



KanCare MCO Workgroup

Authorizations, Claims Processing and Call Center Service
August 13, 2012

Focused on Service and Support



Our Provider Support Services

- **Local Provider Relations staff in addition to online and toll-free support services**

- Local representatives are assigned for each network provider.
- Our account management model includes orientation, education and ongoing support.



- **Provider Experience Program**

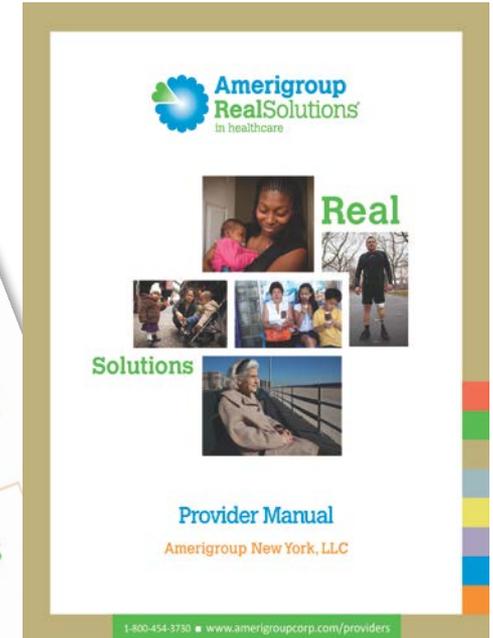
- A dedicated support unit fields provider inquiries for increased first-call resolution rates.
- Cross-functional resources support complex issue resolution.

- **Other Amerigroup Resources**

- We employ more than 1,000 doctors, nurses and social workers who develop disease and care management programs for conditions common among the members we serve.
- Our service centers employ more than 800 associates who reach out to our members and providers by telephone.

We Make It Easy to Do Business With Us

- Automated eligibility, claims and authorization status verification at providers.amerigroup.com or 1-800-454-3730
- Electronic claims submissions and resubmissions, status, payments, and explanations of payment
- Convenient access to Web-based tools and reference materials like provider manuals, quick reference cards, referral directories, announcements, policies and forms
- Regular program updates through blast fax and mail notices

