



# 2022 provider network town hall

# Reminder



Please mute your phone.

Raise your hand to ask questions.

Option to enter questions/comment in Q&A box.

# Q1 agenda

## Welcome:

- Opening statement – Anthony Woods
- Legislative rate increases – Caitlin Safford
- System updates – De'Shanel Childs
- Health Care Authority (HCA) NPI rejection edit – Jennifer Lane
- Digital enhancements – Brittany Davis
- Electronic funds transfer (EFT) enrollment – Brittany Davis
- Open discussion with panelists

# Q2 agenda

## Welcome:

- Opening statement – Anthony Woods
- System updates – Chris Kearney
- SERI update and Amerigroup Washington, Inc. fee schedule – Caitlin Safford
- ConferMED – Maryann Souza/Daren Anderson, MD
- Availity\* chat – Brittany Davis
- Provider manual overhaul – Brittany Davis
- EFT enrollment – Abigail Osborne-Elmer
- HCA NPI edit – Abigail Osborne-Elmer

# Q3 agenda

## Welcome:

- Opening statement – Anthony Woods
- Introduction of new Director of Operations – Kristie Smothers
- System configuration updates – Caitlin Safford
- NPI enrollment and rejection changes – Caitlin Safford
- HCA NPI rejection edit – Abigail Osborne-Elmer
- Provider satisfaction survey – Abigail Osborne-Elmer
- Availity Essentials updates – Nora Chivers & Tammy Deak
- Open discussion with panelists

# Q4 agenda

## Welcome:

- Opening statement – Anthony Woods
- System configuration updates – Kristie Smothers
- Legislative increase update – Mattie Osborn
- Changes to Behavioral Health (BH) team – Amanda Bieber-Mayberry
- Appointment availability and after-hours survey – Brittany Davis
- HCA NPI rejection edit – Abigail Osborne-Elmer
- Open discussion with panelists

# Q4 System configuration updates

- **Medicare *EOB*** – System is configured to accept claims without requiring a Medicare *EOB* for certain taxonomy codes.
- **CPT 80305 SERI *Clinical Laboratory Improvement Amendments (CLIA)* denials** – System configuration is complete to allow CPT 80305 without a *CLIA* certificate for Behavioral Health Agency (BHA) providers.
- **CPT 90619 SL** – Configuration is complete to allow payment of this code; impacted denied claims are being reprocessed.

# Changes to BH clinical teams

- On December 5, 2022, the BH clinical teams at Amerigroup will be delegated to Beacon Health Options.\*
- This will include Utilization Management, Case Management, and Shared Service teams, such as non-clinical intake and after hours.
- The delegation is limited to clinical services and will **not** impact services involving contracting (network), claims, network relations, and grievances and appeals.
- There will be no changes to existing market operations; the interactions our members and providers receive day-to-day will remain the same.
- Amerigroup is committed to and focused on advancing whole person care, empowering individuals, and driving population health.
- The BH clinical teams will have more availability, provide better support to members, and be more focused on quality care outcomes.



# Appointment availability and after-hour survey

- Physical health and BH providers are required to abide by the following HCA standards:
  - Phone service for members must be 24 hours a day, 7 days a week. A 24-hour phone service may be used; the service may be answered by a designee, such as an on-call physician and/or nurse practitioner with physician backup.
  - A provider (or another physician) must be available to provide medically necessary services.
  - It is not acceptable to automatically direct the member to the emergency department (ED) when the PCP is not available.
  - Follow the referral/prior authorization guidelines; this is a requirement for covering physicians.
- Amerigroup conducts annual phone surveys to verify provider appointment availability and after-hours access standards are met.
- Providers will be asked to participate in this survey each year. If you do not meet the standards, your organization will be placed on corrective action until you become compliant with the HCA standards previously outlined.

# Access and availability standards for physical health providers

- PCPs are required to abide by the following standards to ensure physical health access to care for our members:

Type of care	Standard
Emergency	Immediately treat or refer to ED
Urgent care	Within 24 hours
Nonurgent sick care	Within 10 calendar days
Routine or preventive care	Within 30 calendar days
Transitional healthcare by a PCP	Shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or BH disorders or discharge from a substance use disorder treatment program

# Access and availability standards for BH providers

- BH providers are required to abide by the following standards to ensure BH access to care for our members:

Type of care	Standard
Emergency	Immediately treat or refer to ED
Non-life-threatening emergency	Treat within six hours or refer to ED
Urgent care	Within 24 hours of referral
Nonurgent sick care (routine)	Within 10 calendar days
Routine or preventive care	Within 30 calendar days

# Legislative rate increases

## Primary care and family planning providers:

- October 1 rate increases have been loaded in our system and all affected providers should be seeing these increases.

