NewsBlast

TENNESSEE – AUGUST 2014 TNPEC-0804-14

The following entries apply to all Tennessee Amerigroup Community Care Providers.

Refresher on our Appeals and Dispute Processes

Summary: The following excerpts from our provider manual serve as a reminder about our payment dispute and claims appeals processes.

Payment Dispute Process

Providers may access the timely payment dispute resolution process. A payment dispute is any dispute between the health care provider and Amerigroup for reason(s) including:

- Denials for timely filing
- Contractual payment issues/disagreements
- Requests for additional explanation as to services or treatment rendered by a provider
- Provider appeals without member's consent
- Denials for lack of authorization
- Disagreements over reduced or zero paid claims

No action is required by the member. **Payment disputes do not include medical appeals.**

Internal Reconsideration Process

The Amerigroup payment dispute resolution process includes an internal reconsideration process.

A provider may request an independent review with TDCI if:

1. The provider has completed the Amerigroup internal reconsideration process by calling the Provider Services Unit at 800-454-3730 and allowing 30 days for response or resolution.
2. The provider has filed a written appeal and Amerigroup has upheld the original claim determination (i.e. denial).
3. Amerigroup continues to deny payment
4. The provider is not satisfied.

Filing a Payment Dispute

Providers will not be penalized for filing a payment dispute. The Payment Dispute Unit (PDU) will receive, distribute and coordinate all payment disputes. To submit a payment dispute, please complete the Provider Payment Dispute Form located in Appendix A – Forms or online at providers.amerigroup.com and submit to:

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

The network or non-network provider must ensure that a payment dispute is received at Amerigroup within 90 calendar days of the paid date on the EOP. A written request must be submitted with supporting documentation or other written explanation with a copy of the claim. If a claim has been denied for timely filling, the following are acceptable forms of documentation for payment reconsideration:

- Explanation Of Benefits (EOB) or Explanation Of Medicaid Benefits (EOMB) from the primary health payer dated within 120 days of claim submission to Amerigroup
- Confirmation of denial from the health payer within 120 days of claim submission to Amerigroup
- Documentation regarding the provision of the member's health plan insurance information dated within 120 days of claim submission to Amerigroup
- Documentation proving Amerigroup contributed to the filing delay

- Electronic report that states Amerigroup accepted the claim
- Computer-generated activity report that shows the date an electronic claim was originally submitted to
- Amerigroup (an acceptable report must contain a patient name or identification number, the date of
- service, and an indication the original claim was submitted electronically)

The following are not acceptable forms of documentation for timely filing payment reconsideration:

- Screen prints showing dates of a claim previously submitted to the health plan
- CMS or UB form with print date located in Box 31 or Box 86, respectively
- Electronic report stating the health plan has rejected the claim

If the provider payment dispute is received after the 90 calendar day time frame for reconsideration requests, the provider will still have the opportunity to submit the disputed claim for an independent review.

Amerigroup has a time limit of 30 calendar days from the filing date of the payment dispute to resolve the dispute. If the dispute has not been resolved within that time frame and additional time is needed, Amerigroup will notify the provider prior to the 30th day to inform the provider that additional time is needed. Amerigroup will give an estimate of when the provider will receive a response, which will be no later than 60 calendar days from the filing date of the payment dispute.

If required, a committee comprised of the Amerigroup Vice President of Quality Management, Vice President of Provider Services, medical director and any additional members of senior staff, network providers and/or consultants of the same or similar specialty as the provider who have not been involved with the original dispute, meets as necessary to investigate and resolve unsettled payment disputes to a provider's satisfaction. If a provider is dissatisfied with the result of the reconsideration process or if Amerigroup fails to respond to the reconsideration request within 60 days from the received date of the payment dispute, the provider may submit an Independent Review request with TDCI.

Grier Medical Appeal Information

Appeals are managed by TennCare. Members have the right to file appeals regarding adverse actions taken by Amerigroup. Appeal means a member's right to contest, verbally or in writing, any adverse action taken by Amerigroup to deny, reduce, terminate, delay or suspend a covered service; and any other acts or omissions of Amerigroup that impair the quality, timeliness or availability of such benefits.

Amerigroup ensures that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

Amerigroup will include a clear and understandable description of the method to appeal an adverse action in member handbooks, in provider manuals and through providers.amerigroup.com.

Upon request, Amerigroup will provide members a TennCare-approved appeal form(s).

Amerigroup will provide reasonable assistance to all appellants during the appeal process.

Members and their representative(s), including a member's provider, have 30 calendar days (plus additional time for receipt of mailed appeals) from receipt of the adverse action in which to file an appeal. The member may use the TennCare Medical Appeal form but is not required.

The member or member's representative will file an Appeal of an adverse action with TennCare Solutions Unit (TSU).

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593
1-888-345-5575 (Fax) 1-800-772-7647 (TTY/TDD)
1-800-878-3192 (Phone) 1-800-254-7568 (Español)

TSU will forward any valid factual disputes to Amerigroup for reconsideration. An On Request Report will be faxed to Amerigroup by TSU requesting reconsideration of the member's appeal.

Notification of Appeal Reconsideration
In addition to the information indicated in the notification of adverse action section of this procedure, the following will also be included in the notice of the appeal reconsideration:

- The results of the resolution process and the date the decision was completed.
- The member's right to request continuation of benefits during the appeal to the state's fair hearing process and that the member may be held liable for the cost of those continued benefits if the state fair hearing decision upholds the Amerigroup decision.
- Member eligibility and eligibility-related grievances and appeals, including termination of eligibility, effective dates of coverage, and the determination of premium and copayment responsibilities, will be directed to the Department of Human Services.

