Provider Update

Amerigroup RealSolutions in healthcare

Claim payment appeals — changes and clarifications

Summary of change: In keeping with CMS guidelines, the Kansas Department of Health and Environment has issued some clarifications and changes to the claim payment appeal process, which are effective for dates on and after May 1, 2017.

The changes are as follows:

- It is no longer a requirement to request a reconsideration prior to requesting an appeal. A reconsideration is an informal option to request review of a claim and is not mandatory prior to filing an appeal. If providers wish to have their claim payment reconsidered first in order to reserve the appeal rights, this is encouraged as a first step.
- Amerigroup Kansas, Inc. will have 30 calendar days to resolve an appeal. If more time is needed, providers will receive a notification informing them of the updated process time.
- All providers will have 60 calendar days (plus three days for mailing) from the date of the negative action to request a formal appeal. Appeals must be received via our provider website or in writing.
    - If submitting in writing, please send to:

      Amerigroup Kansas, Inc.
      Claim Payment Appeals
      P.O. Box 61599
      Virginia Beach, VA 23466
    - If submitting online, please follow these instructions:
        - Visit https://providers.amerigroup.com/KS and select **Login**.
        - Select **Claims** followed by **Check claim status**. This will redirect you to the Availity website.
        - Complete the *Claim Status Inquiry* and select the claim you wish to reconsider or appeal.
        - Select **Dispute Claim** near the bottom of the screen.

After selecting **Dispute Claim**, a new screen will appear allowing the reconsideration or appeal information to be entered. If the email option is selected, acknowledgment and resolution letters will be sent securely via email. If you specifically wish to bypass the reconsideration, it is strongly recommended you note this in the text box.

What is the impact of this change?

Providers will have two ways to dispute a claim payment:

- Reconsideration:
    - Reconsideration is the informal dispute process. Although recommended, this level is no longer required prior to requesting a formal appeal.

    - Reconsiderations are required to be received within 120 calendar days (plus three days if in writing) of the date on the *Explanation of Payment* (*EOP*) and are allowed to be submitted via phone, online or in writing.
    - If submitting via writing or web, it is recommended that providers attach the *Reimbursement Reconsideration Submission Form*, which is found under the *Forms* section of the provider website.
- Appeal:
    - Appealing is a process with only one level of appeal and must be exercised prior to filing for a state fair hearing.
    - Appeals must be received within 60 calendar days (plus three days if mailed) of the date on the *EOP* or within 60 calendar days (plus three days if mailed) from the date on the reconsideration determination letter (if one was filed).
    - Appeals must be received in writing or through the provider website. **Verbal appeals are not accepted.**
    - Providers should utilize the *Claim Payment Appeal Submission Form* found under the *Forms* section of the provider website — This signals us to consider the dispute a formal appeal instead of a reconsideration.
    - If you filed your appeal via the provider website and wish to bypass the reconsideration, please include the following verbiage in the text box: **Please bypass reconsideration and consider this an appeal.**
    - If the appeal has been completed and the provider still disagrees with the outcome, a state fair hearing may be filed. Please follow the state fair hearing process outlined in your provider manual.

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.