## Specialty BH rate increases:

- For BH capitated providers:
  - Increase has been included in monthly capitation.
  - Retroactive payment from April 1 to October 1 has been paid.
- For fee-for-service (FFS) providers:
  - Decision has been made to provide a lump sum settlement payment for the retro increases – This is currently in process.
  - Estimated completion date: four weeks.
- For PACT/WISe/IRT invoicing providers:
  - Increase has been included in monthly capitation based on new contract stipulations.
  - Retroactive payment from April 1 to October 1 has been paid.

# System updates



- **Behavioral health services only (BHSO) taxonomy** – For BHSO members, Amerigroup implemented a claims edit to deny any BH claims not billed with the appropriate BH taxonomy outlined in SERI. Upon implementation, an error was identified and caused erroneous denial reasons indicating that the claim should be *billed to the State*. System corrections were completed January 24, 2022, and Amerigroup is working to reprocess claims.
- **Medicare EOB** – For providers who are unable to bill Medicare, Amerigroup had a system issue causing erroneous denials and requested providers attach Medicare EOBs to their Apple Health claims. System corrections were implemented January 1, 2022, and Amerigroup is working to reprocess claims.
- **S, H, T codes** – Amerigroup implemented a claims edit to deny claims billed with S, H, and T codes. The claims were denying with a QA0 denial for primary carrier EOP and determined the edit inadvertently also included COB exception codes. This update was completed August 16, 2021, and impacted claims were reprocessed December 20, 2021.

# System updates



- **BHSO taxonomy: remediation of facility requirement:**
  - For BHSO members, Amerigroup implemented a claims edit for specific services to be reimbursed through HCA. A configuration error included facilities in the process.
  - Remediation complete May 3. Claim sweep to reprocess claims underway ECD June 30.
- **CLIA requirement: 80305 with HH/HD/HZ/U5 modifiers does not require CLIA number:**
  - System configuration expected by June 5, 2022.
  - Recurring claim sweeps until system configuration complete. Initial claim sweep completed May 10, includes April 1, 2021, to April 27, 2022.
  - Question submitted to HCA to clarify use of federal taxonomies in addition to those published in SERI guidelines.
- **POS 10 system update:**
  - January 1 update to allow telehealth services rendered when member is at home.
  - Amerigroup completed system update April 13.
  - A claim sweep was completed to process claims denied in error on May 3.
- **T1015 updates:**
  - Multiple units (OB claims): configuration ECD June 5.
  - Billing vs. servicing taxonomy: final configuration solution identified and in testing.
  - E2E T1015 assessment underway.
- **July 1, 2022, DRG and EAPG fee schedule update:**
  - Amerigroup is expecting HCA DRG and EAPG rate updates by June 1.
  - Amerigroup will update DRG and EAPG fee schedules within 60 days of state publication.
  - Amerigroup will meet with hospital partners individually to discuss remediation activities based on contract language should rate adjustments exceed 60-day implementation timeframe.

# BH updates

- SERI updates to be implemented July 1:
  - Our system will be prepared with the new changes to SERI that are coming July 1.
- New BH fee schedule:
  - We have developed a BH fee schedule that aligns with all SERI coding; we are transitioning current FFS providers to this fee schedule over the next quarter.
- 7% BH rate increase:
  - We are tracking the timing of the January 1, 2023, 7% rate increase for providers.
  - For providers who have capitation in your contracts, timeliness of the increase requires partnership, and we will need timely amendment signatures.
  - We will be sharing more about the timeline in our Q3 town hall.

# System configuration updates

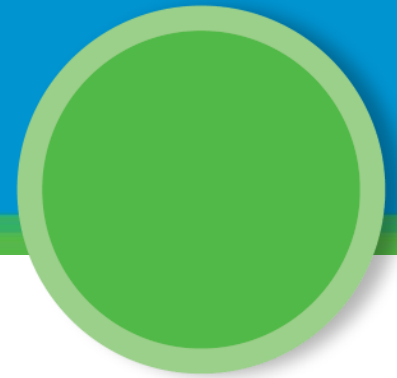
- POS 2, 93, and FQ modifier configuration:
  - Our system is updated for go forward claims, and prior claims are being reprocessed back to the effective date of modifier/POS changes.
- EOBs required for taxonomies that cannot enroll with Medicare:
  - We are researching new issues that have come up around this problem – our goal is to not provide *EOBs*.
- T1015 updates:
  - All but one system configuration updates have been completed – we're currently working on reprocessing projects related to the T1015.
- 2% BH increase:
  - Quality checking our most recent reprocessing.