The medical director who reviews the clinical documentation for the appeal cannot be a subordinate of the reviewer who made the initial adverse action and must not have been involved in making the original denial.

The reconsideration of the adverse action previously made includes at least one practitioner in the same or similar specialty, including chiropractic, that typically manages the medical or dental condition, procedure or treatment under discussion for review of the adverse action, unless otherwise indicated by the state.

The review will be conducted by an actively licensed, practicing MD, DO or DDS not involved in the initial determination.

Amerigroup is responsible for eliciting pertinent medical history information from the treating health care provider(s) for the purpose of making medical necessity coverage determinations. Amerigroup will take action (e.g., sending a provider representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider for failure to request, etc.), to address the problem if a treating health care provider is uncooperative in supplying needed information. Amerigroup will make documentation of such action available to TennCare, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service will not be entitled to payment for the provision of such item or service.

Standard Appeal
The total time for an Amerigroup reconsideration of the appeal will not be more than 14 calendar days from the date Amerigroup receives appeal from TennCare Solutions Unit (TSU). Amerigroup provides a written notice of the outcome of the reconsideration to TSU and the member is notified.

Expedited Appeals
An expedited appeal process is available for adverse actions related to time-sensitive care. Care qualifies as time sensitive if the member's treating physician determines that if the member does not receive the care within 31 days:

- The member will be at risk of serious health problems or death
- The delay will cause serious problems with the member's heart, lungs or other parts of his or her body
- The member will need to go to the hospital

For internal purposes, Amerigroup has five calendar days to respond to the TennCare Bureau.

Excerpt from Provider Manual

Update to TennCare Budget Reduction Communication

The Bureau of TennCare updated its June 13, 2014, communication surrounding programmatic changes to be made by MCOs effective July 1, 2014, as a result of the state fiscal year 2015 budget. A full copy of this and previous TennCare documents can be found on our website at providers.amerigroup.com/TN under the State Communications heading.

TNPEC-0784-14

The following entry applies to all Tennessee Long-Term Services and Supports (LTSS) Providers.

Meet Your Network Consultant Team!

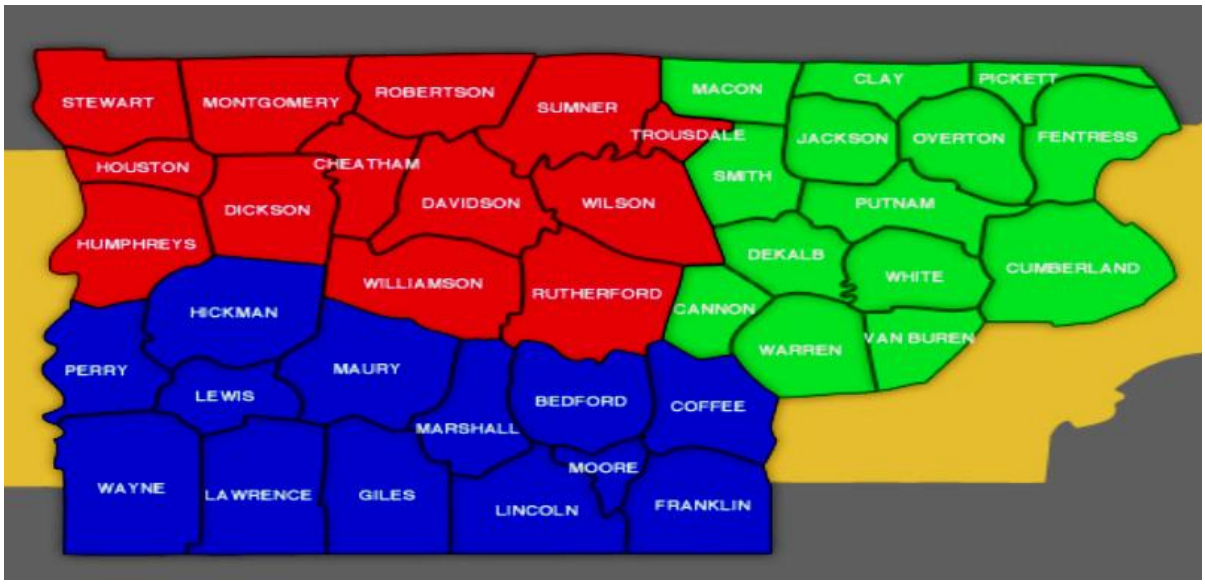
We're here to help you. These are your network consultant contacts:

Quentin Mitchum, Network Consultant
- 615-316-2400, ext. 22657
- Quentin.Mitchum@amerigroup.com
- Serving the following counties: Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Davidson, Wilson, Humphreys, Perry, Hickman, Maury, Marshall, Lewis, Wayne, Lawrence, Giles and Lincoln

Roosevelt Fayne, Network Senior Consultant
- 615-316-2400, ext. 22920
- Roosevelt.Fayne@amerigroup.com
- Serving the following counties: Macon, Clay, Pickett, Jackson, Overton, Fentress, Smith, Putnam, DeKalb, White, Cumberland, Cannon, Warren, Van Buren, Davidson, Williamson, Rutherford, Bedford, Coffee, Moore and Franklin

Paula Kinnard, LTSS Manager
- 615-316-2479
- Paula.Kinnard@amerigroup.com

Rodney Scott, LTSS Director
- 615-316-2443
- Rodney.Scott@amerigroup.com



TNPEC-0780-14