

Long-Term Services and Supports

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc. Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

Long-Term Services and Supports design

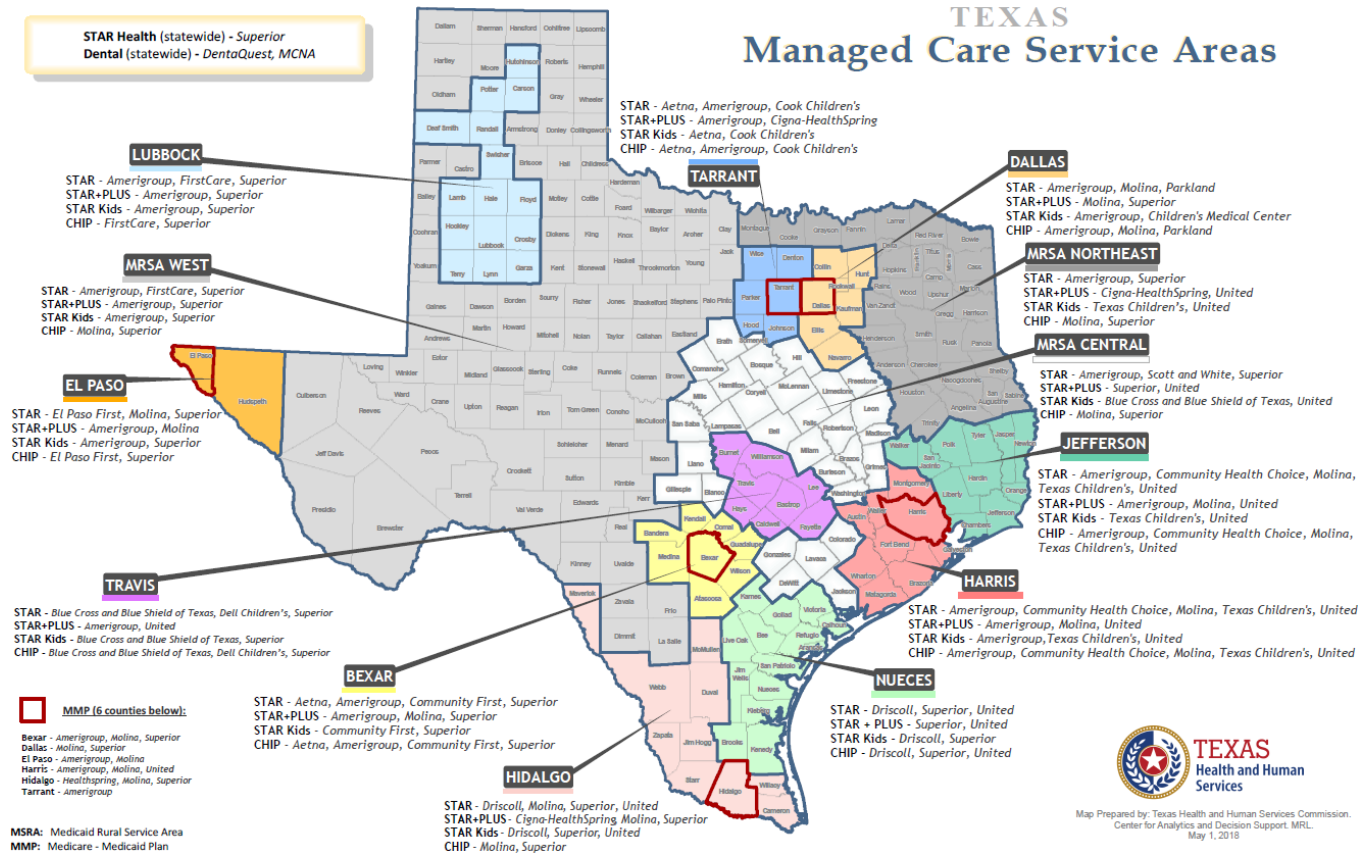
- Managed care is designed to integrate acute, behavioral, social, environmental and long-term services and supports (LTSS).
- Managed care is the preferred delivery system model designed around preventive care, person-centered planning and stable community living for all members.
- Service coordination is the cornerstone to the program. Local, dedicated service coordination teams help members and providers navigate health care delivery systems and interface with Amerigroup.

Long-Term Services and Supports design (cont.)

- Service coordinators act as the member's advocate. They will assess for need, develop a care plan and arrange for the delivery of the needed services.
- Multidirectional communication means members and providers can talk with the Service Coordination team to help manage the member's needs.



Managed care service areas



An Anthem Company

Why Amerigroup?

Amerigroup offers experience with:

- Managing Medicaid programs for more than 20 years, facilitating the integration of physical, behavioral and long-term health care services while emphasizing community-based care.
- Dedicated service coordination through person-centered service and care planning.
- Completing comprehensive health assessments of members to develop detailed service plans.
- Providing comprehensive disease management programs.

Why Amerigroup? (cont.)

Amerigroup offers experience with:

- Encouraging collaborative and stable relationships between providers and members.
- Working with community-based organizations, resources and outreach services.
- Providing a full continuum of resources to promote continuity of care.

Service Coordination

Service coordination provides the member with initial and ongoing assistance identifying, selecting, obtaining, coordinating and using covered services and other supports to enhance the member's well-being, independence, integration in the community and potential for productivity.



Service Coordination (cont.)