# NPI enrollment and rejection changes

- Background: HCA requires all current providers serving Medicaid enrollees to enroll with HCA as a Medicaid provider and acquire a ProviderOne ID.
- Amerigroup put a rejection edit in place on front-end claims to prevent any providers who are not enrolled with HCA from submitting and being paid on claims.
- Our Network Relations team has been educating providers on how to get enrolled with the state so claims won't continue to be rejected.
- Beginning October 1, if we identify claims that were not rejected and were actually paid to providers who are not enrolled with HCA at the date of service, we will be recouping on those claims.

# HCA NPI rejection edit



- Effective January 1, 2022, the HCA implemented an edit to reject encounters for any NPI that is not active in ProviderOne.
- Changes to a provider's Medicaid ID number associated with the active NPI number needs to be communicated to Amerigroup in order to update the Amerigroup system.
- Applications in *Pending Status* are not considered active NPIs in the HCA reports.
- If your NPI is not in active status in ProviderOne, contact the HCA at [providerenrollment@hca.wa.org](mailto:providerenrollment@hca.wa.org) or **800-562-3022, ext. 16137**.

# *Provider Satisfaction Survey*



- *2022 Provider Satisfaction Survey* outreach to begin soon.
- Watch for emails/faxes from *Center for the Study of Services (CSS)*.
- Online completion of survey is recommended.



# Claims follow-up

## Attachments workflow

August 16, 2022

# Where's the claim?



## Scenario one

I used the Claim Status tool, but the claim I was looking for was not returned.  
Where's the claim?

- The Claim Status tool displays the status of claims that have been adjudicated by health plans. Those claims will have a status of finalized, pending, and denied.
- The Claim Status tool does not display claims that were rejected. Your organization can choose to receive free reports that inform users in your organization of accepted and rejected claims.

# Where's the claim?



## Scenario two

I used the Claim Status tool, but the claim I was looking for was not returned.  
Where's the claim?

- When was the claim submitted to the payer? If the claim was submitted to your payer within the last 24 business hours, then it might not be available through Claim Status yet.
- We suggest that you wait for 24 hours and then search for the claim in Claim Status.

# Where's the claim?



## Scenario three

I used the Claim Status tool, but the claim I was looking for was not returned. I want to send attachments to the payer. It has been more than 24 hours since the claim was submitted. It does not display on any report from Availity or the payer as a rejected claim. Where's the claim?

- If the claim does not return in Claim Status and you need to send attachments to the payer, use the following workflow for sending claim attachments.

# Attachments workflow



## Step one

**Select Claims & Payments, and then select Attachments – New.**

The screenshot displays the Availity web application interface. The top navigation bar includes links for 'Availity', 'essentials', 'Home', and 'Notifications'. A user profile dropdown shows 'Demo's Account' and a 'Logout' button. A search bar is labeled 'Keyword Search'. The main menu on the left includes 'Patient Registration', 'Claims & Payments', and 'Notification Center'. The 'Claims & Payments' menu is expanded, showing a list of tools categorized into 'Claim Status & Payments', 'EDI Clearinghouse', 'Patient Payments', and 'Fee Schedules'. The 'Attachments - New' option is highlighted under the 'Claims' section.

Claim Status & Payments	EDI Clearinghouse	Patient Payments	Fee Schedules
<ul style="list-style-type: none"><li>CS Claim Status</li><li>RV Remittance Viewer</li><li>A Appeals</li><li>OP Overpayments</li></ul>	<ul style="list-style-type: none"><li>EDI Send and Receive EDI Files</li><li>FR File Restore</li><li>EDI EDI Reporting Preferences</li><li>FTP FTP and EDI Connection Services</li><li>EDI View EDI Plans</li><li>Payer List</li><li>TE Transaction Enrollment</li></ul>	<ul style="list-style-type: none"><li>CP Collect Payment</li><li>PAF Pre-Authorization Forms</li><li>CF Card on File</li><li>PA Payments Administration</li><li>MA Merchant Activation</li><li>CP Collect Payment</li><li>RP Return Payments</li></ul>	<ul style="list-style-type: none"><li>FSL Fee Schedule Listing</li></ul>

