Amerigroup RealSolutions in healthcare

Provider update

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

Summary of change: Amerigroup is clarifying clean billing standards and requirements using the *UB-04* or equivalent claim form. Universal billing claims received with bill frequency codes ending in 1, 4 or 5 and patient status 30 will be rejected.

What is the impact of this change?

Amerigroup does not allow claim frequency code 1, 4 or 5 with patient status 30. Claim frequency codes 1, 4 and 5 signify the plan of care or treatment for the member has been fulfilled or the member discharged/transferred to a different service provider. Therefore, use of patient status 30 (still a patient) is not an appropriate billing combination. Any claim with this combination will be rejected. Providers will need to correct these claims for acceptance in our system.

It is acceptable to use patient status 30 for interim claims. Those frequency codes indicate care/treatment continues for the member (e.g., frequency codes 2 or 3 — interim first or interim continuing).

In 2016, Amerigroup also communicated a front-end claim edit requiring frequency codes 2, 3 or 4 (interim first, interim continuing and interim last) to be billed with inpatient bill type of 11, 12, 18, 21, 22, 28, 41 or 86. Effective immediately, Amerigroup is removing this edit. As we update our system, we will automatically recycle any claim affected by this edit.

The above edits comply with Health and Human Services Commission and Texas Medicaid Healthcare Partnership encounter reporting requirements. Additional information can be found in the *CMS Claims Processing Manual*. Rejected claims are not clean claims and do not make it into the Amerigroup claim processing system. Rejected claims are reported through either a remittance advice or rejection report. Providers must correct these claims within 95 days (365 days for out-of-state providers or nursing facilities) from date of service/discharge in order to be accepted into our claim processing system. Claims not corrected within the appropriate time frame 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 toll free at 1-800-454-3730.

The information in this update may be an update or change to your provider manual. Find the most current manual at:
https://providers.amerigroup.com

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.
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