Amerigroup Kansas, Inc.

Billing guide

Fall 2016

This billing guide was developed with providers in mind to help avoid some common claim denials and assist in getting claims paid efficiently. Providers are encouraged to also review the full Amerigroup provider manual, as well as the Kansas Medical Assistance Program (KMAP) provider manuals for more detailed information. This guide was developed to include ways to avoid the most common denials we see, but the manuals are much more detailed.

Information at your fingertips

*****A digital copy of this document can be located online at**
https://providers.amerigroup.com/KS > Provider Resources & Documents > Manuals Training Programs > click Billing Guide

Amerigroup Provider Website
https://providers.amerigroup.com/pages/ks.aspx

Amerigroup provider manual
https://providers.amerigroup.com/ProviderDocuments/KSKS_Prov_Manual.pdf

KMAP provider manuals

https://www.kmap-state-ks.us/Public/providermanuals.asp

Availity
Client Services: 1-800-282-4548
Web: www.Availity.com

Claim correspondence form
This form is for corrected claims or to send documentation for a claim that has already been processed (for example, an explanation of benefits EOB from primary insurance or medical records).
https://providers.amerigroup.com/ProviderDocuments/KSKS_ClaimsCorrespondenceForm.pdf

Recoupment notification form
This form is for use when you discover an overpayment and you would like for Amerigroup to initiate a recoupment.
https://providers.amerigroup.com/ProviderDocuments/KSKS_RecoupNotificationForm.pdf

Refund notification form
This form is for use when you discover an overpayment and you would like to refund the overpaid monies immediately. It requires a check to be included and goes directly to a lock-box.
https://providers.amerigroup.com/ProviderDocuments/KSKS_RefundNotif.pdf

Amerigroup Provider Services Unit
1-800-454-3730

Address for paper claims
Amerigroup Kansas, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

Address for written claim payment appeals

Payment Appeal Unit
Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

Address for corrected claims (if submitting on paper)
Include claim correspondence form and send to:
Claims Correspondence
Amerigroup Kansas, Inc.
P.O. Box 61599
Virginia Beach, VA 23466-1599

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Common denials – tips to avoid claim denials

Amerigroup currently serves approximately 128,000 members in the KanCare program, which generates 480,000 claims per month. In order to better serve you, here are some tips to avoid the top denial reasons for claims based on actual claim data.

1) **Prior authorization denials (denial codes Y3Z, Y41, Y40)** – Prior authorization (PA) denials occur when the service rendered was not approved by us in advance, an inpatient stay occurred without notifying us or services were rendered by providers who are not in our network (nonparticipating). To help avoid these denials:
   - All inpatient stays require PA, even when admitted through the ER. Please notify Amerigroup immediately of an inpatient stay via phone at 1-800-454-3730 or fax at 1-800-964-3627 within one business day of admission.
   - Check the Amerigroup PA webpage (https://providers.amerigroup.com/pages/pluto.aspx) to determine if the service you are providing requires PA. Here, you can enter the CPT code of the service you are providing and receive an immediate response if PA is required.
   - All nonemergency services rendered by a nonparticipating provider require PA.
   - Members who have been granted retro eligibility by the state of Kansas often have claims denied for no PA on file. The process for this situation is for the provider to call for an authorization and provide the necessary clinical information **prior to** submitting a claim. Our Utilization Management department will then review this information for medical necessity and enter an authorization. Once the authorization has been entered, the provider should submit a claim to Amerigroup.

2) **Duplicate claim denials (denial codes Y38, 346, CDD)** – Duplicate claims are an unnecessary expense for both providers and Amerigroup. Duplicate claims require costs to be incurred when billed, when received and when completed. Duplicates also take resources from processing current claims and can delay payment of current claims. The single best way to avoid duplicate claim denials is to post your provider remit immediately to your office billing system.

   Another way to avoid duplicate claim denials is to verify your Claim Acceptance Report from your vendor so that you know the original claim was received and accepted by Amerigroup.

   Should you need to submit a corrected claim, please clearly identify the claim as **corrected**.
   - On a CMS-1500 claim, use the following values to identify the claim as being corrected or changed. On a paper claim, this is Field 22. On an electronic claim, this is Loop 2300, Segment CLM-05-03, Value: 7. It is important to include the original claim number on the corrected claim.
     5 – Late charges only claim
     7 – Correction/Replacement of Prior Claim
     8 – Void/Cancel Prior Claim

- On a UB-04 claim, use the following Bill Type frequency codes to indicate a correction was made. On a paper claim, this is Field 4. On an electronic claim, this is Loop 2300, Segment CLM 05-03, Value: 5, 7 or 8.
  0XX5 – Late charges only claim
  0XX7 – Replacement of prior claim
  0XX8 – Void/cancel prior claim
- Providers can submit corrections by using the **resubmit** option on Availity. Use the appropriate choice from the *Billing Frequency* drop-down box. For additional information on how to use Availity, please contact your Provider Relations representative.

  Clearly marked corrected claims can be tied back to the original claim. Please note that hand-written corrections on claims are not permitted.

3) **Primary insurance information (CBP, CBO, YC7)** – Many Amerigroup members have other insurance as primary. Medicaid is the payer of last resort, and we cannot pay most claims when other health insurance (OHI) is involved until we have the primary payer information. Since these claims involve more than one payer, they will take more time in processing. Please allow up to 20 days for processing of these claims involving coordination of benefits. OHI payment information can be submitted with your claim information via electronic submission or paper submission of the other carrier payment. You can also help us keep our member information current by filing claims with primary payers and then to us, along with the name and address of the primary carrier.

4) **Timely filing (denial codes X15, X16, TF0, TF1)** – Please refer to your provider contract and know what your timely filing period is.
   - Primary claims: Claims must be received within your contractual timely filing period.
   - Secondary claims: Timely filing for claims involving other carrier payments begins on the date of the other carrier's resolution of the claim.
   - Corrected claims: For dates of service 1/1/16 and forward, the time period for filing corrected claims is 365 days from the date of service. The claim must be submitted as a corrected claim, in order to be processed appropriately.
   - Claim reconsideration: Unless your provider contract states differently, claim payment reconsiderations must be received within 60 days (plus three days if mailed) of the date of the EOP (explanation of payment).
   - Claim payment appeals: Unless your provider contract states differently, claim payment appeals must be received in writing or via the web within 30 days (plus three days if mailed) of the reconsideration determination letter.
   - Recoupments: If you receive a recoupment notice, and the recoupment was due to a billing error that can be corrected, and the 365 days for timely filing of corrected claims has already passed, you have an additional 70 days from the date of the first recoupment letter in which to submit the correction. You must include a copy of the recoupment letter with your claim. For example: If the date of service of the claim is

1/1/14, and the recoupment letter is dated 1/15/16, you have 70 days from 1/15/16 to submit a corrected claim, along with a copy of the recoupment letter.