- Specialized care management service that is performed by a licensed individual called a service coordinator and includes the following:
 - Providing a holistic evaluation of the member's individual dynamics, needs and preferences
 - Educating and helping provide health-related information to the member, the member's legally authorized representative (LAR) and others in the member's support network
 - Helping to identify the member's physical, behavioral, functional and psychosocial needs
 - Engaging the member, the member's LAR and other caregivers in the design of the member's individual service plan

Service Coordination (cont.)

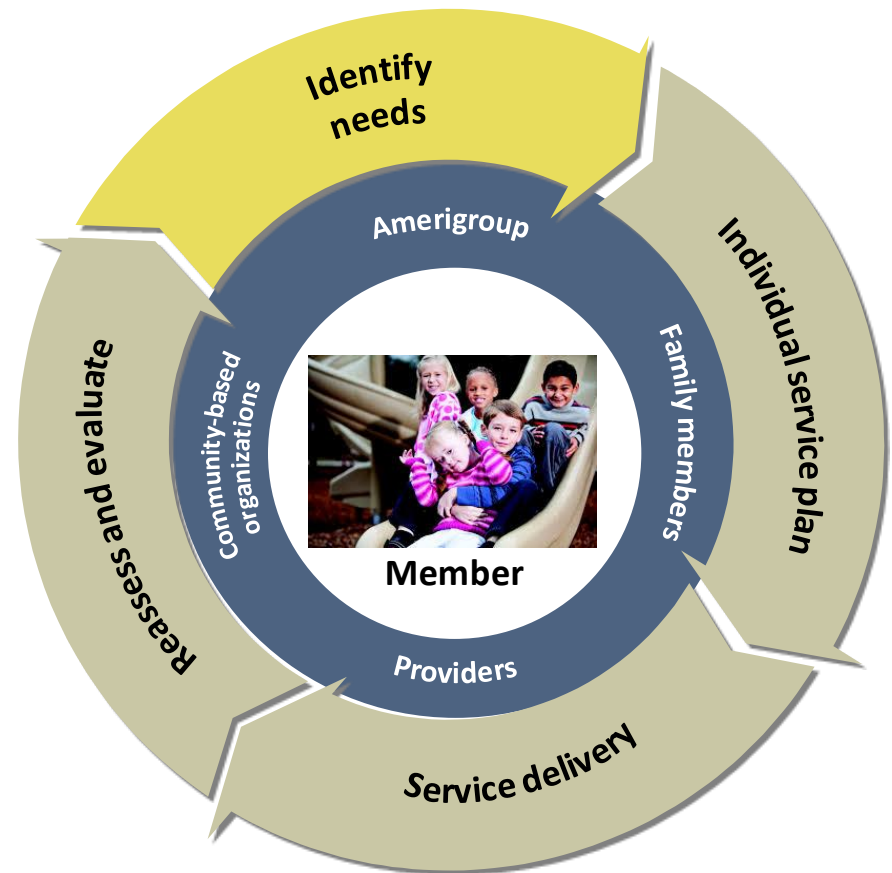
- Connecting the member to covered and noncovered services necessary to meet the member's identified needs
- Monitoring to ensure the member's access to covered services is timely and appropriate

Service Coordination model

Identify needs:

- Members are contacted and screened for complex needs and high-risk conditions.
- The service coordinator identifies complex and high-risk members for a home visit in the next two weeks.*

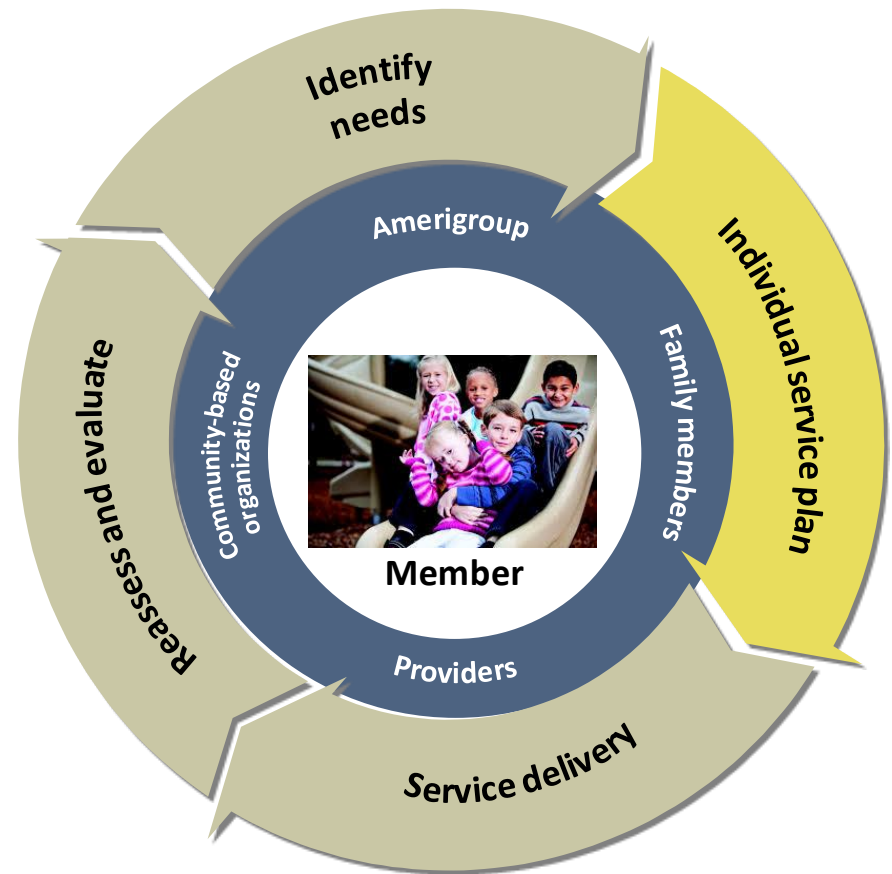
* Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) contacts all members within 90 days of eligibility.



