AMERICIGROUP IOWA
PLAN UPDATES

Provider Solutions
- Implementation of Value-based Payment Programs for selected LTSS, BH, and Medical providers
- Addition of Ancillary Provider Representatives
- Implementation of Crisis Services
- Electronic submission of claims per IME guidelines

Utilization Management
- AIM
  - Rehab Agencies
  - MSK
  - Sleep Studies

Grievance and Appeals

Availity Enhancements
- Claims and Reconsideration Review
- Interactive Care Reviewer
Provider Disputes

- As communicated in the August 2018 Provider Newsletter, the Provider Manual is being updated to reflect the new process and terms related to claim remediation.

- There are two levels of review:
  - Claim Payment Reconsideration
  - Claim Payment Appeal

- A consistent claim payment dispute process that is familiar, easy to navigate, and results in accurate and timely resolution of provider claim payment disputes.

- Enhanced Provider experience when filing disputes through the Availity Portal and ability to check the status easily.

- Reduces paperwork with online attachment capability.

- Worklist of disputes submitted, requiring additional information, and finalized disputes.
Availity: Enhancements That Benefit Our Providers

- Providers will be able to submit and check the status of disputes through the Availity Portal.
- Ability to upload supporting documentation.
- Submit up to five claims on one dispute submission tied to the same member/issue.
- Dispute outcome letters will be posted on Availity, no matter the method of dispute submission.
  - Providers may choose the avenue for communication: Availity, fax, or mail
- Notification when a reconsideration has been reviewed.
Interactive Care Reviewer: The Benefits

• **Determine if a precertification or prior authorization is needed:** For most requests, when you enter patient, service and provider details, you receive a message indicating whether or not review is required.

• **Inquiry capability:** Ordering and servicing physicians as well as facilities can inquire to find information on any precertification or prior authorization they are affiliated with.

• **Reduce the need to fax:** Submit online requests without the need to fax medical records. Our ICR allows both text detail and photo and image attachments to be submitted along with the request.

• **Comprehensive view of all precertification requests:** You have a complete view of your Utilization Management requests submitted online, including status of your requests with views of case updates. Cases include an imaged copy of the associated letters.
Utilization Management: Streamlining Care Guidelines across Medical and Behavioral Health Services

Effective November 1, 2018, MCG Heath Care Guidelines will be used for reviews, to include the use of customizations to certain guidelines and:

• Inpatient and Surgical Care Guidelines.
• General Recovery Care Guidelines.
• Recovery Facility Care Guidelines.
• Chronic Care Guidelines.
• Behavioral Health Care Guidelines (NEW).
• Additionally, effective November 1, 2018, AIM Specialty Health® Proton Beam Therapy will be used for clinical reviews.
• Please share this notice with other members of your practice and office staff.
Confirming Member Eligibility

Providers can verify member eligibility as follows:

• Available 24 hours a day, 7 days a week for real-time member enrollment and eligibility verification for all IA Health Link programs or use the website to determine the member's specific benefit plan and coverage:
  – Automated voice response: 1-800-338-7752

• Contact Provider Services to verify enrollment and benefits for our members:
  – Phone: 1-800-454-3730, Monday to Friday, 7:30 a.m. – 6 p.m. Central time
  – On the Availity web portal at www.Availity.com
    o Or access Availity through our secure provider site (https://providers.amerigroup.com/ia) by selecting Eligibility and Benefits and clicking on the link to redirect to the Availity portal
CLAIMS SUPPORT

• Top Denial Reasons and Remittance Advice Interpretation

• Reimbursement Policy Updates
## Top Denial Reasons

<table>
<thead>
<tr>
<th>Denial</th>
<th>Layman’s Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duplicate Claim (DCC)</strong></td>
<td>Multiple claims received for the same member and date of service. Please ensure corrected claims are marked appropriately.</td>
</tr>
<tr>
<td><strong>Timely filing (TFO)</strong></td>
<td>Timely filing is 180 days from the date of service. For claims where Amerigroup is the secondary payer, timely filing is 180 days from the EOB.</td>
</tr>
<tr>
<td><strong>Units exceeded UM authorization (UM1)</strong></td>
<td>Billed units cannot exceed units authorized. Approved authorizations can be reviewed through Availity at your convenience.</td>
</tr>
<tr>
<td><strong>Deny Preauthorization not Obtained (Y41)</strong></td>
<td>Certain services require prior authorization (PA). Providers can utilize the PLUTO tool on our provider portal in order to verify if preauthorization is required.</td>
</tr>
<tr>
<td><strong>Primary carrier information required (CBP)</strong></td>
<td>This member is listed as having a primary insurance carrier. Please submit the claim to the primary payer, then resubmit to Amerigroup with the primary EOP for any secondary payment due.</td>
</tr>
</tbody>
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## Top Denial Reasons (continued)

<table>
<thead>
<tr>
<th>Denial</th>
<th>Layman’s Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination (ST Termination)</td>
<td>Member is no longer enrolled with benefits under Amerigroup Iowa. Please verify Medicaid and MCO eligibility with Iowa Medicaid</td>
</tr>
<tr>
<td>Service not payable per contract (G18)</td>
<td>Services are reimbursable based upon your provider contract and credentialing. Provider-type specific fee schedules are available at <a href="https://dhs.iowa.gov/ime/providers/csrp/fee-schedule/agreement">https://dhs.iowa.gov/ime/providers/csrp/fee-schedule/agreement</a></td>
</tr>
<tr>
<td>Charges Processed Under Initial Submission (F00)</td>
<td>This service was reimbursed under a previously submitted claim.</td>
</tr>
<tr>
<td>Claim/service lacks information or has submission/billing error(s)</td>
<td>Claim contains incomplete and/or invalid information, the claim is unprocessable. Please submit a new claim with the complete/correct information.</td>
</tr>
<tr>
<td>Primary payment is greater than the allowable (IPI)</td>
<td>A payment made by the member’s Commercial or Medicare insurance was greater than the allowed amount for Medicaid. No additional payment will be made.</td>
</tr>
</tbody>
</table>