5) **Disallow by contract** (**denial codes GDP, G18**) – This denial can mean the service provided is not allowed under the member's benefits or the provider contract.

6) **Member termination (denial code ST)** – Amerigroup gets our member information from the state of Kansas. You can check member eligibility by using Availity; by calling Amerigroup Provider Services Unit (PSU) at 1-800-454-3730; or using the KMAP secure provider site, if you are enrolled with KMAP.

Community mental health centers (CMHC) billing guide

The following are common denial reasons for CMHC claims.

1) **Claims denied due to National Correct Coding Initiative (NCCI) or medically unlikely edits (MUE)** – NCCI and MUE tables are typically updated by CMS on a quarterly basis, and it is the provider's responsibility to keep abreast of any changes. These tables are published on the Medicaid.gov website, and we strongly encourage providers to utilize this information.
   a) NCCI edits dictate that certain procedure code combinations cannot be billed by the same provider, for the same member, for the same date of service. The NCCI tables will specify if a modifier will bypass the NCCI edits but will not specify which modifier to use.
   b) MUE dictates how many units of a service can be billed by the same provider, for the same member, for the same date of service.

2) **T1017 – Targeted case management (TCM)** – TCM is noncovered for members with CHIP/TXXI (Title 21) coverage.

3) **T1023** – **Preadmission assessment** –Effective with dates of service January 1, 2016, and after, T1023 is no longer be covered by Amerigroup.

4) **PA denials**
   a) Although not a complete list of CMHC services that require PA, the following codes are commonly billed by CMHCs and do require PA:

Code	Code description	Additional information
H0004	Outpatient Individual	
H0004 GT	Outpatient Individual/Telemedicine	
H0005	Outpatient Group	
H0005 GT	Outpatient Group/Telemedicine	
H0018	Intermediate	
H0019	Reintegration	
H0036	Community Psychiatric Support/Treatment, all modifiers	144 units per calendar year are allowed without PA
H2021	Wraparound Facilitation	
S5110	Parent Support & Training/Individual	
S5110 TJ	Parent Support & Training/Group	
S5150	Short Term Respite Care	
S9485	Professional Resource Family Care	
T1017	Targeted Case Management	For behavioral health, 96 units per calendar year are allowed without PA
T1019 HK	Attendant Care – SED Waiver	
T2038	Independent Living/Skills Building	

99366	Case Conference, with patient and/or family, 30 min or more, with non-physician qualified health care professionals	
99367	Case Conference, with patient and/or family not present, participation by physician	
99368	Case Conference, with patient and/or family not present, participation by non-physician qualified health care professional	
90822-U3	Positive Behavioral Support/Person-Centered Planning	
H2027	PBS Environmental Assessment	
H2027 U3	PBS Treatment	
96101 96102 96103 96116 96118 96119 96120	Psychological and Neuropsychological Testing	PA is required if over six hours per calendar year are needed for all testing codes combined
90870	Electroconvulsive Therapy	
	***Services provided in hospital may require PA. Examples: diagnostic evaluation, psychotherapies, etc.	

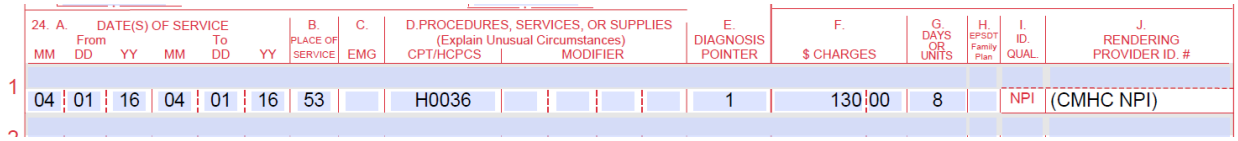
b) **PA denials for serious emotional disturbance (SED) waiver members** – Amerigroup recognizes that there are certain situations when the Kansas Aging Management Information System (KAMIS) does not communicate with the CMHCs with budget information. Often, this will result in services rendered when an authorization has not been entered into the Amerigroup system and the claim denies for no authorization. CMHCs have 180 days to file a timely claim. It is recommended that a claim is not filed until the authorization has been entered into the system, **unless the timely filing period is exhausting**, in which case, Amerigroup should be notified. This will alleviate the denials for no authorization and will eliminate the need for rework.

Duplicate denials – Per state policy, providers are required to submit all same-day services on the same claim. This means that if multiple segments of a service are provided for one member during a single day, all of these services must be submitted **on the same claim**. If the service is rendered by a provider with no individual NPI, bundle these services on the same line, using one place of service, even if there were several segments of the same code provided in different locations.

Examples:

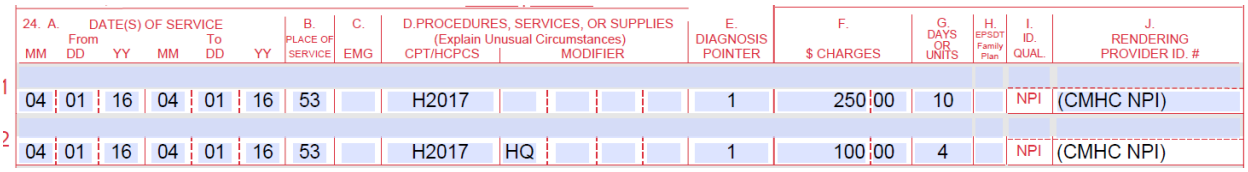
a) **Scenario 1**: Sally Martin, atypical CPST staff, sees member Jane Doe for two segments of CPST on 1/12/15 – one for 3 units, and the other for 2 units at the CMHC. David Mendez,

atypical staff, sees Jane for an additional segment of 3 units on the same day, at home. Even though the services are rendered by two providers, in different locations, they can be submitted on the same claim line.



