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STAR+PLUS and Medicare-Medicaid Plan overview for nursing facility providers

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.

Introduction to STAR+PLUS and MMP

- The **STAR+PLUS** program is a Texas Medicaid managed care program providing integrated acute and long-term services and supports (LTSS) in a Medicaid managed care environment for elderly and disabled adults. Members are considered **nondual** if they only have the STAR+PLUS benefit.
- **Nondual** members are eligible to receive all long-term services and supports (LTSS) and value-added services based on need. Acute care benefits are provided in conjunction with the defined benefit set for Texas Medicaid programs.
- **Dual-eligible** members are eligible to receive LTSS benefits based on assessed need and covered value-added services. Acute care benefits are provided and paid per the defined benefit set of CMS Medicare programs.

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Introduction to STAR+PLUS and MMP (cont.)

- Amerigroup STAR+PLUS MMP **(Medicare-Medicaid Program)** is a Texas plan contracted with **CMS** and **Texas Health and Human Services Commission (HHSC).** Members on this program have both Medicare and Medicaid and are considered **dual-eligible**.
- Amerigroup STAR+PLUS MMP integrates care and reimbursement for members who have Medicare Part A, Part B, Part D and Medicaid benefits (dual-eligible members), and consolidates their care through one **MMP** for full access to both their Medicare and Medicaid benefits.

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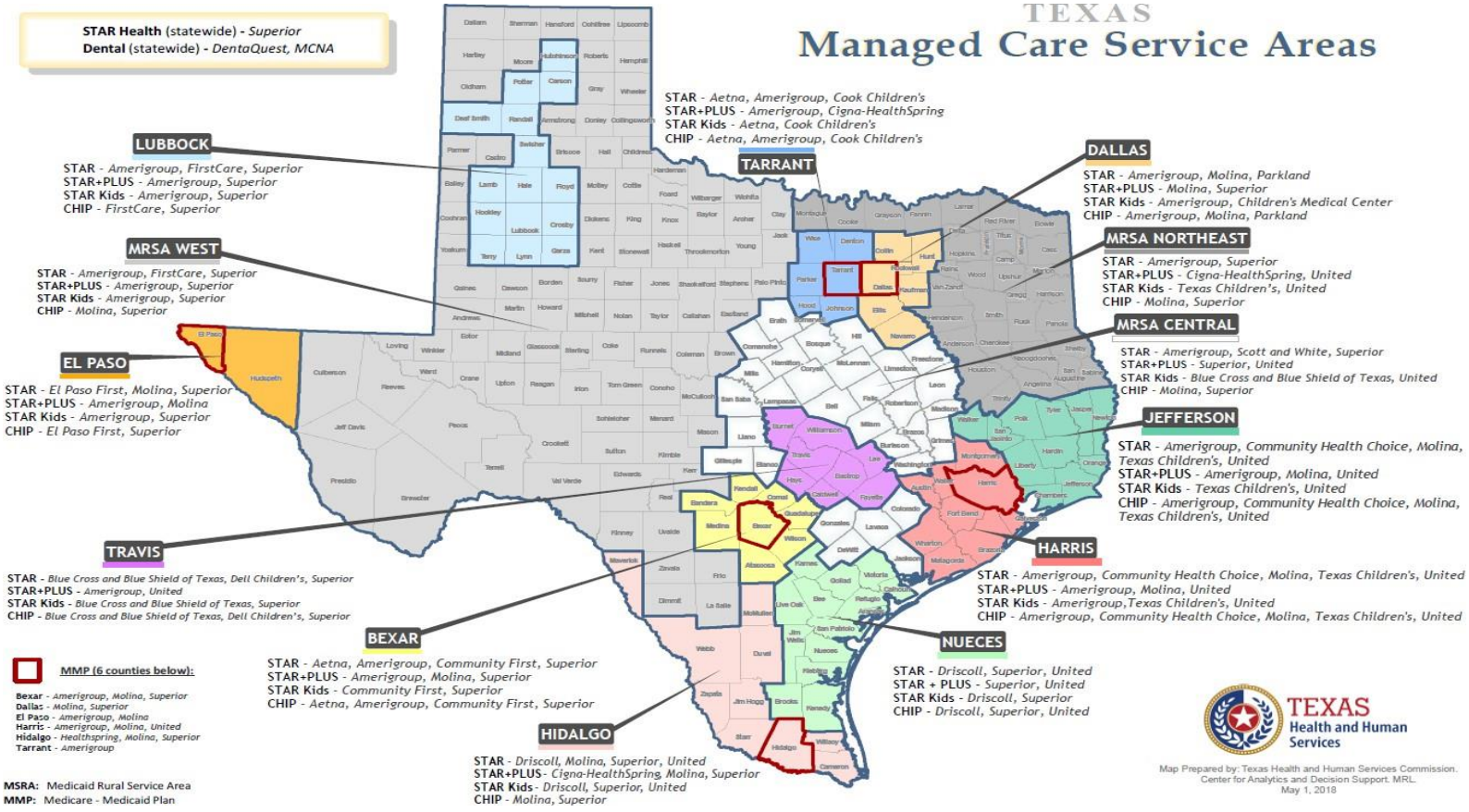
Amerigroup service areas for STAR+PLUS



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https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/starplus

Amerigroup service areas for STAR+PLUS (cont.)

Amerigroup is contracted by HHSC to offer STAR+PLUS in these designated service areas:

- Bexar
- El Paso
- Harris
- Jefferson
- Lubbock
- Tarrant
- Travis
- West Medicaid Rural Service Area (MRSA)

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STAR+PLUS program overview

To get services through STAR+PLUS, a member must be approved for Medicaid and be one or more of the following:

- Age 21 or older, receiving Supplemental Security Income (SSI) benefits and able to get Medicaid due to low income
- Not receiving SSI and able to receive STAR+PLUS Home and Community-Based Services (HCBS)
- Age 21 or older, receiving Medicaid through a Social Security Exclusion program, and meet program rules for income and asset levels
- Age 21 and older residing in a nursing home and receiving Medicaid while in the nursing home.
- In the Medicaid for Breast and Cervical Cancer Program

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STAR+PLUS program overview (cont.)

If a STAR+PLUS member resides in a **nursing facility**, services covered include:

- Daily care services, such as:
  - Room and board.
  - Medical supplies and equipment.
  - Personal needs items.
  - Social services.
  - Over-the-counter drugs.
- Nursing facility add-on services, which include:
  - Emergency dental services.
  - Physician ordered-rehabilitative services.
  - Augmentative communication devices.
  - Customized power wheelchairs.

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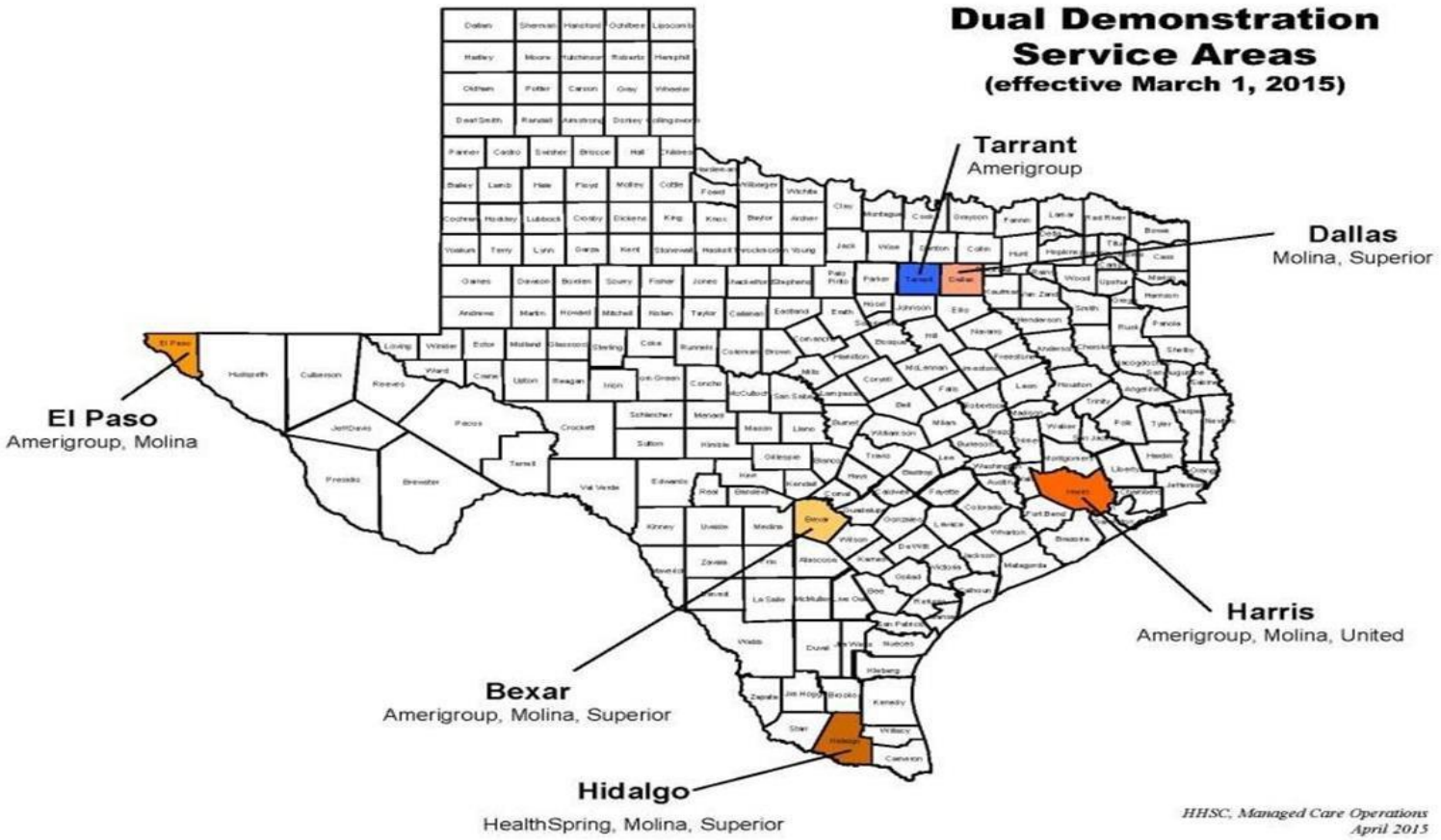
Medicare-Medicaid Plan (MMP) service areas



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MMP service areas (cont.)

MMP is available through Amerigroup for dual-eligible members who reside in one of these four counties:

- Bexar
- El Paso
- Harris
- Tarrant

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MMP overview

Members can be enrolled in MMP if they:

- Are age 21 or older.
- Receive Medicare Part A, B, and D and are receiving full Medicaid benefits.
- Are eligible for or enrolled in the STAR+PLUS program.

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MMP overview (cont.)

- This program integrates care and reimbursement for members who have Medicare Part A, Part B, Part D and Medicaid benefits and consolidates their care through one MMP for full access to both their Medicare and Medicaid benefits.
- Members will have one ID card, one health plan and one Member Services team for their MMP benefits.

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MMP overview (cont.)

- Medicare is always primary for acute care benefits and pharmacy services.
  - All acute care services are covered by the member's Medicare plan (either Original Medicare or a Medicare Advantage plan)
  - Pharmacy/prescription drug services are covered by Medicare Part D.
  - Skilled nursing facility services are covered under the member's Medicare plan. Medicare SNF coinsurances are covered by the member's STAR+PLUS plan.
- Nursing facility custodial care services are covered under the member's STAR+PLUS plan.

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Member identification cards

Members with **STAR+PLUS only (nondual)** will have a card that looks like the example shown below.

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Member identification cards (cont.)

Members with **Medicare and Medicaid** will have a card that looks like the example shown. This card states at the bottom that the member's STAR+PLUS plan only covers Long-Term Services and Supports Benefits **only** and that primary, acute, and behavioral health services are received through Medicare.

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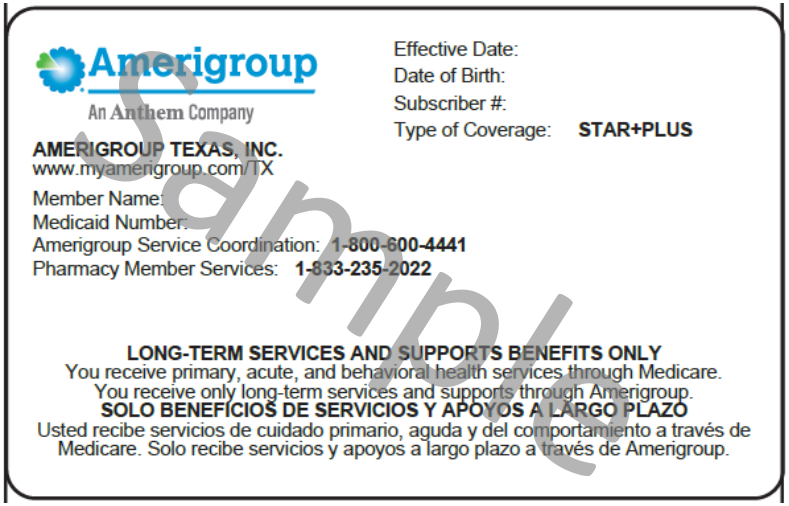
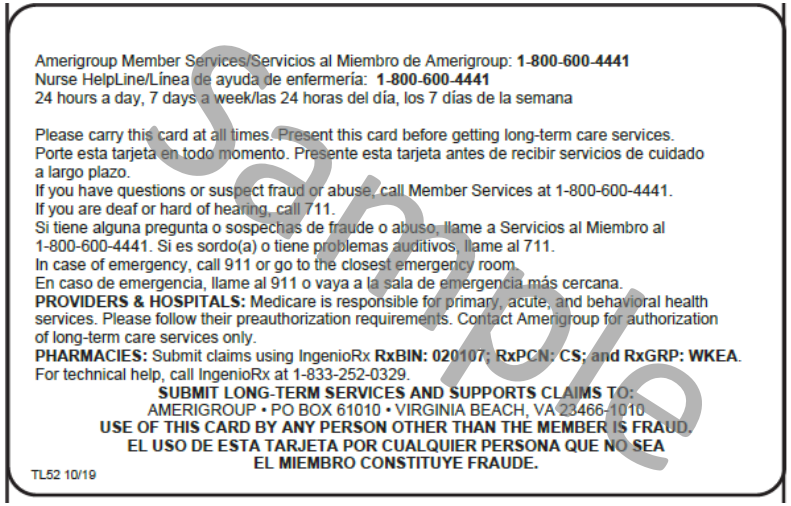
Member identification cards (cont.)

Members that reside in the **Medicaid Rural Service Area** have different ID cards for STAR+PLUS and dual-eligible members since they are served by Amerigroup Insurance Company, whereas all other members are served by Amerigroup Texas, Inc.