**My Top Applications**

- EB Eligibility and Benefits Inquiry



# Attachments workflow



## Step two

**Select Send Attachment, and then select Medical Attachment.**

Availity | essentials | Home | Notifications 1 | My Favorites | State

Patient Registration | Claims & Payments | My Providers | Reporting | Payer Spaces | More

Home > Provider Work Queue

### A Attachments Dashboard

Need Help? Watch a demo | Attachments

Provider Registration | **Send Attachment**

Open Search Form | Sort Ascending By: | Required By ... | Filter by Product Category: | Filter status

Predetermination Attachment  
Medical Attachment

Inbox 0 | Sent | History | Reporting

Select up to 5 requests

Request	Patient	Payer	Provider	Details
There are no items currently in this queue				

# Attachments workflow



## Step three

essentials Home Notifications **1** My Favorites State Help & Training Demo's Account Logout

Patient Registration Claims & Payments My Providers Reporting Payer Spaces More

Home > [Provider Work Queue](#) > Send Attachment

Need Help? [Watch a demo](#) about Attachments

### **A** Medical Attachments

**Organization**

Provider Organization Name

**Payer**

PAYER NAME

**Select an Organization and the Payer Name.**

# Attachments workflow



## Step four

Availity | essentials | Home | Notifications 1 | My Favorites | State | Help & Training | Demo's Account | Logout

Patient Registration | Claims & Payments | My Providers | Reporting | Payer Spaces | Home > Provider Work Queue > Send Attachment

### A Medical Attachments

Organization  
Provider Organization Name

Payer

Documentation Type ⓘ  
Select...

Documentation Type ⓘ  
Select...

Review the information, and then move the cursor off the **Information** icon.

Select one of the following options:

- Quality Claims Review (QCR) – If you received a letter requesting medical records from QCR, select this option.
- Special Investigations Unit (SIU) – If you received a letter requesting medical records from SIU, select this option.
- Other Claim Documentation Request – For all other letters requesting medical records, select this option.

# Attachments workflow



## Step five

Availity | Essentials | Home | Notifications 1 | My Favorites | State | Help & Training | Demo's Account | Logout

Patient Registration | Claims & Payments | My Providers | Reporting | Payer Spaces | More | Keyword Search

Home > Provider Work Queue > Send Attachment

Need Help? Watch a demo about Attachments

### A Medical Attachments

Organization  
Provider Organization Name

Payer  
PAYER NAME

Documentation Type ⓘ

Select...

- Other Claim Documentation Request
- Quality Claims Review (QCR)
- Special Investigations Unit (SIU)

Select an option.

# Attachments workflow



## Step six

Availity | essentials | Home | Notifications 1 | My Favorites | State | Help & Training | Demo's Account | Logout

Patient Registration | Claims & Payments | My Providers | Reporting | Payer Spaces | More | Keyword Search

Home > Provider Work Queue > Send Attachment

Need Help? [Watch a demo](#) about Attachments

### A Medical Attachments

Organization  
Provider Organization Name

Payer  
PAYER NAME

Documentation Type ⓘ  
Other Claim Documentation Request

The next section of the form displays.

Provider  
☒ NPI ☐ Tax ID  
NPI  
Choose an NPI or manually enter an NPI not in the list

# Attachments workflow



## Step seven

Availity | Essentials | Home | Notifications | My Favorites | State | Help & Training | Demo's Account | Logout

Complete the Provider section.

Provider

☒ NPI ☐ Tax ID

NPI

Choose an NPI or manually enter an NPI not in the list

☒ Organization ☐ Individual

Organization Name

Complete the Provider section.

Patient Information

First Name

Middle Name (optional)

Last Name

Subscriber ID

Date of Birth

# Attachments workflow



## Step eight

**Complete the Claim Information section.**

Claim Information

Patient Control Number ⓘ

Claim Number

Claim Amount (optional)

Service From

Service To

**Attach Supporting Documentation**

**ADDING ATTACHMENTS:**

- This Health Plan supports file types including .jpeg, .jpg, .pdf, .tiff, .tif .
- File names cannot contain spaces or special characters with the exception of "\_" and "-".

Reason

Choose one ...

+ Add File

Add Attachment

**Hover over the Information icon for more information about the Patient Control Number.**

Patient Control Number ⓘ

Patient's unique alphanumeric number assigned by the providers practice management system (also known as the Patient Account Number).