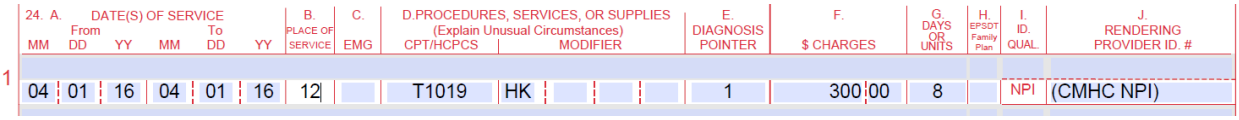
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04	01	16	04	01	16	53		H0036		1	130 00	8		NPI	(CMHC NPI)

b) **Scenario 2**: Sally Martin, atypical staff, sees Jane Doe for 3, 1-hour segments of H2017 Psychosocial Rehab, all at the CMHC. One hour was a group; two hours were individual. David Mendez, atypical staff, also saw Jane for 30 minutes of individual psychosocial rehab in the community.



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04	01	16	04	01	16	53		H2017		1	250 00	10		NPI	(CMHC NPI)
2 04	01	16	04	01	16	53		H2017	HQ	1	100 00	4		NPI	(CMHC NPI)

c) **Scenario 3**: Sally Martin, atypical staff, sees Jane Doe for 4 units, or 1 hour, of T1019-HK (SED Attendant Care) at home. David Mendez also sees Jane for 8 units, or 1 hour of T1019-HK at home.



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04	01	16	04	01	16	12		T1019	HK	1	300 00	8		NPI	(CMHC NPI)

5) **Timely filing denials** – CMHCs have 180 days from the first date of service on the claim for timely filing submission. Any claim received on the 181st day and after will be appropriately denied for timely filing. If the member has OHI that the claim coordinates with, the timely filing period starts on the date of the OHI EOB.

6) **Corrected claims** – Effective with dates of service 1/1/16 and after, corrected claims must be received within 365 days of the date of service. You must submit the corrected claim, using the appropriate resubmission code, as well as the previously processed claim number that you are correcting. You must also include all services that you want paid for on the correction.
For example, if you submitted a claim for T1019-HE, 15 units, but you realize you should have billed for a total of 20 units, you must submit a corrected claim for 20 units. Do not submit a corrected claim for ONLY the additional five units – if you do this, the claim for five units will take the place of the claim for 15 units, and you will be paid for only 5 units. **The corrected claim is a replacement of the prior claim.**

Please refer to the common denials section of the biller's guide for more information on corrected claims.

7) **Denials for OHI EOB**

a) Amerigroup uses the KMAP third-party liability (TPL) noncovered list. In addition, effective with dates of service 7/1/16 and after, there is a specific list of codes designated by KDHE, that will not be coordinated with other health insurance. If a member has a primary insurance plan that is not on the TPL noncovered list and if the procedure code is not included in the list below, we require the OHI EOB or proof that the primary plan does not cover that particular code or rendering provider type. The TPL noncovered list is located at https://www.kmap-state-ks.us/Public/TPL%20Noncovered.asp.

HCBS codes not edited for TPL coordination:				
97532	H2014	H2014	S5165	T2003
99368	H2015	H2015	S5170	T2011
99408	H2017	H2017	S5185	T2016
G0151	H2019	H2019	S5190	T2020
G0152	H2021	H2021	S9128	T2021
G0153	H2023	H2023	S9129	T2023
H0001	H2032	H2032	S9131	T2024
H0002	S0315	S0315	S9446	T2025
H0004	S0316	S0316	S9482	T2028
H0005	S0317	S0317	T1000	T2029
H0017	S5101	S5101	T1002	T2038
H0018	S5102	S5102	T1004	T2039
H0036	S5110	S5110	T1005	T2040
H0038	S5125	S5125	T1016	T2046
H0045	S5126	S5126	T1017	T4521
H0049	S5130	S5130	T1019	T4526
H0050	S5135	S5135	T1023	T4530
H2010	S5150	S5150	T1027	
H2011	S5160	S5160	T1505	
H2012	S5161	S5161	T2002	

b) Amerigroup is required to follow the rules of the primary insurance, and if the primary plan denied the claim, we are required to deny as well in instances such as: PA is required by the primary insurance; the provider is out-of-network with the primary insurance; the member did not obtain a required referral for the service, etc.

8) **Denials for GSR (state responsibility psychiatric residential treatment facility PRTF) or GDC (denied as content of service)** – These are typically related to members who either are in PRTF level of care, or have discharged from PRTF but the Amerigroup eligibility has not been updated. Often, there is a delay in the member's eligibility being updated to show that they are no longer in PRTF, which causes these denials. If you check the KMAP website and see that the eligibility has been updated, please notify Amerigroup so that claims can be reprocessed.

9) **Health Home claim denials - ****Please note that effective with dates of service 7/1/16 and after, Health Home services are no longer covered.**

a) The majority of CMHC claim denials for Health Home services are for services that are not available for certain Health Home members. Providers should know what their contract for Health Homes says, and if it excludes certain member categories, providers should not be rendering services to those members. The tables below show the core services available and the services available for waiver members. It is the responsibility of the provider to know if the member is on a waiver. You can check this by using the KMAP secure provider website.