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Service coordination

A feature of the STAR+PLUS and MMP programs is **service coordination**. Service coordination means specialized care management services that are performed by a licensed, certified, and/or experienced person called a service coordinator. This includes but is not limited to the following activities:

- Identifying a member's needs through an assessment
- Documenting how to meet the member's needs in a care plan
- Arranging for delivery of the needed services
- Establishing a relationship with the member and being an advocate for the member in coordinating care
- Helping with coordination between different types of services, including community transitions
- Making sure the member has a primary care provider

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Service coordination model

Reassess and evaluate:

- Service coordinator contacts member and reassess the member's needs and functional capabilities.
- Service coordinator, in collaboration with the nursing facility team and member/member family, evaluate and revise the service plan as needed.

Service delivery:

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

Identify needs:

- Members contacted and screened for complex needs and high-risk conditions.
- Identify complex and high-risk members.

Service plan:

- Service coordinator makes a minimum of four quarterly visits and conducts a comprehensive assessment of all medical, behavioral, social and long-term care needs.
- Service coordinator works with the nursing facility team of experts to develop a service plan to meet the member's needs.
- Service coordinator contacts the member's PCP/specialist for concurrence, if necessary.
- Member and member's family review the service plan.

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Money Follows the Person program

- **Money Follows the Person** is a program offered to STAR+PLUS and MMP members who want to leave an institutional setting and return to an independent, community-based living setting.
- Service coordinators will work with identified members, their nursing facility clinical case manager and any key parties that the member designates to fully assess the member and their individual capability to safely reside in an independent community living setting.
- Service coordinators use the LTSS benefit of transition assistant services to facilitate the member's return to the community. This benefit provides:
  - A one-time $2,500 benefit to purchase the necessary items or services to allow the member to exit the nursing facility.
  - Contracts with several providers who perform the coordination of this service.

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Role of nursing facilities

Nursing facility responsibilities include but are not limited to:

- Verifying member eligibility.
- Obtaining prior authorization for services prior to provision of those services.
- Coordinating Medicaid/Medicare benefits.
- Notifying Amerigroup of changes in members' physical condition or eligibility within one business day of identification.
- Collaborating with the Amerigroup service coordinator in managing members' health care.
- Managing continuity of care for STAR+PLUS members.
- Allowing Amerigroup service coordinators and other key personnel access to Amerigroup members in the facility and requested medical records information.

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Incident reporting requirements

- Allegations of abuse, neglect and exploitation of a member must be reported, as well as the death of a member, the involvement of law enforcement and any environmental hazards that compromise the health and safety of a member.
- Reports made to Amerigroup or referred to Amerigroup will be investigated through out Quality Review department nursing staff.

Member informed consent

Every provider has the responsibility to respect a member's right to informed decision making by:

- Communicating adequate information about the member's care and/or treatment in an understandable way.
- Respecting the member's decisions.
- Following the member's wishes; this extends to decisions made by authorized representative or written in an advance directive.

Respecting a member's right to informed consent does not imply an obligation to provide care that is medically unnecessary or inappropriate.

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Member informed consent (cont.)

Every member has the right to make informed decisions regarding his or her healthcare and to:

- Be informed of his or her health status.
- Be involved in his or her care planning and treatment.
- Request, consent or refuse treatment.
- Receive information in a manner that is understandable.
- Delegate the right to make an informed decision to someone else.

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Health Insurance Portability and Accountability Act

- Privacy regulations allow the transfer or sharing of member information to conduct business and make decisions about care.
- We strive to ensure both our staff and contracted providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to ***HIPAA***.
- Providers may reference the provider manual for information regarding faxing, mailing, emailing and leaving voicemails that include member information.

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Cultural competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures into a system, agency or among professionals. Cultural competency helps providers and members:

- Acknowledge the importance of culture and language.
- Assess cross-cultural relations.
- Embrace cultural strengths with people and communities.
- Expand their cultural knowledge.
- Understand cultural and linguistic differences.

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Cultural competency (cont.)

Cultural awareness includes:

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- The ability to modify one's own behavior to respond to the needs of others while maintain one's objectivity and identity.

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Nursing facility unit rate

- The nursing facility unit rate includes the types of services included in the HHSC vendor payment rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services and over-the-counter drugs.
- The nursing facility unit rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing facility unit rates exclude nursing facility add-on services.

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Add-on services

- The nursing facility provider manual has detailed information about the coverage of add-on services such as ventilator care, tracheostomy care, rehabilitative services, customized power wheelchairs and augmentative communication devices. https://providers.amerigroup.com/Public%20Documents/TXTX_NFProviderManual.pdf
- For NF add-on therapy services, Amerigroup will accept claims received:

1. From the NF on behalf of employed or contracted therapists, and;
2. Directly from contracted therapists who are contracted with the MCO. All other NF add-on providers must contract directly with and directly bill the MCO.

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Services outside the nursing facility

STAR+PLUS also covers acute care services outside of the nursing facility (billed by the provider and not by the nursing facility), to include, **but is not limited to**:

- Ambulance services – emergency and nonemergency transportation.
- Audiology services, including hearing aids.
- Emergency services.
- Hospital services including inpatient and outpatient.
- Laboratory services.
- Preventive services, including an annual adult well-check.
- Radiology, imaging, and X-rays.
- Telemedicine.
- Prescription drugs, medications and biologicals including pharmacy-dispensed and provider-administered outpatient drugs and biologicals.

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Ambulance transportation services (emergent)

- Ambulance transportation service is a benefit when the member has an emergency medical condition.
- See the *Emergency Services* section of the *Amerigroup Nursing Facility Provider Manual* for what meets the definition of an emergency medical condition.

Non-emergency transportation (NMET)

- Amerigroup is responsible for authorizing non-emergency ambulance transportation for a STAR+PLUS member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation.
- A physician, nursing facility or other healthcare provider is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.
- All requests require clinical information to support the need for the member to be transported by non-emergent ambulance transportation.

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NMET (cont.)

- The ambulance provider may not submit an authorization request; however, they are ultimately responsible for ensuring a prior authorization has been obtained prior to transport.
- If a request for non-emergent ambulance transportation will occur after business hours, authorizations that meet medical necessity will be authorized retrospectively if the request is received the next business day.
- Form link:

https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_NonemergAmbulancePARequest.pdf

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NMET (cont.)

Requests can be faxed, submitted via the Interactive Care Reviewer that is accessed through the Availity Portal* https://www.availity.com or called into Amerigroup via the contact numbers shown in the table below.

Request type	Behavioral health facilities/ behavioral health provider and IDD members	All other members for discharge from facility to home or from home to a provider/facility
Urgent same day	Call 1-800-325-0011, ext. 106.103.6237	Call 1-800-454-3730
Nonurgent requests	Fax request to 1-866-877-5229	Fax request to 1-866-249-1271

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Pharmacy program

- Unless otherwise covered in the nursing facility unit rate, prescriptions can be obtained from licensed prescribers within the Amerigroup network.
- Members with STAR+PLUS must adhere to the *Texas Vendor Drug Program (VDP) Formulary* and *Preferred Drug List* (*PDL*).
- Members with Medicare or MMP continue to access pharmacy benefits through a Medicare Part D provider.
- The formulary and drug list is available on the Amerigroup website at https://providers.amerigroup.com/TX.

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Pharmacy program (cont.)

- Non-formulary drugs are subject to precertification.
- Many over-the-counter products are covered with a written prescription (encouraged as first-line treatment).
- Unless otherwise covered in the nursing facility unit rate, precertification is required for:
  - Non-formulary drug requests.
  - Brand-name medications where there is a generic available.
  - High-cost injectables and specialty drugs.
  - Others as identified on the formulary.

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Pharmacy program (cont.)

- To prescribe medications that require prior authorizations: https://www.covermymeds.com
- Fax prior authorizations forms to Amerigroup at **1-844-474-3341** or call **1-833-262-1726** (IngenioRx*)
- For medical injectables, fax **1-844-512-8995**
- Precertifications are processed by pharmacy technicians and pharmacists; requests that do not meet the medical necessity criteria are reviewed by the plan medical director for determination.

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Credentialing

- Providers are not considered **participating** (in-network) until they have been credentialed with a duly executed contract with Amerigroup.
- Providers are responsible for submitting all requested information necessary to complete the credentialing or recredentialing process.
- Amerigroup adheres to NCQA standards and state requirements and follows the nursing facility credentialing standards outlined in HHSC's Uniformed Managed Care Manual.

Credentialing (cont.)

- Amerigroup utilizes the Texas Association of Health Plans (TAHP's) contracted credentialing verification organization (CVO). The CVO, Aperture Credentialing, LLC, is responsible for receiving completed applications, attestations and primary source verification documents.
- Providers must be **recredentialed** every three years.
- If a facility **moves** to another location, the facility **must** be credentialed under the new address.
- More details about credentialing are available in the Nursing Facility Provider Manual.

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Facility changes

- If your facility goes through a **Change of Ownership (CHOW)** or **DBA name change**, please be sure to reach out to your Provider Relations Representative.
- When notifying your rep of the change, please make sure to provide an updated *W-9* and a letter informing Amerigroup of the change, to include the effective date of the CHOW or DBA name change. Please also provide a *Certificate of Filing* or *Assumed Name Certificate* with a DBA name change.
- Your representative will send you the documents required by Amerigroup to process changes in our contracting and claims system.

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Quality incentive programs (QIPP/NFQIP)

- The Quality Incentive Payment Program (QIPP) through HHSC is a performance-based program that compensates providers for meeting or exceeding certain goals. For more information on this program, please refer to the HHSC QIPP page at https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes.
- Amerigroup has its own incentive program for STAR+PLUS and MMP providers referred to as NFQIP (Nursing Facility Quality Incentive Program). For more information on this program, please reach out to your Provider Relations Representative.

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Authorizations for STAR+PLUS custodial care

- Nursing facilities are responsible for submitting **Form 3618** or **Form 3619**, as applicable, to HHSC's administrative services contractor Texas Medicaid & Healthcare Partnership (TMHP).
- Once the state updates the authorization on the member's record, the state sends a **Statistical Analysis Software (SAS)** file to Amerigroup. That file is then uploaded into the Amerigroup claims processing system, which automatically generates an authorization for the facility.

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Authorizations for MMP: skilled services

- Prior authorization from Amerigroup is always required for admission/readmission to a skilled nursing facility (SNF).
- Nursing facility requests for precertification should be faxed to **1-844-206-3445**.
- Form located at: Precertification/Authorization forms are located at https://providers.amerigroup.com/TX.
- The nursing facility should send clinical information to substantiate medical necessity and medical criteria along with a written physician order, test, treatments, prior and current level of function, intervention performed, and results or outcomes.

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Authorizations for MMP: skilled services (cont.)

- Requests are reviewed by the MMP Utilization Management team for Amerigroup within 72 hours of receipt.
- Upon approval or denial, an MMP utilization nurse will contact the facility via telephone to provide the verbal authorization or denial.
- If the authorization is medically necessary and approved, the authorization will be effective on the date of notification.
- A complete list of all covered services that require precertification can be found at https://providers.amerigroup.com/Pages/PLUTO.aspx.

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Authorizations for MMP: Skill in Place

- Amerigroup encourages that facilities utilize the **Skill in Place** option for members with noncritical conditions rather than transferring to an acute care facility. Please note that members admitted to the hospital or treated in the emergency room who require skilled services upon return to the nursing facility are not opportunities for Skill in Place and are subject to medical necessity review and prior authorization.
- Skill in Place *always* requires an authorization from Amerigroup.

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Authorizations for MMP: Skill in Place (cont.)

- Requests for authorization must be received within one business day of Skill in Place treatment.
- Authorization requests should be faxed to **1-844-206-3445**. Please be sure to write **Skill in Place** on the cover sheet and include all pertinent clinical information to substantiate medical necessity.
- The skilled nursing facilities will receive an initial three-day approval for a Skill in Place request with subsequent approval based on medical necessity.
- After the initial three-day approval, the facility will be required to submit additional approval of ongoing treatment based on medical necessity.

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Authorizations for goal directed therapy (GDT)

- Goal directed therapy is considered an add-on service not covered under the Nursing Facility unit rate for Medicaid nursing facility members who are not eligible for Medicare or other insurance.
- GDT must be provided with the expectation that the member's function will improve measurably in 30 days.
- GDT services must be prior authorized.
- An evaluation should be completed prior to requesting an authorization.
- No authorization is required for the initial evaluation.
- The authorization request form is available on the Amerigroup website.

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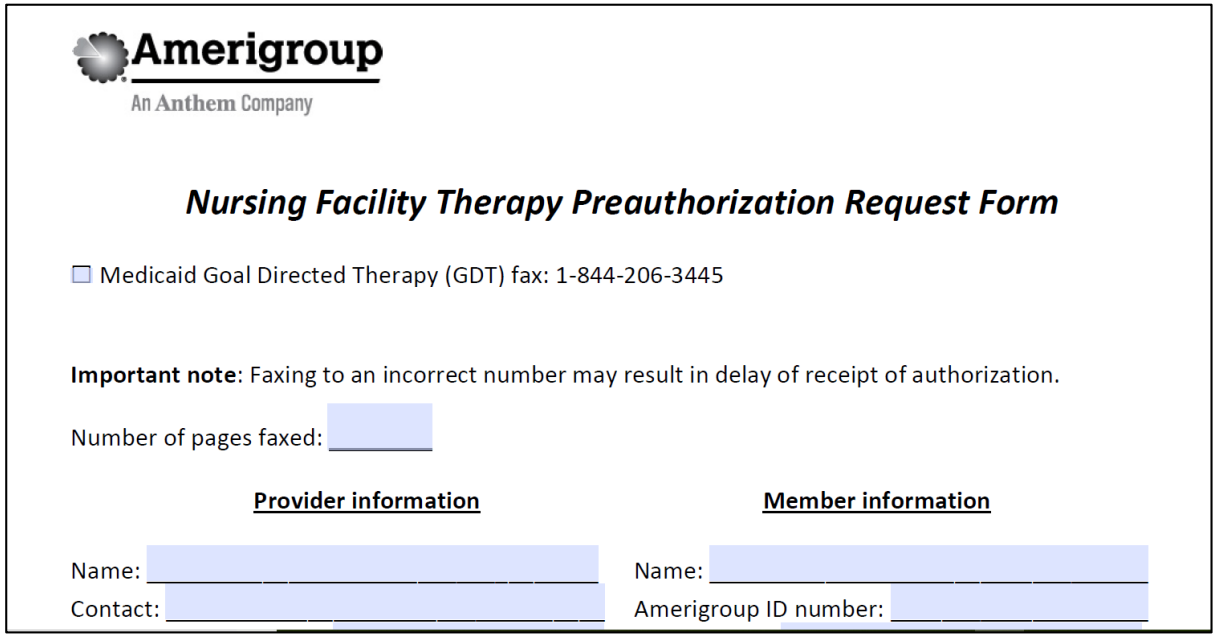
Authorizations for GDT (cont.)

