



Texas Provider Orientation

Today's discussion

- **Doing business with Amerigroup:**
 - Member enrollment
 - Coordination of benefits
 - Credentialing
 - Reference tools/online resources
 - Precertification guidelines
 - Claims submission/payment disputes
 - Grievances/medical appeals



Today's discussion (cont.)

- **Improving health care together**
 - Community involvement
 - Fraud, waste and abuse
 - Cultural competency
 - Translation services
 - Availability standards
 - Disease management
 - Quality management
- **Team/key contacts and additional resources**



Our mission and values

- Amerigroup, a subsidiary of Anthem Inc., has proudly served Texas since 1996, and we are dedicated to various government programs. We were one of the first Medicaid managed care organizations (MCOs) in Texas with a focused mission on serving low-income individuals, families, seniors and people with disabilities.
- It is the Amerigroup mission to improve lives and the communities in which we serve, simplify health care and expect more by challenging ourselves to improve on our performance.
- It is the Amerigroup vision to be the most innovative, valuable and inclusive partner we can be.

Medicaid enrollment

MAXIMUS — state enrollment broker

- Provides education and enrollment services to Texans in Medicaid managed care programs, CHIP and children's dental services.
- Conducts outreach and provides information about the Texas Health Steps program.

Enrollment

- Enrollment kits are sent to clients by MAXIMUS, following receipt of the client's eligibility from the Texas Health and Human Services Commission (HHSC).
- An MCO is automatically assigned if enrollment process is not completed by client.

Medicaid enrollment (cont.)

- Assistance is available with the enrollment process including:
 - Personalized assistance at enrollment assistance sites and during enrollment events. Visit www.txmedicaidevents.com.
 - Home visits scheduled through the Enrollment Broker Helpline.
 - Submission of enrollment forms online, by mail or fax.

Effective dates:

- Before the 15th of the month — effective the first day of following month (for example, enroll January 10 to effective February 1)
- After the 15th of the month — effective the first day of next full month (for example, enroll January 20 to effective March 1)

Plan changes

- Must contact MAXIMUS for plan changes.
- Same effective date rules apply.

Medicaid enrollment (cont.)

Those who wish to complete the enrollment on their own may submit their applications by mail, online or by fax. The contact information is provided below:

- **Enrollment Broker Helpline: 1-800-964-2777**
- **Special Populations Helpline: 1-877-782-6440**
- **Mail:** P.O. Box 149023, Austin, TX 78714-9023
- **Online:** <https://yourtexasbenefits.com>
- **Fax: 1-855-671-6038**

Marketing Activities

Sanctioned marketing activities:

- Attendance at MAXIMUS-sponsored member enrollment events
- Approved MCO-sponsored health fairs and community events
- Radio, television and print advertisements


In Texas, the following activities are prohibited:

- Conducting direct-contact marketing except through the HHSC-sponsored enrollment events
- Making any written or oral statement containing material that misrepresents facts or laws relating to Amerigroup or the STAR, STAR+PLUS, STAR Kids and CHIP programs
- Promoting one MCO over another if contracted with more than one MCO

Community involvement



Member ID cards



An Anthem Company

AMERIGROUP TEXAS, INC.
www.myamergroup.com/TX

Member Name:
Medicaid Number:
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:

PCP Effective Date:
Date of Birth:
Subscriber #:
Type of Coverage: **STAR**

Vision: 1-800-428-8789 Pharmacy Member Services: 1-833-235-2022
Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-800-600-4441
24-Hour Nurse HelpLine: 1-800-600-4441



An Anthem Company

AMERIGROUP TEXAS, INC.
www.myamergroup.com/TX

Member Name:
Medicaid Number:
Amerigroup Service Coordination: 1-800-600-4441
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:

PCP Effective Date:
Date of Birth:
Subscriber #:
Type of Coverage: **STAR+PLUS**

Vision: 1-800-428-8789 Pharmacy Member Services: 1-833-235-2022
Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-800-600-4441
24-Hour Nurse HelpLine: 1-800-600-4441



An Anthem Company

AMERIGROUP TEXAS, INC.
www.myamergroup.com/TX

Member Name:
CHIP Number:
Primary Care Provider (PCP):
PCP Telephone #:
Copays: Office Visits: \$5 Emergency Room Visits: \$5
Pharmacy: \$0 FOR GENERIC / \$5 FOR BRAND NAME

PCP Effective Date:
Date of Birth:
Subscriber #:
Type of Coverage: **CHIP**

Vision: 1-800-428-8789 Pharmacy Member Services: 1-833-235-2022

Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-800-600-4441
24-hour Nurse HelpLine: 1-800-600-4441

TDI




An Anthem Company

AMERIGROUP INSURANCE COMPANY
www.myamergroup.com/TX

Member Name:
Medicaid Number:
Amerigroup Service Coordination: 1-866-696-0710
Primary Care Provider (PCP):
PCP Telephone #:
PCP Address:

PCP Effective Date:
Date of Birth:
Subscriber #:
Type of Coverage: **STAR Kids**

Vision: 1-800-428-8789 Pharmacy Member Services: 1-833-370-7463
Amerigroup STAR Kids Only Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-844-756-4600
24-hour Nurse HelpLine: 1-844-756-4600



An Anthem Company

AMERIGROUP TEXAS, INC.
www.myamergroup.com/TX

Member Name:
Medicaid Number:
Amerigroup Service Coordination: 1-800-600-4441
Pharmacy Member Services: 1-833-235-2022

Effective Date:
Date of Birth:
Subscriber #:
Type of Coverage: **STAR+PLUS**

LONG-TERM SERVICES AND SUPPORTS BENEFITS ONLY
You receive primary, acute, and behavioral health services through Medicare.
You receive only long-term services and supports through Amerigroup.
SOLO BENEFICIOS DE SERVICIOS Y APOYOS A LARGO PLAZO
Usted recibe servicios de cuidado primario, aguda y del comportamiento a través de Medicare. Solo recibe servicios y apoyos a largo plazo a través de Amerigroup.



An Anthem Company

AMERIGROUP TEXAS, INC.
www.myamergroup.com/TX

Member Name:
CHIP Perinate Number:
Pharmacy Member Services: 1-833-235-2022

Effective Date:
Date of Birth:
Subscriber #:
Type of Coverage: **CHIP**

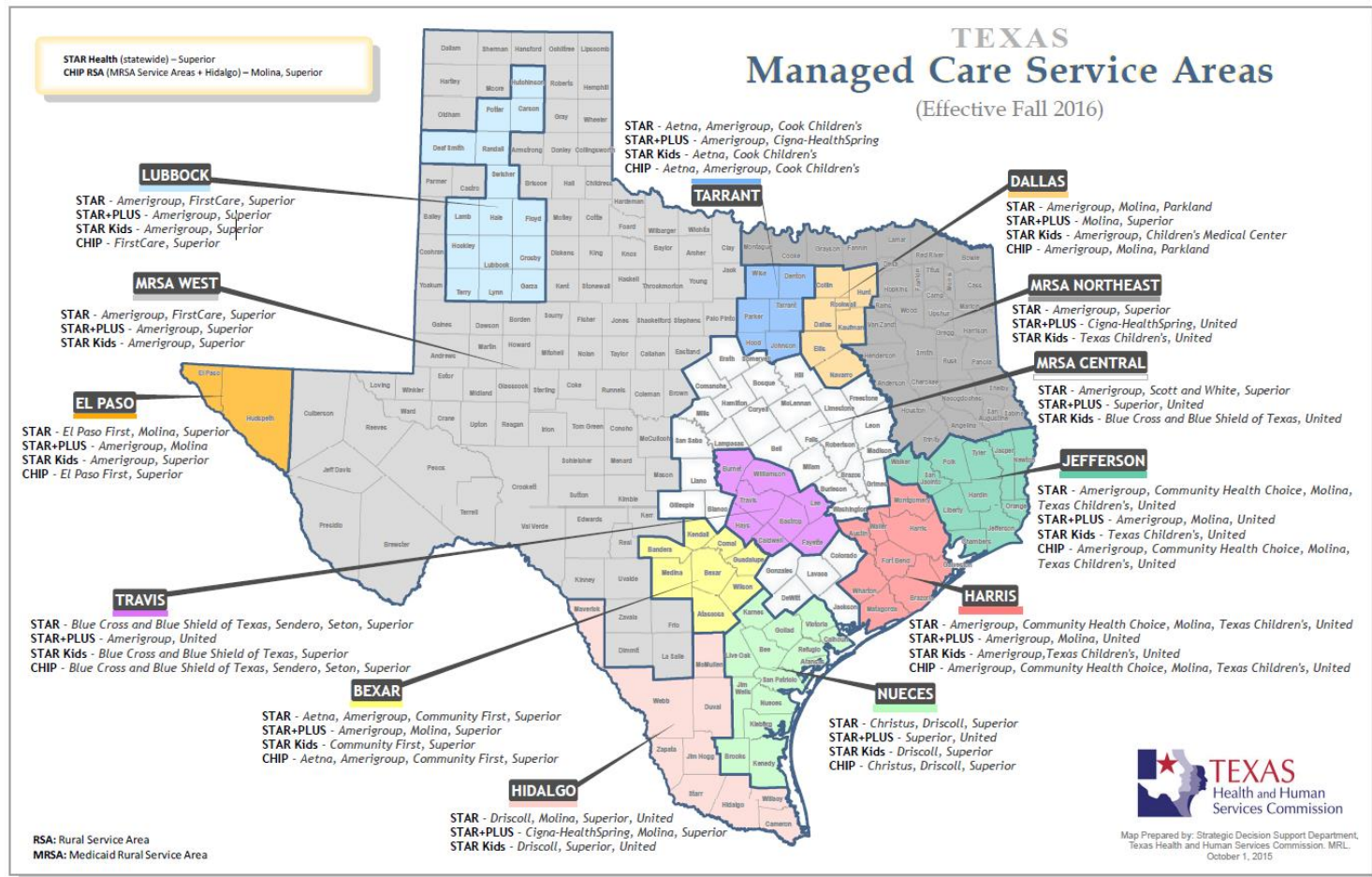
Amerigroup Member Services and Behavioral Health
(24 hours a day, 7 days a week): 1-800-600-4441
24-hour Nurse HelpLine: 1-800-600-4441