Core Services	Severe Mental Illness Billing
Comprehensive care management	S0280 UC HE
Care coordination	S0281 UC HE
Health promotion	S0280 U1 HE
Comprehensive transitional care	S0281 U1 HE
Patient and family support	S0280 U8 HE
Referral to community and social support services	S0281 U8 HE

POPULATION*	BILLING CODE	MODIFIER
ID/DD WAIVER	S0280 S0280	UC HE U1 HE
TBI WAIVER	S0280 S0280	UC HE U1 HE
WORK WAIVER	S0280 S0280	UC HE U1 HE
DUAL PD WAIVER	S0280 S0280	UC HE U1 HE
NON-DUAL PD WAIVER	S0280 S0280	UC HE U1 HE
NON-DUAL FE WAIVER	S0280 S0280	UC HE U1 HE
TECHNOLOGY ASSISTED WAIVER	S0280 S0280	UC HE U1 HE
AUTISM WAIVER	S0280 S0280	UC HE U1 HE
SED WAIVER	S0280 S0281 S0280 S0281 S0280 S0281	UC HE UC HE U1 HE U1 HE U8 HE U8 HE

b) **Denials for Health Home members on spenddown** – Members who are on a spenddown plan are not eligible to receive Health Home services until they meet their spenddown balance. If there is a spenddown balance at the time the claim is received, the claim will deny. Providers should check the KMAP website to see if there is a spenddown balance on the date of service.

c) TCM (T017) should not be billed for members who are in Health Homes. Even if the member is assigned to a Health Home Partner who is not the CMHC providing the TCM, TCM should not be billed. TCM is considered part of the Health Home program, and reimbursement for TCM should be negotiated with the Health Home Partner. The only exception to this is for members who are assigned to Amerigroup as the HHP – in which case, providers may bill T2022 for TCM.

d) Health Home services are not covered for members in an institutional setting (nursing facility, PRTF, ICF-I/DD).

Home and community based services (HCBS)

HCBS is an alternative care program in which Medicaid members have the option to live more independently based on the community-based screening team's assessment and subsequent recommendations. Amerigroup does not determine eligibility for waivers. When a member is approved for a waiver, this information is sent to us by the state of Kansas.

All members receiving HCBS services must have a plan of care in place. The Amerigroup service coordinator will do an assessment on each HCBS member, and in conjunction with the member and family, develop a plan of care. Any changes to the plan of care require the approval of the service coordinator.

If the member is newly approved for a waiver, a provider is not guaranteed payment for services until an assessment is completed and they have received an approval for services in writing from Amerigroup.

If the member is a transfer from another managed care organization (MCO), the plan of care from the previous MCO will be honored for the first 30 days or until Amerigroup does our own assessment of the member, whichever comes first.

Types of waivers

- Autism
- Frail elderly (FE)
- Intellectual disability/development disability (ID/IDD)
- Physical disability (PD)
- Technology assisted (TA)
- Traumatic brain injury (TBI)

Timely filing

Please review your provider contract and know what your timely filing period is. Claims must be received within your contracted time frame for filing clean claims. If you discover that you need to correct a claim to add additional charges or units, this claim must be marked as a corrected claim and must be received within 365 days of the date of service (effective with dates of service 1/1/16 and after). Please refer to the *Common denials* section of this biller's guide for more information on timely filing, corrected claims and appeals.

Corrected claims

You may need to submit a corrected claim for a variety of reasons: You did not bill enough units; the billed charges were incorrect; the dates on the claim were incorrect; etc. Please note the following tips:

- The Authenticare system does not support submission of corrected claims. Therefore, you will need to submit those directly to Amerigroup. You can do that by submitting them on paper or through our Availity system.
- If the claim was underpaid, you must identify claims that need to be corrected within 365 days of the date of service (effective with dates of service 1/1/16 and after).

- If the claim was overpaid, there is no timely filing limit for a provider to return overpaid monies. However, if your timely filing period has expired, this should be done through the overpayment process instead of by submitted a corrected claim.
- Corrected claims must have the proper resubmission code of 7 on the claim in order for our system to recognize that the claim is a correction to a previously processed claim. It should also include the previously processed claim number so we know which claim you are correcting. The corrected claim will replace the previous claim, so be sure to include all units or services on the correction that you provided that day – not just the number of units that you are adding.
  - For example: You submitted a claim for 22 units and were paid for 22 units. However, you discover that you should have billed for 32 units. Do not submit a corrected claim for 10 units. If you do this, the previous claim for 22 units will be recouped, and you will only be paid for 10 units. You need to submit the corrected claim for 32 units so that you are paid the additional 10 units.

Claim submission options

You may submit claims through a variety of channels:

1) Electronically through an established claim clearinghouse. Use these electronic payer IDs:
   - Emdeon: 27514
   - Capario: 28804
   - Availity: 26375
2) Electronically through the KanCare front-end billing option (KMAP)
3) On paper — submit your paper claims to:

Amerigroup Kansas, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

Note: Many home and community-based services require electronic visit verification (EVV) and are billed via AuthentiCare.

Date span billing

Span billing is permitted in the Amerigroup system. When billing using span dates:

- Dates of service must be within the same month.
- Dates of service with the span cannot overlap (e.g., October 1, 2013, to October 15, 2013, then October 15, 2013, to October 31, 2013).
- If the dates of service on one claim overlap another, the entire claim will deny as a duplicate.
- Units billed must be equal to or less than units authorized for that month — any units in excess of the authorized amount will be denied.
- To correct a billing error (e.g., your claim is for 21 units from October 1, 2013, to October 31, 2013, but should have been for 22 units), you must submit a corrected claim. Claims for a single date of service within the span that was already paid will be denied as a duplicate.

Third-party liability (TPL)

Amerigroup follows state and federal guidelines in determining which services must be coordinated prior to payment. Effective with dates of service 7/1/16 and after, there is a specific list of codes designated by KDHE, that will not be coordinated with other health insurance. If a member has a primary insurance plan that is not on the TPL noncovered list and if the procedure code is not included in the list below, we require the OHI EOB or proof that the primary plan does not cover that particular code or rendering provider type. The TPL noncovered list is located at https://www.kmap-state-ks.us/Public/TPL%20Noncovered.asp.

HCBS codes not edited for TPL coordination:

97532	H2014	H2014	S5165	T2003
99368	H2015	H2015	S5170	T2011
99408	H2017	H2017	S5185	T2016
G0151	H2019	H2019	S5190	T2020
G0152	H2021	H2021	S9128	T2021
G0153	H2023	H2023	S9129	T2023
H0001	H2032	H2032	S9131	T2024
H0002	S0315	S0315	S9446	T2025
H0004	S0316	S0316	S9482	T2028
H0005	S0317	S0317	T1000	T2029
H0017	S5101	S5101	T1002	T2038
H0018	S5102	S5102	T1004	T2039
H0036	S5110	S5110	T1005	T2040
H0038	S5125	S5125	T1016	T2046
H0045	S5126	S5126	T1017	T4521
H0049	S5130	S5130	T1019	T4526
H0050	S5135	S5135	T1023	T4530
H2010	S5150	S5150	T1027	
H2011	S5160	S5160	T1505	
H2012	S5161	S5161	T2002	

Amerigroup does not require providers to bill Medicare first for any code that Medicare does not cover. Some codes (G0151, G0152, G0153, H0004, 97532, H2014, S5126-UC, T2025) must be billed with a GY modifier in order for Amerigroup not to require coordination with Medicare

PA or utilization management (UM) denials

If you receive a claim denial for PA or UM, please contact our Provider Services Unit (PSU) at 1-800-454-3730. They can look at the authorization and refer you to the case specialist if needed.