The *Preauthorization Request Form* can be found on the Amerigroup provider website:

https://providers.amerigroup.com/Public%20Documents/TXTX_NF_TherapyPAForm.pdf



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Nursing Facility Therapy Preauthorization Request Form

☐ Medicaid Goal Directed Therapy (GDT) fax: 1-844-206-3445

Important note: Faxing to an incorrect number may result in delay of receipt of authorization.

Number of pages faxed: _____

Provider information

Name: _____

Contact: _____

Member information

Name: _____

Amerigroup ID number: _____

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Notification requirements

Nursing facilities are required to notify Amerigroup within one business day of:

- New admission for an existing member.
- Discharge of a member due to:
  - Emergency care.
  - Hospitalization.
  - Death.
  - Extended leave from the facility.
  - Significant change in condition.
  - Form link: https://providers.amerigroup.com/Public%20Documents/TXTX_NFCoordNotification.pdf.

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Level of care determination appeals — TMHP

- Medicaid nursing facility residents have the right to appeal level of care determinations issued by TMHP as part of the minimum data set (MDS) medical necessity level of care determination.
- Amerigroup is not responsible for issuing MDS level of care determinations such as RUG levels of care. Appeals must be filed to TMHP.
- HCBS STAR+PLUS Waiver appeals are also to be filed to TMHP as Amerigroup is not responsible for this process.
- For additional information, please refer to the TMHP website at www.tmhp.com or contact TMHP at **1-800-925-9126**.

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Member medical appeals — Amerigroup

- Member medical **appeals** can be initiated by the member or the provider, on behalf of the member with the member's signed consent, and must be submitted within **60 calendar days** from the date of an adverse benefit determination.
- Member medical appeals can be submitted by:
  - Calling Member Services at **1-800-600-4441** (TTY **711**); or
  - Sending a written request to —

Appeals

Amerigroup
2505 N Highway 360, Suite 300

Grand Prairie, TX 75050

- For further details on the medical appeals process, please refer to the **Medical Appeal Process and Procedures** section of the Nursing Facility Provider Manual.

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Claims submission

- All nursing facility services must be billed using an electronic billing format that is 5010 level 7 edit compliant via the *HIPAA* 837I format for a *CMS-1450 Claim Form*. No paper claims will be accepted.
- Nursing facilities can bill at any frequency they wish – weekly, bi-weekly, monthly. Providers have three options for submitting claims to Amerigroup:
  - A clearinghouse or billing company that transmits to the Availity Electronic Data Interchange (EDI) Gateway
  - Availity Provider Portal
  - TMHP website claim portal
- Although providers can still bill through the TMHP claims website, it is not the preferred method for billing. Amerigroup is not responsible for any claims that do not cross over from TMHP as TMHP is not a clearinghouse. TMHP will transfer claims to Amerigroup if the claim is accepted on their end.

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Timely filing limitations

Providers must adhere to the following guidelines and time limits for claims to be considered for payment:

- Clean claims for nursing facility unit rate or Medicare skilled nursing coinsurance claims must be submitted within 365 days from the last date of service represented on the claim.
- All other STAR+PLUS service claims (including add-on services) must be filed within 95 days from the date of service or per the terms of the provider agreement.
- Corrected claims must be submitted within 120 days from the date of the *Explanation of Payment* (*EOP*).

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Corrected claims

- Providers may submit corrected claims through their billing software, if it has the capability, or through the Availity portal.
- It is important to clearly identify that the claim is a correction to a previously submitted claim. The original claim number must be referenced on the claim. This number can be entered under the original document control number (DCN).
- Claims must be submitted with a Type of Bill 217 to indicate a replacement/correction.

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Claims adjustment

- **Clean** claims for NF unit rate and Medicare Coinsurance are adjudicated within 10 days from the date of submission. Amerigroup will pay providers interest on all clean claims not adjudicated within the 10-day requirement.
- **Clean** claims for NF add-on services or other services negotiated into the provider's contract are adjudicated within 30 days from receipt of the claim. If not adjudicated within this 30-day requirement, these claims are also subject to interest payments.
- Claim reimbursement is based on the provider's contract. Amerigroup is responsible for paying qualified providers their liability insurance add-on and an enhanced fee to NF providers who are part of the HHSC Direct Care Staff Rate Enhancement Payment Program. The fees will be built into the provider's unit rate payment fee schedule.

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Automatic claims adjustments

- Amerigroup will make adjustments to previously adjudicated claims within 30 days from the date of receipt of an adjustment from the state using an automated process to reflect changes to such things as: nursing facility daily rates, provider contracts, service authorizations, applied income, and level of service (RUG).
- Any adjustments other than the ones listed above and some denials may require a corrected claim.

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Patient driven payment model (PDPM)

- The patient driven payment model (PDPM) is a new classification system within the original Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS). It has replaced the case-mix classification system, the Resource Utilization Group, version IV (RUG-IV). For dates of service October 1, 2019, and forward, CMS will no longer base SNF PPS rates on the RUG-IV classification system.
- Amerigroup has implemented the new classification for their MMP program. MMP SNF Part A claims will be processed according to the PDPM methodology.

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PDPM (cont.)

- For all MMP SNF PPS claims, Amerigroup will continue to require SNFs to bill at least one revenue code 22 line with a Health Insurance Prospective Payment System (HIPPS) code. The HIPPS codes have changed to accommodate the PDPM.
- Amerigroup Amerivantage (Medicare Advantage) SNF Part A claims are paid according to the provider's contract.*

* Please reach out to your Amerigroup provider representative for additional details about this program.

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Respite care

- Providers must obtain authorizations for respite care directly from Amerigroup.
- Respite care claims should be submitted on a *CMS-1450* claim form in accordance with NF guidelines. One unit equals one day.
- Nursing facilities will have flexibility in the Type of Bill used – 11X, 13X, or 21X.
- When submitting claims for respite care, a service code description is required next to the HCPCS code S5151. If billing for respite through Availity, you must click the check box next to the code to add.
- Reimbursement for respite care is based on the contract terms or the NF daily unit rate (less the insurance add-on).

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Claim coding

The following codes should be used when billing these service types to Amerigroup.

Service type	Revenue code	Procedure code	Modifier 1	Modifier 2	Modifier 3
Daily unit rate	0100				
Ventilator – full	0230	94004	U1	UA	U7
Ventilator – partial	0230	94004	U1	UA	U8
	0230	94005	U1	UA	U8
Child trach – ages 21-22 only	0410	99199			
Respite care	0663	S5151			
Medicare co-insurance	0101				

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Additional claims information

- For members with MMP, providers can bill for a skilled nursing bed and coinsurance on the same claim using a *CMS-1450* format. The revenue code 0101 can be added as another line to the claim.
- The following add-on services must be billed by the provider rendering the service:
  - Emergency dental – Amerigroup uses DentaQuest*
  - Augmentative communication devices – participating Amerigroup DME vendors*
  - All other DME – participating Amerigroup DME vendors*

* See our Provider Network Directory for a list of participating vendors.

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Additional claims information (cont.)

The following nursing facility services are not the responsibility of Amerigroup and should continue to be billed by the nursing facility to TMHP for payment:

- Services for residents under the age of 21
- Services identified as pre-admission screening and resident review services
- Services for hospice daily care
- Services for daily care in a Veterans Affairs (VA) home
- Services for hospice daily care in a VA home

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Claim payment disputes

- If you disagree with the outcome of a claim, you may utilize the Amerigroup **provider payment dispute process**.
- A provider has **120 days** from the date of an *Explanation of Payment* (*EOP*) to file a payment dispute. Providers have three options for submitting disputes:
  - Use the online payment dispute tool at https://www.availity.com
  - Fax dispute requests to **1-844-756-4607** — not for MMP
  - Mail dispute requests to:

Payment Dispute Unit

Amerigroup

P.O. Box 61599

Virginia Beach, VA 23466-1599

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Claim payment disputes (cont.)

- The dispute process consists of two internal options:
  - **Claim payment reconsideration**: This is a provider's initial request to investigate the outcome of a finalized claim. Most issues are resolved with a claim payment reconsideration.
  - **Claim payment appeal**: If you disagree with the outcome of the reconsideration, you may request a claim payment appeal.
- When submitting claim payment disputes, please include as much information as you can to help the claims team understand why you think the claim was not paid as you would expect. Amerigroup will resolve the claim payment dispute within 30 calendar days of receipt.

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Claim payment disputes (cont.)

- Amerigroup requires the following information when submitting a claim payment dispute by fax or mail:
  - Provider name, NPI, TIN, address, contact person name, phone number and email
  - Member name and their Amerigroup or Medicaid ID
  - A listing of disputed claim, which should include the Amerigroup claim number and the date(s) of service(s)
  - All supporting statements and documentation
- When submitting a payment dispute, we recommend providers retain all documentation including fax cover pages, email correspondence and logs of telephone communication at least until the dispute is resolved.

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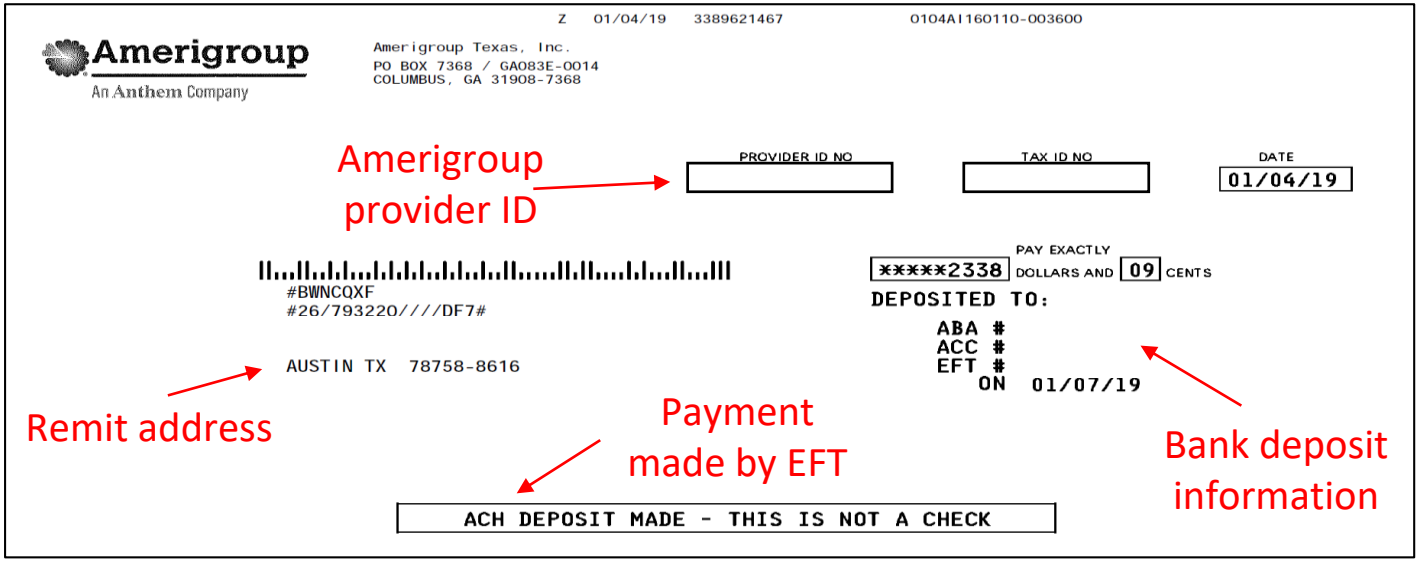
Explanation of payments (EOP)

This portion of the *EOP* is the **header**. The box labeled Provider ID No is your unique provider ID assigned by Amerigroup. This is a number we use to identify your provider record based on the NPI and tax ID used for billing. This header also includes the bank deposit information, remit address and whether the payment was made by EFT.



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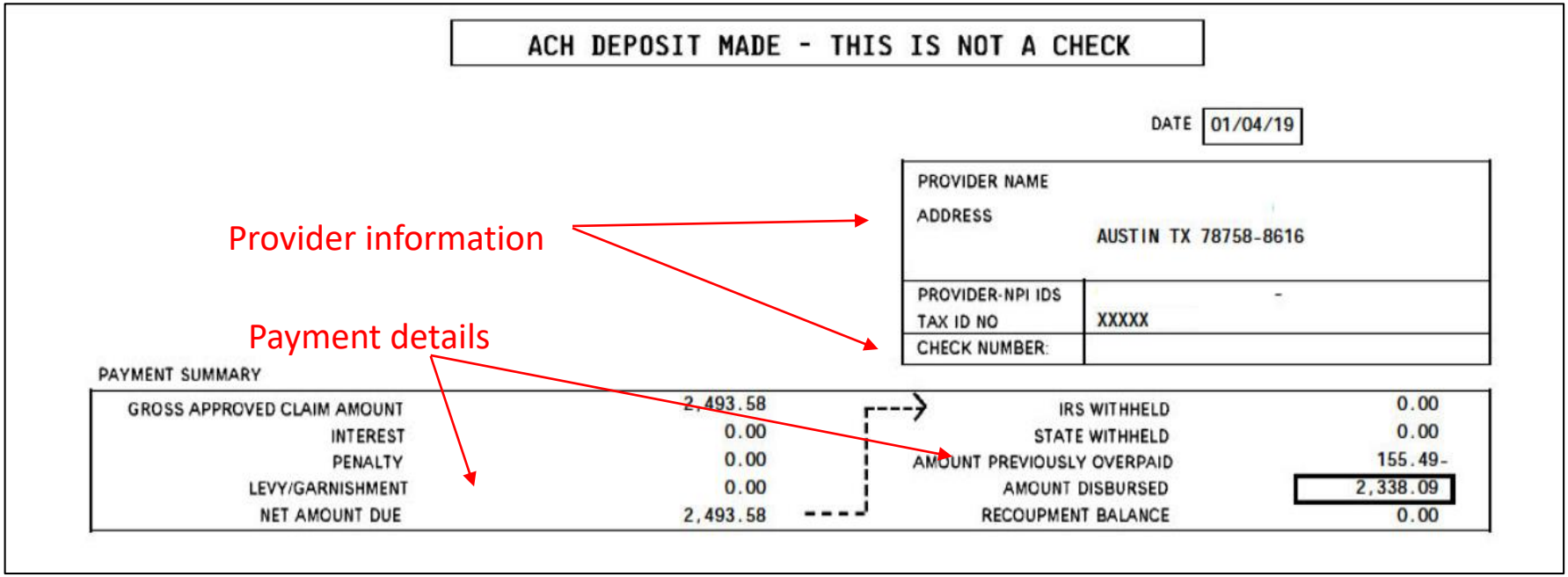
*EOP*s (cont.)

This portion of the *EOP* is the **payment summary**. This section includes provider information and payment details.



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*EOP*s (cont.)

The **body of the *EOP*** includes service detail columns and itemized claim information lines.

