in school should be evaluated for school-based therapy.
- Therapies for rehabilitative care are covered as medically necessary.

OrthoNet conducts medical necessity reviews for speech, physical and occupational therapy. Treatment requests must be reviewed by OrthoNet for prior authorization (PA). You may request PA by submitting complete clinical information to OrthoNet by:

- Phone: 1-844-511-2873
- Fax: 1-844-365-9036

Skilled Nursing Facility

Precertification is required.

Sterilization

- No precertification is required for sterilization, tubal ligation or vasectomy.
- We require a sterilization consent form for claims submissions. We do not cover reversal of sterilization.

No precertification is required for a participating facility.

Transportation

No precertification is required.

Urgent Care Center

No precertification is required for a participating facility.

Well-woman Exam

No precertification is required. We cover one well-woman exam per calendar year when performed by her PCP or an in-network gynecologist. The visit includes:

- Examination
- Routine lab work
- STI screening
- Mammograms for members 35 and older
- Pap smears

Members can receive family planning services without precertification at any qualified provider. Encourage patients to receive family planning services from an in-network provider to ensure continuity of service.

Revenue (RV) Codes

Precertification is required for services billed by facilities with RV codes for:

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

Refer to the Quick Tools on our provider self-service website for code-specific precertification requirements. For a complete list of specific RV codes, visit our provider website.

Important Contact Information

Our Service Partners

Service partner	Phone
LabCorp (lab services and diagnostic testing)	1-800-345-4363
Quest Diagnostics (lab services and diagnostic testing)	1-866-MY-QUEST (1-866-697-8378)
Southeastrans (nonemergent transportation)	1-877-892-3988
Superior Vision (vision services)	1-866-819-4298
AIM Specialty Health (diagnostic or imaging services, for authorizations only)	1-800-714-0040
OrthoNet (speech, physical and occupational therapy)	1-844-511-2873
OrthoNet (spine therapy)	1-844-677-2610

Provider Experience Program

Our Provider Services team offers precertification, case and disease management, automated member eligibility, claims status, health education materials, outreach services, and more. Call 1-800-454-3730, Monday through Friday from 7 a.m. to 7 p.m. Central time.

Local Provider Relations

We also offer local Provider Relations representatives who will help your office with ongoing education, contract and fee issues, procedural issues, and more. Your office has a designated representative:

- New Orleans and Metairie, call 504-834-1271
- Baton Rouge, call 225-819-4893

Provider Website and IVR Available 24/7/365: To verify eligibility, check claims and referral authorization status, and look up precertification/notification requirements, visit our provider self-service website.

Can't access the Internet? Call Provider Services and simply say your national provider ID when prompted by the recorded voice. The recording guides you through our menu of options – just select the information or materials you need when you hear it.

Claims Services

Timely filing is within 365 calendar days 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.

Because of the importance of EPSDT screenings and the collection of data related to these services, we encourage you to submit EPSDT claims as soon as possible within the timely filing period. For cases of coordination of benefits/subrogation, the time frame for filing a claim will begin on the date the third party documents resolution of the claim. In situations of enrollment in Amerigroup with a retroactive eligibility date, the time frame for filing a claim will begin on the date we receive notification from the enrollment broker of the member's eligibility/enrollment.

Electronic Data Interchange (EDI)

Call our EDI hotline at 1-800-590-5745 to get started. We accept claims through three clearinghouses:

- Emdeon (payer 27514)
- Availity (payer 26375)
- Capario (payer 28804)

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. AMA- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code. Mail to:
Claims Department, Amerigroup Louisiana, Inc.
P.O. Box 61010, Virginia Beach, VA 23466-1010

Payment Disputes

Claims payment disputes must be filed within 90 days of the adjudication date on your explanations of payment. Forms for provider appeals are available on our provider self-service website. Mail to:
Payment Dispute Unit, Amerigroup Louisiana, Inc.
P.O. Box 61599, Virginia Beach, VA 23466-1599

Changes and/or errors on claims, responses to itemized bill requests, and submission of coordination of benefits/third-party liability information are not considered payment disputes. These should be resubmitted with a notation of corrected claim or claim correspondence to:
Claims Department, Amerigroup Louisiana, Inc.
P.O. Box 61010, Virginia Beach, VA 23466-1010

Peer-to-Peer Discussion

If the medical director denies coverage of a request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or attending physician, and the member. You have the right to discuss this decision with our medical director by calling Provider Services.

As an attending provider acting on behalf of a member, you have the right to discuss this decision with our medical director by calling our Health Care Management Services department.

Additional guidelines regarding inpatient peer-to-peer (P2P) discussions are below:

- We will allow P2Ps to be scheduled within five business days from the issuance of the faxed denial notification for inpatient concurrent stays.
- We'll send the fax notification via a log to the requesting hospital UM department outlining approvals and denials every day.
- We will not complete P2P discussions on retrospective eligible, post discharge hospitalizations. For retrospective eligible post discharge adverse determination, please follow the Amerigroup formal medical necessity appeals process.
- If the request is for denied outpatient services, the requesting provider will receive the faxed denial notification.

If the request for the P2P is outside of the established time frame, you'll need to follow the formal medical necessity appeal process.

- The provider will be outreached by an Amerigroup associate to schedule the P2P within one business day.