Client obligation

Amerigroup service coordinators will designate a specific provider on the member's plan of care who will assess and bill the member for all client obligation amounts. This designation will

remain a part of the member's record and claim payment until services are discontinued or the designated provider is changed by the service coordinator. Designated claims will be reduced by the specified client obligation amounts until the obligation is exhausted. Amerigroup follows the state guidelines on services against which obligation can be assessed. If the designated provider does not bill enough client obligation-eligible services to meet the member's obligation, Amerigroup may deduct the remaining amount from the provider who has billed for HCBS services in the same month. It is the responsibility of the provider to collect the client obligation. If the member refuses or is not able to pay the client obligation, please notify the member's service coordinator.

HCBS services generally excluded from monthly client obligation

Codes	Service	HCBS program
H2015	Autism Specialist	Autism Waiver
T2040 U2	FMS - Admin	FE, I/DD, TBI, MFP, TA, PD
S5170	Meals Providers	PD, MFP, TBI
T1002	Interim Med Services	TA
S5160	PER - Install, Home (Emergency Response)	FE, PD, MFP, TBI
S0315	Telehealth - install	FE, MFP
S5161	PER (Emergency Response)	FE, I/DD, PD, MFP, TBI
S5190	Wellness Monitoring	I/DD, PD, MFP
S5185	Medication Reminder	TBI
T1505 UB	Med Reminder Dispenser	TBI
T1505	Med Reminder Install	TBI
T1017	Targeted Case Management	I/DD

***Providers may refer to the KMAP HCBS provider manuals for details on HCPCS codes allowed for each waiver.

Hospice

Hospice care is available to members who:

1) Have been certified terminally ill by the medical director of the hospice or the physician member of the hospice interdisciplinary team.
2) Have been certified terminally ill by the attending physician.
3) Have filed an election statement with a hospice that meets Medicare conditions of participation for hospice.

Preauthorization

PA is required for all hospice services. Coverage of hospice services includes two 90-day episodes and subsequent 60-day episodes of care as needed, with appropriate physician recertification for continued hospice care. Please fill out and return the Hospice Precertification Request Form (https://providers.amerigroup.com/ProviderDocuments/KSKS_CAID_HospicePARequestForm.pdf) and return it by fax to the number on the form, along with the Hospice Notice of Election Statement.

For questions regarding hospice PA, please call 913-749-5955, ext. 50103.

If the member's status changes (examples: revocation, expired, transferred to another hospice agency), please fill out a new Hospice Precertification Form and fax to Amerigroup so that our records may be updated timely.

Hospice notice of election statement (NOES)

Hospice providers must submit the NOES to the fiscal agent (KMAP) within five days of the hospice admission. When a NOES is submitted late, Amerigroup will not cover and pay for the days of the hospice care from the hospice admission date to the date the NOES is submitted and accepted. If Amerigroup receives the Hospice Precertification Form from a provider but KMAP does not show the member has elected hospice, Amerigroup will not authorize nor pay for the services until KMAP has received the NOES Form from the provider.

When electing hospice, the provider must make the member aware that all services related to the treatment of the terminal condition or a related condition will not be covered nor paid for by Amerigroup. In addition, services provided by another hospice agency, not the designated hospice, will also not be paid for by Amerigroup.

The NOES may be revoked at any time by the member by filing a signed revocation statement with the hospice. This revocation must be sent to KMAP and to Amerigroup.

Hospice care for children in Medicaid

Limitations

Hospice care for children will be covered for the duration needed. An individual may choose to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period

- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

Medical services and concurrent care for children receiving hospice services
Children receiving hospice services can continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition. PA is required.

Claim submission
You may submit claims through a variety of channels:
1) Electronically through an established claim clearinghouse. Use these electronic payer IDs:
    - Emdeon: 27514
    - Capario: 28804
    - Availity: 26375
2) Electronically through the KanCare front-end billing option (KMAP)
3) On paper — submit your paper claims to:

Amerigroup Kansas, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

The following hospice codes are billed on a CMS-1500 claim
- **T2042:** Hospice routine home care, per diem, days 1-60 (payable at the high county rate where the member resides)
- **T2042U2:** Hospice routine home care, per diem, days 61 and forward (payable at the low county rate where the member resides), effective with dates of service 1/1/16 and forward
- **G0154TD** – Service Intensity Add-on payment for the last 7 days of life, billed by RN and when hospice routine home care is also provided
- **G0155** – Service Intensity Add-on payment for last 7 days of life, billed by social worker and when hospice routine home care is also provided
- **T2043**: Hospice continuous home care, per hour (payable at the county rate where the member resides)
- **T2044:** Hospice inpatient respite care, per diem (payable at the county rate the hospice facility is located)
- **T2045:** Hospice general inpatient care, per diem (payable at the county rate the hospice facility is located)
- **T2046**: Hospice long-term care, room and board only, per diem (payable at 95 percent of the Nursing Facility Rate)
- **T2046 U4:** Hospice long term care, room and board reserve bed, per diem (payable at 67 percent of the Nursing Facility Rate)

Hospice room and board
1) For hospice room and board, you must enter the name of the facility where the member resides in Box 17, and the NPI of the facility in Box 17b.

2) Claims submitted without the facility information are subject to denial.

Amerigroup is the payer of last resort and is to be billed only after payment has been sought from primary insurance carriers (including Medicare). **Examples**

1) The member resides in a skilled nursing facility (NF) and is covered by both Medicare and Medicaid. Election of hospice benefits from both carriers must occur concurrently.
2) The member resides in an NF and has skilled NF insurance coverage. Payment must continue to be sought from the primary carrier. If additional payment is requested for room and board services following the primary carrier's payment, claims submitted must report the primary payment in the appropriate TPL amount field.
3) The member resides in a skilled NF and meets the criteria to receive Medicare's skilled nursing benefit for a condition unrelated to the diagnosis for which hospice care was elected. Billing Amerigroup must occur only after payment has been sought from Medicare or after the exhaustion of benefits.

