Amerigroup RealSolutions in healthcare

Provider update

This is an update about information in the provider manual.
For access to the latest provider manual, go online to https://providers.amerigroup.com/TX.

Universal billing claim requirements using type of bill and patient status 30

Summary:
Universal billing (UB) claims with bill types ending in two, three or four must be billed with inpatient bill types only. Any UB with a type of bill (TOB) ending in two, three or four billed for any outpatient services will be denied or rejected. Texas Medicaid does not accept outpatient services using patient status 30 with interim bill types 132, 133 and 134.

What is the impact of this change?

In 2014, Amerigroup* notified our provider network that Texas Medicaid does not accept interim bill types 132, 133 and 134 with patient status 30 (still patient or expected to return for outpatient services). We are reminding providers to comply with this clean claim requirement. This applies to all providers billing on a UB-04 claim form including therapy (physical therapy, occupational therapy, speech therapy and comprehensive outpatient rehabilitation facility), home health, hospitals or any other provider billing on a UB-04 form. No changes will occur for Medicare crossover claims or Medicare claims as these bill types are recognized by CMS.

In addition, UB claims received with an interim bill frequency code of two, three or four are required to be billed with an inpatient bill type. Any TOB with a bill frequency code of two, three or four with an outpatient TOB will be denied or rejected.

This complies with the Health and Human Services Commission claim submissions and encounter reporting requirements. Rejected claims are reported through either a remittance advice or rejection report. Rejected claims are not clean claims and do not make it into the Amerigroup claim processing system. In order to be accepted into our claim processing system, providers must correct these claims within 95 days (365 days for out-of-state providers and nursing facilities) from the date of service/discharge. Claims not corrected within the appropriate timeline will not be accepted and will be rejected for timely filing

In the event the claim is received into our claim processing system without meeting these claim requirements, the claim will be denied. Any overpaid claims are subject to recovery or recoupment. Denied claims are reported on your explanation of payment (EOP). Providers have 120 days from the date of the EOP to correct these claims.

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.

**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.*