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Welcome!

Network Town Hall

Agenda

- **System updates:** Miranda Richter, Director, Operations
- **Claim submission:** Mica Rockefeller, Provider Experience Consultant
- **Claim rejections:** Molly Mathis, Manager, Provider Experience
- ***Explanation of Benefit* issues:** Jeremy Reynolds, Provider Experience Consultant
- **Reconsideration/appeal submissions:** Kenny Sok, Provider Experience Consultant
- **Provider data and credentialing:** Brittany Davis, Provider Experience Manager, Sr.
- **Digital provider enrollment:** Jennifer Lane, Provider Experience Manager, Sr.

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Agenda

- **Prior authorizations:** Molly Mathis, Manager, Provider Experience
- **Digital chat:** Abigail Osborne-Elmer, Provider Experience Manager, Sr.
- **Medical attachments/*Medical Policies*:** Rachelle Tadena-Clark, Provider Experience Consultant
- **Cost Containment Unit:** Jennifer Lane, Provider Experience Manager, Sr.
- **Contracting and *Shared Savings Agreements*:** Preston Cody, Sr. Provider Network Manager
- **Q&A facilitator:** Abigail Osborne-Elmer, Provider Experience Manager, Sr.
- **Survey feedback — *We want to hear from you!***

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System updates

- Behavioral health (BH) taxonomy edit — Amerigroup Washington, Inc. has implemented a claim edit that will deny any BH claims not billed with the appropriate BH taxonomy outlined in Service Encounter Reporting Instructions (SERI). The denial reason will indicate that the claim should be billed to the state. We have noticed an error in the implementation in this edit. The edit was set at the rendering provider level and not at the billing provider level. This is causing erroneous denials. We are working to update this edit and reprocess any impacted claims.

- P.O. Box in Billing Address Field — We are implementing a claim rejection beginning on April 1, 2021, that will reject all claims that list a P.O. Box in the billing address field on a claim form. Please ensure that claims are billed with a valid physical street address in this claim field moving forward. This is in line with the National Uniform Claim Committee guidelines.

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System updates (cont.)

- T1015 Encounter Billers — GD9 is a denial and claim processing defect that applies to claims with multiple dates of service for T1015 billed on the same claim. We are working on fixing this error; no ETA on completion at this time. In the interim, claims submitted for T1015 can be split by date of service or we will reprocess these denials in a claims sweep once per month.

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Initial claim submission

- Amerigroup encourages the use of electronic claim submission as you will be able to:
  - Submit claims either through a clearinghouse or through the Availity* Portal.
  - Receive payments quickly.
  - Eliminate paper.
  - Save money.
- You do have the option of submitting claims electronically or by mail.
- Any claim submitted to Amerigroup without a taxonomy code for the billing and servicing (if applicable) provider will be rejected. Providers should select the taxonomy that best describes the service rendered and also be within the scope of licensure for the provider performing the service.
  - Paper claim submissions must include the *ZZ* qualifier in front of the taxonomy codes.

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Initial claim submission (cont.)

Claim submission through Availity:

- Payer ID: 26375
- Website: https://www.availity.com
- Phone: **1-877-334-8446**

Paper claim submission

- You must submit a properly completed *CMS-1450* or *CMS-1500* claim form; it must be an original red claim form (not black and white or photocopied); it must be laser printed or typed (not handwritten) and it must be a large, dark font.
- Submit paper claims to:
  Washington Claims
  Amerigroup Washington, Inc.
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

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Corrected claims for paper submissions

- For a corrected claim to be accepted, it must include the *Claim Correspondence Form* and your corrected claim.
- Documents should be mailed to:

  Claims Correspondence

  Amerigroup Washington, Inc.

  P.O. Box 61599

  Virginia Beach, VA 23466-1599

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EDI corrected claims submission

- For corrected professional ***(837P)*** claims, use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:
  - 7 – Replacement of Prior Claim
  - 8 – Void/Cancel Prior Claim
  - Indicator Placement — Loop: 2300 (Claim Information)
  - Segment: CLM 05-03 (Claim Frequency Type Code): Value: 7, 8
- For corrected institutional ***(837I)***, use Bill Type Frequency Codes to indicate a correction was made to a previously submitted and adjudicated claim:
  - 0XX7 — Replacement of Prior Claim
  - 0XX8 — Void/Cancel Prior Claim
- Electronic Data Interchange (EDI) Hotline [**1-800-590-5745**]

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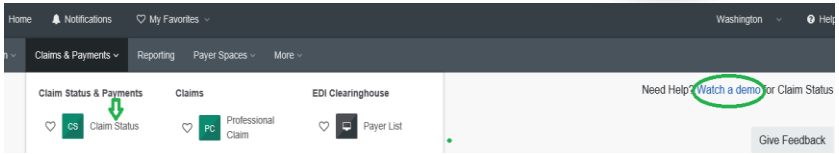
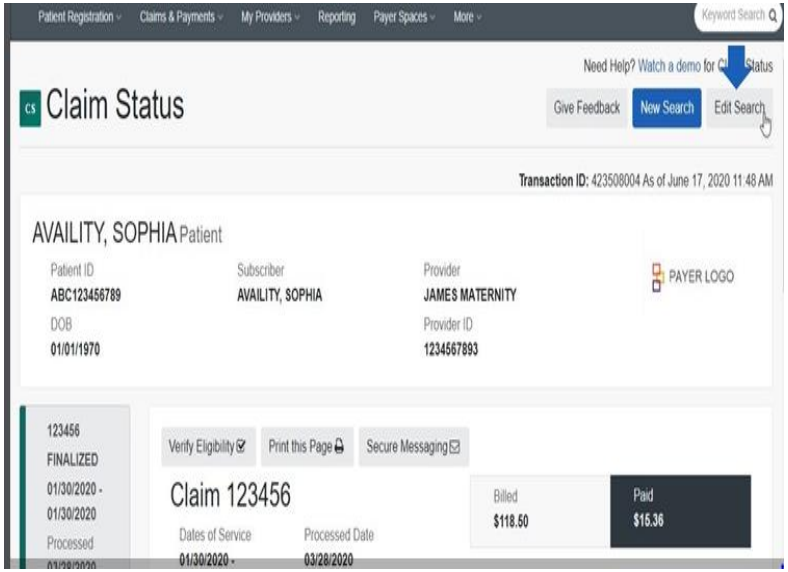
Availity corrected claim submission