TDI

Eligibility and benefits

	STAR	STAR+PLUS	STAR Kids	CHIP	CHIP Perinatal
Eligibility	Temporary Assistance for Needy Families (TANF), pregnant women, children receiving Medicaid assistance only, AAPCA services	SSI adult population including dual-eligible clients, Non-SSI adults who qualify for home- and community-based service (HCBS) STAR+PLUS waiver services, MBCC services	Children age 20 and younger who have Medicaid through SSI or 1915(c) waiver programs, AAPCA services	Uninsured children ages 18 and below in families with incomes too high to qualify for Medicaid	Unborn children of pregnant women who do not have health insurance and do not qualify for Medicaid
Covered services	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, Texas Health Steps	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, long-term services and supports (LTSS), service coordination	Inpatient and outpatient hospital, emergency, physician services, lab, X-ray, home health, family planning, behavioral health services, pharmacy, service coordination, LTSS, Texas Health Steps	Inpatient and outpatient hospital, emergency, physician, lab, X-ray, home health, behavioral health services, pharmacy, well-child visits	Care related to pregnancy only, including prenatal visits, labor and delivery, postpartum visits

Service areas



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Benefits of STAR+PLUS

	Other community — nondual	STAR+PLUS waiver — nondual	Other community — dual	STAR+PLUS waiver — dual
Acute benefits	Covered and coordinated through Amerigroup based on the traditionally defined state Medicaid benefit package	Covered and coordinated through Amerigroup based on the traditionally defined state Medicaid benefit package	Covered through a member's traditional Medicare or Medicare Advantage Plan — Amerigroup will assist members in Coordination of care.	Covered through a member's traditional Medicare or Medicare Advantage Plan. — Amerigroup will assist members in Coordination of care.
Behavioral and mental health benefits	Covered and coordinated through Amerigroup based on the traditionally defined state Medicaid benefit package	Covered and coordinated through Amerigroup based on the traditionally defined state Medicaid benefit package	Covered through a member's traditional Medicare or Medicare Advantage Plan — Amerigroup will assist members in Coordination of care.	Covered through a member's traditional Medicare or Medicare Advantage Plan — Amerigroup will assist members in coordination of care.
Pharmacy benefits	Covered and coordinated through Amerigroup based on the traditionally defined state drug formulary	Covered and coordinated through Amerigroup based on the traditionally defined state drug formulary.	Medicare Part D plans — Amerigroup will offer state-defined assistance with copays and doughnut hole coverage.	Medicare Part D Plans — Amerigroup will offer state defined assistance with copays and doughnut hole coverage.
LTSS benefits	Covered and coordinated through Amerigroup, limited to primary home care and day activity health services.	Covered and coordinated through Amerigroup — includes primary home care and day activity health services as well as all defined 1915(c) or 1115 waiver services	Covered and coordinated through Amerigroup, limited to primary home care and day activity health services	Covered and coordinated through Amerigroup — includes primary home care and day activity health services as well as all defined 1915.c or 1115 waiver services

Texas Health Steps

- Texas Health Steps is for members from 0 to 20 years of age who have Medicaid. Texas Health Steps provides regular medical and dental checkups and case management services to babies, children, teens and young adults at no cost to the member.
- Providers must be enrolled in the Texas Health Steps program to administer Texas Health Steps services.
- Providers can enroll through www.thmp.com.
- Call Texas Health Steps toll-free **1-877-847-8377** (**1-877-THSTEPS**) Monday to Friday from 8 a.m. to 8 p.m. Central time.
- Also, reference www.tmhp.com for the latest *Texas Health Steps Quick Reference Guide*.

Early Childhood Intervention

- Early Childhood Intervention (ECI) is a federally mandated program for infants and toddlers under the age of 3 years with or at risk for developmental delays and/or disabilities.
- The federal ECI regulations are found at *34 C.F.R. § 303.1 et seq.*
- The state ECI rules are found within the *Texas Administrative Code, Title 40, part 2, chapter 108.*
- Amerigroup must ensure network providers are educated regarding the federal laws on child-find and referral procedures, for example, 20 U.S.C. § 1435(a)(5); 34 C.F.R. § 303.303.

ECI responsibilities

- Amerigroup must require network providers identify and refer any member under the age of 3 years suspected of having a developmental delay or disability or otherwise meeting eligibility criteria for ECI services in accordance with *40 Texas Administrative Code, chapter 108* to the designated ECI program for screening and assessment within seven calendar days from the day the provider identifies the member.
- Amerigroup must use written educational materials developed or approved by HHSC for ECI services for these child-find activities. Materials are located at: <https://hhs.texas.gov/services/disability/early-childhood-intervention-services>.
- The local ECI program will determine eligibility for ECI services using the criteria contained in *40 Texas Administrative Code, chapter 108*.
- ECI providers must submit claims for all physical, occupational, speech and language therapy to Amerigroup.

ECI responsibilities (cont.)

- ECI-targeted case management services and ECI specialized skills training are noncapitated services.
 - ECI providers are to bill Texas Medicaid & Healthcare Partnership (TMHP) for these services.
- Amerigroup must contract with qualified ECI providers to provide ECI-covered services to members under the age of 3 who are eligible for ECI services.
- Amerigroup must permit members to self-refer to local ECI service providers without requiring a referral from the member's PCP.
- The Individual Family Service Plan (IFSP) is the authorization for the program-provided services (for example, services provided by the ECI contractor) included in the plan.

ECI responsibilities (cont.)

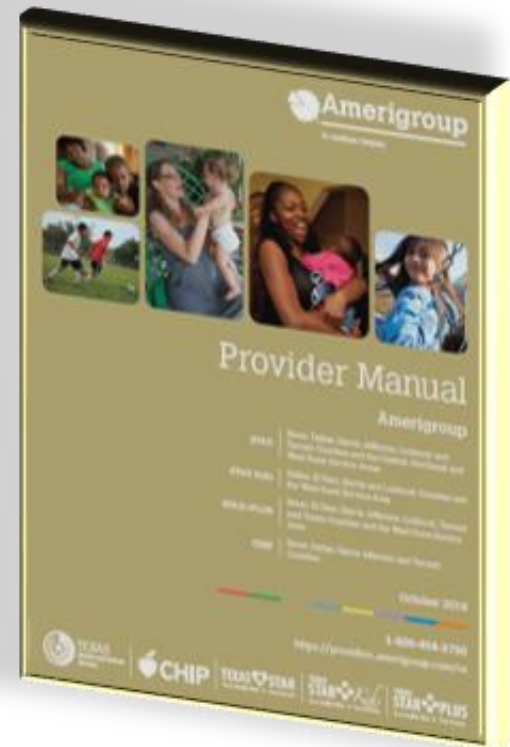
- Precertification is not required for the initial ECI assessment or for the services in the plan after the IFSP is finalized.
- All medically necessary health and behavioral health program-provided services contained in the IFSP must be provided to the member in the amount, duration, scope and service setting established in the IFSP.