Service Coordination model (cont.)

Individual Service Plan:

- The service coordinator makes a home visit and conducts a comprehensive assessment of all medical, behavioral, social and long-term care needs.
- The service coordinator works with a team of experts to develop a service plan to meet the member's needs.
- The service coordinator contacts the member's PCP for concurrence.
- The member and member's family review and sign the service plan.



Service Coordination model (cont.)

Service delivery

- The member selects providers from the network.
- The service coordinator works with the care team to authorize and deliver services.
- The service coordinator ensures all appropriate services are authorized and delivered according to the service plan.



Service Coordination model (cont.)

Reassess and evaluate

- The service coordinator contacts member and reassesses the member's needs and functional capabilities.
- The service coordinator and member evaluate and revise the service plan as needed.



LTSS prior authorization

- All LTSS require prior authorization (PA) for services to be rendered to a member.
- To request PA, complete a *Precertification Request Form* and fax the request to the appropriate number per service area.
- The approval or denial of a PA request will be faxed back to the provider.

STAR+PLUS service area fax numbers:

- Austin: 1-877-744-2334
- El Paso: 1-888-822-5790
- Houston/Beaumont: 1-888-220-6828
- Lubbock: 1-888-822-5761
- San Antonio: 1-877-820-9014
- Tarrant/West RSA: 1-888-562-5160

STAR Kids fax number: 1-844-756-4604

Amerigroup STAR+PLUS MMP service area fax number:

- MMP SDA: 1-844-206-3450

Referrals

- **LTSS referrals:** A provider can make a referral directly to Amerigroup if a member requires specific LTSS services. Depending on the type of service, the member's service coordinator will complete an assessment with them in order to authorize and coordinate the care for the service.
- **In-network referrals:** A provider can make a referral directly to another provider or specialist physician that is in-network with Amerigroup to provide and administer the service that is being referred. Certain services may require a PA.

Role of LTSS providers

- LTSS provider responsibilities include:
 - Contacting Amerigroup (or using Availity*) to verify member eligibility.
 - Coordinating Medicaid and Medicare benefits.
 - Obtaining authorizations for services prior to provision of those services.
 - Notifying us immediately if unable to render authorized services to the full extent authorized.
 - Notifying Amerigroup of changes in a member's physical condition or eligibility.
 - Partnering with our service coordinator in managing a member's healthcare.

Role of LTSS providers (cont.)

- LTSS provider responsibilities include:
 - Managing continuity of care.
 - Developing and updating quarterly plans for delivering employment assistance services (employment assistance providers).
 - Developing and updating quarterly plans for delivering supported employment services (supported-employment providers).

Role of LTSS providers (cont.)

- All home- and community-based support services agency providers must notify Amerigroup if a member experiences any of the following:
 - A significant change in physical or mental condition or environment
 - Hospitalization
 - An emergency department visit
 - Two or more missed appointments

Your responsibilities



- Providers should review both member and provider responsibilities, which are detailed in the provider manual.
- The Medicaid provider manual can be accessed by visiting: <https://providers.amerigroup.com/TX> > Provider Resources & Documents > Manuals & QRCs > Medicaid/CHIP Provider Manual.
- The Amerigroup STAR+PLUS MMP provider manual can be accessed by visiting: <https://providers.amerigroup.com/TX> > Provider Resources & Documents > STAR+PLUS Medicare-Medicaid Program > Amerigroup STAR+PLUS Medicare-Medicaid Plan (MMP) Provider Manual.

Ongoing credentialing

- Recredentialing occurs every three years or sooner if required by state law.
- Please notify us if you have any changes in licensure, demographics or participation status.



Check status on eligibility, authorizations and claims

- Amerigroup offers both online and telephonic options for checking the status of eligibility, authorizations, PA and claims:
 - **Online:** Visit Availity for registration, member eligibility, precertification and benefits information; claims submission; claims status inquiry; and payment disputes.
 - **Telephonic:** Access is available by calling Medicaid Provider Services at **1-800-454-3730**. For MMP Provider Services, please call **1-855-878-1785**.
- Both features are available 24/7.

Continuity of care

90-day continuity of care:

- Amerigroup ensures members receiving services through a PA or where an authorization was not previously required, who are transitioning from another managed care organization (MCO) or from Medicaid fee-for-service, receive continued authorization of those services for the same amount, duration and scope.
- For both STAR+PLUS and STAR Kids members, continuity of care does not exempt providers from following billing guidelines, such as correct coding and timely filing. Claims can be denied for these errors.

Continuity of care (cont.)

90-day continuity of care for acute care services:

- Members will receive continued authorization of those services for the same amount, duration and scope for the shortest period of the following:
 - Ninety calendar days after the transition to a new MCO
 - The time it takes for us to evaluate and assess the member and issue or deny a new authorization
 - Until the end of the current authorization period

Continuity of care (cont.)

90-day continuity of care for LTSS:

- For members enrolling in an existing program and service area, we will honor existing LTSS authorizations for up to 90 calendar days or until we have evaluated and assessed the member and issued new authorizations.