SERVICE DATE(S)	SERVICE/ REVENUE CODE(S)	COUNT/ DAYS	POS	CHARGE	ALLOWED	DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	CONTRACTUAL DIFFERENCE	TPP	PROV RESP AMOUNT	EXPL/ANSI CODE(S)	INSURED'S RESP AMOUNT	EXPL/ANSI CODE(S)	NET PAID
PATIENT NAME:					MEMBER ID:		STATE/ALT ID:			DRG#:				FOR INQUIRIES CALL:
PATIENT ACCOUNT#:					CLAIM NUMBER:		133306900000	TOB: 213		RECEIVED DATE:	05/17/2016			(800) 454-3730
SERVICE PROVIDER NAME:					SERVICE PROVIDER ID:			AUTH#:		EXPL CD:				APPEALS CODE: AG3
05/06/16 05/12/16	0100 0100	7	21	665.21-	665.21-	0.00	32.74-	0.00	0.00	0.00		0.00		632.47-
TOTAL:				665.21-	665.21-	0.00	32.74-	0.00	0.00	0.00		0.00		632.47-
INTEREST														0.00
	TOTAL NET PAID													632.47-

For more specific EOP training, please reach out to your facility's Provider Relations representative.

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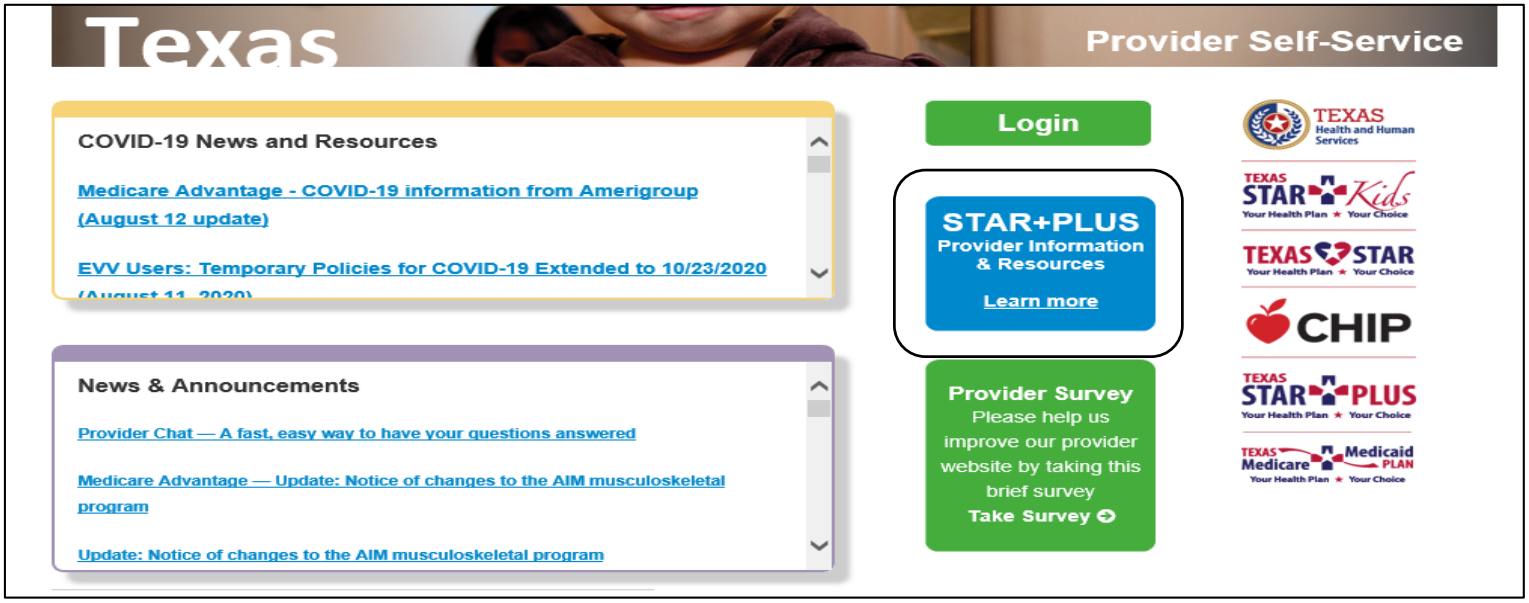
Nursing facility resources

There are many resources and documents available on the Amerigroup Provider Self-Service website at https://providers.amerigroup.com/TX.

Additional Nursing Facility-Specific Information is available in the link tied to the blue box labeled *STAR+PLUS Provider Information & Resources*.



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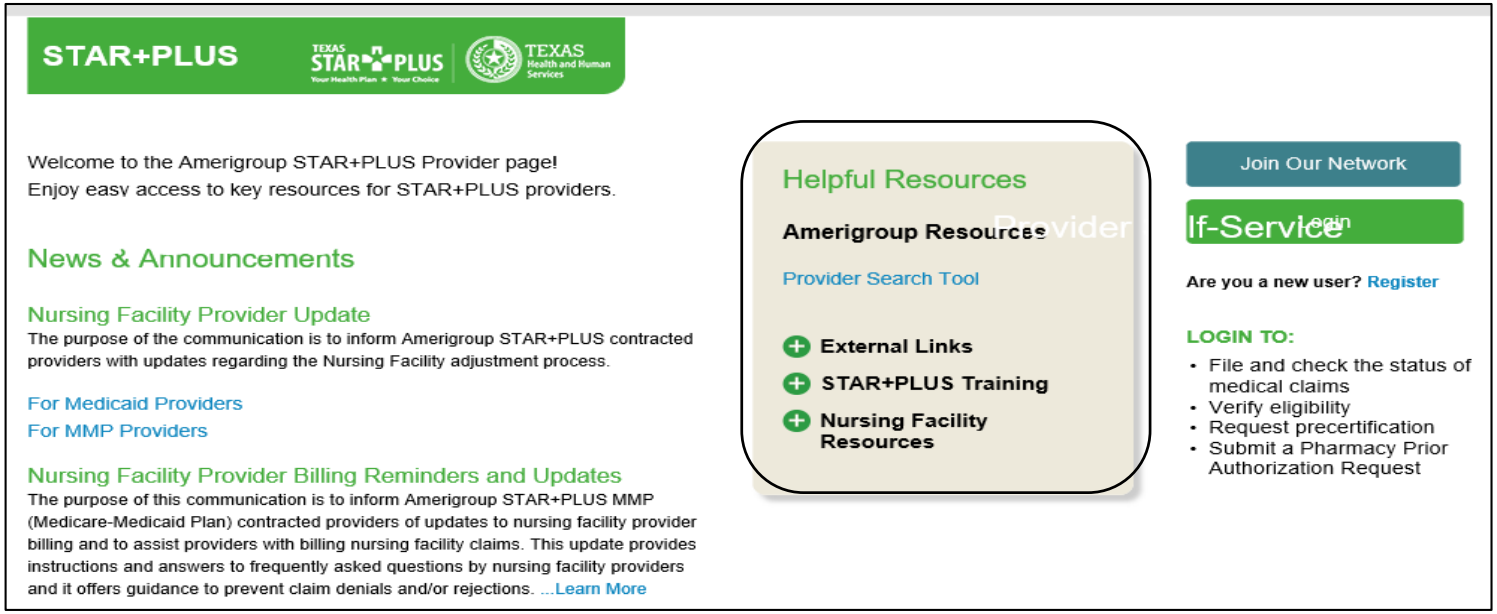
Nursing facility resources

After clicking on the blue link shown on the previous slide, you will find a beige box titled *Helpful Resources*. In this section, you will find a link to Nursing Facility Resources. Click the green + sign to expand the list of available documents.



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Interpreter services

Another resource Amerigroup provides is interpreter services to assist providers with any communication needs they may have for our members.

To utilize this resource, you can contact our Provider Services:

- Telephone services for those who are deaf or hard of hearing: **711**
- Non-English telephone services: **1-800-454-3730** (language line available)
- In-person interpretation: **1-800-454-3730**
- For MMP: **(1-855-878-1785)**

Services are available 24 hours a day, 7 days a week.

We recommend that providers call at least 24 hours prior to a member's office visit to request an interpreter.

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Electronic funds transfer (EFT) registration

- To receive **claims** payment through EFT, providers must register through **EnrollHub™**, a Council for Affordable Quality Healthcare (**CAQH**) Solutions™ enrollment tool – http://www.caqh.org/solutions/enro
- If the Tax ID is **not shared** with another provider, you can enroll at the Tax ID level. If you enroll a bank account for EFT at the Tax ID level, *all* payments for that Tax ID will route to that bank account. If the Tax ID **is shared** with another provider, it is highly recommended you enroll at the **NPI level**.
- QIPP EFT deposits cannot be updated through CAQH. Please contact your Provider Relations representative for an EFT form to update these types of deposits.
- Contact the CAQH Provider Help Desk at **1-844-815-9763** to resolve any issues.

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Electronic remittance advice (ERA) registration

- New ERA enrollments and account changes to existing ERA enrollments are managed through Availity, https://www.availity.com. From the main menu, select **More**, then **Payer List**.
- You will receive an email notification the ERA enrollment process is complete. From the time you are notified, allow an additional 48 hours before you start receiving ERAs.
- Once you begin receiving ERAs, you can import them into your billing system.
- The Help & Training option in Availity provides step-by-step instructions on ERA set up. Contact Availity at **1-800-282-4548** to resolve any issues.

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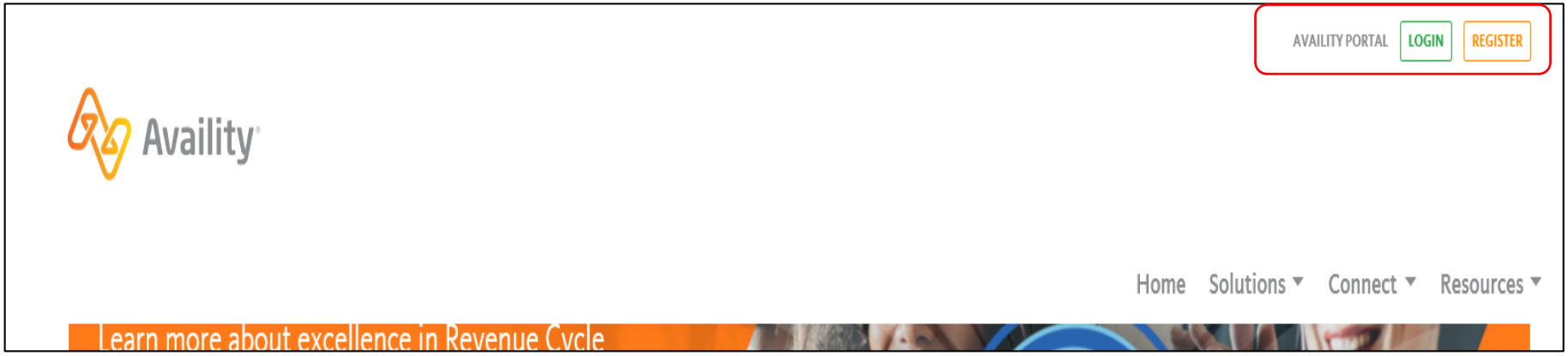
Logging into Availity

You can access the Availity portal at https://www.availity.com. If you are a new user to Availity, click on the orange **Register** link to sign up for services. If you are already a registered user, click the green Login link to access the portal.



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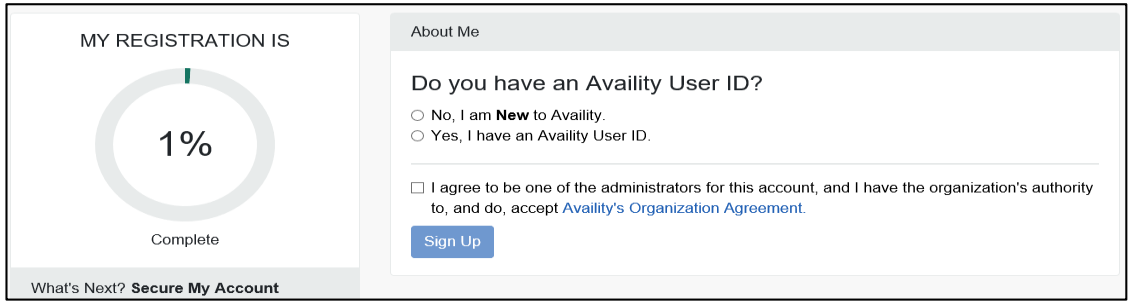
Availity registration

To register, select **Providers** as your organization type and then proceed with the next steps.



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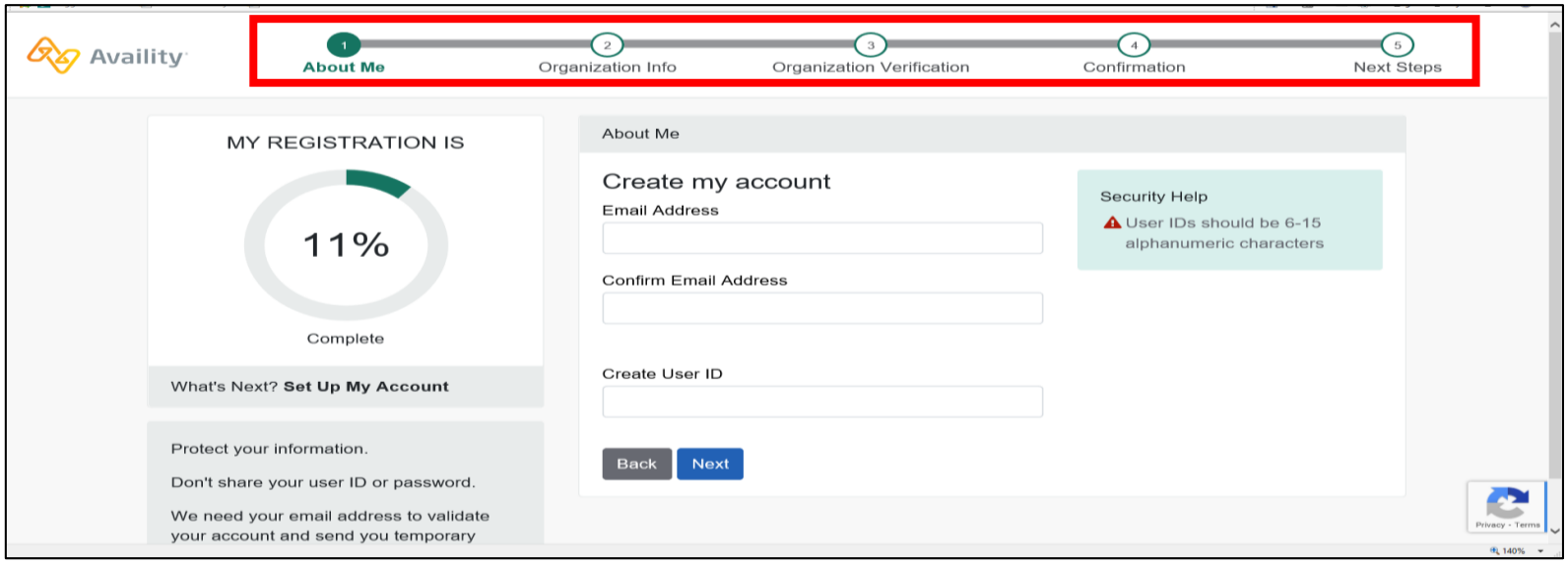
Availity registration (cont.)

