Preventing claim denials
We will cover

- Contacts for Amerigroup Kansas, Inc.
- Routine claim inquiries
- Amerigroup provider website
- Top denials
- Specific ways to avoid denials
- Reconsideration and appeals

- Precertification
- Coordination of benefits and third-party liability
- Your Provider Relations representative
Fraud, waste and abuse

Help us prevent it and tell us if you suspect it!

• Bill accurately
• Verify patient identity
• Ensure services are medically necessary
• Document medical records completely
Provider contacts

- Dedicated Provider Services Unit: 1-800-454-3730
- Provider website: https://providers.amerigroup.com/KS
- Electronic Data Interchange (EDI): 1-800-590-5745
- Availity: 1-800-282-4548
Routine claim inquiries

Provider Services can help you with claim inquiries:

• Review denied or underpaid claims
• Reprocess claims
• Start a reconsideration
• Start an appeal
• Redirect you to the correct department
• Help navigate our website
• Assist with stop payments and reissuing checks
https://providers.amerigroup.com/KS

The provider website is available to all providers, regardless of participation status.

The tools on the site allow you to perform key transactions.
News & Announcements

Prior authorization for I/DD HCBS waiver services and I/DD TCM services
Effective with dates of service July 1, 2015, Amerigroup Kansas, Inc. will lift the waiver on prior authorization(s) for I/DD home and community based services (HCBS) and for I/DD targeted case management (TCM) services. Learn more

E&M codes billed with respiratory services
Effective with claims processed on and after August 3, 2015, evaluation and management (E&M) services (99201-99499) will not be paid when billed on the same day of service as diagnostic and therapeutic respiratory services (94010-94799) for the same member, by the same rendering provider, unless the appropriate billing modifier of 25 is appended. Learn more
Top reasons for denials

• Member not eligible
• Claims not submitted timely
• Duplicate claim submission
• Precertification not obtained
• Member has other health insurance (OHI)
• Missing or incorrect diagnosis
Member eligibility

• Before you provide services, it is important to check member eligibility.
  o Having the most current and accurate membership information will reduce the number of denied claims you receive.
  o Membership can be checked either through Kansas Medical Assistance Program (KMAP) or Availity.
Eligibility and benefits

The Service Type description box lists the benefit details for the selected benefit/service.

Select the **Payer** for which you are submitting the transaction; you can access eligibility and benefit information for any member.

**Add to Batch** allows you to query multiple patients from multiple payers in one batch submission.
Timely claim submission

• Check your Amerigroup or MultiPlan contract; know your timely filing limits.

• Timely filing is calculated by adding the number of days (business/calendar) from the date of the explanation of payment (EOP).

• Timely claims submission documentation requirements are also listed in the provider manual.
Rejected vs. denied claims

We will send you a notice if your claim was rejected or denied. There are differences between rejected and denied claims. They are:

Rejected claims
• Do not enter the adjudication system because of incorrect or missing information
• The claim will be returned

Denied claims
• Go through the adjudication process, but payment is denied
• The provider will receive an explanation of payment
Rejected claims

- Check your EDI submission reports timely.
- If a claim is not listed on your EOP (as either paid or denied) and submitted electronically, use the EDI Hotline at 1-800-590-5745.
- EDI can assist you with resolving electronic submission issues or electronic claims rejections.
- Rejected claims do not enter the processing system and can’t be corrected or appealed.
Claim correction vs. appeal

**Correction**
- Change information on a claim (e.g., the date of service)
- Adding additional services; units or modifiers
- Adding additional information such as third-party liability (TPL) information

**Reconsideration or appeal**
- Disagree with how a claim was processed
- Claim was denied for preauthorization, but one was obtained
- Claim denied for units of service
- Claim denied for National Correct Coding Initiative (NCCI) or medically unlikely edit (MUE)
Claim corrections

Claims can be corrected by:

- Submitting the corrected claim through Availity
- Submitting the corrected claim through the clearinghouse
- Submitting the corrected claim electronically to KMAP
- Completing a correspondence form located on the provider website

Make sure to include the original claim number and the resubmission code of “7.”
Duplicate claims

• All services for the same date of service should be submitted on one claim.
  o If additional services need to be billed for the same date of service, correct the claim.

• If a claim is denied for preauthorization, **do not** submit a new claim. Call Provider Services for assistance.

• If it’s unclear why the claim denied, contact Provider Services for assistance. Do not file another claim.
Duplicate claims (cont.)

