Amerigroup
Claims Processing Technical Document for Nursing Facilities/HCBS Providers

Amerigroup Provider Services/Provider Relations Contact Information and Resources

- Provider Services: 1-800-454-3730
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Amerigroup Kansas Provider Portal Address : Providers.amerigroup.com/KS

- Available to all providers regardless of participation status
- Key Transactions available on website
    - Claims submission
    - Claims verification
    - Precertification
    - Eligibility Reports

Verifying Member Eligibility

- Verifying member eligibility can be done through a couple of means:
    - **Visit the Kansas Medical Assistance Program (KMAP) website:** www.kmap-state-ks.us/
- **Call our Provider Services team:** 1-800-454-3730

Amerigroup Claims Submission Procedures

- **Claims Submission Clearinghouses:**
    - Emdeon (formerly WebMD): payer ID 27514
    - Capario (formerly MedAvant): payer ID 28804
    - Availity (formerly THIN): payer ID 26375
- Direct submission through Amerigroup website
- Continue submitting claims to the Kansas Department of Health and Environment (KDHE) via state MMIS
- Continued submission of paper claims to KMAP

  KMAP
  Office of the Fiscal Agent
  P.O. Box 3571 Topeka, KS 66601

- **Timeframes for accepting claims submissions**
    - AGP Web Portal accepts same day submission until 1p Central Time
    - KMAP Web Portal creates files every two hours | AGP retrieves between 8am – 12noon
    - Submitter receives reject notification from PMS or on 277CA for EDI submissions

Amerigroup Claims Payment Cycle

- Amerigroup pays claims on Tuesday, Wednesday, Thursday and Saturday

The following is a table of the claims payment cycle by submission source.

	Submission Source			
	FEB	**Clearinghouse**	**MCO Portal**	**Claim Status**
Claim Submission	Until 8a Daily	Cut-off May Vary	Until 1p Daily	Source Reject Report Only
o Deadline for claim entry will vary by vendor - submitters should confirm submission deadlines when using 3rd party sources o **Authenticare (EVV) submissions may experience up to 24 hours between authentication and claim file creation.**				
Claim Files Retrieval	8a - 12p Daily	8a - 12p Daily	2p Daily	File Reject Report - 277CA
o AGP retreives consolidated files from all sources once per day between 8am and 12 noon. o AGP creates a data reject report for any file that is not retrievable				
Claim Processing	12p - 6a Daily	12p-6a Daily	2p-6a Daily	Pending / Paid / Reject
o Consolidated claim files are processed once per day. Each claim successfully processed is assigned a status o AGP creates a written notice for any claim rejected which is mailed to the provider				
Claim Review	1-10 days	1-10 days	1-10 days	Pending / Paid by 6a on portal
o Currently AGP is manually reviewing every claim submitted to confirm the integrity of our adjudication process o After implementation clean claims will be assigned a paid status and process during the next cycle o Claims that require review may pend for an additional period | AGP will meet the state standard for TAT				
Pay/Deny Status (P/D-S)	1 day	1 day	1 day	Pending / Paid
o Claims placed in a paid/denied status will generate an EOP | EOPs process on Tues/Weds/Thurs/Sat				
EFT / Check Disbursement	1 day	1 day	1 day	Paid
o During the EOP process a EFT transaction file is created and sent through our vendor to banking institutions for disbursement of funds o Banking institutions vary on when funds become available in the customer's account				
Check Delivered	1-5 days	1-5 days	1-5 days	Paid
o Checks are sent USPS 1st Class | 1st Class delivery guarantee by USPS is 1-5 days				
Total Processing Time	4-17 days	4-17 days	3-16 days	Paid

Additional Notes on Nursing Facility Claims

- Bill UB-04 form
- Nursing facility bill type requirements: Nursing/Intermediate Care Facility Provider Manual. Billing Section, Paragraph 7020 pg. 7-3 specifies that Skilled Nursing Facilities should use Bill Type 21X; Intermediate Care Facilities should use 65X or 66X.
- Third party liability amount goes in box 39 with value code 23
- Submit the appropriate Revenue (REV) code for the services rendered
- Reimbursement to nursing facility is based on a per diem methodology according to the applicable KanCare nursing facility rates.

Amerigroup Nursing Facility Prior Authorization Requirements

- Prior authorization for a nursing facility stay is not required at any time if the member has Medicare as the primary payer.
- If a member enters the nursing facility through the Medicare skilled nursing benefit and the member exhausts their Medicare benefit and Medicaid becomes the primary payer for the stay, an authorization is needed for dates of service after Medicare criteria is no longer satisfied for a continued stay or the benefit is exhausted. ,
- If a member is admitted and Medicaid is the primary payer Amerigroup requires that an authorization be obtained.
- To obtain an authorization, the nursing facility provider may contact the LTSS unit at **1-877-434-7579 ext. 50103** and a long term services case specialist will assist you in obtaining the authorization.
- Information may also be faxed to **1-855-225-9937** where a long term case specialist will process the authorization.
- If a member enters the facility from a hospital, it is the nursing facilities responsibility to obtain the authorization if the person is entering the facility as Medicaid primary.
- If the admission is a planned, admission the nursing facility should obtain authorization 72 hours before the admission.
- For unplanned admissions, an authorization should be obtained the next business day.
- An authorization is not necessary when a member re-enters the facility if it is within the 10 bed reserve days. If the member exhausts the 10 reserve days and is re-admitted to the facility an authorization is required.

Important Amerigroup LTSS Contact Informatiion:

1-877-434-7579 ext. 50103 – For authorization and nursing facility questions

1-855-255-9937 – Fax number for authorizations