From the Availity homepage:

- Select **Claims & Payments** from the top navigation.
- Select **Claim Status** from the drop-down menu.
- Complete required fields in the claim form.
- Select the option to *replace or void/cancel* a prior claim.
- There is an additional field for the Payer Control number.
    - ICN/DCN number





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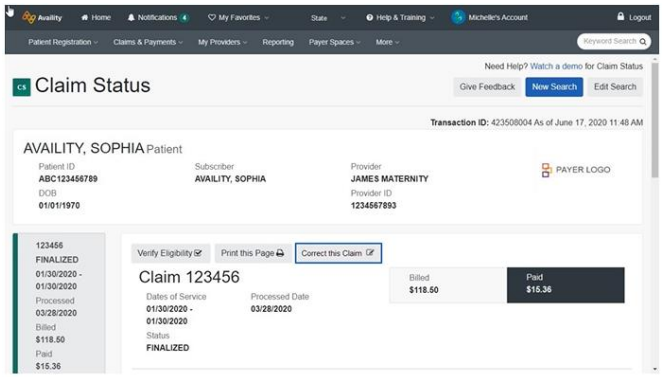
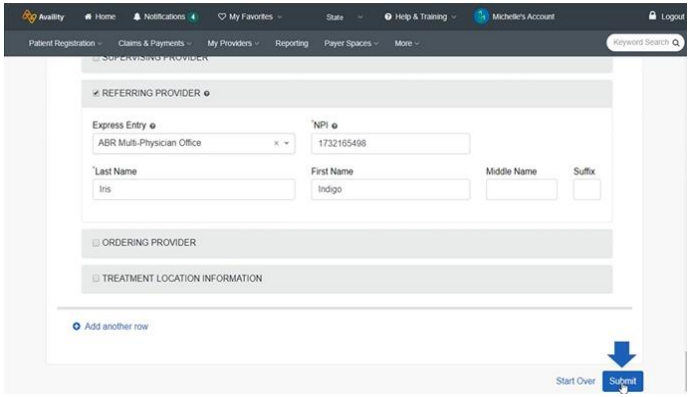
Availity corrected claim submission (cont.)

To correct the information in a claim, do the following:

- Submit a claim status inquiry for the claim to correct.
- From the search results, select the claim that you want to correct.
- On the Cl*aim Status* page, select **Correct this Claim**.
- On the *Claim Correction* page, make appropriate changes.
- Select **Submit**.





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Timely filing education

- You must submit claims within the timely filing guidelines outlined in your contract.
  - Please review your specific contract for the time frame of submission of original and corrected claims

- There are exceptions to the timely filing requirements. They include:
  - Cases of coordination of benefits/subrogation: The time frames for filing a claim will begin on the date of the third party's resolution of the claim.
  - Cases where a member has retroactive eligibility: The time frames for filing a claim will begin on the date Amerigroup receives notification from the enrollment broker of the member's eligibility/enrollment.

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Claim rejections

- Claim rejections happen when there is missing or incorrect information on the *CMS-1500* or *UB-04*.
- Amerigroup will send a notification with the reason why your claim was not accepted/rejected prior to entering our claim system.
- For assistance, contact the EDI Hotline at **1-800-590-5745** or email EDI.ENT.Support@anthem.com. EDI is available to assist you with setup questions and help resolve submission issues or electronic claims rejections.

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Common *Explanation of Benefit* concerns

- Claims for members with another health insurance coverage that is primary to their Amerigroup plan should first be billed to that primary plan prior to submitting to Amerigroup.
- Amerigroup secondary claims should be billed after the primary plan has processed and submitted with a copy of the primary *Explanation Of Benefit* (*EOB*) attached to the secondary claim.
- You can attach primary *EOBs* with your Amerigroup secondary claim submission through the Availity Portal (covered in more detail later).
- Information regarding the order of liability should be available when checking members' benefits and eligibility either online or through our call center.
- Please note: CPT® H, S & T codes are exempt from the BH *EOB* requirement.

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Claim payment disputes/appeals

Timeline to file an initial claims payment dispute

- Reconsiderations: writing, verbally and through our secure website **within 24 months from the date on the *EOP*.**

How to file a Claims Payment Dispute

- Secure website: Submit reconsiderations on the *Reconsideration Form*, located under *Resources* > Forms.
- Verbally (for reconsiderations only): Call Provider Services at **1-800-454-3730**.
- Via mail:

  Payment Dispute Unit
  Amerigroup Washington, Inc.
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

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Claim payment disputes/appeals (cont.)

Timeline to file a second-level claim payment appeal

- If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal. We accept claim payment appeals through our provider website or in writing within **60 calendar days** of the date on the reconsideration determination letter.

How to file a second-level claims payment dispute

- Submit written claim payment appeals on the *Claim Payment Appeal Form*, located under Resources > Forms.
- Online at the Availity Payment Appeal Tool at https://www.availity.com.

Please note: Clean claims timely filing has a standard 365 days, **unless otherwise stated in your contract**. Corrected claim timely filing is within that same 365-day time period. A corrected claim is documenting the original claim was not a clean claim; therefore standard and contract timely filing are applied.

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Provider data management

- To support with proper claims reimbursement, it is essential to notify Amerigroup about any demographic and/or roster changes prior to [30 days] of the specified change.
- Submit all provider adds, changes and terminations to Provider Data Management on the *WA Provider Master Roster* under Provider Demographics/Credentialing.
- The *WA Provider Master Roster* is approved by the Health Care Authority (HCA) and used by all MCOs.
- Confirm that all columns are populated, and do not change the layout of the columns.
- If provider has multiple practicing locations, please add the locations on separate lines.
- When you submit an email with adds, changes and terminations to Provider Data Management, you will receive an email including a case number for reference.