Children of Migrant Farmworkers

- HHSC defines a migrant farm worker as *a migratory agriculture worker whose principal employment is in agriculture on a seasonal basis, who has been employed in the last 24 months and who establishes for the purpose of such employment a temporary abode.*
- Texas farmworker children face higher proportions of dental, nutritional and chronic health problems than nonmigrant children.
- Amerigroup assists children of migrant farmworkers in receiving accelerated services while they are in the area.
- We ask primary care providers to assist Amerigroup in identifying a child of a migrant farmworker by asking the child or parent during an office visit.
- Call Amerigroup if you identify a child of a migrant farmworker at **1-800-600-4441.**

Your responsibilities

Providers should review both provider and member responsibilities which are detailed in the provider manuals found at <https://providers.amerigroup.com/TX>.



Provider demographic updates

Please update us immediately concerning changes in:

- Address
- Phone
- Fax
- Office hours
- Access and availability
- Panel status



Please also remember to update your demographic information with TMHP.

Ongoing credentialing

- Credentialing is for a three-year period.
- Recredentialing efforts begin six months prior to the end of the current credentialing period.
- First notice and second notice letters are faxed/mailed to providers.
- Third notice and final notice letters are mailed to providers.
- Providers who do not respond or submit a complete recredentialing packet will be decertified/considered out of network.
- Providers must begin the contracting and credentialing process from the beginning to rejoin the Amerigroup network.
- Notify your Provider Relations representative with changes in licensure, demographics or participation status as soon as possible.

Collaboration and communication

- Collaboration leads to well-informed treatment decisions. Providers work together to develop compatible courses of treatment, increasing the chances for positive health outcomes and avoiding adverse interaction.
- Communication between the member's PCP or medical home, specialists, hospitals, home health agencies, therapy providers is key to ensure our members — your patients — receive quality care that is thorough and seamless. Each provider type is responsible to conduct timely provider-to-provider communication as appropriate. For additional information related to this requirement please visit https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_ProviderManual.pdf

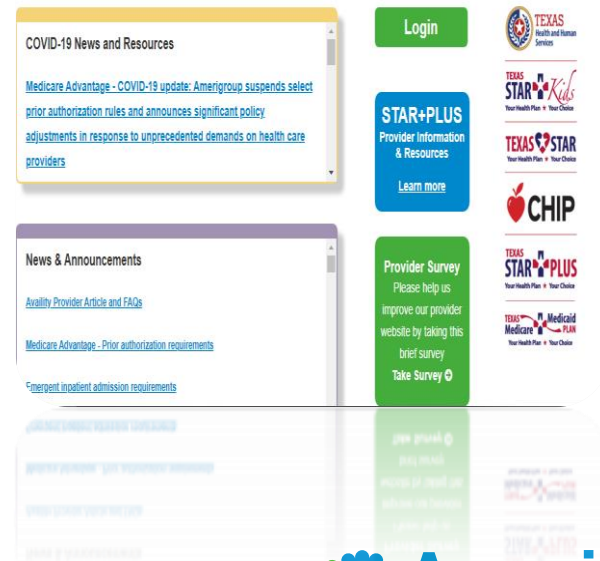
Appointment availability and after hour standards

- We are dedicated to arranging access to care for our members. Our ability to provide quality access depends upon the accessibility of network providers. We evaluate HHSC, Texas Department of Insurance and National Committee for Quality Assurance (NCQA) requirements and follow the most stringent standards among the three sources.
- Providers are required to adhere to access standards that apply to both Medicaid and CHIP unless specified. Standards are measured from the date of presentation or request, whichever occurs first.



Provider website

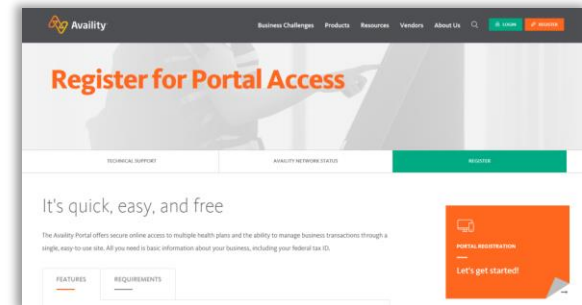
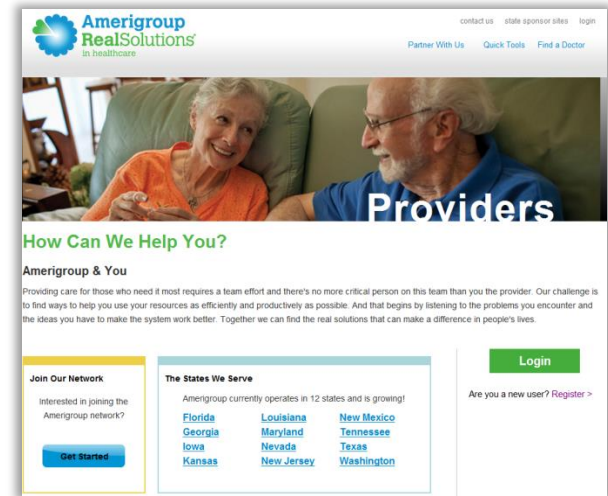
- Available to all providers regardless of participation status
- Multiple resources available without login
- Accessible 24/7



An Anthem Company

Secured website registration

- Registration for the secured content on our website is easy.
- Begin by selecting **Register** on our provider website. You will be redirected to the Availity* Portal to complete the registration process.
- There are multiple resources and trainings available to support Availity and Amerigroup website navigation.



Availity

- **Multiple payers:** Availity has single sign-on with access to multiple payers.
- **No charge:** Amerigroup transactions are available at no charge to providers.
- **Accessible:** Availity functions are available 24 hours a day from any computer with internet access.
- **Compliant:** Availity is compliant with the *HIPAA* regulations.
- **Training:** No-cost, live, web-based and prerecorded training seminars (webinars) are available to users; FAQ and comprehensive help topics are available online as well.
- **Support:** Availity Client Services is available at **1-800-282-4548** (**1-800-AVAILITY**) Monday to Friday 9 a.m.to 6 p.m. Central time.
- **Reporting:** Reporting by user allows the primary access administrator to track associates' work.

Verifying eligibility

- Check one member or use online batch management to check multiple members from multiple payers.
- Search with either Amerigroup subscriber or Medicaid/CHIP identification number.

The screenshot displays the 'Member Eligibility' section of the Amerigroup web application. On the left is a navigation menu with links: Home, Claims, Precertification, Medical, Pharmacy, Members (highlighted), PCP Member Listing, Member Reports, Member Health Assessment, Health Action Plan, Personal Disaster Plan, Member Rights & Responsibilities, and Eligibility. The main content area is titled 'Member Eligibility' and includes a note: 'Online eligibility will now be available exclusively through Availity.' Below this is a yellow button labeled 'Go to Availity' with the text 'You are already logged in to your account.' Below the navigation menu, there is a sidebar with a list of links: Eligibility and Benefits, Eligibility and Benefits Inquiry, Online Batch Management, Auths and Referrals, Claims Management, Availity Payer List, EDI File Management, Enrollments, My Payer Portals, My Account, Reporting, and Payer Support. The main content area shows the 'Eligibility & Benefits Inquiry' form. This form includes sections for 'Provider Information' and 'Patient Information'. The 'Provider Information' section has fields for 'Payer' (a dropdown menu), 'Organization' (a dropdown menu), 'Express Entry - Provider' (a dropdown menu), and 'NPI' (a text field). The 'Patient Information' section has fields for 'Benefit/Service Type' (a dropdown menu), 'As of Date' (a date picker), 'Search Option' (a dropdown menu), 'Patient ID' (a text field), 'Patient Last Name' (a text field), 'Patient First Name' (a text field), 'Date of Birth' (a date picker), and 'Patient's Relationship to Subscriber' (a dropdown menu). At the bottom of the form are buttons for 'Submit', 'Clear', and 'Add to Batch'.

Easy access panel reports

- Providers can access their panel reports from the secured Amerigroup website.
- The user has the option of downloading the listing for the entire TIN or selecting a specific provider. It's that easy!



Eligibility

Retro-enrollment

- Medicaid coverage may be assigned retroactively for a client. For claims for an individual who has been approved for Medicaid coverage but has not been assigned a Medicaid client number, the 95-day filing deadline does not begin until the date the notification of eligibility is received from HHSC and added to the TMHP eligibility file.

Retro-disenrollment

- If TMHP finds that the member did not meet eligibility guidelines after application or if the member does not complete the necessary paperwork to complete the application, then the member's temporary initial enrollment can be reversed. If this occurs the state will request funds back from the MCO who will subsequently request those funds back from the provider.

