Q&A session for Amerigroup Washington, Inc. provider network town hall

Date: Tuesday, May 18, 2021

Q: Can I get a copy of the slides that you are going over?

A: A copy of the Provider Network Town Hall can be found on our provider website under ***Training Academy***. Current edits of the Town Hall slides are being approved and will be updated in our Training Academy.

Q: When will the P.O. Box rejection be implemented?

A: There is no completion date yet determined for the P.O. Box update, but yes, a provider notice will be issued.

Q: Good afternoon! Will we get a notice when the P.O. Box reject will come into effect?

A: There is no completion date yet determined for the P.O. Box update, but yes, a provider notice will be issued.

Q: Do you have an estimate of when the facility taxonomy update will be completed? There's $400K+ E&T stay reimbursement pending for Compass Health due to inability to process Medicare primary/ Amerigroup (for Medicaid) secondary claims.

A: Yes, E&T will be affected. It is a high-priority request and will be prioritized in the next 30 days.

Q: Are you aware that often when a corrected claim is submitted and attachment sent, that they are not seen? Regarding attachments, for clarification, I am referring to submitting documents via Availity, LLC.* I usually have to call in and ask them to look for it, then they see it and have to send the claim back for reprocessing.

A: Contact Provider Services initially; if you need further assistance, contact your Provider Experience consultant.

Q: Our agency keeps receiving denials for no authorization, but there is no requirement for our services to have an authorization. I have brought this up with Jeremy several times, but I have not seen them reprocessed. What do you suggest? Examples: H2015 case management or H0038 for peer services.

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

A: Jeremy will follow up with Sue directly and continue to discuss during weekly meetings. Sue confirmed there are no configuration issues.

Q: We have been working with Brittany regarding newborn ID numbers. Amerigroup is not accepting mom's ID or Medicaid ID any longer. A temporary ID needs to be provided so we can submit our billing. Customer Service is not providing a temporary ID number unless it is a sick baby. We were told this policy was being updated. Is there an update on this? Our billing is being delayed while we wait on the temporary ID number.

A: System update is complete. Here is the guidance: The Amerigroup process to comply with this RCW is as follows: Upon receipt of the first newborn claim, Amerigroup will determine if the Health Care Authority (HCA) has issued the newborn a member ID. If the HCA has issued the newborn a member ID, Amerigroup will require the newborn's ID on claims and will process the claims under that ID. Amerigroup does not process newborn claims under the mother's ID. Therefore, if the HCA has not yet issued an ID to the newborn, you may contact Provider Services for a temporary ID.

Q: Just to confirm, when we take on a new staff member to our facility, we're to enter this information into OneHealthPort? I currently just send an email with an updated roster for our agency when new staff start and old staff leave.

A: For facility-based practices, you would continue to use the MCO provider roster.

Q: Is primary insurance verified prior to denial? We see a lot of claims where Amerigroup is denying claims because they show primary policy that has termed.

A: Claim operations do not verify insurance prior to processing claims to determine current eligibility.

Q: Can we submit the claims with a physical address prior to the final configuration, or are we waiting for the go-ahead?

A: Yes, you can submit claims now.

Q: Hello, how is it determined who is exempt from billing Medicare? Is this by taxonomy?

A: We are gathering information on this high-priority request and expect to have more information in the next 30 days.

Q: Is the MCO roster that we submit to all MCOs not going to work for licensed and/or ARNP providers? Are we going to have to submit the provider's credentialing another way?

A: If you are a facility-based agency and have historically been submitting on a roster, you can continue to submit on a roster through your current process. However, if there is a carve-out (separate rates) in your contract for in-house PCP or NP that need credentialing, those providers would need to go through credentialing via Digital Provider Enrollment.

Q: If corrected claims cannot be sent with attachments, what is the best way to send a corrected claim where the issue to resolve requires an attachment?

A: If you have challenges with submitting the attachments via Availity, while you are working on those challenges, you can submit paper corrected claims with your supporting documentation and the claim correspondence form mailed to the address listed within the *Claim Correspondence* form: **https://provider.amerigroup.com/docs/gpp/WAWA_CAID_Claimcorrespondenceform.pdf?v=20200604 1825**.

Q: We bill room & board for hospice, and we keep getting denials due to the facility information not being on the claim. We have verified on our claims, the clearinghouse, and the information is showing; however, when it reaches your end, it vanishes. How are we supposed to get this corrected?

A: Claim Operations and your Provider Experience consultant are currently meeting with your leadership and manager regarding this issue. Amerigroup has asked your group for reference numbers from EDI for follow-up.

Q: I've been working with our Provider Representative regarding secondary BHSO plans not being billed to Medicare first. I was told an escalations team was working on it and/or communicating with HCA and that I would have updates soon, but I am wondering if you happen to know anything about that and/or how the communication with HCA on that is going so far? If not, I'll wait for correspondence on that. "Issue 1B: 90853 Denial Code CBP – Medicare EOP Primary"

A: The escalation is in process, and the PIR Team is responsible for updating you every 10 days. If you need additional information, reach out to your Provider Experience consultant.

Q: I might be confused. In the IMC, we add providers through the roster. Would we not add them in a digital environment as well?

A: If you are a facility-based agency and have historically been submitting on a roster, you can continue to submit on a roster through your current. However, if there is a carve-out (separate rates) in your contract for in-house PCP or NP that need credentialing, those providers would need to go through credentialing via Digital Provider Enrollment.

Q: We are having the same COB issue and have not gotten any relief.

A: We are gathering information on this high-priority request to ensure we understand your concern completely. Your Provider Experience consultant will follow up with you to ensure your specific issue has been identified.