Claim Number

Claim Amount (optional)

Service From

Service To

# Attachments workflow





## Step nine

Important: Enter the correct **Claim Number** to link the claim to the attachments.

State ▾ Help & Training ▾ Demo's Account ▾ Logout

Payer Spaces ▾ More ▾ Keyword Search 🔍

Claim Number  Claim Amount (optional)


Service From   Service To  

**Review the guidelines in Adding Attachments.**

Attach Supporting Documentation

**ADDING ATTACHMENTS:**

- This Health Plan supports file types including .jpeg, .jpg, .pdf, .tiff, .tif.
- File names cannot contain spaces or special characters with the exception of "\_" and "-".

Reason  
Choose one ... ▾  Add File

Add Attachment

Clear Values Send Attachment(s)



# Attachments workflow



## Step 10

Attach Supporting Documentation

### ADDING ATTACHMENTS:

- This Health Plan supports file types including .jpeg, .jpg, .pdf, .tiff, .tif
- File names cannot contain spaces or special characters

Select a Reason.

Reason

52030-4 - Explanation of Benefits

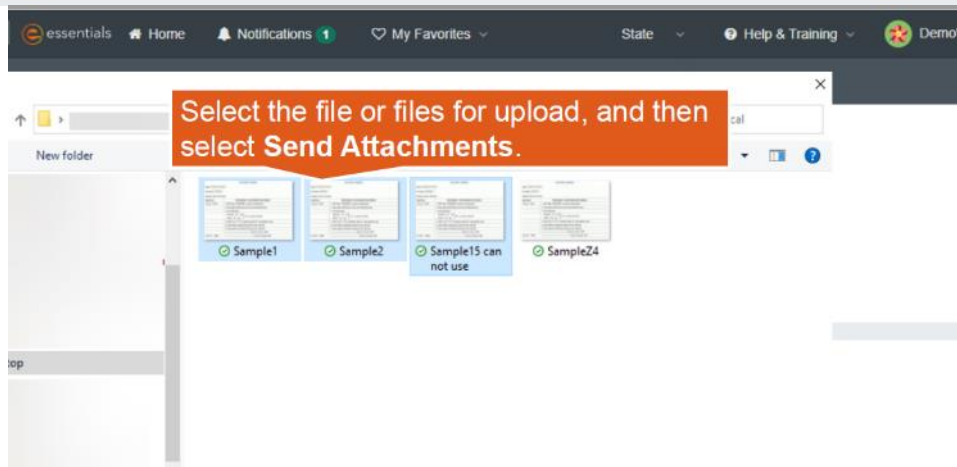
Add File

Select Add File.

Add Attachment

Clear Values

Send Attachment(s)



# Availity digital enhancements

## Easier reconciliation: remittance with zero payment:

- Inconsistent remittance number for the paper remittance advice and the 835 electronic remittance advice (ERA):
  - *Paper Remittance – 10 bytes – 9999999999*
  - *835 ERA – 27 bytes – 9999999999 + year (#####)*
- Inability to search or retrieve paper PDF by check number or reconcile the 835:
  - **All** remittances with zero payment had the same number (9999999999).
  - To search, a date range and tax ID is needed to locate a specific remittance.
- **Enhancements make it easier to reconcile zero payment remittances:**
  - Eliminate the 9999999999 check number.
  - Assign a unique check number.
  - Unique check number is used on all methods of reconciliation:
    - *EOP*
    - 277 claim status
    - 835 ERA

# Remittance with zero payment before enhancement

**ZERO AMOUNT -- THIS IS NOT A CHECK**

INSURANCE COMPANIES, INC.  
P.O. BOX 105187  
ATLANTA, GA 30348-5187

DATE 11/29/21

PROVIDER NAME  
ADDRESS  
PROVIDER NPI ID  
TAX ID NO  
CHECK NUMBER 999999999

**PAYMENT SUMMARY**

GROSS APPROVED CLAIM AMOUNT	4,254.86	IRS WITHHELD	0.00
INTEREST	86.73	STATE WITHHELD	0.00
PENALTY	0.00	AMOUNT PREVIOUSLY OVERPAID	27,489.00
LEVY/GARNISHMENT	0.00	AMOUNT DISBURSED	0.00

Paper Explanation of Payment (EOP)  
Check # is all 9's

**Check Details**

INSURANCE COMPANIES, INC.  
3075 VANDERCAR WAY  
CINCINNATI, OH 45209  
www.availity.com