Patient360

- Patient360 is a tool in Availity that provides an in depth view of the treatment and care your patient is receiving. This tool allows all providers to view information regarding patient demographic information, pharmacy details, authorizations on file, claim summaries such as what other providers the patient is seeing. Sharing relevant case information in a timely, useful and confidential manner is an Amerigroup requirement. Using this tool will allow you to access what providers will need summary of care you are providing.
- Improving provider-to-provider communication will help to eliminate barriers when coordinating member care, improve the quality of care a member receives and improve the member's experience.
- To access Patient360, log in to <https://www.availity.com>, select **Amerigroup** under *Payer Spaces*, and it will appear under the *Applications* tab on the bottom portion of the screen.

Precertification requests

- Submit precertification requests online (Interactive Care Reviewer), via fax or by calling Provider Services.



Is precertification required?

- Our Precertification Lookup Tool allows you to search by market, member's product and CPT® code.
- All inpatient stays require precertification.
- All out-of-network service requests require precertification.
- All nonemergent ambulance transportation requires precertification.
- Obtaining a precertification is not a guarantee of payment.
- Precertification forms available at <https://providers.amerigroup.com/TX>.



Interactive Care Reviewer

- The Interactive Care Reviewer (ICR) offers a streamlined process to request inpatient and outpatient prior authorization through the Availity Portal.

Request Tracking ID	Reference Number	Status	Patient Name	Service Date Range	Request Type	Requesting Provider NPI	Submit Date	Created By	Updated Date	Updated By
		Review In Progress		10/09/2015 - 10/09/2015	Outpatient	1073549929	2015-10-06 12:22:54 PM		2015-10-06 12:23:52 PM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10:41:44 AM		2015-10-07 10:54:43 AM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10:30:37 AM		2015-10-07 10:35:34 AM	System
		See Details		10/09/2015 - 10/10/2015	Inpatient	1912007543	2015-10-07 10:06:40 AM		2015-10-07 10:17:39 AM	System
		Review In Progress		09/30/2015 - 09/30/2015	Inpatient	1922098342	2015-10-01 11:54:06 AM		2015-10-06 11:07:34 AM	System
		Review In Progress		09/28/2015 - 10/12/2015	Inpatient	1396714663	2015-10-06 09:53:39 AM		2015-10-06 09:54:29 AM	System
		Approved		10/06/2015 - 10/06/2015	Outpatient	1922098342	2015-10-05 12:19:36 PM		2015-10-05 12:24:42 PM	System

Peer-to-peer review

- We know your time is important and want to make the peer-to-peer process easy for you. We now allow office staff to call on your behalf to schedule a peer review with our medical director.
- If you received a denial or notification that a case is under review that you would like to discuss with our medical director, please follow these steps:
 - Call **817-861-7768** and provide:
 - Your name or the name of physician our medical director needs to call with the contact number and a convenient time for us to call.
 - Member name, date of birth or Member ID and the authorization or reference number for the case you would like to discuss.
 - If your office staff reaches a voicemail, please ensure they leave their name and contact number in the event our representatives need to call back for additional information.

Peer-to-peer review (cont.)

- Our medical director will make every effort to call you back within one business day.
- Please note: If the notification you received indicates the case was denied, you may contact us within two business days to set up a peer-to-peer for possible reconsideration. After two business days, the case will need to follow the appeal process outlined in the letter you received.



Precertification fax information

Inpatient/outpatient surgeries/general requests fax:	1-800-964-3627
Therapy fax (PT/ST/OT):	1-844-756-4608
Durable medical equipment fax:	1-866-249-1271
Home health nursing/pain management/wound care fax:	1-866-249-1271
STAR+PLUS: LTSS and personal attendant services (PAS) fax by service area:	
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/RSA West:	1-888-562-5160
Behavioral health services:	
Behavioral health fax — inpatient:	1-877-434-7578
Behavioral health fax — outpatient:	1-866-877-5229
Specialized diagnostic testing:	
AIM Specialty Health*	
(cardiology, radiology (high-tech), genetic testing, radiation oncology, sleep studies)	1-800-714-0040
www.aimspecialtyhealth.com/goweb	

Referrals

Specialty referrals

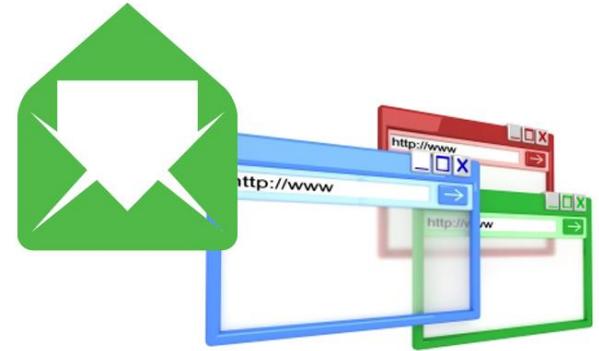
- Providers are not required to call Amerigroup and authorize a referral to a specialist; referrals may be coordinated directly between the PCP and in network chosen specialist.

Approval of a specialist as a PCP

- Amerigroup does require authorization for specialist to act as a PCP. Medical necessity of the request is reviewed by the medical director. Please see the provider website for the *Approval of a Specialist as a PCP* form.

Claim submission options

- Availity Portal
- Batch 837
- Via clearinghouse
- By mail
- Timely filing is within 95 days from the date of service.



Paper submissions	Electronic submission payers
Amerigroup P.O. Box 61010 Virginia Beach, VA 23466-1010	<ul style="list-style-type: none">• Emdeon: 1-866-858-8938 — 27514• Carpario: 1-800-586-6938 — 28804• Availity: 1-800-282-4548 — 26375• Smart Data Solutions: 81237

Claims submission

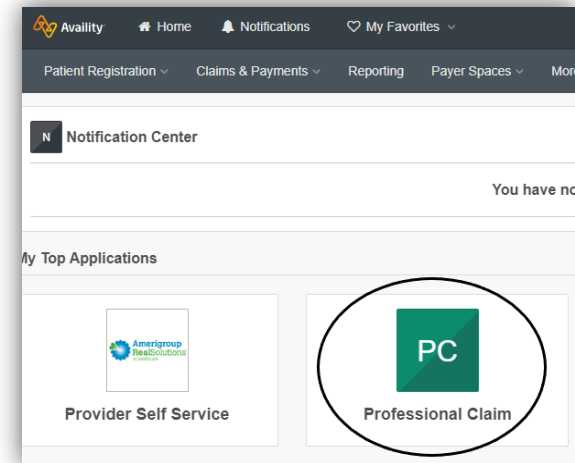
- Paper claims should be submitted on *CMS-1500*, *UB-04* or successor forms as applicable to the provider contract.
- The taxonomy in 24J shaded should correspond with the NPI in the unshaded portion and the taxonomy in 33B should match the NPI in 33A respectively.
 - On the new *UB-04* form, NPI should be in box 56 and taxonomy in box 57.
- Claims without a verifiable ID number will be denied or rejected.
- To ensure timely adjudication of a claim, please utilize the NPI/taxonomy attested with TMHP.

Availity claim submission

Amerigroup has designated Availity to operate and service your EDI entry point (EDI Gateway).

Online claims submission:
Use our free online claim submission tool at <https://www.availity.com>.

Please refer to QRC for additional information.

A screenshot of the Availity Professional Health Care Claim submission form. The left sidebar contains a menu with options: Eligibility and Benefits, Auths and Referrals, Claims Management (highlighted), Claim Status Inquiry, Professional Claim (highlighted), Facility Claim, Online Batch Management, and Availity Payer List. The main content area is titled 'Professional Health Care Claim' and includes a 'Learn More >>' link. Below the title is a legend: '* indicates a required field'. The form contains several dropdown menus: Payer (AMERIGROUP), Organization (Amerigroup Corporation), Transaction Type (Professional Claim), and Responsibility Sequence (Primary).

Routine claim inquiries

Our Provider Services Unit ensures provider claim inquiries are handled efficiently and in a timely manner.

Call **1-800-454-3730**



Rejected versus denied claims

What is the difference between a rejected and a denied claim?

Rejected

- Does not enter the adjudication system due to missing or incorrect information
- Resubmission subject to 95-day timely filing deadline

Denied

- Does go through the adjudication process, but is denied for payment
- Appeal deadline of 120 days from the *Explanation of Payment (EOP)* date applies.

Clear Claim Connection™

Clear Claim Connection

McKesson Edit DevelopmentGlossaryAbout

CLAIM ENTRY

Market

Claim TypeProfessional

GenderMaleFemale

Date of Birth

ICD Code SetICD9ICD10

Diagnosis Codes12345678

Bill Type

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

LINE	PRIMARY SPECIALTY	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6
1																			
2																			
3																			
4																			
5																			

- Provides guidance for code combinations and modifiers
- Does not guarantee payment

Submitting a corrected claim

Claim Information

* Patient Control Number / Claim Number: ?