For a complete review of the KMAP hospice manual, see:
https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/HOSPICE

Hospital/facility

Claim type
Facility claims, such as a hospital and nursing facilities, must be submitted on a UB-04 claim when requesting payment of medical services and/or supplies.

Methods of submission
Claims can be submitted in the following ways:
1) Electronically through an established claim clearinghouse. Use these electronic payer IDs:
    - Emdeon: 27514
    - Capario: 28804
    - Availity: 26375
2) By using the Amerigroup provider web portal (Availity)
3) Electronically through the KanCare front-end billing option (KMAP)
4) On paper — submit your paper claims to:

Amerigroup Kansas, Inc.
P.O. Box 61010
Virginia Beach, VA 23466-1010

***Faxed claims are not accepted.

Secondary claims
Secondary claims can be submitted on paper with the primary payor's EOB attached or via Availity. If submitting electronically, providers can enter the primary payor's information, and/or attach a copy of the EOB for coordinating benefits.

Corrected claims
Effective with dates of service 1/1/16 and forward, corrected claims must be received by Amerigroup within 365 days of the date of service. Please see the *Common denials* section of this handbook for more information on corrected claims.

Handwritten claims
Amerigroup does not accept claims that have been altered (information marked out, whited out or handwritten on a typed form). We will only accept handwritten information on a claim if the entire claim is handwritten.

Outpatient facility claims
Outpatient facility claims using revenue codes must also have a valid HCPCS code in order to be considered for payment. Outpatient facility claims with no HCPCS codes will deny.

Attending provider
The attending provider's NPI and name are required on all institutional claims.

Timely filing
All providers must submit claims within the contractual timely filing period for clean claims. Corrected claims must be received within this timely filing period – there is no extension for corrections. Providers should review their contracts to determine what their timely filing period is. Please refer to the *Common denials* section of this biller's guide for more details on timely filing.

Authorizations
Precertification is required at least 72 hours prior to the admission for all services rendered by an inpatient hospital, with the exception of emergency admissions. For emergent admissions, providers must notify Amerigroup of the admission within one business day and provide clinical information within 72 hours of admission. We are available 24 hours a day, 7 days a week to accept precertification requests.

- Phone: 1-800-454-3730
- Fax: 1-800-964-3627
- Web: providers.amerigroup.com/KS

Retroactive KanCare eligibility
We understand that it is not uncommon for a patient to admit to the hospital with no KanCare eligibility and at some point during their treatment, or after the fact, receive retroactive eligibility that covers the hospital stay. In these instances, you must still obtain authorization prior to submitting a claim.

When you receive notification that the member has obtained retroactive eligibility, please contact Amerigroup and request an authorization for a retro-eligible member **prior to** submitting a claim. If you submit a claim before securing the authorization, the claim will deny for "no PA". You will need to appeal the denial, and provide medical records for review.

Inpatient billing

1) **Present on admission indicators**
   Present on admission (POA) indicators are required on all inpatient claims, including critical access, LTC, cancer and children's hospitals, freestanding psychiatric and rehabilitation facilities.

   POA is defined as present at the time the order for inpatient admission occurs. The POA code should be on all diagnosis codes – primary, secondary and all other diagnoses, and the external cause of injury codes. The POA indicator must be valid and claims will deny if it is not valid.
   - Y (for yes) – Present at the time of inpatient admission
   - N (for no) – Not present at the time of admission
   - U (for unknown) – Documentation is insufficient to determine if condition is present on admission
   - W (for clinically undetermined) – Provider is unable to clinically determine whether condition was present on admission or not

- Exempt from POA reporting – Some diagnosis codes do not require a POA indicator; paper claims will require a POA indicator of "1" for exempt diagnosis codes; leave blank for electronic claims

2) **Inpatient payment methodology**
Payment for inpatient claims is based on diagnosis-related group (DRG) weight, times the group payment rate, plus any outlier costs, if appropriate, using the lesser of the DRG amount or billed amount. Providers must include the DRG on the claim.

3) **Interim billing for hospitals**
Interim billing is allowed once every 30 days. If an interim bill is received prior to 30 days, the claim will be denied.

4) **Readmissions within 30 days**
Readmissions within 30 days of a discharge will be reviewed. If any of the first five diagnosis codes fall into the same grouping as the previously paid claim, the claim may be subject to recoupment.

Outpatient facility billing

1) **ER services**
- ER services must be billed using evaluation and management (E&M) emergency department or critical care procedure code. The E&M or critical care codes must be billed with the appropriate modifier appended for facilities.
- Nonemergent ER services must be billed using 99281-ET. Claims for nonemergent services (i.e., the diagnosis codes on the claim are nonemergent) will be reduced to the 99281-ET rate.
- Radiology, when billed as part of an ER visit, does not require PA.
- ER services are considered content of service of respiratory services unless the ER visit is a significant separately identifiable service.
- Medical supplies and injections (99070 and J7030-J7130) are also considered content of service of the ER visit.

2) **Billing of supplies and physician clinic services in a hospital setting**
- Physician clinic services in a hospital setting – G0463 is effective and payable for dates of service April 1, 2015, and forward for Peer Group 2 and Peer Group 3 providers. This is not payable for Peer Group 1 providers.
- Supplies – Hospitals should bill 99070 for supplies <u>without modifier ET</u>. Only one supply is allowed per day.

3) **Observation**
Observation in the outpatient setting is a service that requires monitoring the patient's condition beyond the usual amount of time in an outpatient setting. Examples of appropriate use of the observation room include monitoring head trauma, drug overdose,

cardiac arrhythmias and false labor. Recovery room services shall not be considered observation services.