Medical transportation services

- The medical transportation program through the Texas Health and Human Services Commission (HHSC) sets up nonemergency rides for people who have no other way to get to their Medicaid health care visits.
- The program does not set up rides in an ambulance, even for nonemergency purposes, but the program can reimburse someone who uses their personal car to drive a Medicaid member to and from their Medicaid-related health visit.

Medical transportation services (cont.)

To set up a ride:

- Call at least two working days or more before a ride is needed. If the travel is a long way out of town to see a doctor, call at least five work days before a ride is needed.
- The following information is needed to set up a ride:
 - Medicaid ID number
 - Social Security number
 - Pick-up location address and phone number
 - Name, address and phone number of the doctor or drug store where the member needs to go
 - Date and time of the appointment
 - Any other special member needs

Medical transportation services (cont.)

To set up a ride:

- Toll-free phone numbers:
 - Houston and Beaumont areas: **1-855-687-4786**
 - Dallas and Fort Worth areas: **1-855-687-3255**
 - All other areas: **1-877-MED-TRIP (1-877-633-8747)**
 - MMP members: **1-844-300-3631**

Medical transportation services (cont.)

Individual transportation participants (ITP):

- These are friends and family members who provide rides to Medicaid-related health visits. They get reimbursed per mile at the state mileage rate.
- To become an ITP, a person must sign up through the transportation provider in their region:
 - Houston and Beaumont areas: **1-855-687-4786**
 - Dallas/Fort Worth area: **1-855-687-3255**
 - All other areas: **1-877-MED-TRIP (1-877-633-8747)**

Cultural competency

We expect our providers and their staff to continually increase knowledge, skill, attitudes and sensitivities to diverse cultures.

The result is effective care and services for all people by taking into account each person's conditions, values and linguistic needs.

Critical events

Providers are obligated to identify and report to the state a critical event or incident such as abuse, neglect or exploitation related to LTSS delivered in the STAR+PLUS and STAR Kids programs.

In the Medicaid/CHIP, STAR+PLUS Nursing Facility and Amerigroup STAR+PLUS MMP provider manuals, see section *Reporting Abuse, Neglect, or Exploitation (ANE)* for further information.

Fraud, waste and abuse

- Amerigroup follows and meets all requirements set by HHSC Office of Inspector General, Texas Government (Code § 531.113 and § 533.012, and 1 TAC § 353.501-353.505).
- In order to ensure compliance with requirements, Amerigroup will complete the following:
 - **Utilization management reviews:** This review process makes sure the service that is requested for the member is medically needed and that the member meets certain medically necessary criteria to be approved for the service that is requested.
 - **Fraud, waste and abuse training:** Training is provided to all employees and subcontractors with Amerigroup. Information about fraud, waste and abuse is also on our website for both members and providers.

Fraud, waste and abuse (cont.)

- **Audits:** The audit process allows for Amerigroup to monitor services and ensure services are being rendered and authorized correctly. Depending on the type of audit, these will be completed at various times. Audits are performed on claims, authorizations and LTSS provider agencies. Internal audits are performed on service coordinator's assessments.

Electronic payment services

If you sign up for electronic remittance advice (ERA) or electronic funds transfer (EFT), you can:

- Start receiving ERAs and import the information directly into your patient management or patient accounting system.
- Route EFTs to the bank account of your choice.
- Create your own custom reports within your office.
- Access reports 24/7.

Electronic payment services (cont.)

- **Summary of change:** Effective September 1, 2018, the provider disbursement process has changed. These changes include the following:
 - New EFT enrollment: Go to EnrollHub™, a Council for Affordable Quality Healthcare (CAQH) Solutions™ enrollment tool.

Electronic payment services (cont.)

- New ERA-only enrollment and change management for existing ERA-only enrollments are managed through Availity.
- Go to <https://www.availity.com> and select **Enrollments Center** in the *My Account Dashboard* on the home page. Select **ERA Enrollment** in the *Multi-Payer Enrollments* section. Then, simply follow the wizard and submit. After submitting, you will be notified by email that enrollment is complete and start receiving 835s through Availity.

Electronic payment services (cont.)

- Change Healthcare and PaySpan will no longer be used for EFT/ERA enrollment.
- Providers now have access to *Explanation of Payment* letters through the secure self-service provider website.
- Medicaid, Medicare and MMP remittance advices have been consolidated.

LTSS billing grid

- Both the STAR+PLUS and STAR Kids LTSS billing grids can be found on the HHSC website:
 - For STAR+PLUS: See Appendix XVI in the STAR+PLUS Handbook at <https://hhs.texas.gov/laws-regulations/handbooks/sph/appendices>
 - For STAR Kids: See the Provider Resources section at <https://hhs.texas.gov/services/health/medicaid-chip/programs/star-kids>
- LTSS billing information, including Amerigroup fee schedules, are on the Availity Portal.



LTSS billing grid (cont.)

- HHSC has updated the LTSS billing matrix for both the STAR+PLUS and STAR Kids programs. The updates reflect new codes related to electronic visit verification (EVV), changes to the units of service (for example, 15-minute intervals), revised modifiers and compliance to the National Correct Coding Initiative in Medicaid (NCCI) standards, and follow the requirements for the billing structure outlined in the *Texas Medicaid Provider Procedures Manual*.
- The LTSS billing matrix was **effective September 1, 2019**.