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Credentialing

- New providers joining your existing group:
  - Submit their credentialing application on either of the following sites:

    OneHealthPort or Council for Affordable Quality Healthcare (CAQH®)
- Recredentialing takes place every [three] years once initially credentialed. Amerigroup will proactively notify providers in advance of your credentialing lapsing.
- Notify Amerigroup via email if you have any changes in licensure, demographics or participation status at Provider Data Management.
- Please note, it is ultimately the provider's responsibility to maintain good standing on your credentialing status.
- For further details, visit the provider website.

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Digital provider enrollment

New digital provider enrollment tool to be added to Availity for Washington.

- In 2021, Amerigroup will be adding a new functionality to the Washington provider enrollment tool hosted on the Availity Portal to further automate and improve your online enrollment experience.

Who can use this new tool?

- Professional providers whose organizations do not have a credentialing delegation agreement with Amerigroup may use this new tool.
- Note: Providers who submit via roster or have delegated agreements will continue to use the process currently in place.

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Digital provider enrollment (cont.)

What does the tool provide?

- The ability to add new providers to an already existing group
- The ability to apply and request a contract. After review, a contract can be sent back to you digitally for an electronic signature. This eliminates the need for paper applications or paper contracts.
  - Enroll a new group of providers
  - Enroll as an individual/solo provider
  - Add a provider to an already existing group
- A dashboard for real-time status on the submitted applications
- Streamlined, complete data submission

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Digital provider enrollment (cont.)

How the online enrollment application works:

- The system automatically accesses CAQH to pull in all updated information you've already included in your CAQH application. The CAQH information automatically populates the information Amerigroup needs to complete the enrollment process, including credentialing and loading your new provider to our database. Please ensure that your provider information on CAQH is updated and is in a complete or reattested status.
- The Availity online application will guide you through the enrollment process, providing status updates using a dashboard. As a result, you know where each provider is in the process without having to call or email for a status.
- **Please note**: For any **changes** to your practice profile and demographics, continue to use the new online provider maintenance form that allows you to electronically submit any changes to your practice profile and demographics to Amerigroup. Availity administrators and assistant administrators can access the form on Availity > Payer Spaces > Resources.

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Prior authorizations

- To determine if a service needs prior authorization, use the Prior Authorization Lookup Tool on the provider website.
- The Prior Authorization Lookup Tool allows you to search by market, member's product and CPT code.
- If you don't know the exact code, you can also search by description.

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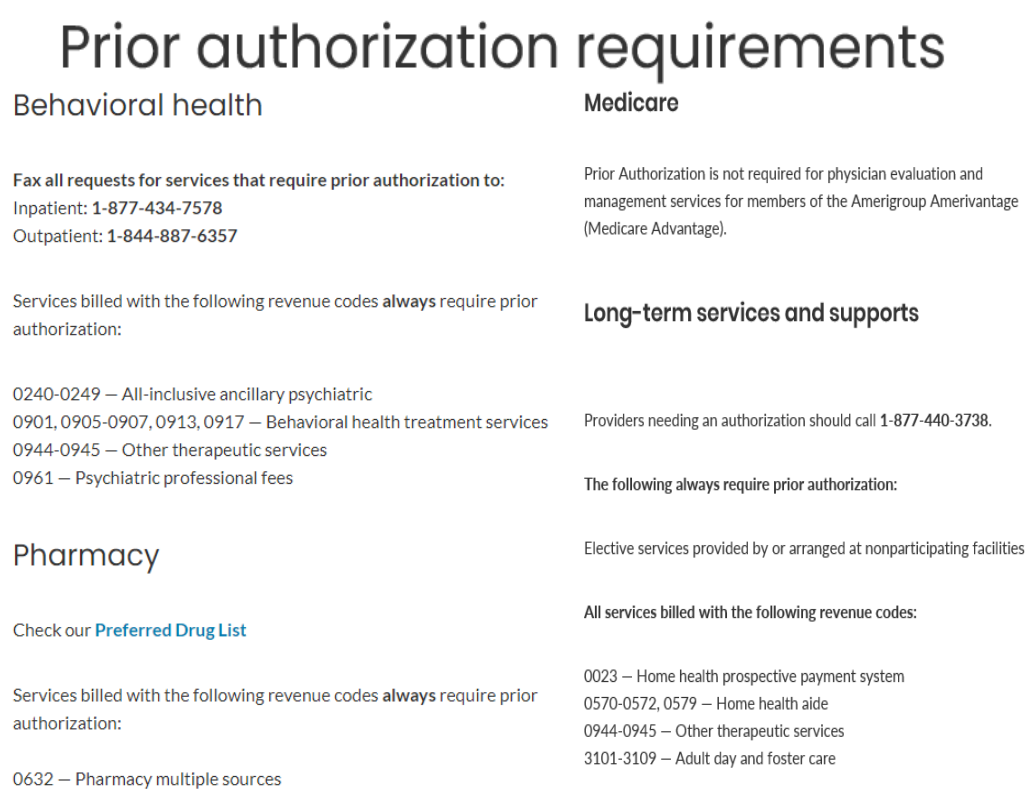
Prior authorizations (cont.)

Prior authorization is required for:

- All inpatient elective admissions.
- Nonemergency facility to facility transfer.
- Higher level behavioral health services (detox, residential, etc.)
- Certain nonemergent outpatient and ancillary services.
- Home health care services (for example, skilled nursing, speech therapy, physical therapy, occupational therapy, social workers and home health aides).



Prior authorization requirements

Behavioral health

Fax all requests for services that require prior authorization to:
Inpatient: **1-877-434-7578**
Outpatient: **1-844-887-6357**

Services billed with the following revenue codes **always** require prior authorization:

0240-0249 — All-inclusive ancillary psychiatric
0901, 0905-0907, 0913, 0917 — Behavioral health treatment services
0944-0945 — Other therapeutic services
0961 — Psychiatric professional fees

Pharmacy

Check our **Preferred Drug List**

Services billed with the following revenue codes **always** require prior authorization:

0632 — Pharmacy multiple sources

Medicare

Prior Authorization is not required for physician evaluation and management services for members of the Amerigroup Amerivantage (Medicare Advantage).

Long-term services and supports

Providers needing an authorization should call **1-877-440-3738.**

The following always require prior authorization:

Elective services provided by or arranged at nonparticipating facilities

All services billed with the following revenue codes:

0023 — Home health prospective payment system
0570-0572, 0579 — Home health aide
0944-0945 — Other therapeutic services
3101-3109 — Adult day and foster care

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Prior authorizations (cont.)