- **Nonpsychiatric observation** – For dates of service before April 1, 2015, use 99218 ET. For dates of service on and after April 1, 2015, hospitals should use G0378 (no ET modifier) for the observation facility charge. This is a per-hour code and is limited to 48 hours. Medical supplies and injections (99070 and J7030-J7130) are considered content of service to the observation and will not be reimbursed separately.
- **Psychiatric observation** – Use code H2013. Psychiatric observation is covered for up to two consecutive days, and this is a per-diem payment. When an inpatient admission follows a psychiatric observation stay, the observation days should be billed on the inpatient claim and they become part of the DRG payment to the hospital.

4) **Outpatient to inpatient**
With the exception of critical access hospital outpatient procedures, outpatient procedures provided within three days of a hospital admission for the same or similar diagnosis are considered content of service and must be billed on the same inpatient hospital claim.

UB-04 form requirements	Inpatient/outpatient (I, O or B)	Field location
• Provider name address and telephone number	B	1
• Patient control number	B	3a
• Type of bill (TOB)	B	4
• Federal tax number	B	5
• Statement covers period, from and through dates	B	6
• Patient name and address	B	8b/9
• Birthdate	B	10
• Sex	B	11
• Admission date	B	12
• Admission hour	B	13
• Admission type	B	14
• Admission source (SRC)	B	15
• Discharge hour	I	16
• Status (inpatient only)	B	17
• Value codes (if applicable)	B	39-41
• Revenue codes (inpatient only)	B	42
• HCPCS/rate/CPT codes (outpatient only)	B	44
• Service date (outpatient only)	O	45
• Service units	B	46
• Total charges	B	47
• Payer name	B	50

• Release of information indicator	B	52
• Assignment of benefits indicator	B	53
• Prior payments (when OHI involved)	B	54
• Estimated amount due	B	55
• NPI	B	56
• Insureds name	B	58
• Patient relation to the insured	B	59
• Insureds unique ID	B	60
• Treatment authorization codes	B	63
• Diagnosis/procedure code qualifier	B	66
• Principle diagnosis code/other DX codes	B	67
• Diagnosis code (including the admitting DX)	B	69
• POA indicator (with DX codes)	B	66
• External cause of injury code (ECI) and POA if applicable		72
• Principal procedure and any additional	B	74
• Attending name/ID-Qualifier 1G	B	76
• Operating information		77
• NDC code	Where applicable for code	43

INPATIENT

1 Any Hospital 123 Any Street Philadelphia PA 19103	2 Any Hospital 456 Any Street Philadelphia PA 19103	3a PAT. CNTL # 1234 b. MED. REC. # 98765 5 FED. TAX NO. 221234567 6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06	4 TYPE OF BILL 0111 7 RESERVED

8 PATIENT NAME a Patient ID if different from Sub
b Doe, John

9 PATIENT ADDRESS a 1234 Main Street
b Philadelphia c PA d 19111 e County code if other than USA

10 BIRTHDATE	11 SEX	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
03 20 1971	M	11 03 06	08	3	3	12	01	Condition Codes Required Identifying Events	PA	RESERVED

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37
Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing — FUTURE USE

38
John Doe
1234 Main Street
Philadelphia, PA 19111

39–41 VALUE CODES CODE / AMOUNT
a A1 952.00
b Value Codes and amounts required when necessary to process claim

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0129	Semi-Private	200.00		2	400.00	0.00	Future Use
0250	Pharmacy			1	50.00	0.00	
0360	OR Services				100.00	0.00	
	PAGE 1 OF 1	CREATION DATE		TOTALS	550.00	0.00	

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 2222222222
A Independence Blue Cross	Report HIPAA National Health Plan Identifier when mandatory	Y	Y	Required when indicated payer has paid amount to Provider	Amount estimated to be due	57 OTHER PRV ID 1234567890
B Secondary Payer						Secondary
C Tertiary Payer						Tertiary

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A Doe, John	18	ABC1234567800	Watch Repair, Inc.	1234
B Secondary				
C Tertiary				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A 02468	491234	Watch Repair, Inc.
B Secondary		
C Tertiary		

66 DX 9 67 3910 — Use A through Q to report "Other Diagnosis" if applicable — 68 Reserved

69 ADMIT DX 4280 — 70 PATIENT REASON DX May be used to report reason for visit — 71 PPS CODE DRG — 72 ECI May be used to report external cause of injury — 73 Reserved

74 PRINCIPAL PROCEDURE CODE 3749 DATE 11 03 06; a.–e. OTHER PROCEDURE CODE / DATE

75 Reserved

76 ATTENDING NPI 2222222222 QUAL 1G 1234569822
LAST Smith FIRST David

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS
May be used to report additional information.

81CC a B3 282N00000X
b Secondary
c Tertiary
d

UB-04 CMS-1450 APPROVED OMB NO. NUBC THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

OUTPATIENT

1 Any Hospital 123 Any Street Philadelphia PA 19103	2 Any Hospital 456 Any Street Philadelphia PA 19103	3a PAT. CNTL. # 1234 b MED. REC. # 98765 4 TYPE OF BILL 0131 5 FED. TAX NO. 221234567 6 STATEMENT COVERS PERIOD FROM 11 03 06 THROUGH 11 04 06 7 RESERVED	

8 PATIENT NAME a Patient ID if different from Sub b Doe, John	9 PATIENT ADDRESS a 1234 Main Street b Philadelphia c PA d 19111 Country code if other than USA										
10 BIRTHDATE 03 20 1971	11 SEX M	12 ADMISSION DATE 11 03 06	13 HR 08	14 TYPE 3	15 SRC 3	16 DHR 12	17 STAT 01	18-28 CONDITION CODES Condition Codes Required Identifying Events	29 ACCT STATE PA	30 RESERVED	
31 OCCURRENCE CODE DATE	32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE SPAN CODE FROM THROUGH	36 OCCURRENCE SPAN CODE FROM THROUGH	37					
a Occurrence and Occurrence Span Codes may be used to define a significant event that may affect payer processing										FUTURE USE	

38 John Doe 1234 Main Street Philadelphia, PA 19111	39 VALUE CODES AMOUNT a A1 952.00 b Value Codes and amounts required when necessary to process claim c d	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0310	Laboratory N400093723106	88173	11 03 06	1	100.00	0.00	Future Use
2	0402	Ultrasoud	76942	11 04 06	1	100.00	0.00	
3	0360	OR Services	3749	11 04 06	1	100.00	0.00	
4								
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20								
21								
22								
23		PAGE 1 OF 1		CREATION DATE		TOTALS	300.00	0.00