Medical Record Number:

* Place of Service: ?

* Billing Frequency: ?

* Payer Control Number (ICN / DCN): ?

☐ this is an HMO claim

* Provider Signature on File:

Prior Authorization Number: ?

Care Plan Oversight Number (for Medicare Patients): ?

Chiropractic Patient Condition Code:

This claim also includes...

Billing Medicaid members

- Our agreement with the state indicates that our members should not be burdened with any non-approved, out-of-pocket expenses for services covered under the Medicaid program.
- Fundamental principal does not change when member has other insurance.
- Members should receive the best benefits available from both coverage plans.

Member should not be billed..

- When claims are denied or reduced for services that are within the amount, duration and scope of benefits of the Medicaid program.
- For services not submitted for payment, including claims not received
- When claims are denied for timely filing (95 days)
- When there is failure to submit corrected claims within 120 days
- When there is failure to appeal claims within the 120 day appeal period
- When there is failure to appeal a medical denial
- When submission of unsigned or otherwise incomplete claims such as:
 - Omission of *Hysterectomy Acknowledgement Form*
 - *Sterilization Consent Form*

Billing Medicaid members for noncovered services

Before billing members for services not covered, providers must:

- Inform the member in writing of the cost of the service.
- Inform the member that the service is not covered by Amerigroup.
- Inform the member that they can be charged.
- Obtain member's signature on a *Client Acknowledgement* form before providing the service.

Sample *Client Acknowledgment Statement*

I understand my doctor, (provider's name) or Amerigroup has said the services or items I have asked for on (dates of service) are not covered under my health plan. Amerigroup will not pay for these services. Amerigroup has setup the administrative rules and medical necessity standards for the services or items I get. I may have to pay for them if Amerigroup decides they are not medically necessary or are not a covered benefit, and if I sign an agreement with my provider prior to the service being rendered that I understand that I am liable for payment.

Member name (print): _____ **Member signature:** _____ **Date:** _____

Participating providers may bill a member for a service that has been denied as not medically necessary or not a covered benefit only if the following conditions are true:

- The member requests the specific service or item.
- The member was notified by the provider of the financial liability in advance of the service.
- The provider obtains and keeps a written acknowledgement statement signed by the provider and by the member, above, prior to the service being rendered.

Provider name (print): _____ **Provider signature:** _____ **Date:** _____

Above sample found in your provider manual.

Coordination of benefits payment methodology

- Amerigroup is the payer of last resort.
- Coordination of benefits claims are paid up to the Amerigroup allowable, regardless of the primary carrier's allowable:

- **Example 1:**

Amerigroup allowable:	\$4,000
Minus primary carrier payment:	\$2,000
Minus Amerigroup payment:	<u>\$2,000</u>
Final balance:	\$ 0

When the primary carrier denies your claim...

- If the primary carrier does not cover a service because the member or provider did not follow guidelines for the primary payer, then Amerigroup becomes the next payment source.
- At this point, the Amerigroup standard requirements such as authorization rules and timely filing rules are applied.
- Primary *EOPs* must still be submitted within 95 days from the date of the primary *EOP* with some exceptions.

Amerigroup is the payer of last resort

- Some common exceptions include:
 - The Texas Kidney Health Care Program.
 - The Crime Victim's Compensation Program.
 - Adoption agencies.
 - Home- and community-based waiver programs.
- Amerigroup will not pay for any expenses that the member would not have a legal obligation to pay if he or she did not have Amerigroup.


Amerigroup provider complaints

- We track all provider grievances until they are resolved.
- The provider manual details filing and escalation processes and contact information.
- Examples of grievances include:
 - Issues with eligibility.
 - Contract disputes.
 - Authorization process difficulties.
 - Member/associate behavior concerns.

Filing a formal HHSC complaint

Amerigroup is committed to providing quality service to our members and providers that support our network.

To comply with state requirements, Health and Human Services Commission has requested that managed care organizations notify newly credentialed providers of their process to resolve provider complaints. As a part of this requirement, Amerigroup is sharing with you this notification.




How to Submit a Complaint as a Medicaid Provider


Providers wishing to submit a complaint about a health or dental plan (managed care or dental maintenance organization) such as concerns about a claim, follow these steps.

STEP 1: Contact the health or dental plan

Refer to the MCO or DMO complaints/appeals section of the provider manual or website.



For other complaints such as provider enrollment and re-enrollment, or traditional Medicaid claims:

- › Call **800-925-9126** 
- › or write to:
TMHP, Complaints Resolution Department
PO Box 204270, Austin, TX, 78720-4270

STEP 2: Contact HHSC

Send a secure email to HHSC at hpm_complaints@hhsc.state.tx.us or fill out this online form: <https://texashhs.org/ManagedCareProviderComplaint>

What you'll need when you contact HHSC:	What you can expect from HHSC:
<ul style="list-style-type: none">› Provider's name, national provider identifier number, phone number, and contact person submitting complaint› Member's Medicaid ID number, name, birthday and address› Summary of complaint and any associated documents to be sent via secure email	<ul style="list-style-type: none">› Send you an acknowledgement letter within three to five business days› Start working on your complaint› Check in with you within five business days of receiving the complaint› Tell you what happened and anything you might need to do

For a complaint on behalf of a member, please follow step 1, and then submit a complaint to HHSC at <http://bit.ly/ComplaintSubmission> if you still need help.

For CHIP health or CHIP dental complaints, please follow step 1, and then contact TDI at ConsumerProtection@tdi.texas.gov if you still need help.

TXPEC-4014-20October 2020



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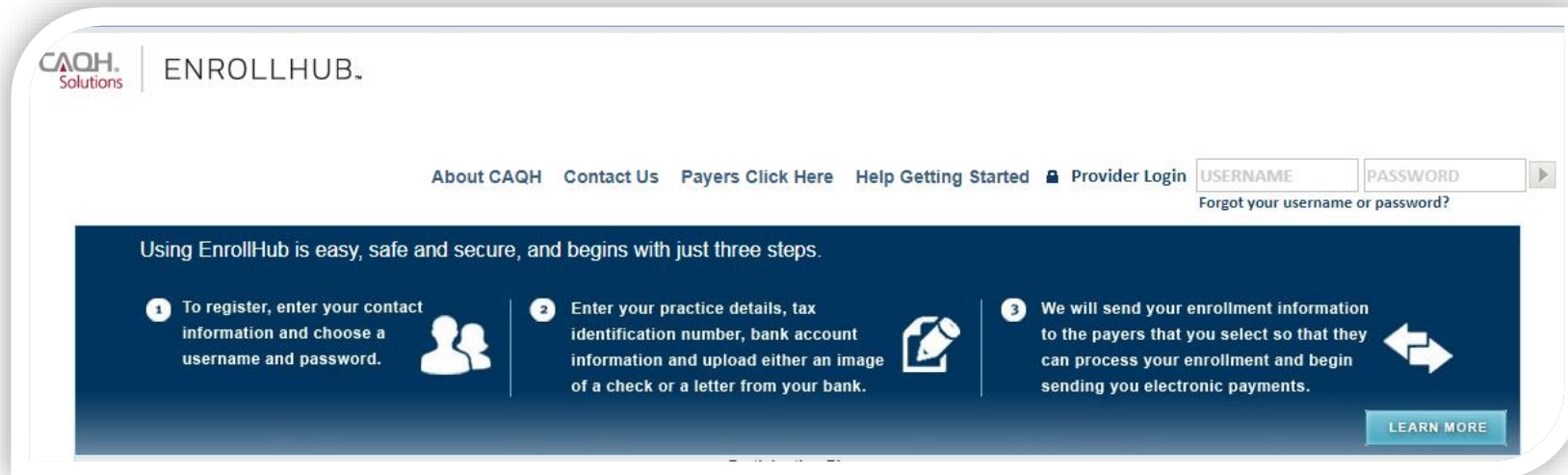
Payment dispute process

- There is a 120-day filing deadline from the date of the *EOP*.
- Providers may utilize the payment dispute tool at <https://www.availity.com>. Supporting documentation can be uploaded using the attachment feature.
- Providers can Submit *Provider Payment Dispute* form and relevant supporting documentation including the original *EOP*, corrected claim, invoices, medical records, reference materials, etc.:
 - **Fax: 1-844-756-4607**
 - **Mail:** Amerigroup
Payment Dispute Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