To continue registration, after you have chosen **No, I am new to Availity**, you will then start the process by creating an account and go through each step in the red box to register your account with Availity. In the event you have any questions contact Availity at **1-800-AVAILITY (282.4548)**.



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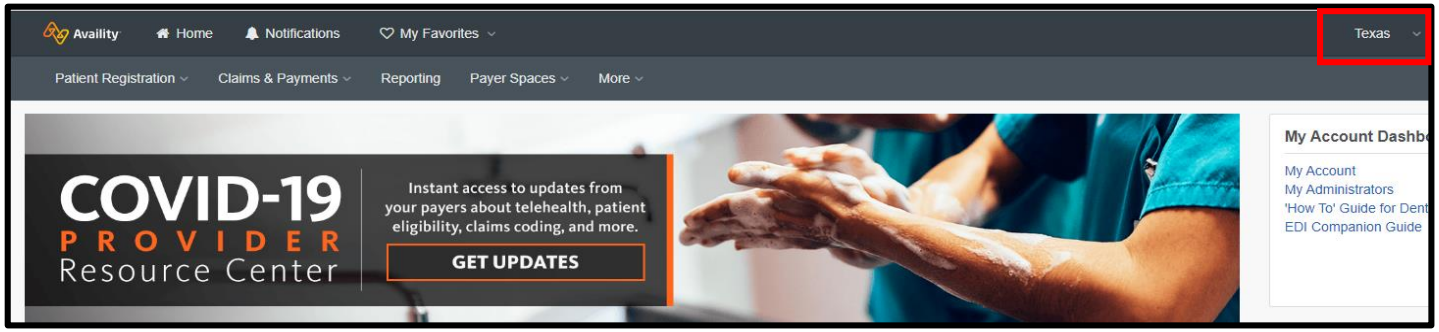
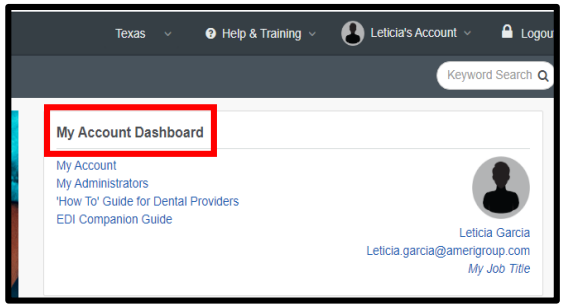
My account dashboard in Availity

Once logged into Availity, set your account to Texas. Use the navigation bar to locate all the transactions available to you in Availity.





Under My Account Dashboard, providers have the ability to modify their user access and manage their organization set up.

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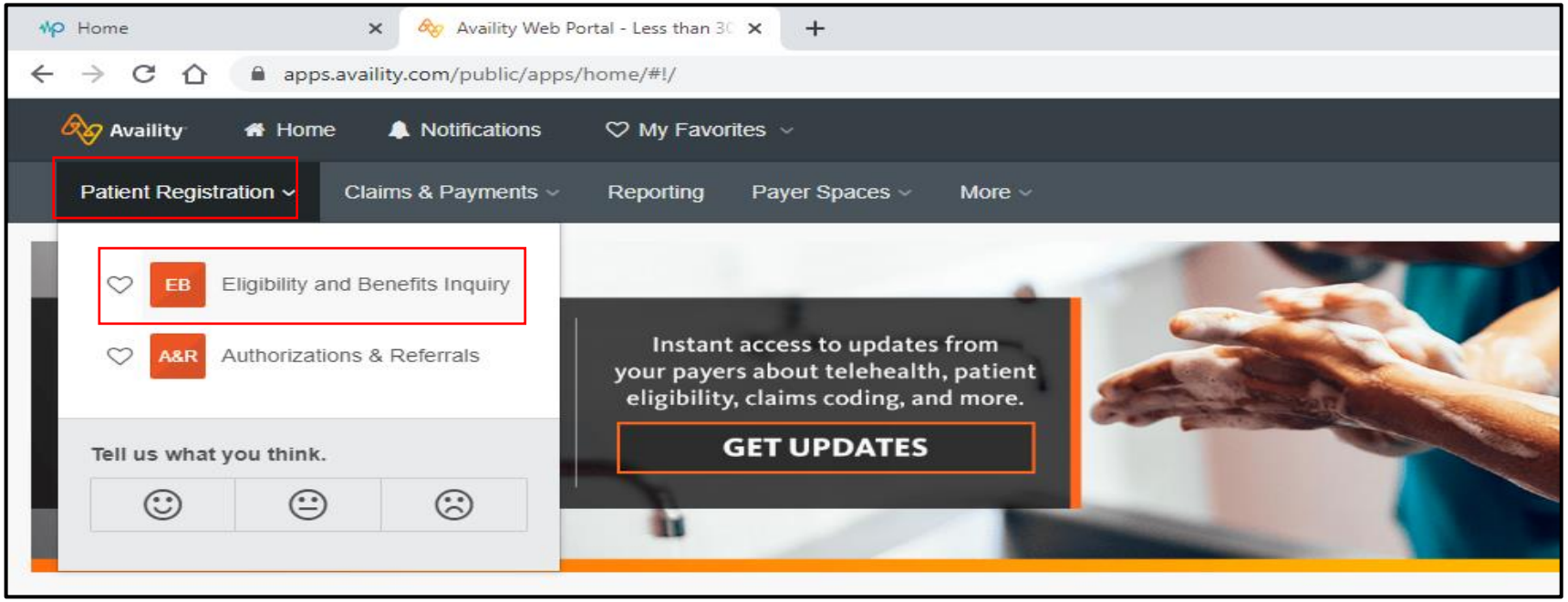
Verifying eligibility and benefits in Availity

Availity may be utilized to verify **Eligibility and Benefits** for a member by selecting the Patient Registration tab and then Eligibility and Benefits Inquiry.



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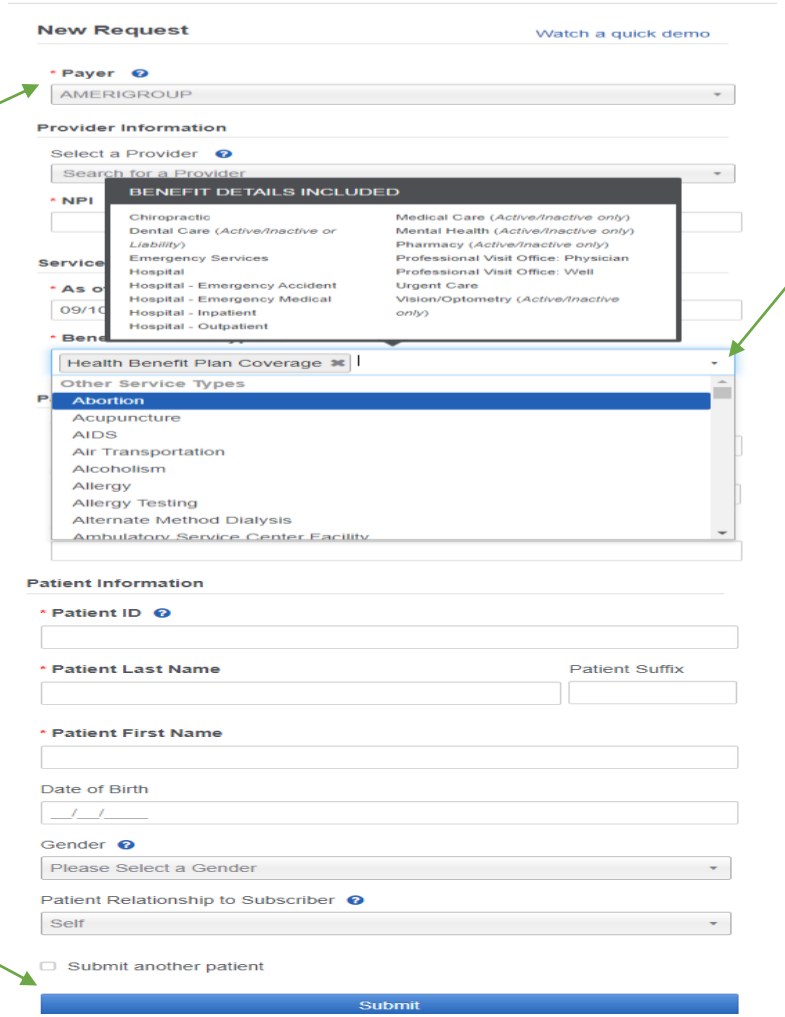
Verifying eligibility and benefits in Availity (cont.)

All fields with a red asterisk (*) must be completed when verifying benefits

Under New Request, select Amerigroup as the **Payer**.



In the **Benefit/Service Type** description box, select the appropriate type of service – Skilled Nursing Facility.

To submit inquiries for multiple members, click the check box next to **Submit another patient**. Then, you will select the blue **Submit** button, which will allow you to add members to a batch.

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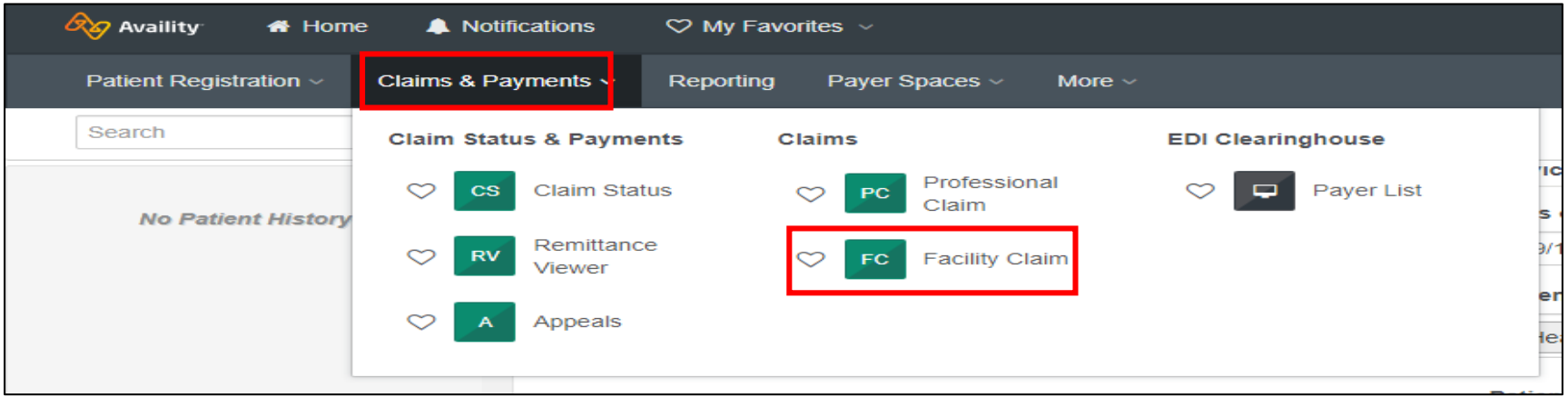
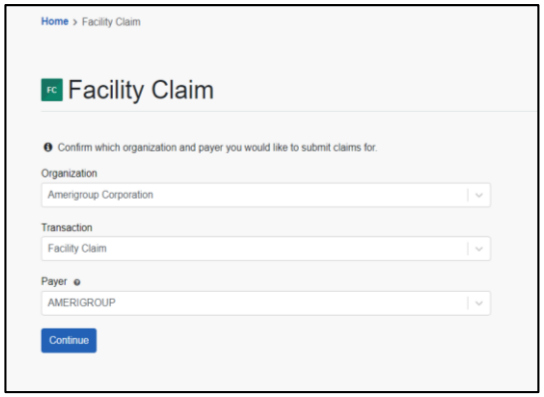
Submitting a facility claim in Availity

Availity allows providers to submit claims by choosing **Claims & Payments**, then **Facility Claim**.



Under Facility Claim a new screen appears requesting information regarding Organization, Transaction and Payer information.



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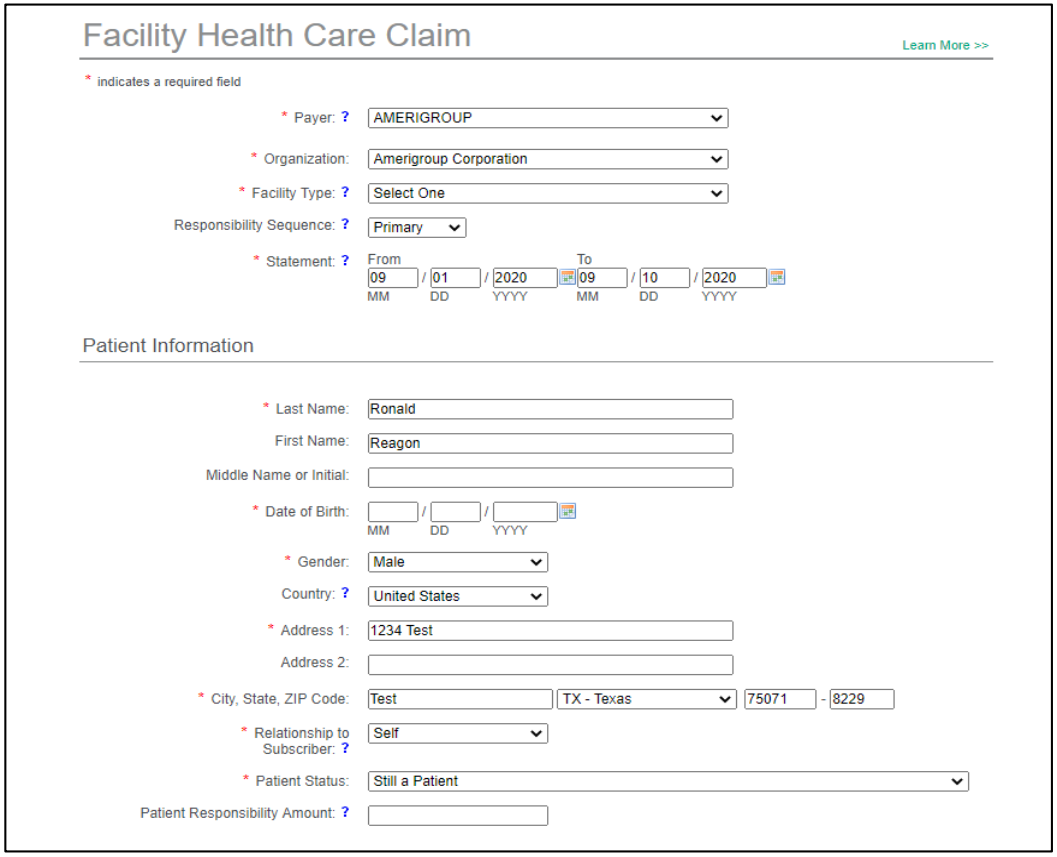
Submitting a facility claim in Availity (cont.)