Prior authorization is not required for:

- Emergent admissions (Withdrawal Management ASAM 3.7, 3.2).
- Substance use disorder (SUD) (Residential Treatment ASAM 3.5, 3.3, 3.1 and Tribal Facilities).
- In-office specialty services.
- Evaluation and management-level testing and procedures.
- ER visits or observation.
- Home health care evaluations.
- Physical therapy evaluations provided at outpatient facilities.
- Most outpatient behavioral health services.

Please make sure you're using the most up-to-date and appropriate forms from the website for the services being requesting.

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Honor authorizations

- Must use *Honor Authorization Request Form*
- Must fax to number on the form: **1-844-887-6356**
- If providers do not follow the correct process, requests will be returned.
- Effective January 1, 2021, the following are changes in accordance with ESHB 2642:
  - Prior authorization is not allowed.
  - It is a requirement that the provider/facility check ProviderOne and then coordinate with the appropriate MCO.
  - MCOs will coordinate with the provider/facility to confirm they are the correct payer and that legislation allows the admission.

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No Wrong Door

- Effective January 1, 2021, the following are changes in accordance with ESHB 2642:
  - Prior authorization is not allowed for withdrawal management services (ASAM 3.7, 3.2) and residential (ASAM 3.5, 3.3, 3.1) SUD treatment services.
  - Requires a minimum covered benefit of three calendar days for withdrawal management and two business days for inpatient/residential SUD treatment services prior to initiating utilization review.
  - Behavioral health agencies must notify the MCO within 24 hours of the admission
  - Honor authorizations:
    - It is a requirement the provider/facility check ProviderOne and then coordinate with the appropriate MCO.
    - MCOs will coordinate with the provider/facility to confirm they are the correct payer and that legislation allows the admission.

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Prior authorization requests

Submit **inpatient and outpatient service** prior authorization requests via:

- Web: Availity website
- Fax: **1-800-964-3627**
- Phone: **1-800-454-3730**

Submit **behavioral health** prior authorization requests via:

- Web: Availity website
- Inpatient fax: **1-877-434-7578**
- Outpatient fax: **1-844-887-6357**
- Phone: **1-800-454-3730**

Be prepared to provide the prior authorization nurse with the member's information.

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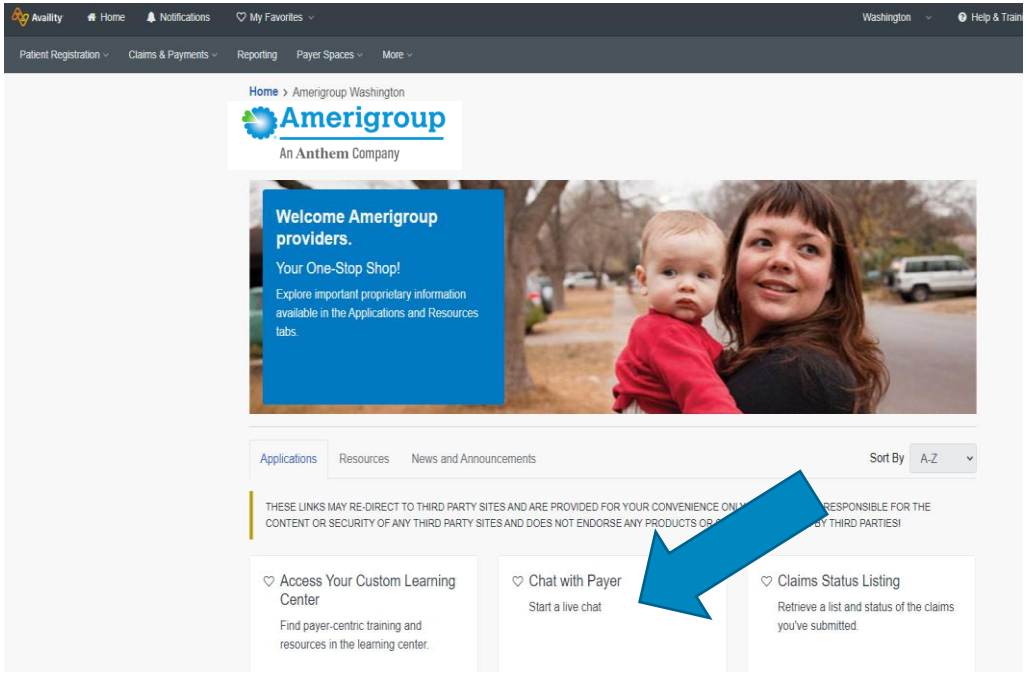
Digital chat function

Have questions about a claim or services?

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



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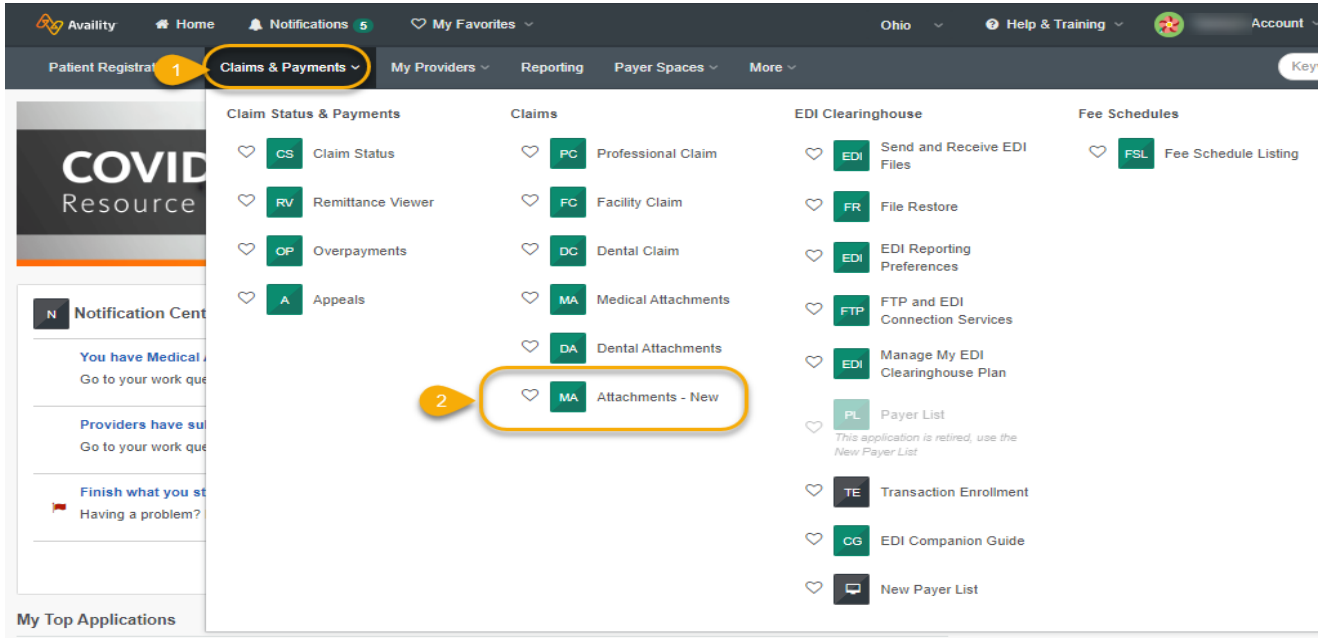
Medical attachments in Availity