The image shows a 'Claim Payment Appeal - Submission Form' from Amerigroup RealSolutions. The form is titled 'Claim Payment Appeal - Submission Form' and includes a note: 'This form should be completed by providers for payment appeals only.' It contains several sections for data entry: 'Member Information' (Member First/Last Name, Member Coverage, Member ID, Member Date of Birth), 'Provider/Provider Representative Information' (Provider First/Last Name, Provider Street Address, City, State, NPI Number, ZIP Code, and checkboxes for 'I am a participating provider' and 'I am a nonparticipating provider'), 'Provider Representative Information' (Representative Contact Name, Representative Street Address, City, State, ZIP Code, Contact Phone, and Email), and 'Claim Information**' (Claim Number, Start Date of Service, End Date of Service, Billed Amount, Amount Received, and Authorization Number). There is also a 'Payment Appeal' section with checkboxes for 'First-level Appeal' and 'Second-level Appeal', and a 'To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination provided on the Amerigroup determination letter or Explanation of Payment.' section with checkboxes for 'Unduly filing', 'No authorization', 'Denied for Other Health Insurance (OHI), but member doesn't have OHI', 'Experimental/investigational procedure denial', 'Claim code editing denial', 'Retrospective authorization issue', 'Disagreement that you were paid according to your contract', 'Data elements on the claim on file does not match the claim originally submitted', 'Denied as duplicate', 'Denial related to provider data issue', 'Member retro-eligibility issue', and 'Other'. At the bottom, it says 'Mail this form, a listing of claims (if applicable) and supporting documentation to: Payment Appeals, Amerigroup, P.O. Box 61599, Virginia Beach, VA 23466-1599'.

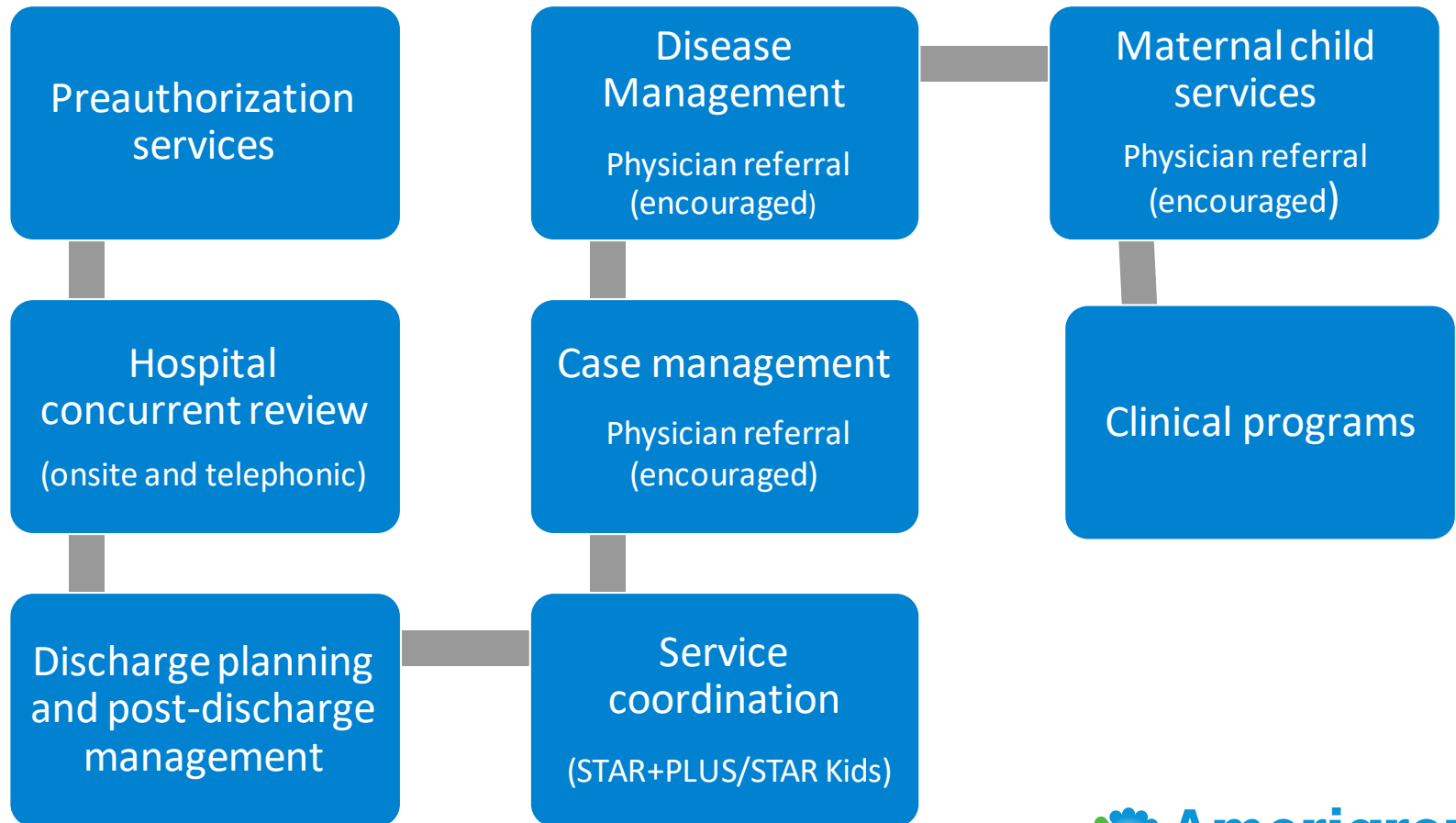
Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) enrollment

- You should register to receive your ERAs through Availity at <https://www.availity.com>.
- Enroll in EFT through CAQH EnrollHub; visit www.caqh.org and select the **EnrollHub** tab to register.