Check/EFT Number 999999999-2021112900043560  
Check/EFT Date 11/28/2021  
Check Amount \$0.00

Payee Name  
Payee Tax ID  
Payee NP  
Payment Method Code NON  
Transaction Type H:Notification Only

Electronic Remittance Advice (ERA) 835  
Check # is 27 bytes, which includes 10 from paper above

Verify Eligibility ☒ Print this Page [Chat with Payer](#) Secure Messaging ☒ Dispute Claim ☒

**Claim**

Dates of Service 10/29/2021 - 10/29/2021  
Status FINALIZED

Processed Date 11/07/2021

Billed \$360.00 Paid \$0.00

Check Number 999999999 Check Date 11/28/21 Patient Account #

Claim Receipt Date 11/1/21

**Pay to Details**

Paid To PROVIDER Paid To Name Tax ID  
Address

**Other Insurance Information**

Carrier	Paid Amount
N/A	\$0.00

**Explanation of Benefits Details**

Allowed Total Amount	Coinurance Amount	Copayment Amount
\$0.00	\$0.00	\$50.00
Deductible Total Amount	Interest Total Amount	

Claim Status - 277  
Check # is all 9's

# Easier reconciliation: remittance with zero payment

**ZERO AMOUNT -- THIS IS NOT A CHECK**

INSURANCE COMPANIES, INC.  
P.O. BOX 105187  
ATLANTA, GA 30348-5187

DATE 11/29/21

PROVIDER NAME  
ADDRESS

PROVIDER NPI IDS  
TAX ID NO  
CHECK NUMBER 9000005733

**PAYMENT SUMMARY**

GROSS APPROVED CLAIM AMOUNT	4,254.86	IRS WITHHELD	0.00
INTEREST	86.73	STATE WITHHELD	0.00
PENALTY	0.00	AMOUNT PREVIOUSLY OVERPAID	27,489.00
LEVY/GARNISHMENT	0.00	AMOUNT DISBURSED	0.00

**Check Details**

INSURANCE COMPANIES, INC.  
3075 VANDERCAR WAY  
CINCINNATI, OH 45209  
www.availity.com

Check/EFT Number 9000005733  
Check/EFT Date 11/28/2021  
Check Amount \$0.00

Payee Name  
Payee Tax ID  
Payee NPI  
Payment Method Code NON  
Transaction Type H: Notification Only

Verify Eligibility ☒ Print this Page [Chat with Payer](#) Secure Messaging ☒ Dispute Claim

**Claim** [Redacted]

Dates of Service: 10/29/2021 - 10/29/2021  
Status: FINALIZED

Processed Date: 11/07/2021

Billed	Paid
\$360.00	\$0.00

Check Number 9000005733 Check Date 11/28/21 Patient Account # [Redacted]  
Claim Receipt Date 11/1/21

**Pay to Details**

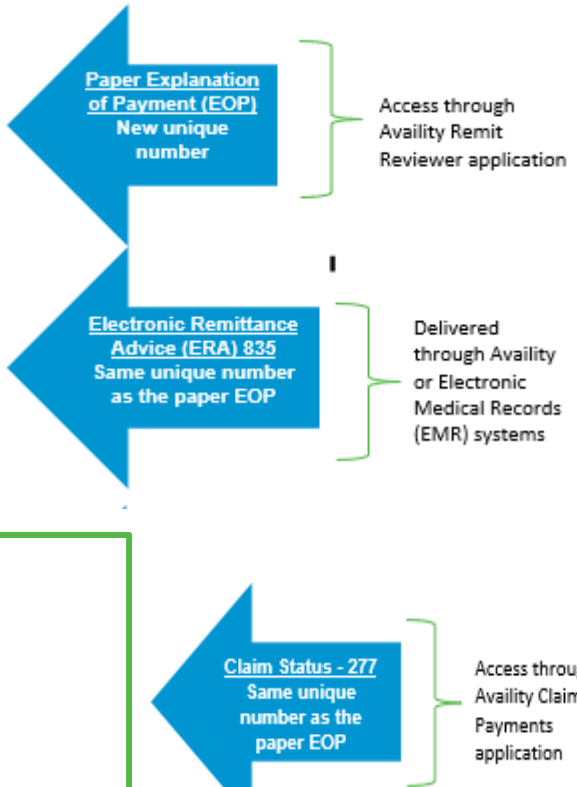
Paid To PROVIDER  
Paid To Name [Redacted] Tax ID [Redacted]  
Address [Redacted]