The user will log in to Availity Portal and select **Attachments – New** from the *Claims & Payments* menu.



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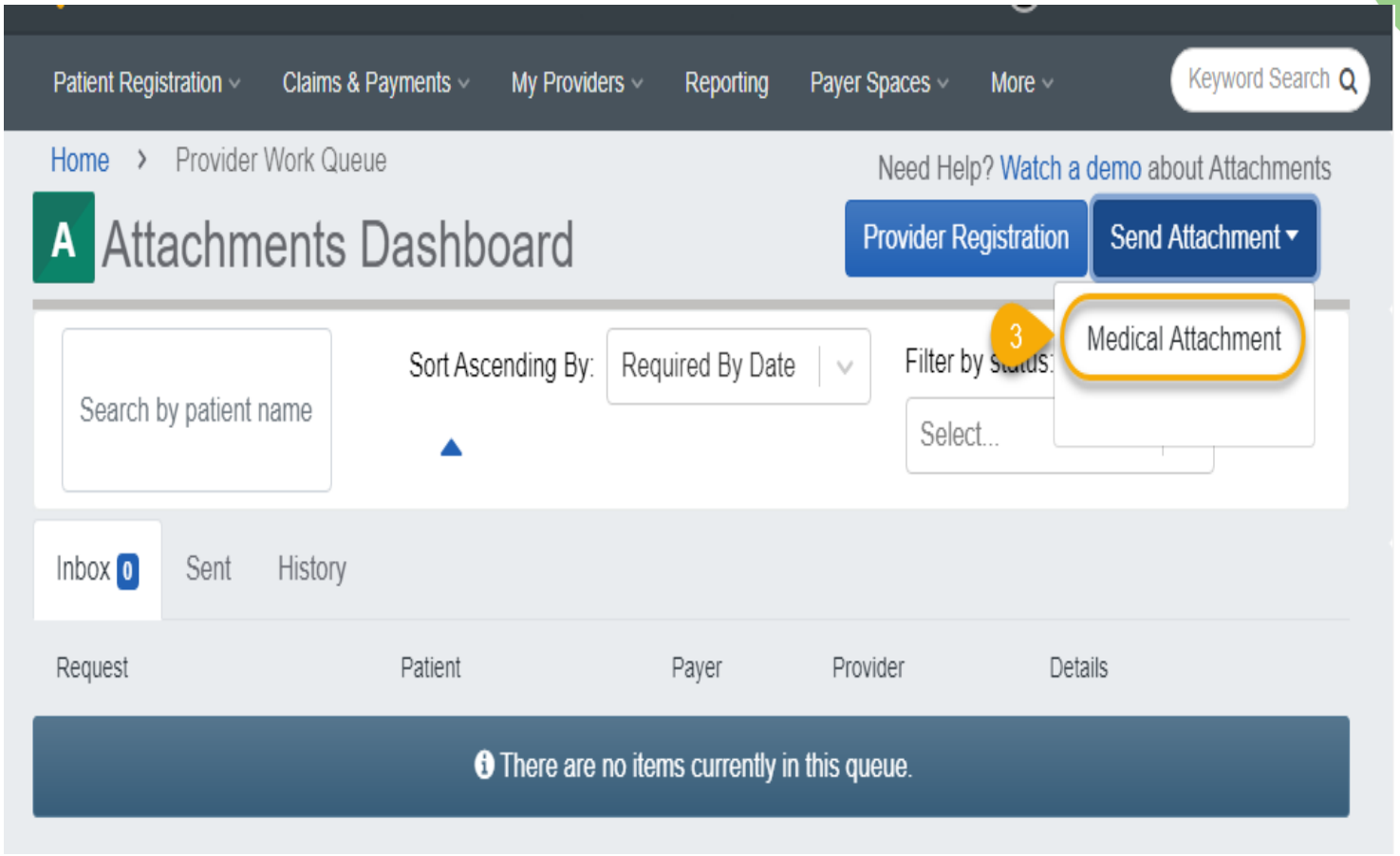
Medical attachments in Availity (cont.)



To send an attachment, select **Send Attachment** > **Medical Attachment**.