Avoid duplicate claims by:

• Posting payments as soon as your EOP is received
• Allowing at least 30 days before submitting another claim
• Checking your claim’s EDI acceptance/rejection reports
• Correctly submitting a correction so it doesn't show as duplicate in our processing system
Rate changes

• When the state notifies Amerigroup of rate changes, we:
  o Update our claims payment system accordingly.
  o Reprocess claims regardless of if the rate change is lower or higher than the past rate.
• Do not resubmit claims; it will cause duplicate claims.
• Make sure to check your EOP for the status of adjusted claims.
If you would like to file a reconsideration or appeal:

- Reconsiderations may be filed verbally by contacting Provider Services at 1-800-454-3730, via the web or by mail.
- Reconsiderations must be submitted within 60 days, plus three days allowed for mailing.
- A reconsideration is the first level of review and must be completed prior to submitting an appeal.
Payment appeals post reconsideration

• You may submit an appeal within 33 days of the response of reconsideration.
• Appeals may be submitted online via the web or in writing.
• A State Fair Hearing can only be filed after our final determination on your appeal.
State Fair Hearing

After you have exhausted the Amerigroup internal appeal process, you may submit a State Fair Hearing.

• An appeal must be exhausted before filing a State Fair Hearing (SFH).
• Requests for SFH are to be submitted to the Office of the Administrative Hearing at 1020 S. Kansas Ave., Topeka, KS 66612-1327 or faxed to 1-785-296-4848.
• SFH may also be submitted to Amerigroup using the following channels:
  o Mail: Amerigroup, Attention State Fair Hearings, 9225 Indian Creek Pkwy., Building 32, Suite 400, Overland Park, KS 66210
  o Email: ks1providersupport@amerigroup.com
  o Fax: 1-844-664-7183
• Requests need to be submitted within 33 days of the date of notice of the Amerigroup appeal determination letter.
• Make sure to include the final appeal determination letter.
We track all provider grievances until they are resolved. The provider manual includes how to file a grievance, the escalation process and contact information.
Precertification

All inpatient stays require precertification, even when admitted through the ER.

- https://providers.amerigroup.com/KS
- Call 1-800-454-3730
- Fax 1-800-964-3627
- All services rendered by a nonparticipating provider
Is precertification required?

Our Precertification Lookup tool lets you search by market, member’s product and CPT code.
Precertification requests

Submit precertification requests through our provider website, via fax or by calling Provider Services.
What is the status of the precertification?

You can check the status of your precertification request on the provider website or contact Provider Services.
Precertification

What should you do if a claim denies for precertification, but precertification was obtained?

• Call Provider Services at 1-800-454-3730 with the precertification number.

• Submit an appeal and provide the precertification number.
Retro-eligibility

• To obtain retro-authorization for members retroactively eligible for KanCare, a waiver program or a nursing facility (prior to claim submission):
  o Contact Amerigroup at 1-800-454-3730 on the next business day
  o Specify the request is for a retro-eligible member
• Submit claims through the normal processes
• Inpatient admission requests are subject to further review, including length of stay and level of care reviews
• If the provider fails to obtain precertification before submitting the claim, an appeal will need to be submitted along with clinical documentation
• As of January 2015, spreadsheet submissions to provider representatives for retro-eligible members will no longer be accepted
Home and community-based services providers

For claims denied for no preauthorization or exceeding units:

• Contact our LTSS team to have the preauthorization reviewed.
  o LTSS specialists email: kscasespec@amerigroup.com
    Phone: 1-800-454-3730, ext. 50103

• Do not submit a new claim; submitting a new claim will cause a duplicate denial.

• Contact Provider Services to assist in the review of the claim.
Behavioral health providers

When providing behavioral health services, please contact our Provider Services team at 1-800-454-3730 and ask for a member of our behavioral health staff.

Their fax numbers are:
General: 1-800-964-3627
Inpatient: 1-877-434-7578
Outpatient: 1-800-505-1193
Hospital claims

Top denial reasons for hospital claims are:

• Missing or incorrect diagnosis-related group codes (DRG)
• Present on admission (POA) information missing, incorrect or with incorrect indicators
• No precertification
• Other health insurance (OHI)
• Retro-eligibility
Claims denied for other insurance

Amerigroup follows the Kansas-specific guidelines, as well as all the federal regulations when coordinating benefits.

For examples of exceptions, see your provider manual.
Claims denied for other insurance (cont.)

• Some claims cannot be processed without the primary insurance information
• Other payer information can be submitted via electronic claim submission or paper submission
• Review the KMAP TPL list to avoid billing the primary unnecessarily
Third-party liability

The KMAP TPL list can be found at https://www.kmap-state-ks.us/Public/TPL%20Noncovered.asp.

- You will need to know the member’s primary insurance coverage to use the list.
- The TPL list can change; check for updates.
Resources

• Amerigroup provider manual: 

• Amerigroup provider forms: 
  https://providers.amerigroup.com/KS

• POA indicators (for ICD-10): 
Your Provider Relations representative

If you have questions, contact your Provider Relations representative at <Name and contact info>.
Thank you for partnering with Amerigroup RealSolutions in healthcare