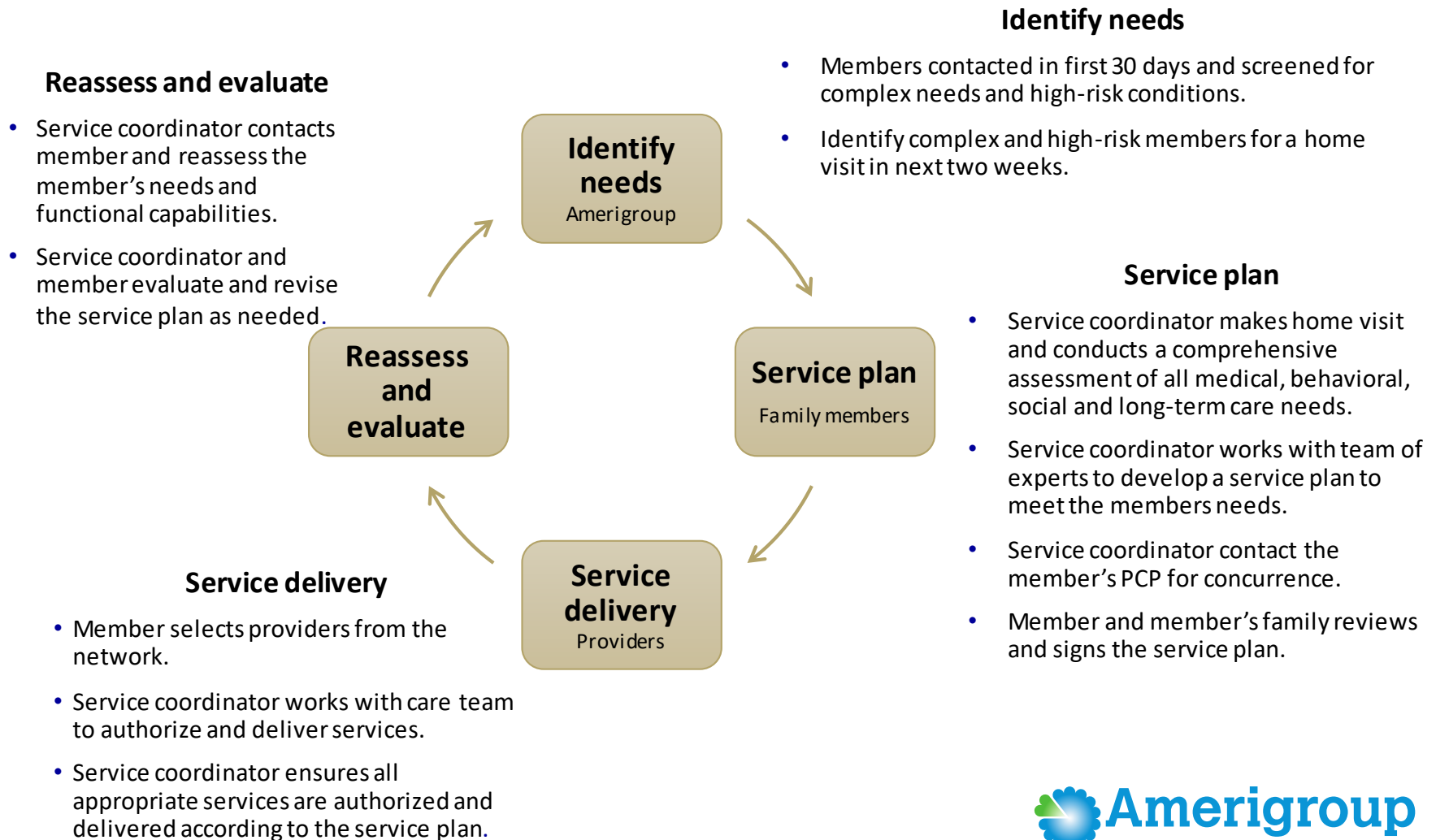


The screenshot displays the CAQH EnrollHub website. At the top left is the CAQH Solutions logo. The main header area contains the text "ENROLLHUB." and a navigation menu with links: "About CAQH", "Contact Us", "Payers Click Here", "Help Getting Started", and "Provider Login". To the right of the navigation menu are input fields for "USERNAME" and "PASSWORD", with a "Forgot your username or password?" link below them. The main content area features a dark blue banner with the text "Using EnrollHub is easy, safe and secure, and begins with just three steps." Below this banner are three numbered steps: 1. "To register, enter your contact information and choose a username and password." (accompanied by a person icon), 2. "Enter your practice details, tax identification number, bank account information and upload either an image of a check or a letter from your bank." (accompanied by a document icon), and 3. "We will send your enrollment information to the payers that you select so that they can process your enrollment and begin sending you electronic payments." (accompanied by a double arrow icon). A "LEARN MORE" button is located at the bottom right of the banner.

Medical management services

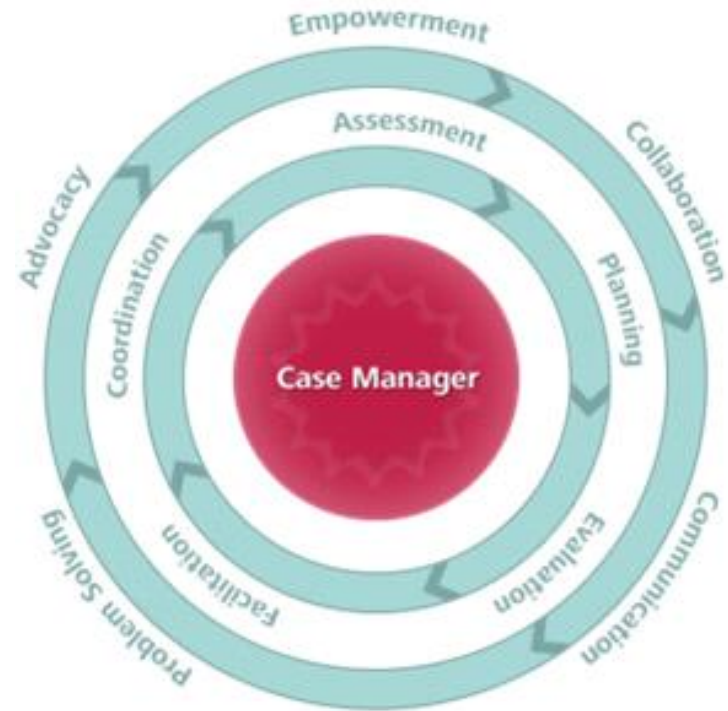


Service coordination model



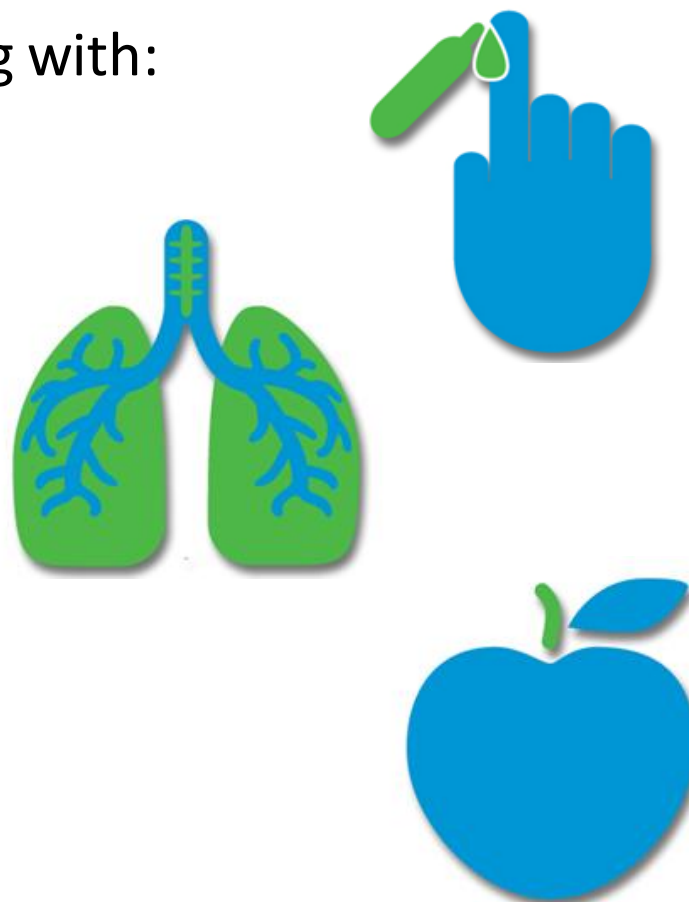
Case Management Program

- Available for members with complex medical conditions
- Focuses on members who have experienced a critical event or diagnosis
- Super utilizer program
- Members with special health care needs
- Social workers available



Disease management

- We offer programs for members living with:
 - Asthma
 - Bipolar disorder
 - Congestive heart failure
 - Coronary artery disease
 - Chronic obstructive pulmonary Disease
 - Diabetes
 - HIV/AIDS
 - Hypertension
 - Major depressive disorder
 - Schizophrenia
 - Substance use disorder



Maternal Child Services

- Individualized, one-on-one case management support for identified high-risk pregnancy
- Care coordination for moms who may need a little extra support
- Educational materials and information on community resources
- Incentives to keep up with prenatal and postpartum checkups and well-child visits after the baby is born



Mental health/substance abuse services

- Amerigroup will coordinate care for members with mental health needs or substance abuse disorders.
 - Authorizations:
 - **Phone: 1-800-454-3730**
 - **Fax — inpatient: 1-877-434-7578**
 - **Fax — outpatient: 1-866-877-5229**



Pharmacy Program

- The Texas Vendor Drug Program formulary and *Preferred Drug List* are available on our website.
- Prior authorization is required for:
 - Nonformulary drug requests.
 - Brand-name medications when generics are available.
 - High-cost injectable and specialty drugs.
 - Any other drugs identified in the formulary as needing prior authorization.

Laboratory services

- Notification or precertification is not required if lab work is performed in a physician's office, participating hospital outpatient department (if applicable) or by one of our preferred lab vendors (Quest, LabCorp and Clinical Pathology Laboratories)



Translation services

- Provider Services: **1-800-454-3730**
- Member Services: **1-800-600-4441**
- TTY Service: **711**
- Over 170 languages
- Available 24/7



LiveHealth Online (LHO)

- Members may access a video visit to a doctor, therapist or psychiatrist 24/7 using a smartphone, tablet or computer using LiveHealth Online.
- Amerigroup offers video visits at no cost to Amerigroup members. CHIP members may pay a typical office visit copayment.
- If you are interested in joining as a Online Care Network (OCG) provider, please submit an application via this link: <https://providers.amwell.com>
- Members eligible to use LHO are STAR, STAR+PLUS, CHIP and STAR Kids, *excluded* is CHIP Perinate.

Please inform your patients that sign up is free by going to <https://livehealthonline.com> or by downloading the free LiveHealth Online mobile app. If a member needs assistance with the service, please have them call **1-888-548-3432 (TTY 711)**



Telehealth and telemedicine services

Telemedicine medical services are defined as health care services delivered by a physician licensed in Texas or health professional who acts under the delegation and supervision of a health professional licensed in Texas and within the scope of the health professional's license to a patient at a different physical location using telecommunications or information technology.

Telehealth services are a benefit of Texas Medicaid. Telehealth services are defined as health care services, other than telemedicine medical services, delivered by a health professional licensed, certified or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location other than the health professional using telecommunications or information technology.