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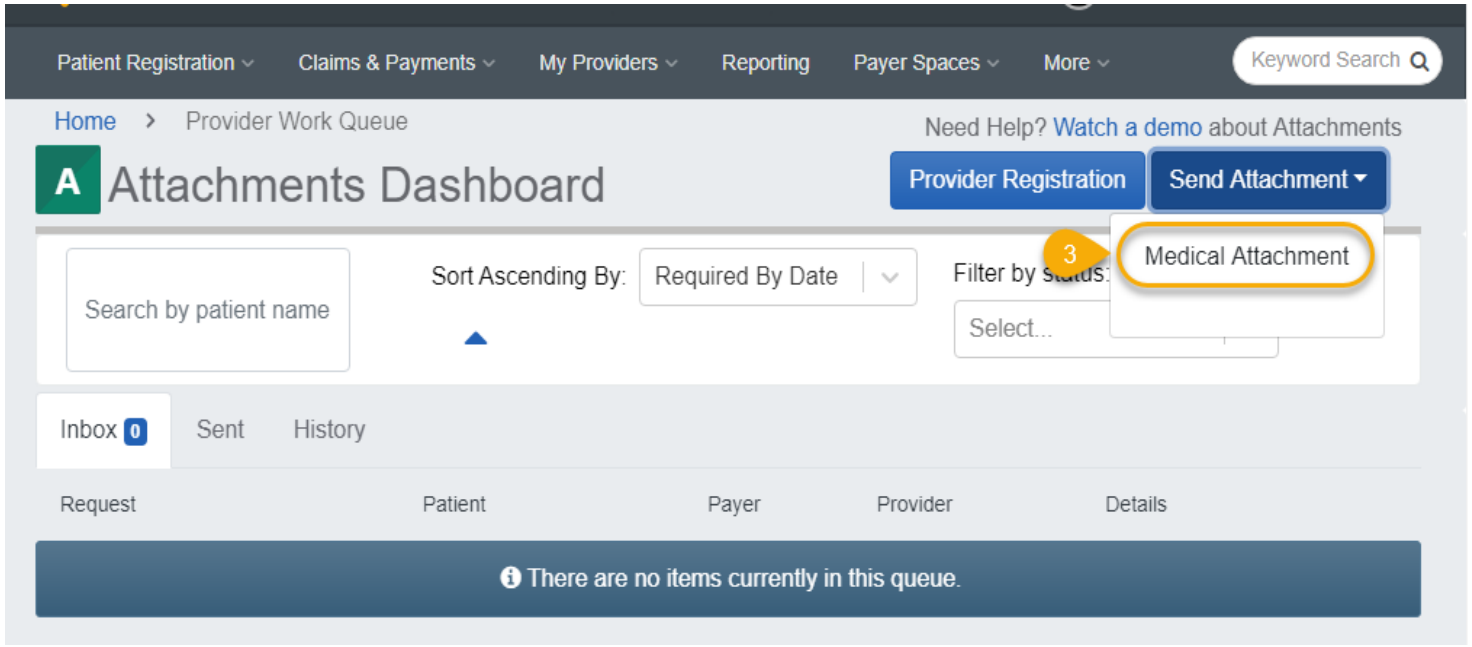
Medical attachments in Availity (cont.)



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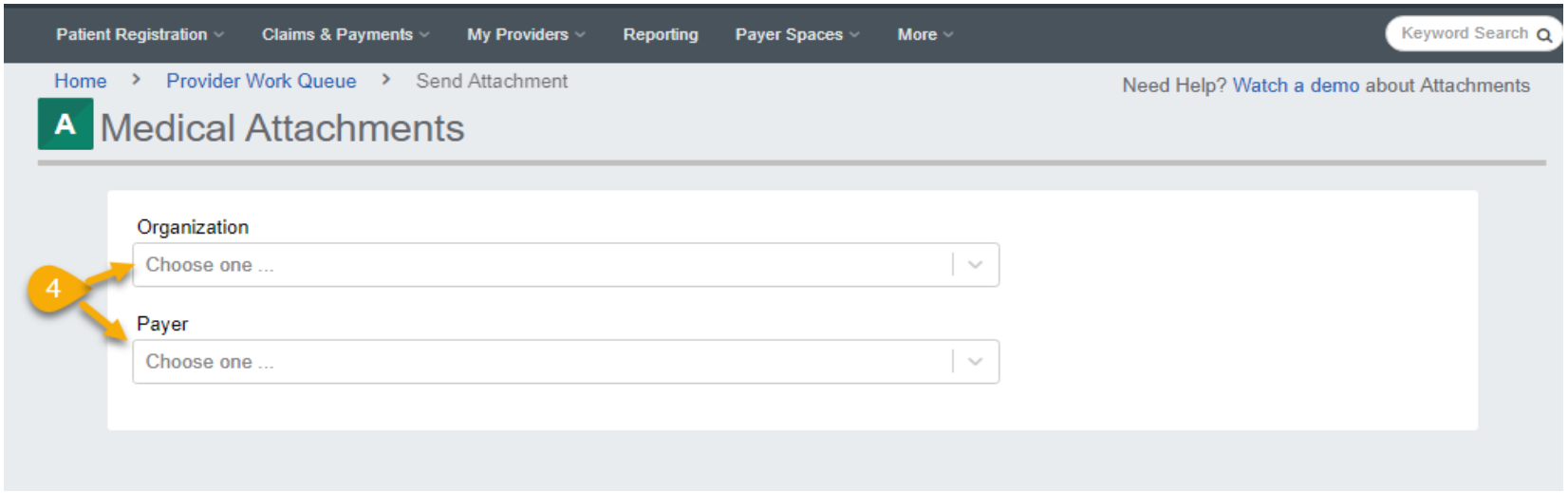
Medical attachments in Availity (cont.)

- Select **Organization**.
- Select **Payer**.