Attendant compensation enhancement payment

- Participation requires a contract or contract amendment with Amerigroup, and participation in the HHSC program for attendant compensation enhancement.
- Participation is not guaranteed. Participation in the HHSC program does not constitute automatic enrollment into the Amerigroup program. Amendments are prospective only.
- Amerigroup will make an exception for:
 - Providers who only have an HHSC community-based alternatives (CBA) contract, as CBA contracts are no longer awarded in STAR+PLUS and STAR Kids areas.
 - Cases where HHSC will not offer participation due to funding restrictions.

Attendant care enhancement payment

- Amerigroup uses the state's rate enhancement structure, which has 35 levels.
- Providers must include the enhancement amount in their billed charge. Attendant enhancement payment is made at the time of claim payment.
- Participation with Amerigroup continues unless the provider withdraws, the program is canceled or the provider becomes noncompliant.

Attendant care enhancement payment (cont.)

- The program requires providers to provide an annual report of how they allocated the additional compensation funds paid through this program per qualified methods, as described in *1 TAC § 355.103(b)(2)(A-B)* and *355.105(b)(2)(B)(xi)*.
 - Reporting periods are based on the state's fiscal year of September 1 through August 31.
 - Reports to Amerigroup are due each January 30 following the close of the state's fiscal year.

Electronic visit verification (EVV)

- EVV is a computer-based system that electronically verifies that service visits occur, including documentation of the date and time that service delivery begins and ends.
- EVV replaces paper timesheets for EVV required services.
- EVV visit transactions are required for EVV claim payment and must fully match the claim.
- Before serving an Amerigroup member, all providers must be fully on boarded and using an HHSC-approved EVV system. Please refer to the *EVV System Selection Policy* for more information at <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-systems-selection-policy.pdf>.

EVV (cont.)

- Training is mandatory for all attendants and other assigned staff prior to beginning services with members. The program provider, Financial Management Services Agencies (FMSA), and Consumer Directed Services (CDS) employers are responsible for keeping track of details of training for staff. This documentation may be reviewed by Amerigroup upon reasonable request. To read the full EVV training requirements, please refer to the *EVV Training Policy* at: <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/evv-training-policy.pdf>.
- Sign up for HHSC GovDelivery email notices and receive EVV alerts at https://public.govdelivery.com/accounts/TXHHSC/subscriber/new?topic_id=TX_HHSC_247.
- All visits must be electronically documented in the EVV system, and the EVV visit transaction must be verified to confirm the service was provided to an Amerigroup member.

EVV (cont.)

- Visit maintenance must be completed within 60 days from date of service.
- Amerigroup offers EVV provider training once a month covering:
 - EVV policies.
 - EVV provider (FMSA) and CDS employer requirements.
 - EVV claims.
 - EVV claims matching process and much more.
- To meet the EVV training policy requirements, providers are encouraged to register and attend one of the monthly Amerigroup EVV provider training sessions.
- Providers are encouraged to frequently check the Amerigroup EVV provider website at <https://providers.amerigroup.com/Pages/tx-electronic-visit-verification.aspx> for updates, changes and alerts on:
 - The EVV provider training schedule, found under the *EVV Training Schedule and Materials* section.
 - All EVV policies and procedures, posted under the *EVV Policies & Procedures* section. Please read all *EVV Policies & Procedures*.

EVV (cont.)

The following services are currently required to use EVV.

All claims for the services listed below must be submitted directly to Texas Medicaid & Healthcare Partnership (TMHP) starting on and after September 1, 2019.

- Amerigroup STAR+PLUS MMP:
 - In-home respite care (agency model)
 - Personal Assistance Service (PAS) (agency model)
 - Personal Assistance Service Protective Supervision (PAS-PS) (agency model)
 - Community First Choice (CFC) Personal Assistance Service (agency model)
 - CFC Habilitation (HAB) (agency model)
- STAR Kids:
 - CFC Personal Care Service (PCS) (agency model)
 - CFC Habilitation (agency model)
 - PCS (agency model)
 - PCS Behavioral Health (BH) Condition (agency model)
 - In-home Respite Care (agency model)
 - Flexible Family Support Services (agency model)

EVV (cont.)

The following services will be required for EVV under the 21st Century Cures Act EVV Expansion.

- Effective October 1, 2020, claims with dates of service on or after October 1, 2020, must be submitted directly to TMHP. Amerigroup will reject claims submitted for the services listed below on or after date of service October 1, 2020, and the provider will be informed to submit the claim to TMHP.
- Effective January 1, 2021, claims with dates of service on or after January 1, 2021, will be denied if there is no match to an EVV visit transaction for the services listed below.
 - Amerigroup STAR+PLUS MMP:
 - In-home Respite Care (CDS and SRO)
 - Personal Assistance Service (PAS) (CDS and SRO)
 - Personal Assistance Service Protective Supervision (PAS-PS) (CDS and SRO)
 - Community First Choice (CFC) Personal Assistance Service (CDS and SRO)
 - CFC Habilitation (HAB) (CDS and SRO)
 - STAR Kids
 - CFC Personal Care Service (PCS) (CDS and SRO)
 - CFC Habilitation (CDS and SRO)
 - PCS (CDS and SRO)
 - PCS, Behavioral Health (BH) Condition (CDS and SRO)
 - In-home Respite Care (CDS and SRO)
 - Flexible Family Support Services (CDS and SRO)

Billing and reimbursement

Billing requirements:

- Check eligibility, at a minimum, the first of every month.
- Be sure you have an authorization to provide for the service for which you are billing.
- Bill within 95 days of the date of service.
- LTSS are billed on a *CMS-1500* or as otherwise noted in the provider's contract using the coding defined per the uniform billing code set.
- Use a valid ICD-10 diagnosis code.