Telehealth and telemedicine guidelines

- Amerigroup follows the guidelines set forth by TMHP regarding telemedicine and telehealth services.
- TMHP publishes the *Texas Medicaid Provider Procedures Manual – Telecommunication Services Handbook* on their website. The handbook offers information regarding telemedicine and telehealth services, provider types, billing guidelines, procedure codes and modifiers, and documentation requirements for the services.
- The handbook can be located at:
http://www.tmhp.com/Manuals_PDF/TMPPM/TMPPM_Living_Manual_Current/2_Telecommunication_Srvs.pdf.

Telehealth and telemedicine notifications to PCPs

- The use of telemedicine and telehealth services is intended to promote and support patient-centered medical homes and care coordination.
- As outlined in *Senate Bill 670* from the 86th Legislature, Medicaid telemedicine and telehealth providers are required to notify the Medicaid member's PCP or provider of the telemedicine or telehealth service, provided the member or their parent/legal guardian consents to the notice. This includes a summary of the telemedicine or telehealth service rendered, exam findings, a list of prescribed or administered medications, and patient instructions.

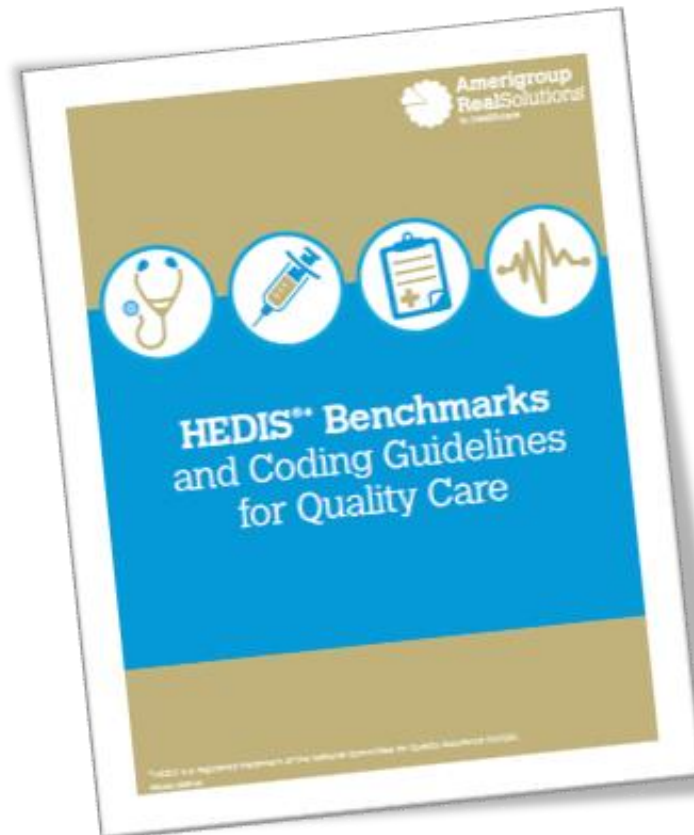
Telehealth and telemedicine notifications to PCPs (cont.)

- Telehealth and telemedicine providers must attest that they are providing notice of all telemedicine/telehealth encounters and outcomes to the member's PCP, providing the parent/legal guardian consents.
- An attestation form will be sent to Medicaid telemedicine and telehealth providers to sign and return to the Provider Services representative at Amerigroup.
- Telemedicine and telehealth providers must keep a record of notifications to primary care physicians and providers in the member's medical records.

Note: ECI providers do not follow these requirements. Behavioral health providers are not required to report telemedicine or telehealth services to PCPs unless the service is provided in the school setting.

Quality management

- Our quality management team continually analyzes provider performance and member outcomes for improvement opportunities.



Provider Satisfaction Survey

- Annually, Amerigroup sends out a *Provider Satisfaction Survey* to engage our provider network to provide feedback to improve and strengthen our processes and operations.
- We use your survey responses to better understand your experiences and continue to improve our programs. You can complete the survey online by obtaining a unique password/username or you may choose to mail back your response. Please remember to complete the survey!

Consumer Assessment of Healthcare Providers and Systems Survey

Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) is an annual survey to assess consumers' experience with their health and health care services from a patient's perspective. Here are a few reasons why Amerigroup conducts this type of survey.

Why focus on patient experience



- There is a strong correlation between patient experience and health care outcomes.
- Patients with chronic conditions demonstrate greater self-management skills and quality of life.
- Patient retention is greater when there is a high-quality relationship with the provider.
- Decreased malpractice risk.
- Efforts to improve patient experience have resulted in decreased employee turnover.

How to improve patient experience



- Ensure all office staff are courteous and empathetic.
- Respect cultural differences and beliefs.
- Demonstrate active listening by asking questions and making confirmatory statements.
- Spend enough time with the patient to address all of their concerns.
- Provide clear explanation of treatments and procedures.
- Obtain and review records from hospitals and other providers.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Additional resource

What Matters Most: Improving the Patient Experience www.patientexptraining.com. For a full CAHPS overview, visit the <https://providers.amerigroup.com/TX> webpage.



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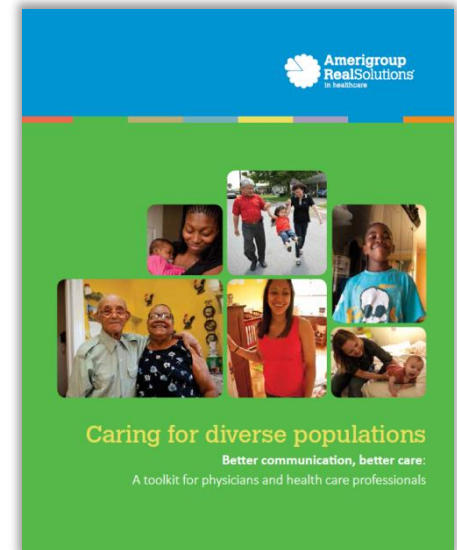
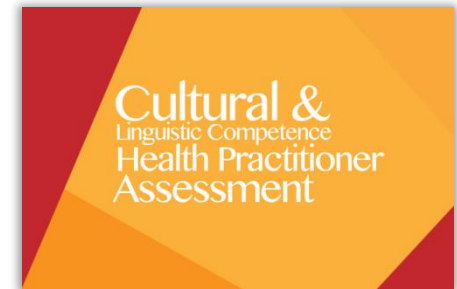
Fraud, waste, and abuse

Help us prevent it and tell us if you suspect it!

- Verify patient's identity.
- Ensure services are medically necessary.
- Document medical records completely.
- Bill accurately.
- Report suspected fraud to **1-866-847-8247** or **Provider Services**.

Cultural competency

- Amerigroup believes that we must recognize and thoroughly understand the role that culture and ethnicity play in the lives of our members in order to ensure everyone receives equitable and effective health care.
- Expectations are that our providers and their staff share our commitment.
- Resources, training materials and information is available online, including:
 - *The Cultural Competency Plan.*
 - Self-Assessment Tool.
 - Cultural Competency Tool Kit.
 - Cultural competency training



Medicaid contact information

- Amerigroup website (online tool) address:
<https://providers.amerigroup.com/TX>
 - Check eligibility, claims status and authorizations
- Provider Services/Provider Inquiry Line (IVR): **1-800-454-3730**
 - Check eligibility, claims status and authorizations
 - Provider Services available Monday to Friday 7 a.m. to 7 p.m. Central time
 - IVR available 24/7
 - Service coordinator, Case Management or Disease Management:
1-800-454-3730 TTY: 771
- Nurse Helpline: **1-800-600-4441**
- STAR Kids Nurse HelpLine: **1-844-756-4600**

Medicaid contact information (cont.)

- Clinical services available 24/7
- Member Services: **1-800-600-4441**
- STAR Kids Member Services: **1-844-756-4600**
- Behavioral health services: **1-800-454-3730**
- Behavioral health fax (inpatient): **1-877-434-7578**
- Behavioral health fax (outpatient): **1-866-877-5229**
- AIM Specialty Health (cardiology, radiology high-tech, radiation oncology, sleep studies, genetic testing): **1-800-714-0040**
 - www.aimspecialtyhealth.com/goweb
- Superior Vision:* **1-866-819-4298**

Additional resources and information

Centers for Medicare & Medicaid Services

<https://www.CMS.gov>

National Committee for Quality Assurance

www.ncqa.com

Health and Human Services Commission

www.hhsc.state.tx.us

Texas Medicaid Health Partnership

www.tmhp.com

Next steps

- Complete the *Orientation Feedback Survey*.
- Register for Availity.
- Register for electronic data interchange.
- Register for EFT services.
- Read your provider manual.



Thank you for partnering with us!



- * Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup.
- * IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Amerigroup.
- * AIM Specialty Health is an independent company providing some utilization review services on behalf of Amerigroup.
- * Superior Vision is an independent company providing vision services on behalf of Amerigroup.