**Other Insurance Information**


Carrier	Paid Amount
N/A	\$0.00

**Explanation of Benefits Details**

Allowed Total Amount	Coinurance Amount	Copayment Amount
\$0.00	\$0.00	\$50.00
Deductible Total Amount	Interest Total Amount	



# Remittance inquiry search enhancement – paper *EOP*



Simply Healthcare Plans

PO BOX 7368 / GADSDEN-2016

COLUMBIA, GA 31906-7368

11/25/21

800005733


1125A1140557-003701000005

PROVIDER ID NO

TAX ID NO

DATE

11/25/21



88 WNC QX F

ZERO AMOUNT -- THIS IS NOT A CHECK

Simply Healthcare Plans

DATE 11/25/21

PROVIDER NAME

ADDRESS

PROVIDER NPI ID

TAX ID NO

CHECK NUMBER

800005733

PAYMENT SUMMARY

GROSS APPROVED CLAIM AMOUNT	0.00	IRS WITHHELD	0.00
INTEREST	0.00	STATE WITHHELD	0.00
PENALTY	0.00	AMOUNT PREVIOUSLY OVERPAID	0.00
LEVY/GARNISHMENT	0.00	AMOUNT DISBURSED	0.00
NET AMOUNT DUE	0.00	RECURRENT BALANCE	0.00

**Paper EOP now has new unique number and not 9#####**

# ConferMED — created by primary care providers *for* primary care providers

**We know how hard it is to practice primary care. Our goal is to support providers:**

- Keep more of your patient's care in your health center.
- Confer with specialists rapidly and easily in 40 specialties, adult and pediatric.
- Reduce the time it takes to get answers to your specialty-related questions.



***Our average response time is 17 hours.***

- Improve patient outcomes.



# eConsults

An eConsult is a referral sent electronically to a specialist including appropriate PHI from the patient's chart and a formal consult note in response from the ConferMED specialist:



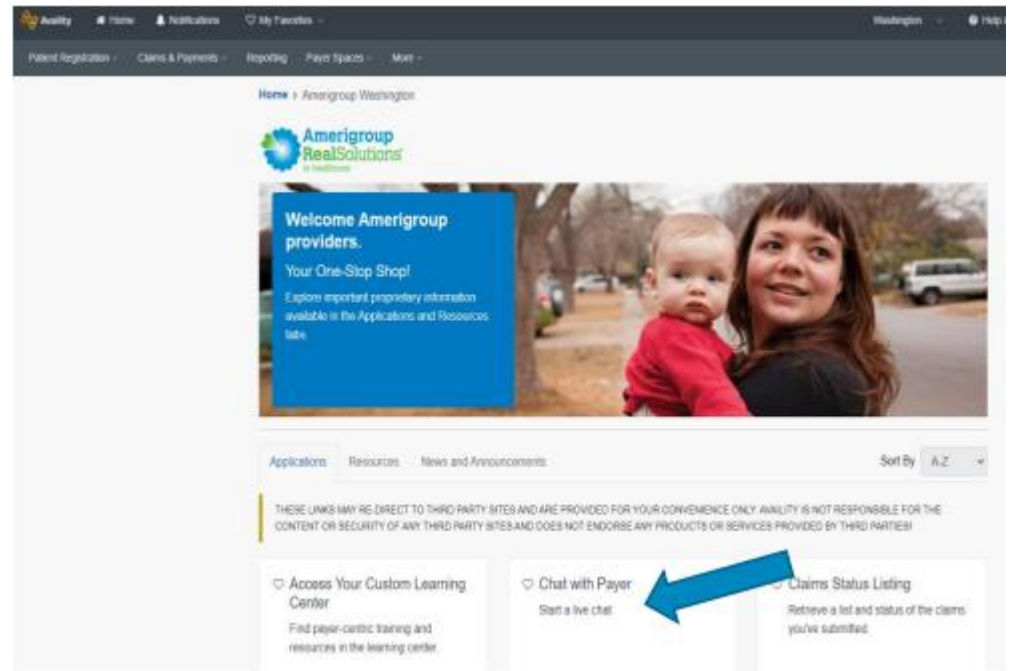
- Rapid advice from expert specialists
- Help patients avoid unnecessary visits
- Hone your primary care skills
- Optimize your work-up before a face-to-face visit