Billing and reimbursement (cont.)

- Include your NPI and taxonomy code or your assigned application programming interface in the correct box or field location.
- Bill via paper, electronic clearinghouse or Availity.
- Reimbursement is based on the terms of your contract with Amerigroup.
- Claim disputes may be filed within 120 days from the date of an *Explanation of Payment*.
- Amerigroup offers claim support via a dedicated claim unit and through our local Provider Relations representatives.

Claims

- Claims must be received within 95 calendar days from the date of service or discharge.
- For paper claims, send to:
Amerigroup
P.O. Box 61010
Virginia Beach, VA 23466-1010

Claims can be submitted electronically or by paper, via:

- Availity.
- Batch 837.
- Clearinghouse.
- U.S. mail.

Claims (cont.)

Electronic data interchange (EDI) submission:

- Use the Availity EDI Gateway at <https://apps.availity.com/web/welcome/#/edi> to begin the process.
- The Payer ID list can be found on the Availity website at <https://apps.availity.com/public/apps/payer-list/#/basic>.
- Providers who wish to use a clearing house or billing company should work with that organization to ensure connectivity to the Availity EDI Gateway.
- Availity Client Services can be contacted for assistance at **1-800-AVAILITY (1-800-282-4548)**, Monday through Friday from 7 a.m. to 6:30 p.m., Central time.

Claims (cont.)

Rejected claims:

- Claims that have been rejected either by mail or EDI must be resubmitted correctly within the 95-day filing limit.
- Once successfully accepted, the claim will be adjudicated for benefits payable.

Claims (cont.)

Accepted claims:

- These are claims that have been accepted into the claim payment platform, have adjudicated, and have produced a paid or denied response.
- Providers can file a corrected claim for accepted claims within 120 days of processing found on the *Explanation of Payment* and label as the run date.
- Providers must correct necessary items via Availity by locating the original claim, correcting it, and resubmitting it in a corrected claim format or via paper submission.

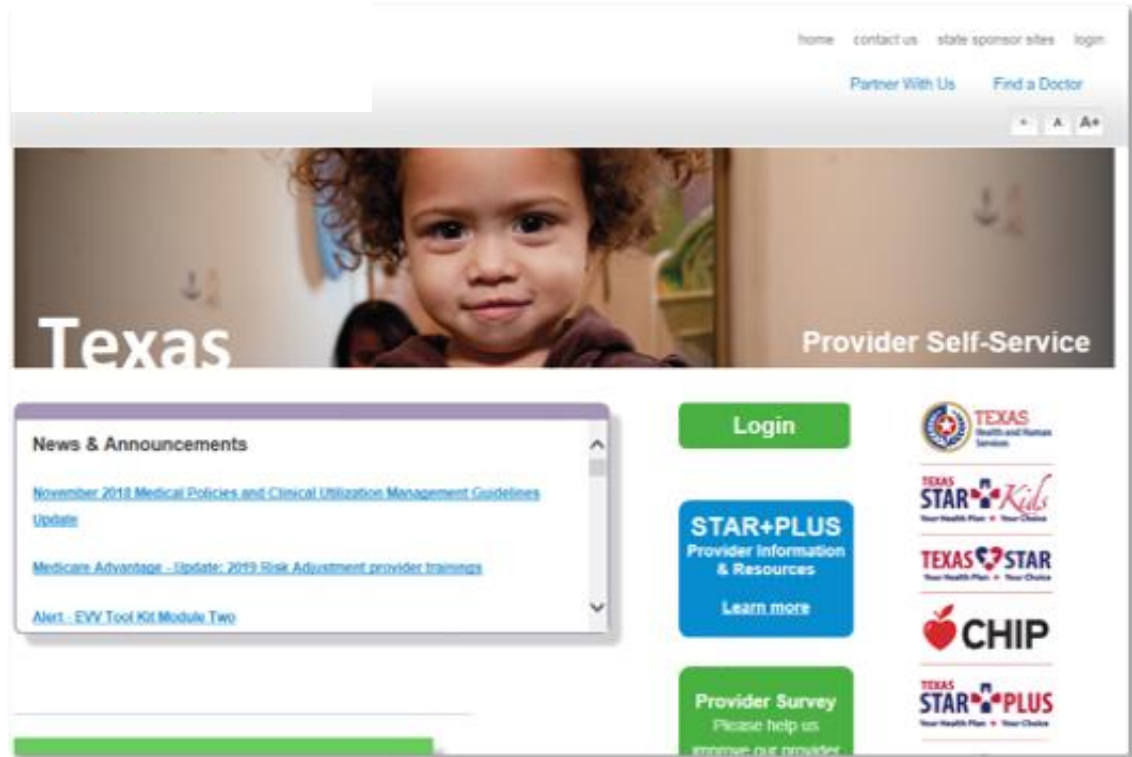
Claims (cont.)

Accepted claims:

- Claims for additional units must reflect the original claim's billed units plus the added units. The provider's billed charge should include the billed amount for original units plus the billed amount for added units to equal the full billed charge.

The provider website and Availity

- The provider website is available to all providers, regardless of participation status.
- The website provides valuable information including provider manuals and important announcements.



<https://providers.amerigroup.com/TX>

The provider website and Availity (cont.)