In the ***Facility Health Care Claim*** form, all fields with a red asterisk (*) must be completed. If an error message appears when submitting a claim, the missing or incorrect information will appear in red. Questions marks (?) provide you specific information related to what is needed.



Facility Health Care Claim

Learn More >>

* indicates a required field

* Payer: ? AMERIGROUP

* Organization: Amerigroup Corporation

* Facility Type: ? Select One

Responsibility Sequence: ? Primary

* Statement: ? From 09 / 01 / 2020 (MM / DD / YYYY) To 09 / 10 / 2020 (MM / DD / YYYY)

Patient Information

* Last Name: Ronald

First Name: Reagon

Middle Name or Initial:

* Date of Birth: (MM / DD / YYYY)

* Gender: Male

Country: ? United States

* Address 1: 1234 Test

Address 2:

* City, State, ZIP Code: Test TX - Texas 75071 - 8229

* Relationship to Subscriber: ? Self

* Patient Status: Still a Patient

Patient Responsibility Amount: ?

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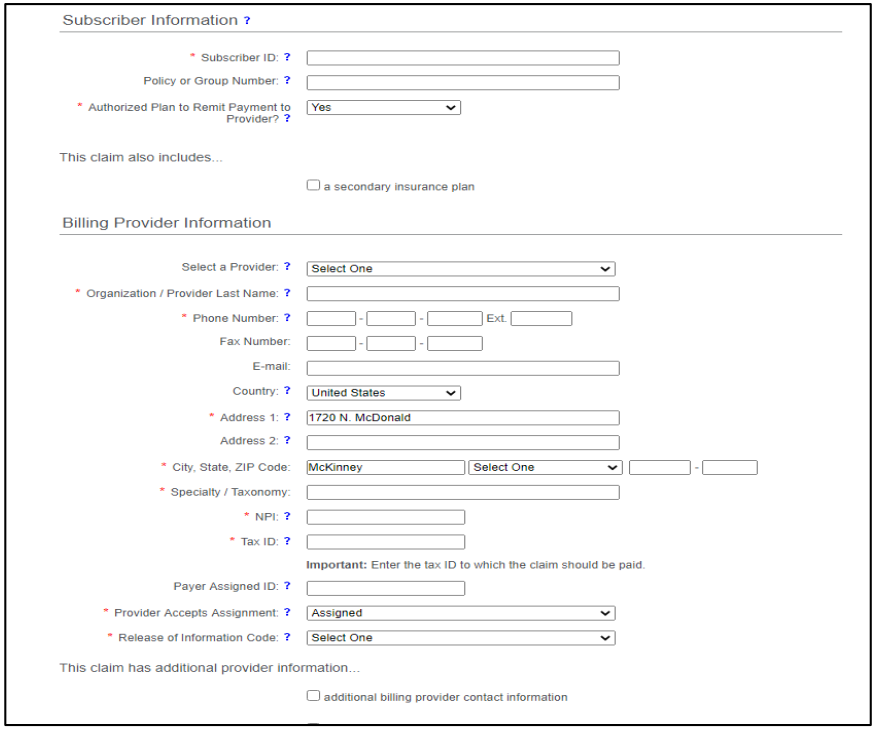
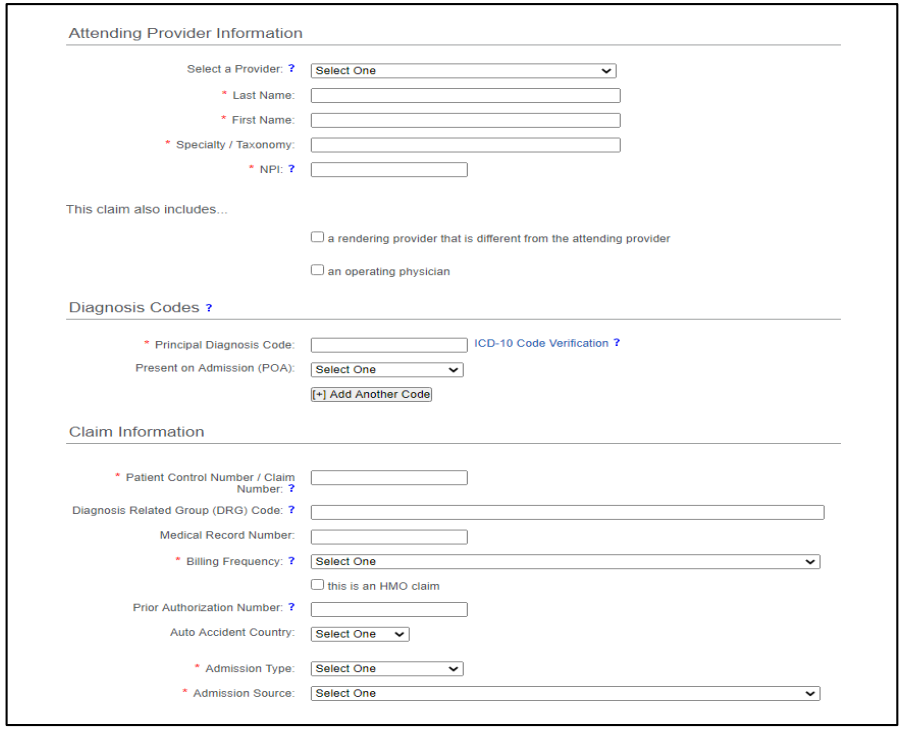
Submitting a facility claim in Availity (cont.)

Continue entering claim information in fields with red asterisks such as **Billing Provider**, **Attending Provider Information**, **Diagnosis Codes** and **Claim Information**. Many fields will prepopulate if you have pre-loaded your provider information in Availity.





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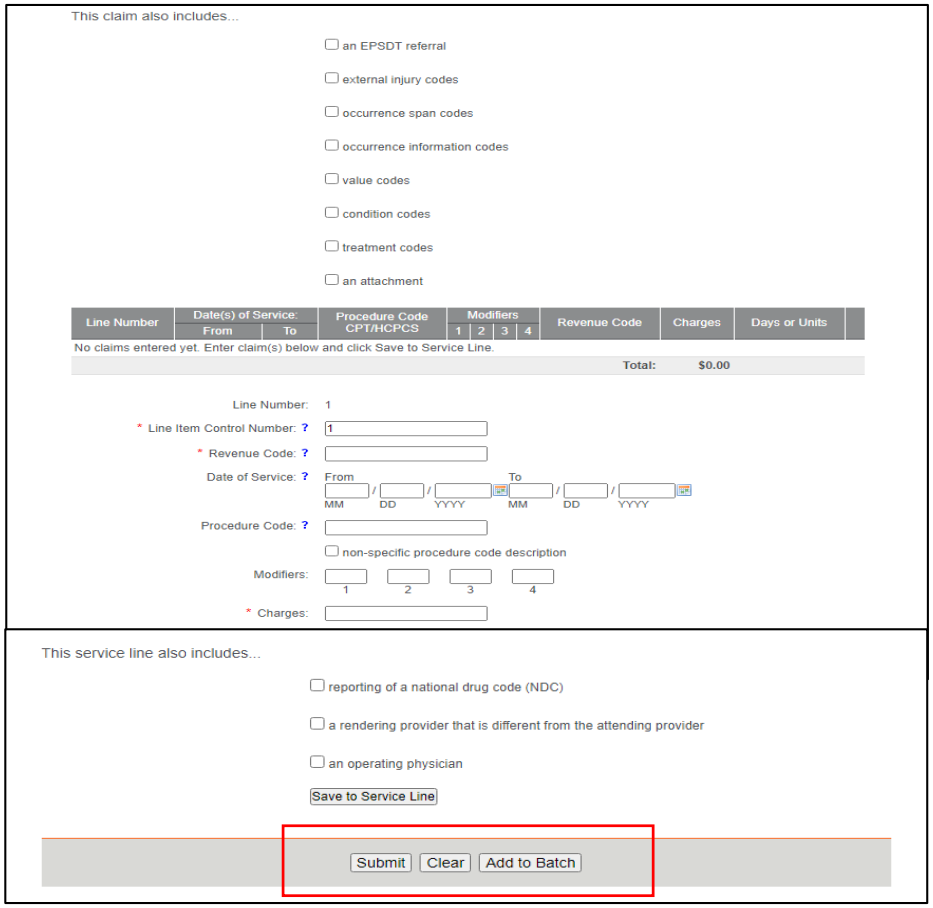
Submitting a facility claim in Availity (cont.)

Continue to enter claim information in fields with red asterisks. Upon completion of the required fields, select **Submit** for a single claim or **Add to Batch** for multiple claims.



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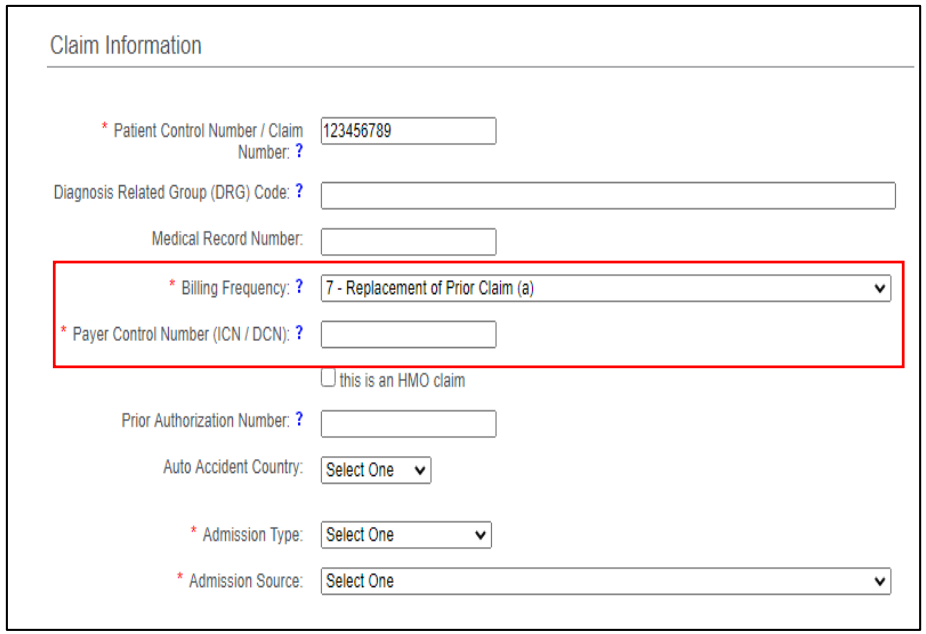
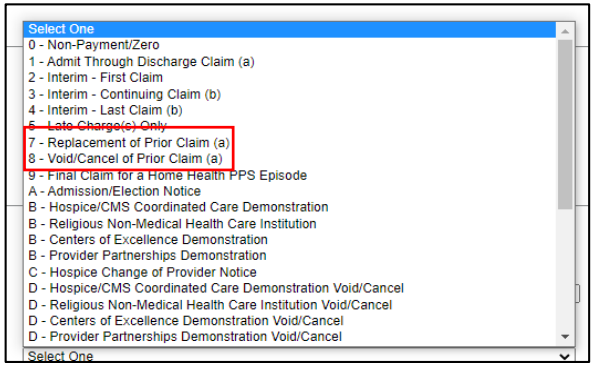
Submitting a corrected or voided claim in Availity

In the **Billing Frequency** field, select 7 for a corrected claim or 8 for a voided/cancelled claim. Under **Payer Control Number (ICN/DCN)**, enter the original claim number. All other fields are completed as with any other original claim.





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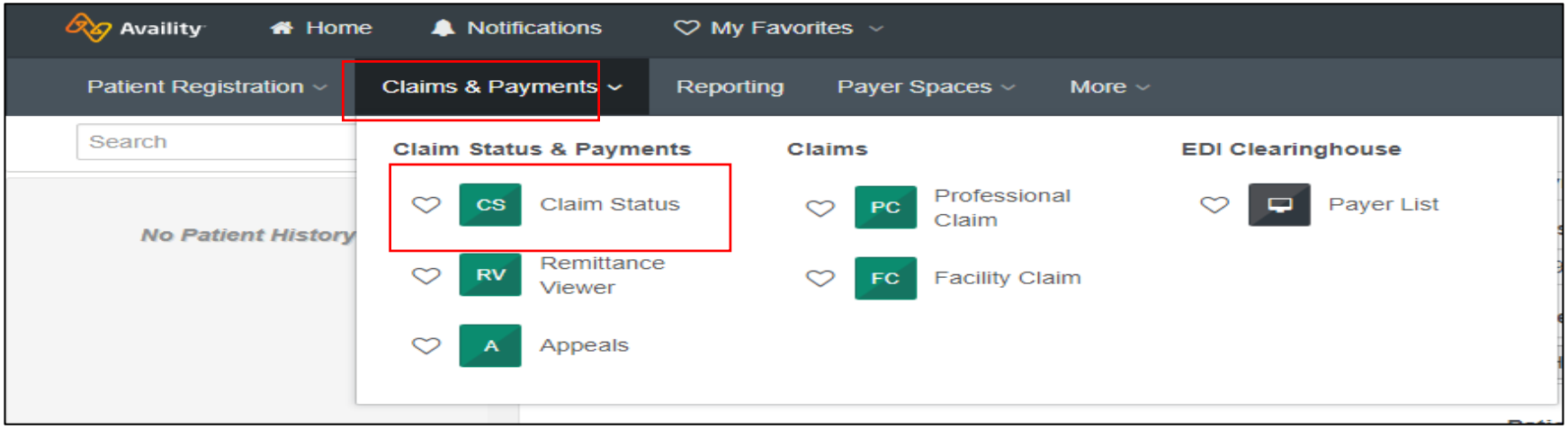
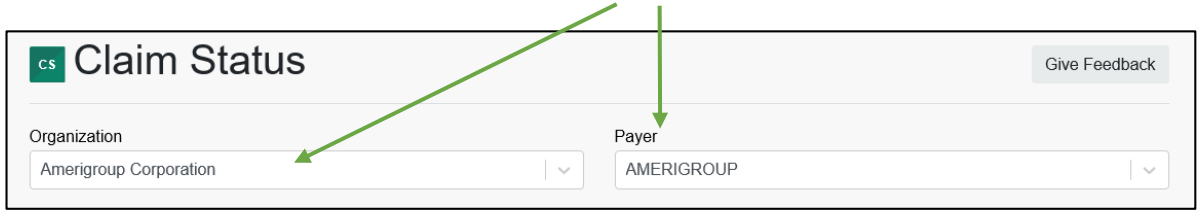
Reviewing a claim in Availity

Select **Claims & Payments**, then **Claim Status**. Next, choose the **Organization** and **Payer**.