**ConferMED contact: Maryann Souza at [souzam@chc1.com](mailto:souzam@chc1.com)**

# Digital chat function

## Have questions about a claim or services?

- Use the Provider Chat function in Availity:
  - Standard business call hours
  - Real-time chat with Amerigroup Provider Services



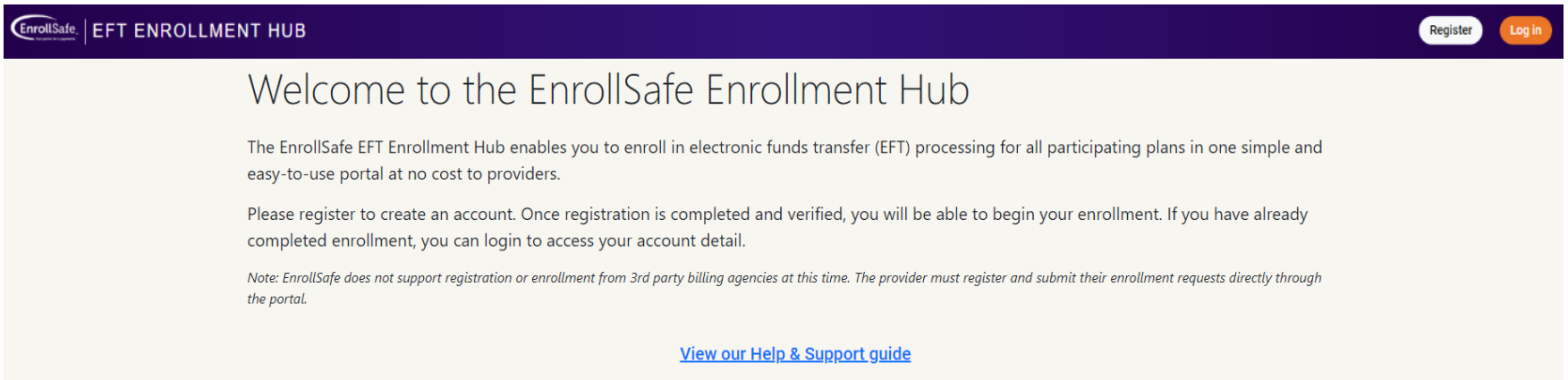


# Provider manual revitalizing project

- Amerigroup is excited to share that we are revitalizing the provider manual. We are seeking feedback from our partners in helping us to improve the layout and content. Amerigroup is requesting that you provide your valuable feedback through the following survey link: <https://www.surveymonkey.com/r/Z925CRC>.
- Network Relations will also be requesting this feedback through 1:1 meetings, telephone calls, and Joint Operation Committee meetings.
- The topics we would like to gather feedback on are:
  - *Are there topics that you wish were included within our current provider manual that you don't see currently?*
  - *What are common topics that you utilize the provider manual for most?*
  - *How does the Amerigroup provider manual compare to other MCOs?*
  - *Is the Amerigroup provider manual easy to follow and utilize?*

# EFT enrollment

- EFT is the most efficient way to receive your payments:
  - No cost to providers
  - Access reports 24 hours per day, 7 days per week
  - Route EFTs to bank account of your choice
- EnrollSafe\* is the enrollment portal for providers and can be accessed through [Availability.com](https://availability.com) or <https://enrollsafe.payeehub.org>.



The screenshot shows the EnrollSafe EFT Enrollment Hub website. The header is dark purple with the EnrollSafe logo and 'EFT ENROLLMENT HUB' text. On the right, there are 'Register' and 'Log in' buttons. The main content area is light gray and contains the following text:

## Welcome to the EnrollSafe Enrollment Hub

The EnrollSafe EFT Enrollment Hub enables you to enroll in electronic funds transfer (EFT) processing for all participating plans in one simple and easy-to-use portal at no cost to providers.

Please register to create an account. Once registration is completed and verified, you will be able to begin your enrollment. If you have already completed enrollment, you can login to access your account detail.

*Note: EnrollSafe does not support registration or enrollment from 3rd party billing agencies at this time. The provider must register and submit their enrollment requests directly through the portal.*

[View our Help & Support guide](#)

# Open discussion



We want to hear from you!

Reminder:

Please complete the post-event survey after the town hall.



\* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Washington, Inc. Beacon Health Options is an independent company providing behavioral health services on behalf of Amerigroup Washington, Inc. EnrollSafe is a tool developed by Zelis Payments, an independent organization offering electronic funds transfer services on behalf of Amerigroup Washington, Inc.

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