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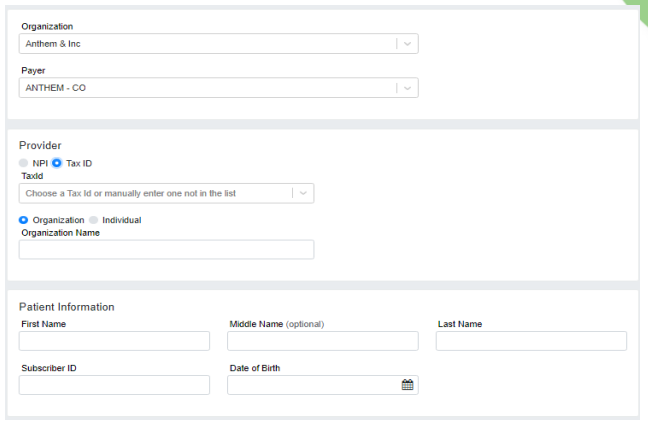
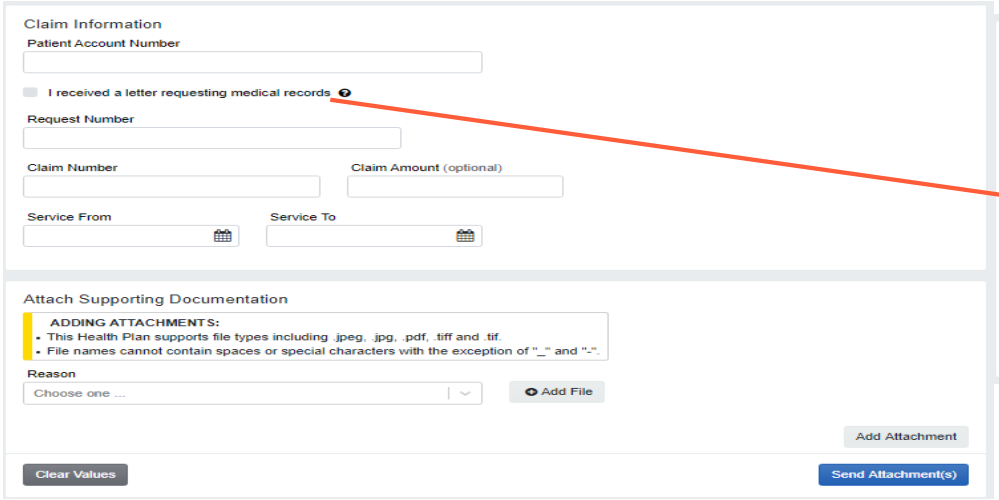
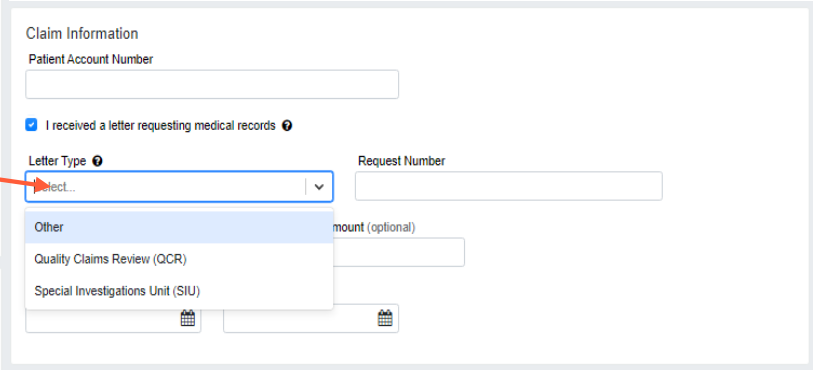
Medical attachments in Availity (cont.)

- Enter provider NPI or tax ID.
- Enter patient information.
- Enter claim information.
- Attach supporting documentation.







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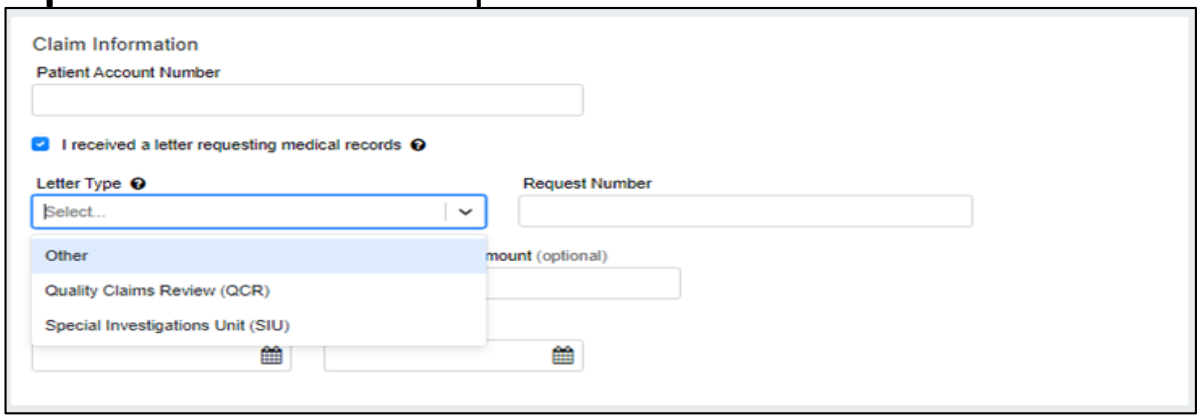
Medical attachments in Availity (cont.)

If you have checked the box indicating that you received a letter (solicited request), here are some guidelines to follow:

- **Letter type options:**
  - Other: Letters that have been received requesting additional documentation (in other words, medical records)
  - Quality Claims Review (QCR): Select this option if the letter indicates the request came from QCR.
  - Special Investigations Unit (SIU): Select this option if the letter indicates the request came from SIU.
- **Request number:** This required number is included within the letter.



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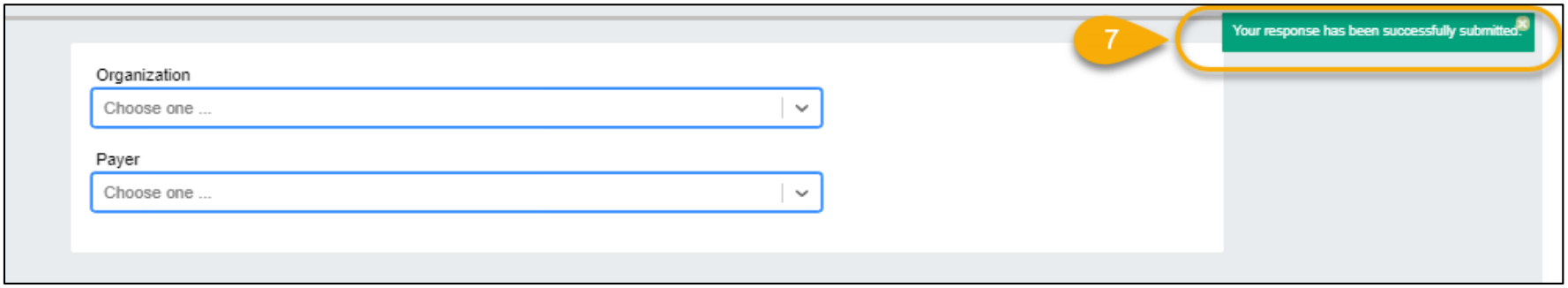
Medical attachments in Availity (cont.)