Choose Organization and Payer



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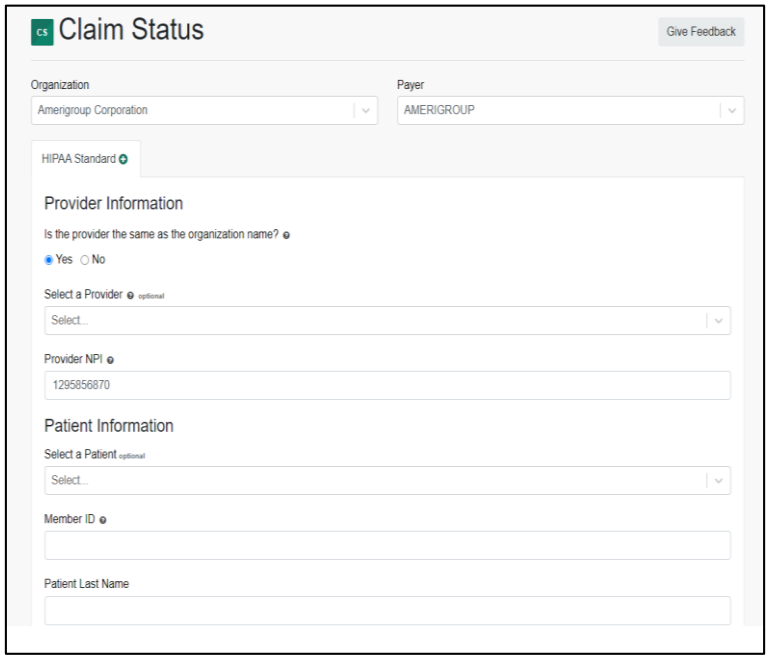
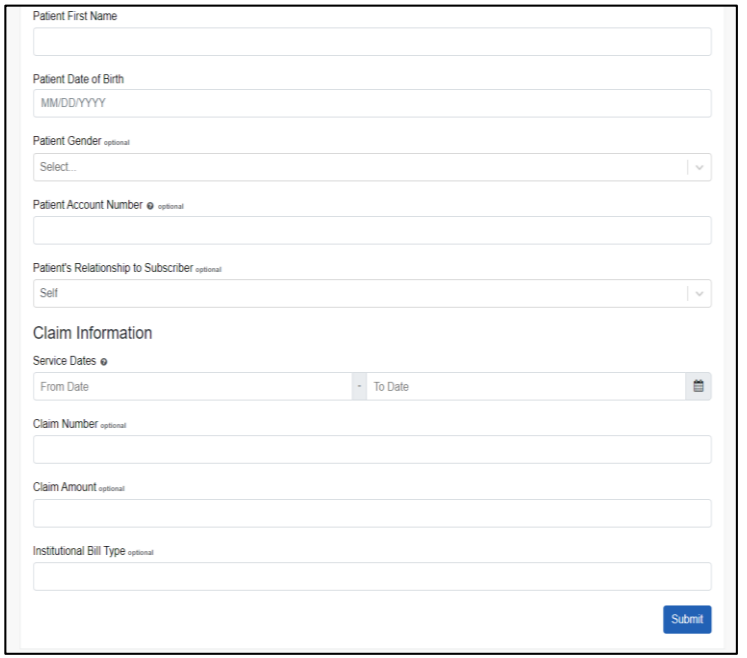
Reviewing a claim in Availity (cont.)

To view the status of a claim, the **Provider Information** must be entered, along with three member identifiers in the **Patient Information** fields. **Claim information** must also be filled out in order to move forward. Then, you would select **Submit**.





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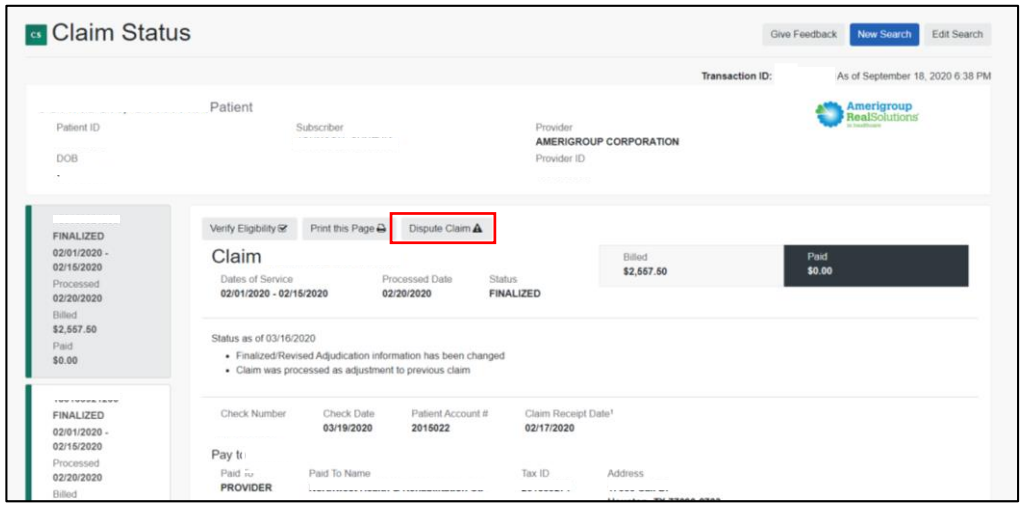
Submitting a claim payment dispute in Availity

Once you have completed the necessary fields, the claim information will populate. If in disagreement with the outcome of a claim, you have the ability to submit a *claim payment dispute* from this section. To initiate a dispute, select **Dispute Claim**. Availity allows you to dispute claims as far back as 24 months. Please keep in mind, if the claim did not pay correctly due to a billing error, you cannot use the dispute process. You must submit a corrected claim for those types of issues.



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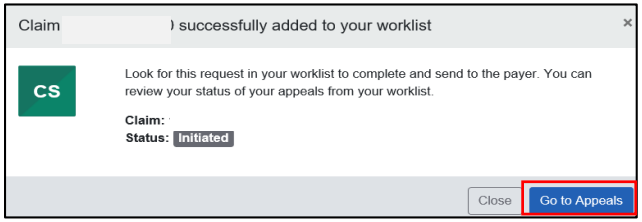
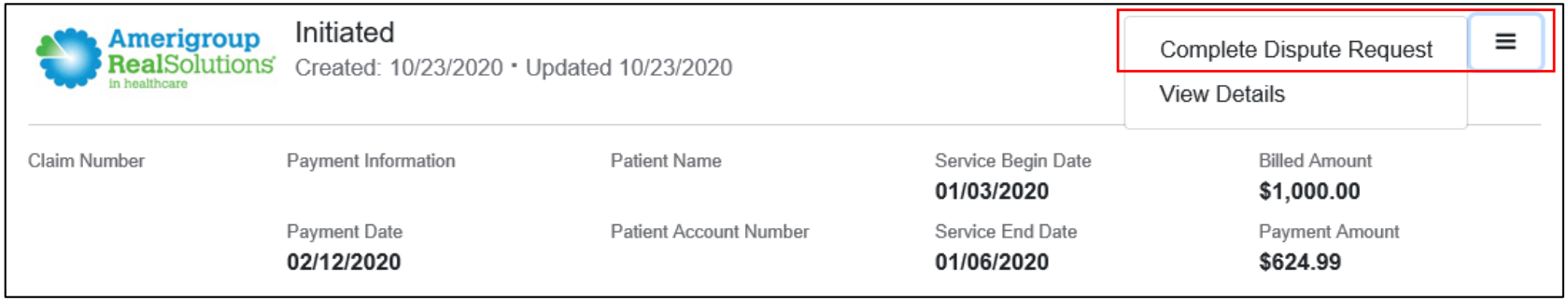
Submitting a claim payment dispute in Availity (cont.)

After you click Dispute Claim, you will receive a message informing you that this claim has been successfully added to your worklist. The status will show the dispute has been **Initiated**. From here, select **Go to Appeals**.



Next, select on the three stacked lines on the far right. Then, select **Complete Dispute Request**.



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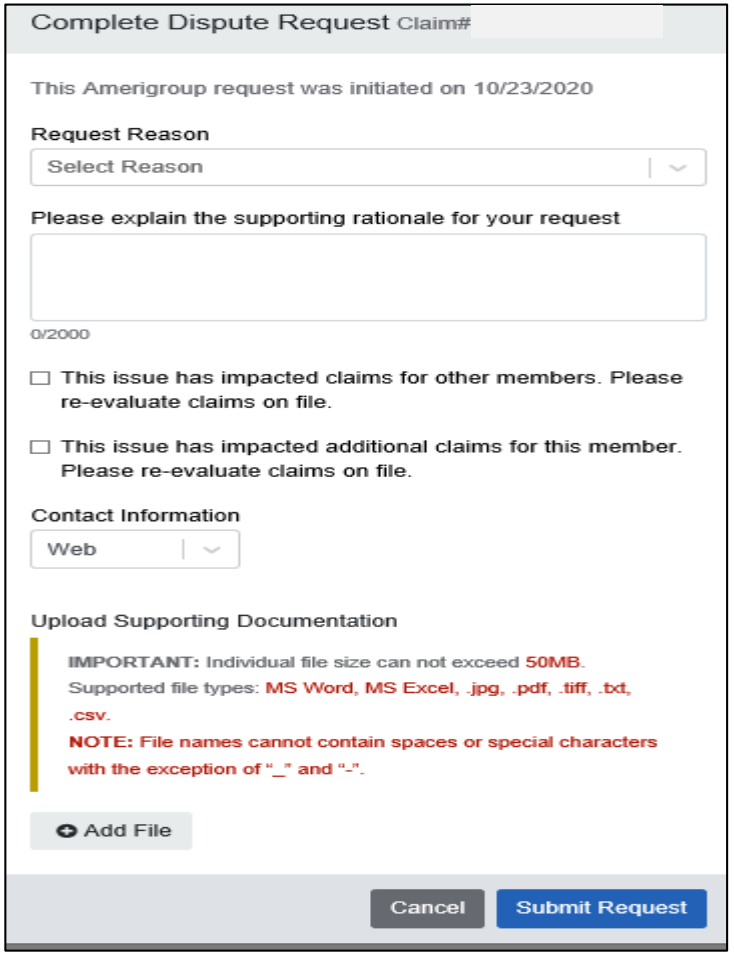
Submitting a claim payment dispute in Availity (cont.)

A box will appear allowing you to select a **Request Reason** as to why you are disputing the claim, as well as an **explanation** supporting your request.

You also have the ability to **dispute multiple claims** in one request:

- If this **same** issue has impacted claims for **other members**, you can check the first box.
- If this **same** issue has impacted additional claims for this **one member**, you can check the second box.
- In the notes, **be very specific** that you want multiple claims reviewed. Even if you check one of the boxes, you have to indicate in the notes you want all claims reviewed; otherwise, the claims team will only review the claim initially selected.

Upload any supporting documentation that could help your case. **Submit Request**.



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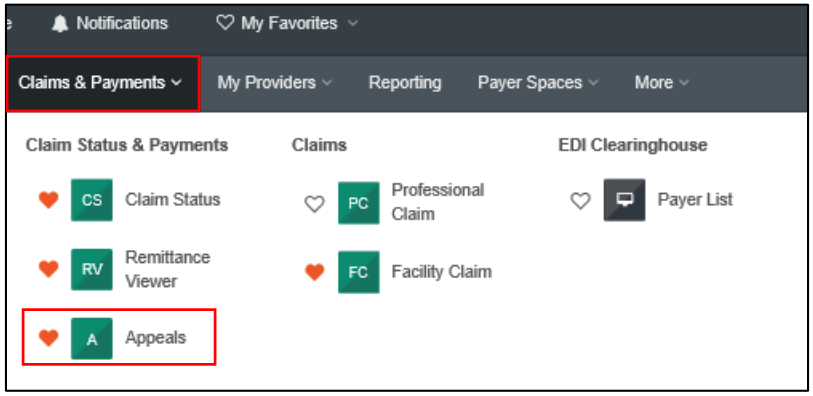
Requesting a second level review in Availity

To review and track submitted disputes, go to **Claims & Payments**, then **Appeals**.



A *Search By* and *Filter* option is available to narrow down your search criteria.

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Requesting a second level review in Availity (cont.)

Dispute response from Amerigroup will either be **Overturned**, **Upheld**, or **Dismissed**. If the dispute is upheld or dismissed, you can request that your dispute be re-reviewed. Select the three stacked lines on the far right and **Request another review**. You will follow the same steps as the initial dispute; however, this time, in the notes be more specific if necessary and be sure to upload any supporting documentation.

If you are still not satisfied with the outcome of your dispute after your second level review, you can then reach out to your Amerigroup Provider Network Relations Consultant for assistance.

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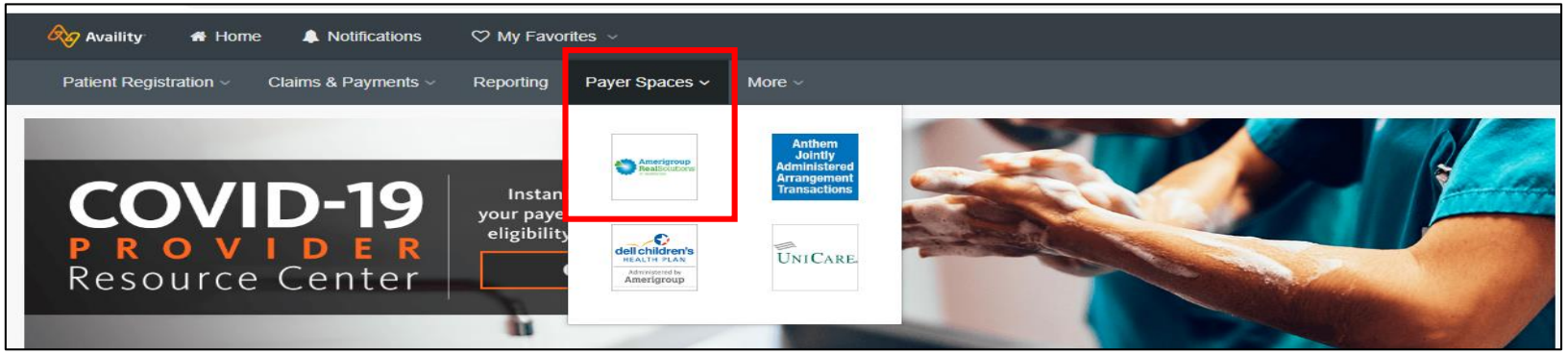
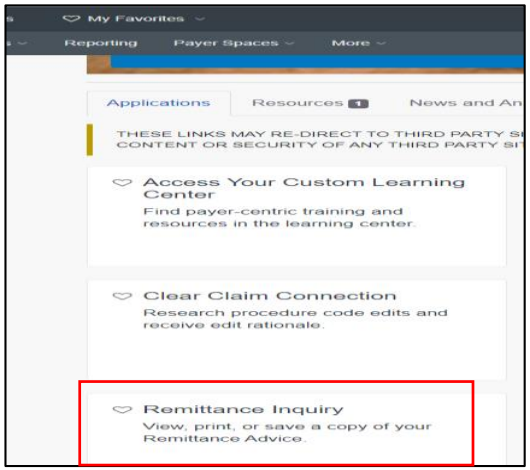
Viewing a remittance advice in Availity

From the Availity home page, select **Payer Spaces**, then select **Amerigroup** from the list of payer options. From the *Applications* tab, select **Remittance Inquiry**.





