Provider Update

This is an update about information in the provider manual. For access to the latest provider manual, go online to https://providers.amerigroup.com/ia.

Policies and procedures update for prior authorizations

Summary of update: This is an update to the Amerigroup Iowa, Inc. policies and procedures for prior authorizations (PAs) when Medicaid is secondary.

What this means to you: We want to work with you in partnership. Please see below for the most recent updates to our policies and procedures when Amerigroup is the secondary payer.

Determination of primary health insurer:

The managed care organization (MCO) becomes the primary health insurer under the conditions listed below:

- If the primary health insurance does not cover a service, the MCO becomes the primary health insurance and is responsible within the scope of the MCO rules.
- When primary insurance has exhausted, the provider must provide to the MCO an explanation of benefit (EOB) from the primary carrier showing the services that are exhausted and/or a letter explaining the benefit determination or member termination from the plan.

Coordination when secondary:

- After review of the primary carrier EOB, the claim is coordinated by calculating the MCO's allowable amount minus the primary carrier's payment. The MCO will determine the Medicaid allowable amount permitted by the state contract. The MCO will be responsible for any unpaid balance up to the limit of its responsibility or the member's responsibility, whichever is lesser, and will pay any remaining balance leftover up to that allowable amount. This includes any copays, deductibles or coinsurance and capitation amounts included in the primary calculation and payment (such as Medicare cost shares or deductibles).

The MCO is not the primary health insurer (primary payer) under the conditions listed below:

- If the primary health insurance does not pay for a service because the member or provider did not follow the primary insurance guidelines, then the service becomes noncovered by Medicaid and the MCO would not be responsible for payment.
- If the member or provider fails to comply with the MCO's rules, including PA or timely filing (180 days), the claim can also be denied.

Note: Timely filing is based on the date of the primary health carrier EOB, not the date of service.

What if I need assistance?

If you have questions about this communication, received this fax in error or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-454-3730.