- A confirmation message will display in the upper right, or an error message next to a field if a detail is missing.
- On successful submission, the user is returned to a new, blank *Send Attachment* page.

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Medical attachments in Availity (cont.)

Guidelines when sending attachments:

- File size limitation of 100 MB maximum for all attachments combined.
- **If the file is in the wrong format or is too large,** Availity displays an error message and will not upload the file.
- Providers should determine the best process for:
  - Saving documents in an acceptable format.
  - Splitting documents into an acceptable file size.
- Attachments cannot include special characters in the file name except for a hyphen and underscore.
- Acceptable file formats include TIFF (.tif), JPEG (.jpg) and PDF (.pdf).
- Attachments role must be assigned by the organization's administrator.
- Records remain in the history for two years after the finalized date.

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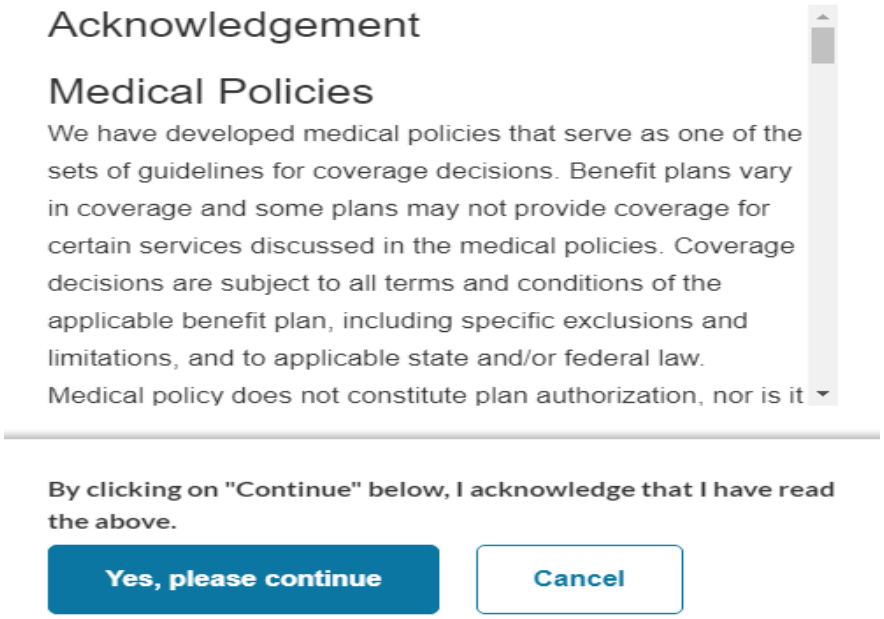
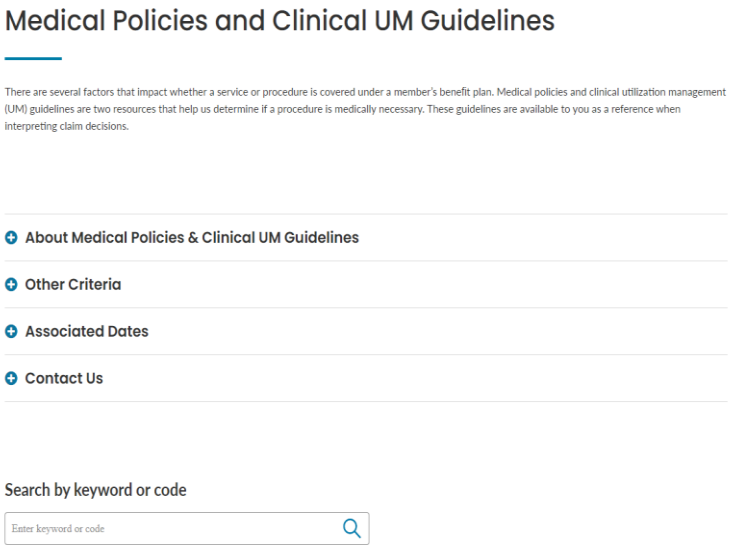
Medical Policies

Claim Reimbursement Policies





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Medical Policies (cont.)

Medical Policies* and *Clinical Utilization Management Guidelines

- There are several factors that impact whether a service or procedure is covered under a member's benefit plan. *Medical Policies* and *Clinical Utilization Management Guidelines* are two resources that help us determine if a procedure is medically necessary. These guidelines are available to you as a reference when interpreting claim decisions.

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Cost containment

For immediate assistance on existing projects:

- Providers can call the **Cost Containment Unit (CCU) inquiry team at 1-844-410-6892** with questions on claims in a CCU recovery project or for status of a provider dispute/correspondence.
- Providers can call **RNF/Cash Receipts at 1-844-410-6894** with questions involving a refund check that has been sent.
- Providers can call the **Escalated Recoveries team at 1-844-418-7534** with questions related to negative balances.

For additional assistance regarding the *Overpayment Refund Notification Form* or the *Provider Authorization to Adjust Claims and Offset*, please visit our provider website under Forms > Claims and Billing.

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Contracting and *Shared Savings Agreements*

Contracting:

- If you are interested in contracting with or changing an existing agreement with Amerigroup contact your contract manager or email wacontractintake@anthem.com.

Shared Savings Agreements

- Amerigroup offers a variety of shared savings programs that focus on improving quality of care for members while reducing overall cost. Providers are financially rewarded for improved performance and outcomes.

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Contracting and *Shared Savings Agreements* (cont.)

- Below are a few examples of the Amerigroup shared savings programs:
  - Non-provider Quality Incentive Program Shared Savings Program: 1,000+ members
  - Provider Quality Incentive Program: 1,000+ members
  - Provider Quality Incentive Program Essentials: 250 to 999 members
  - Behavioral Health Facility Incentive Program: 50+ members
  - Behavioral Health Quality Incentive Program: 10+ members
  - Pay for Quality: No membership threshold
- For more information about these programs, contact your contract manager or email wacontractintake@anthem.com.

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Questions?

We want to hear from you!

This time is for you to ask questions and/or provide comments.

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* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Washington, Inc.