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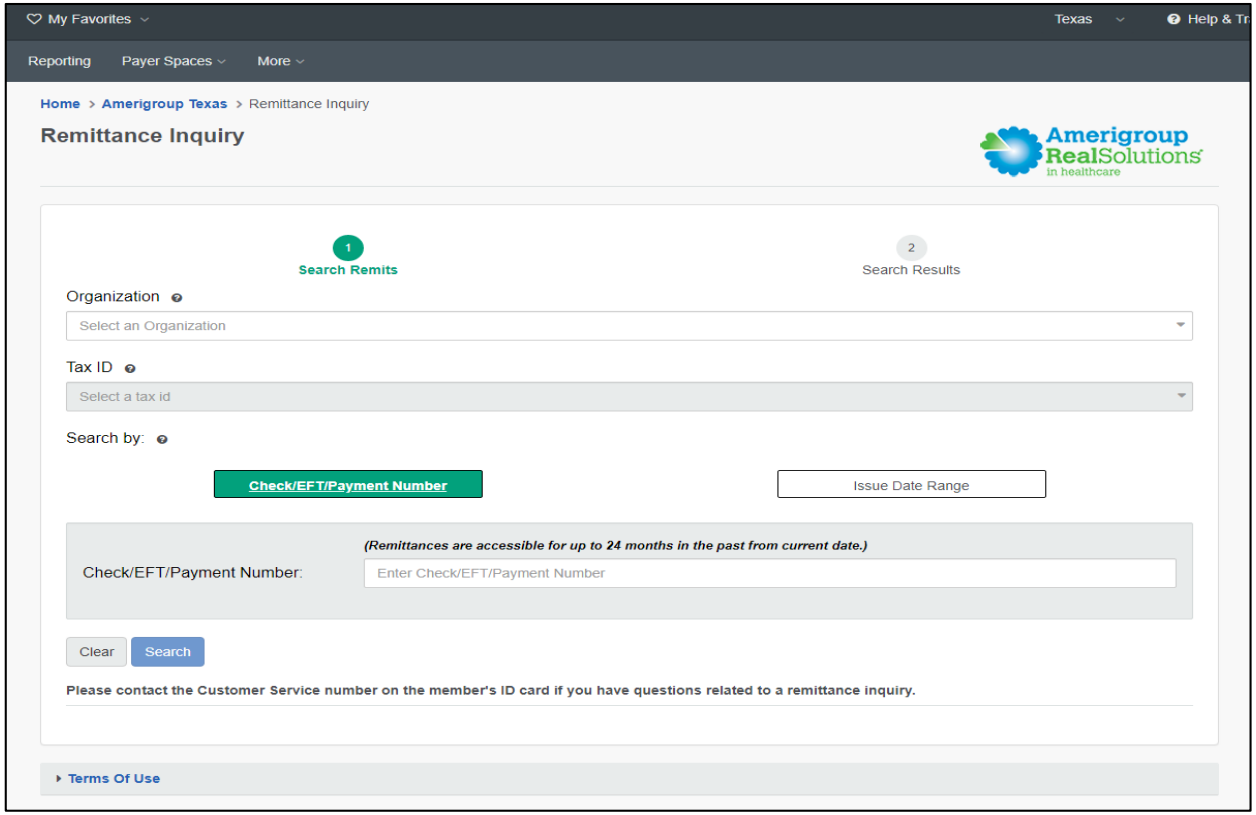
Viewing a remittance advice in Availity (cont.)

After selecting the **Organization**, select the **Tax ID** number from the drop-down list. The Search by feature allows you to sort your results by **Check/EFT/Payment Number** or **Issue Date Range**.



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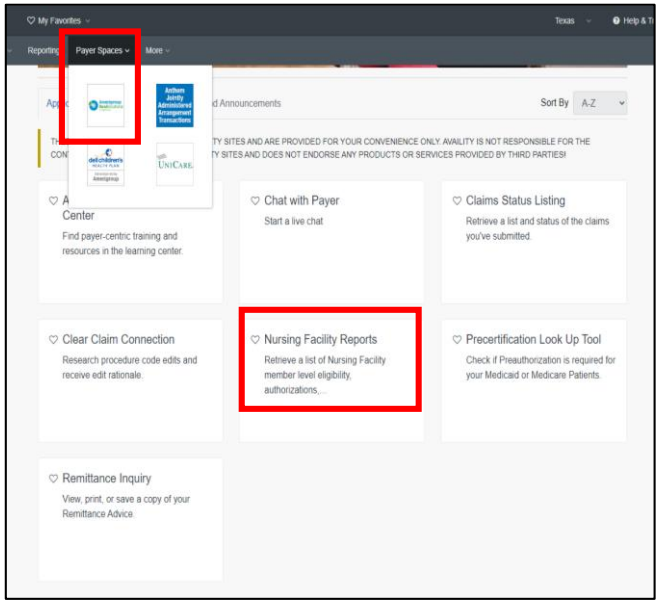
Accessing reports in Availity

Under **Payer Spaces** in Availity, select **Amerigroup** then **Nursing Facility Reports**. After entering organization and provider information, you have the option of a **Report Type Selection**.



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Amerigroup provider services team

Your **Amerigroup Support System** includes your **Service Coordinator**, **Network Relations Consultant** and your Nursing Facility **Provider Services Hotline** at **1-866-696-0710** option **6**.

Name	Title	Email	Phone #
Arlene Salazar	PR Manager	Arlene.salazar@amerigroup.com	**1-210-319-8899**
Cheryl Green	Network Relations Consultant	cheryl.green@amerigroup.com	**1-800-454-3730, ext. 106-123-8059**
Deborah Robertson	Network Relations Consultant	deborah.robertson@amerigroup.com	**1-800-454-3730, ext. 106-122-0025**
Leticia Garcia	Network Relations Consultant	leticia.garcia@amerigroup.com	**1-800-454-3730, ext. 106-124-3041**
Pearl Adkison	Network Relations Consultant	pearl.adkison@amerigroup.com	**1-800-454-3730, ext. 106-124-0072**
Rikki Smith	Network Relations Consultant	rhonda.smith@amerigroup.com	**1-800-454-3730, ext. 106-124-8120**
Shawncy Watts	Network Relations Consultant	shawncy.watts@amerigroup.com	**1-800-454-3730, ext. 106-126-3036**
Timothy Matthews	Network Relations Consultant	timothy.matthews@amerigroup.com	**1-800-454-3730, ext. 106-122-0023**

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Amerigroup provider services team (cont.)

For a listing of Provider Network Relations Consultants by facility, please visit our website at https://providers.amerigroup.com/Public%20Documents/TXTX_NFPRRepList.pdf. The Provider Services triage and escalation process is outlined below.

First-level contact: Nursing Facility Provider Hotline

1-866-696-0710, Option **6**

↓

Second-level contact: Provider Network Relations Consultants

1-866-696-0710 (Extensions for each representative are listed on slide 93 and on the Amerigroup website)

↓

Third-level contact: Provider Network Relations Manager

Arlene Salazar – **1-210-319-8899**

↓

Fourth-level contact: Provider Network Relations Director

Marcella A. Webb – **1-806-473-8408**

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Amerigroup clinical services team

For a listing of service coordinators by facility, please visit our website at https://providers.amerigroup.com/Public%20Documents/TXTX_NF_ServiceCoordAssignments.pdf. The clinical triage and escalation process is listed below.

First-level contact: Precertification Hotline

1-866-696-0710, Option **5**; Fax: 1-**844-206-3445** (STAR+PLUS), **1-888-235-8468** (MMP Part B)

↓

Second-level contact: Service Coordinators

1-866-696-0710, Option **4** (Individual extensions are listed on the Amerigroup website)

↓

Third-level contact: Service Coordinator Managers

Manager names, emails, and phone numbers listed by service area on the Amerigroup website

↓

Fourth-level contact: Service Coordinator Directors

STAR+PLUS: Rachel Poe, BSN, RN, **1-512-495-7405**; MMP: Gloria Burton, LMSW, CCM, **1-832-577-8400**

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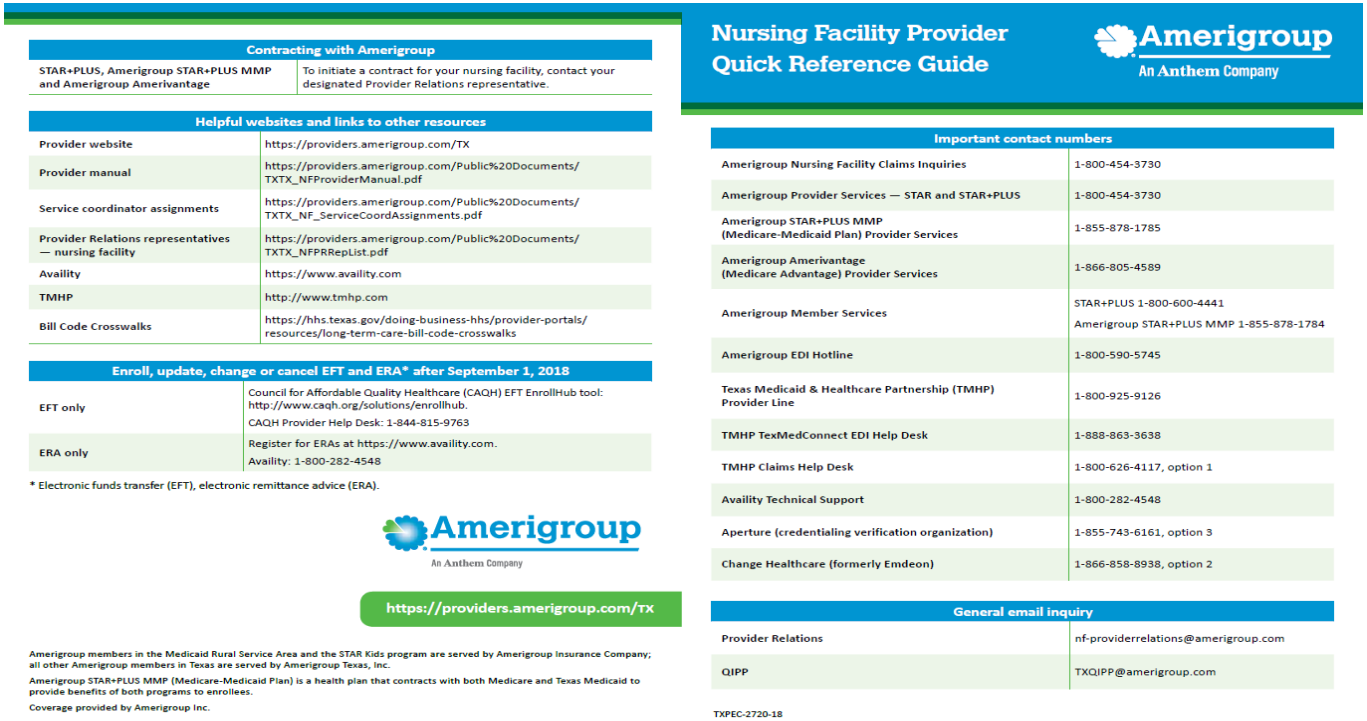
Nursing Facility Provider Quick Reference Guide

https://providers.amerigroup.com/Public%20Documents/TXTX_CAID_NFQuickReferenceSheet.pdf



Contracting with Amerigroup	
STAR+PLUS, Amerigroup STAR+PLUS MMP and Amerigroup Amerivantage	To initiate a contract for your nursing facility, contact your designated Provider Relations representative.

Helpful websites and links to other resources	
Provider website	https://providers.amerigroup.com/TX
Provider manual	https://providers.amerigroup.com/Public%20Documents/TXTX_NFProviderManual.pdf
Service coordinator assignments	https://providers.amerigroup.com/Public%20Documents/TXTX_NF_ServiceCoordAssignments.pdf
Provider Relations representatives — nursing facility	https://providers.amerigroup.com/Public%20Documents/TXTX_NFPRRepList.pdf
Availity	https://www.availity.com
TMHP	http://www.tmhp.com
Bill Code Crosswalks	https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/long-term-care-bill-code-crosswalks

Enroll, update, change or cancel EFT and ERA* after September 1, 2018	
EFT only	Council for Affordable Quality Healthcare (CAQH) EFT EnrollHub tool: http://www.caqh.org/solutions/enrollhub. CAQH Provider Help Desk: 1-844-815-9763
ERA only	Register for ERAs at https://www.availity.com. Availity: 1-800-282-4548

* Electronic funds transfer (EFT), electronic remittance advice (ERA).

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https://providers.amerigroup.com/TX

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.

Coverage provided by Amerigroup Inc.

Nursing Facility Provider Quick Reference Guide

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Important contact numbers	
Amerigroup Nursing Facility Claims Inquiries	1-800-454-3730
Amerigroup Provider Services — STAR and STAR+PLUS	1-800-454-3730
Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) Provider Services	1-855-878-1785
Amerigroup Amerivantage (Medicare Advantage) Provider Services	1-866-805-4589
Amerigroup Member Services	STAR+PLUS 1-800-600-4441 Amerigroup STAR+PLUS MMP 1-855-878-1784
Amerigroup EDI Hotline	1-800-590-5745
Texas Medicaid & Healthcare Partnership (TMHP) Provider Line	1-800-925-9126
TMHP TexMedConnect EDI Help Desk	1-888-863-3638
TMHP Claims Help Desk	1-800-626-4117, option 1
Availity Technical Support	1-800-282-4548
Aperture (credentialing verification organization)	1-855-743-6161, option 3
Change Healthcare (formerly Emdeon)	1-866-858-8938, option 2

General email inquiry	
Provider Relations	nf-providerrelations@amerigroup.com
QIPP	TXQIPP@amerigroup.com

TXPEC-2720-18

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Additional training opportunities

- Our Nursing Facility Provider Relations team offers **monthly webinars**. The webinar schedule can be found on the Amerigroup provider website at https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_LTSSProvOrientation.pdf.
- Additional **topic-specific training** is available on the Amerigroup provider website https://providers.amerigroup.com/Pages/starplus.aspx.
- Providers can also reach out to their Network Relations Consultants for additional training opportunities.

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Questions?

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* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup. DentaQuest is an independent company providing emergency dental services on behalf of Amerigroup. IngenioRx is an independent company providing pharmacy benefit management services on behalf of Amerigroup.