- Amerigroup collaborates with Availity, a multipayer portal, for providers to conduct transactions and exchange information with many payers in one online location.
- With a single sign-on, providers can move between the resources and tools of both the Amerigroup and Availity sites.
- Providers use Availity for registration, member eligibility, PA and benefits information, as well as claims submission, status inquiry and payment disputes.
- Providers use the Amerigroup provider site for information, tools and resources.

Availity

Key features of Availity:

- **Multiple payers:** Multiple payers can be accessed with a single sign-on.
- **No charge:** Amerigroup transactions are available at no charge to providers.
- **Accessible:** Availity functions are available 24/7 from any computer with internet access.
- **User-friendly:** It's easy to find the necessary information needed within Availity's standard screen format, increasing staff productivity.
- **Compliant:** Availity is compliant with the *HIPAA* regulations.

Availity (cont.)

Key features of Availity

- **Training:** No-cost, live, web-based and prerecorded training webinars are available to users; FAQ and comprehensive help topics are available online as well.
- **Support:** Availity Client Services is available at **1-800-AVAILITY (1-800-282-4548)**, Monday through Friday from 7 a.m. to 6:30 p.m. Central time.
- **Reporting:** Reporting by user allows the primary access administrator to track associates' work.

Availity (cont.)

- Effective February 16, 2019, you have the ability to submit claim payment disputes through the Availity Portal with more functionality, including:
 - Immediate acknowledgement at the time of submission.
 - Notification when a dispute has been finalized.
 - A worklist of open submissions to check the status of a dispute submitted through Availity.
- This means an enhanced experience when:
 - Filing a claim payment dispute.
 - Checking the status of your claim payment dispute.
 - Viewing your claim payment dispute history.
 - Sending supporting documentation.

Availity (cont.)

- With the new electronic functionality, when a claim payment dispute is submitted through the Availity Portal, Amerigroup will:
 - Investigate the request.
 - Communicate an outcome through the Availity Portal.
 - Notify the Availity Portal user who submitted the claim payment dispute that an outcome has been determined and the review has been completed.
 - Include any next steps available in case you are not satisfied with the outcome of the decision.

Availity (cont.)

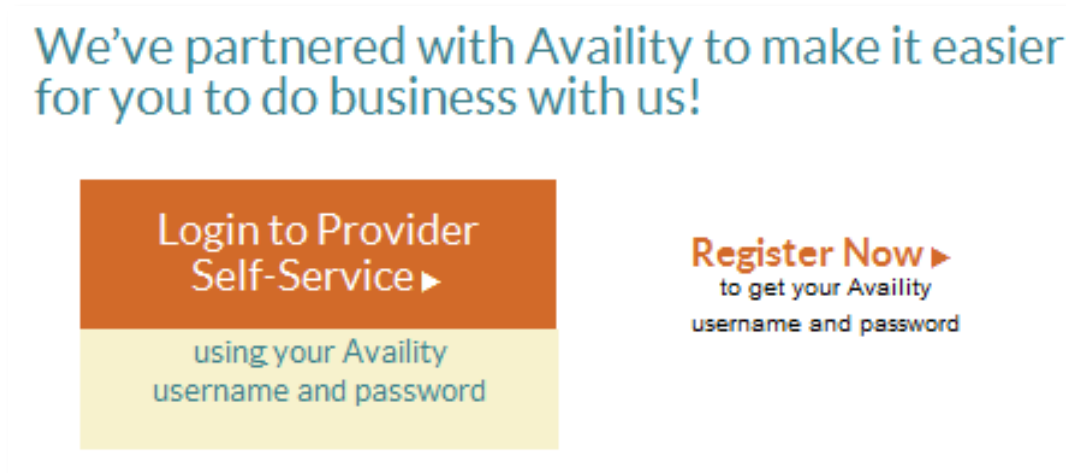
Registering for a scheduled Availity webinar or listening to a recording:

- Log in to the Availity Portal > Help & Training > Get Trained.
- From the Availity Learning Center, enroll using one of the following methods: Select the Dashboard dropdown arrow > Catalog > Sessions > select the date of the webinar > Appeal webinar > Enroll.
- While in the Catalog, Search > enter Appeal > Enroll.