50 PAYER NAME A Independence Blue Cross B Secondary Payer C Tertiary Payer	51 HEALTH PLAN ID Report HIPAA National Health Plan Identifier when mandatory	52 REL. INFO Y	53 ASG. BEN. Y	54 PRIOR PAYMENTS Required when indicated payer has paid amount to Provider	55 EST. AMOUNT DUE Amount estimated to be due	56 NPI 2222222222 57 OTHER A 1234567890 B Secondary C Tertiary

58 INSURED'S NAME A Doe, John B Secondary C Tertiary	59 P REL 18	60 INSURED'S UNIQUE ID ABC1234567800	61 GROUP NAME Watch Repair, Inc.	62 INSURANCE GROUP NO. 1234

63 TREATMENT AUTHORIZATION CODES A 02468 B Secondary C Tertiary	64 DOCUMENT CONTROL NUMBER 491234	65 EMPLOYER NAME Watch Repair, Inc.

66 DX 9	3910	Use A through Q to report "Other Diagnosis" if applicable								67 Reserved	
67 ADMIT DX	4280	68 PATIENT REASON DX	May be used to report reason for visit			69 ADMIT DRG CODE	DRG	70 PPS-C	May be used to report external cause of injury	71 PPS-I	Reserved
74 PRINCIPAL PROCEDURE CODE	DATE 3749	11 04 06	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	c. OTHER PROCEDURE CODE	DATE	75 Reserved		
d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	f. OTHER PROCEDURE CODE	DATE						

76 ATTENDING NPI 2222222222 QUAL 1G 1234569822 LAST Smith FIRST David	77 OPERATING NPI QUAL LAST FIRST	78 OTHER NPI QUAL LAST FIRST	79 OTHER NPI QUAL LAST FIRST	80 REMARKS May be used to report additional information.	81 CC a B3 282N00000X b Secondary c Tertiary d

USO4 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Precertification/preauthorization

Prior notification – Notifying Amerigroup of services to be given to the member **before** the member receives treatment or services. This must be done via our provider website, fax or phone. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified.

Precertification/preauthorization – The prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided. We are available 24 hours a day, 7 days a week, to accept precertification requests.

Preauthorization is not a guarantee of payment. Claims payment is subject to eligibility, benefits and medical necessity review at the time of service.

When Amerigroup is the secondary payor – If the primary insurance covers the service, no PA is required with Amerigroup. However, if the primary insurance denies the claim, or if the member's primary insurance benefits are exhausted and Amerigroup becomes the primary payor, authorization is required. Please call Amerigroup and request authorization and explain the situation, or file an appeal for your denied claim and submit medical records for review within the appropriate time frames.

Out-of-network providers – When Amerigroup is the primary payer, all out-of-network/nonparticipating providers require precertification for all services.

Time frames – PA must be received prior to rendering services, unless it is an emergency. In some instances, such as inpatient admissions through the ER, providers must notify Amerigroup within one business day of admission. Below are some general guidelines for different types of service.

- Inpatient elective: Authorization will be determined within 14 calendar days from receipt of request
- Inpatient elective – expedited: Providers must document that this is an expedited request. If determined to be an expedited request, authorization will be determined within 72 hours from receipt of request.
- Inpatient emergent: Notification within one business day of admission. Clinical information must be received within 72 hours and medical necessity criteria will be applied.
- Hospice – inpatient or outpatient: Authorization will be determined within one business day from receipt of request.
- Inpatient rehab: Authorization will be determined within 14 calendar days from receipt of request.

- Inpatient rehab – Expedited: Providers must document that this is an expedited request. If determined to be an expedited request, authorization will be determined within 72 hours from receipt of request.

Retroactive eligibility

For cases where the member is made retroactively eligible for KanCare, a waiver program or a nursing facility, please contact Amerigroup on the next business day to obtain retro-certification for the applicable services and prior to submitting a claim. If a claim is submitted prior to obtaining authorization, the claim will deny for no PA. You will need to appeal the denial and provide medical records for review.

Precertification and notification contact information

Medical claims: Amerigroup • Online at https://providers.amerigroup.com/KS • Fax: 1-800-964-3627 • Phone: 1-800-454-3730	**Pharmacy: Express Scripts** • Online at www.express-scripts.com • Fax: 1-800-601-4829 • Phone: 1-855-201-7170
Behavioral health • Online at https://providers.amerigroup.com/KS • Inpatient faxes: 1-877-434-7578 • Outpatient faxes: 1-800-505-1193 • Phone: 1-800-454-3730	**Medical Injectable precertification and notification** • Fax: 1-855-363-0728 • Phone: 1-800-454-3730
Radiology and imaging: AIM Online at aimspecialtyhealth.com/goweb Phone: 1-800-714-0040	
Please provide the following information with your requests: • Member or Medicaid ID • Member's Social Security number if available • Member's date of birth • Legible name of referring provider • Legible name of person referred to provider • Number of visits/services • Date(s) of service • Diagnosis • CPT/HCPCS codes	

PA denials

If your request is denied by our medical director, you will have the opportunity to discuss your case with him or her before the final determination. We will mail a denial letter to the

requesting provider, the member's PCP and the member. Appeal and fair hearing rights, along with process information is included in the information sent to the member.

Services always requiring precertification when Amerigroup is the primary payer (this is not an all-inclusive list; refer to Amerigroup provider manual for details):

- Inpatient hospitalization, including behavioral health and SUD inpatient
- PRTF (psychiatric residential treatment facility)
- Physical/occupational/speech therapy
- Home health
- Sleep studies
- Hospice
- Many DME purchases and all DME rentals
- HCBS services
- High-tech imaging (examples not all-inclusive: MRIs, MRAs, CT scans, nuclear cardiology, echocardiograms and video EEG)
- Nonemergency services by all nonparticipating providers

Tools for participating providers

- Use the Precertification Lookup Tool (PLUTO) to check specific codes for Amerigroup providers at https://providers.amerigroup.com/pages/pluto.aspx.
- Various precertification guidelines are found in the Amerigroup Kansas, Inc. provider manual at https://providers.amerigroup.com/ProviderDocuments/KSKS_Prov_Manual.pdf.