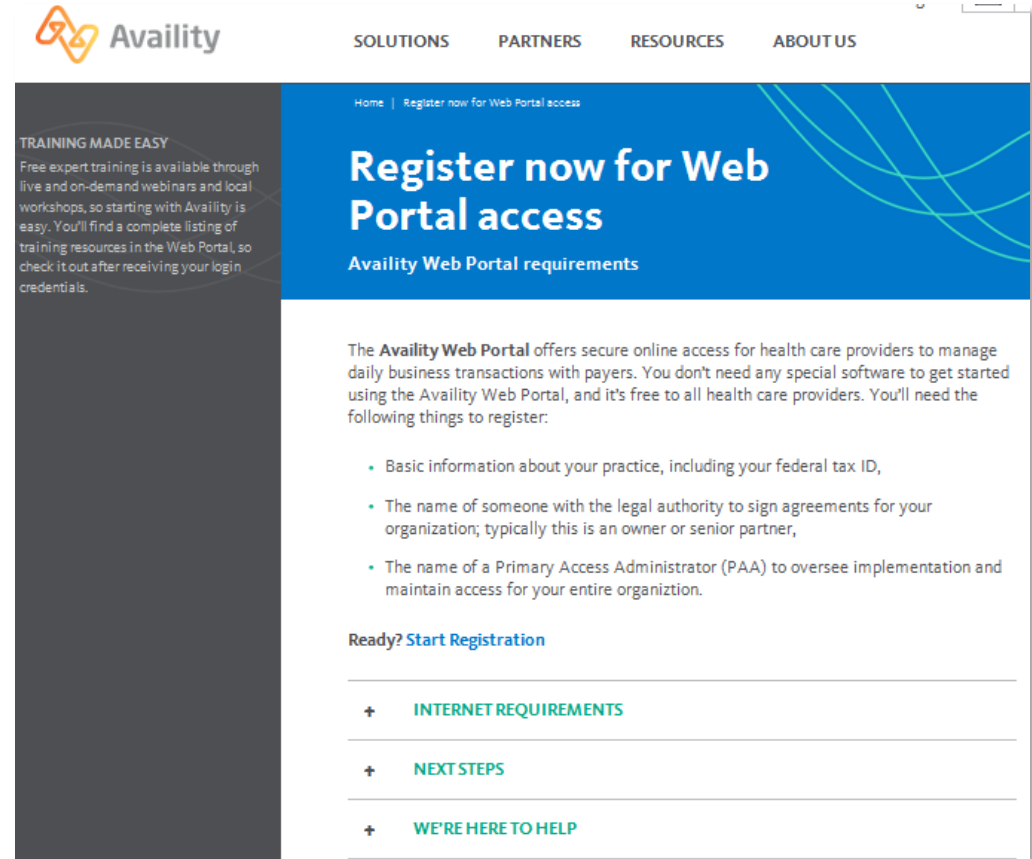
Website registration

- We encourage providers to register so they can use the secured content on our website.
- Select **Register Now** to begin the registration process on the Availity site.



Website registration (cont.)

- The registration process is easy.
- There are multiple resources and trainings available to support Availity and our provider site navigation.



The screenshot shows the Availity website's registration page. The header includes the Availity logo and navigation links for SOLUTIONS, PARTNERS, RESOURCES, and ABOUT US. A secondary navigation bar contains links for Home and Register now for Web Portal access. The main content area is titled "Register now for Web Portal access" and lists the "Availity Web Portal requirements". These requirements include: Basic information about your practice, including your federal tax ID; The name of someone with the legal authority to sign agreements for your organization; typically this is an owner or senior partner; and The name of a Primary Access Administrator (PAA) to oversee implementation and maintain access for your entire organization. Below the requirements, there is a section titled "Ready? Start Registration" with three expandable sections: "INTERNET REQUIREMENTS", "NEXT STEPS", and "WE'RE HERE TO HELP".

Availity

SOLUTIONS PARTNERS RESOURCES ABOUT US

Home | Register now for Web Portal access

Register now for Web Portal access

Availity Web Portal requirements

The **Availity Web Portal** offers secure online access for health care providers to manage daily business transactions with payers. You don't need any special software to get started using the Availity Web Portal, and it's free to all health care providers. You'll need the following things to register:

- Basic information about your practice, including your federal tax ID,
- The name of someone with the legal authority to sign agreements for your organization; typically this is an owner or senior partner,
- The name of a Primary Access Administrator (PAA) to oversee implementation and maintain access for your entire organization.

Ready? **Start Registration**

- + **INTERNET REQUIREMENTS**
- + **NEXT STEPS**
- + **WE'RE HERE TO HELP**

Verifying eligibility

- Availity allows providers to easily check eligibility and benefits.

Verifying eligibility (cont.)

- Check one member or use online batch management to check multiple members from multiple payers.

Eligibility and Benefits

Eligibility and Benefits Inquiry

Online Batch Management

Auths and Referrals

Claims Management

Availability Payer List

EDI File Management

Enrollments

My Payer Portals

My Account

Reporting

Payer Support

Eligibility & Benefits Inquiry

* indicates a required field

* Payer: ?

* Organization:

Provider Information

Express Entry - Provider: ?

* NPI: ? ☐ Save this provider

Patient Information

* Benefit/Service Type: ?
Select more than one benefit/service type

* As of Date: ? / /
MM DD YYYY

Search Option: ?

* Patient ID: ?

* Patient Last Name: Suffix:

* Patient First Name:

* Date of Birth: / /
MM DD YYYY

Patient's Relationship to Subscriber: ?

Submitting claims

- Submitting claims through Availity is easy. Simply enter the required information and select **Submit**, and your claim is on its way to Amerigroup. Claims are usually entered into our system in as quickly as 24 to 48 hours.

Submitting claims (cont.)

- Assistance is at your fingertips:
 - Select the blue question mark for additional information about a field.
 - Select **Learn More** for help topics related to the page you are on at the time.

The screenshot shows a web interface for submitting a 'Professional Health Care Claim'. On the left is a navigation menu with links: 'Eligibility and Benefits', 'Auths and Referrals', 'Claims Management' (highlighted in green), 'Claim Status Inquiry', 'Professional Claim' (highlighted in grey), 'Facility Claim', 'Online Batch Management', and 'Availability Payer List'. The main content area is titled 'Professional Health Care Claim' with a 'Learn More >>' link. Below the title, a red asterisk indicates that fields marked with a question mark are required. The form contains four fields: 'Payer: ?' with a dropdown menu showing 'AMERIGROUP', 'Organization: ?' with a dropdown menu showing 'Amerigroup Corporation', 'Transaction Type: ?' with a dropdown menu showing 'Professional Claim', and 'Responsibility Sequence: ?' with a dropdown menu showing 'Primary'.

Provider Relations

Contact your Provider Services representative with any questions you may have:

- Medicaid: **1-800-454-3730**
- MMP: **1-855-878-1785**



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