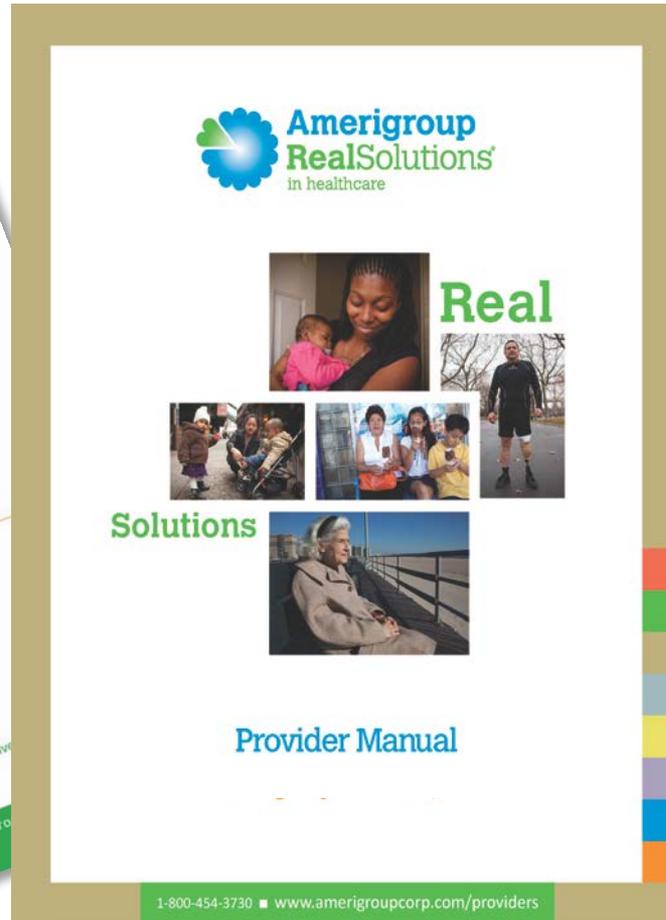


Provider Orientation and Education Programs

- **Amerigroup will conduct new provider orientation within 30 days of effective date of participation in our network**
 - Sessions are offered in various modes including hosted forums, in-person at your site, or via webinars
 - Materials will be available on our provider website
- **Amerigroup offers Provider Education Programs on:**
 - Enhancing your Cultural Competency
 - Increasing Screening Rates for EPSDT Services for PCPs and Maternity Care Specialists
 - Integrating Physical and Behavioral Health Services for PCPs
 - Long Term Support Service Provider Training
 - Billing Training for Nursing Facilities
 - Indian Health Service Provider Training
 - Diabetes Care Training for PCPs



Reference Tools



Provider Website

www.amerigroupcorp.com/providers

The screenshot shows the top navigation bar with links for home, main, contact us, state sponsor sites, and logout. A search box is located on the right. Below the navigation bar are links for Partner With Us, Login Help, Quick Tools, and Find a Provider. The main banner features a photograph of a woman and the text "for providers". Below the banner, there is a "RealStories..." section with a photo of a healthcare professional. To the right of this is a "How can we help you?" section with a paragraph of text. Further right is a "Login" section with input fields for User Name and a password, a LOGIN button, and a dropdown menu for Registration Login Help.

Amerigroup
RealSolutions
in healthcare

home main contact us state sponsor sites logout search

Partner With Us Login Help Quick Tools Find a Provider

for providers

RealStories...

How can we help you?

Providing care for those who need it the most requires a total team effort and there's no more critical person on this team than you the provider. Our challenge is to find ways to help you use your resources as efficiently and productively as possible. And that begins by listening—listening to the problems you encounter and the ideas you have to make the system work better. Together we can find the real solutions that can make a real difference in people's lives.

Login

User Name

LOGIN

Registration Login Help

Website Registration

[login](#) [help](#)

New User Registration

[Activate Your Account](#)

[Forgot User Name](#)

[Forgot Password](#)

[Forgot Activation Code](#)

Complete the form below to register. You will only need to enter a Registration Code if you are the first user for your practice or if you are registering as a delegated administrator.

For Non-Participating Amerigroup providers (who have previously submitted claims with us), we invite you to register.

If you don't have a registration code, contact your provider relations representative to get started.

New User Registration

First Name *	<input type="text" value="John"/>	
Last Name *	<input type="text" value="Doe"/>	
Phone Number *	<input type="text" value="555-666-7777"/>	
Email Address *	<input type="text" value="jdoe@yahoo.com"/>	
TIN *	<input type="text" value="123456789"/>	
Amerigroup Provider ID *	<input type="text" value="8685431"/>	
Registration Code	<input type="text" value="MB4B8D"/>	
User Name *	<input type="text" value="TestProvider1"/>	
Password *	<input type="password" value="••••••••"/>	
Confirm Password *	<input type="password" value="••••••••"/>	



Precertification and Notification



Is Precertification Required?

■ Precertification required for:

- Elective admissions
- Outpatient high-tech, high-cost imaging
- Some outpatient services like plastic and obesity-related surgery
- High-cost durable medical equipment
- High-cost pharmaceuticals
- All Long Term Service Support and Nursing Facility Services

■ Recertification not required:

- Most outpatient in-network specialty visits have no gatekeeper process
 - Emergency department visits
 - Hospital observation status
- ## ■ Our precertification list was reduced by 75 percent during the past two years

Is precertification required?

Precertification Lookup

This tool outlines the Amerigroup requirements for precertification and notification.

Please see our announcement regarding Precertification rule changes! (Georgia & Maryland are excluded).

 [CLICK HERE to see our Precertification User Guide >>](#)

To determine if a precertification or notification is required, complete the form below, then click FIND A CODE

* - Required Field

Market *	<input type="text" value="Select Market"/>
Line of Business *	<input type="text" value="Select Line of Business"/>
CPT/HCPCS Code or Code	<input type="text"/>
Description *	<input type="text"/>

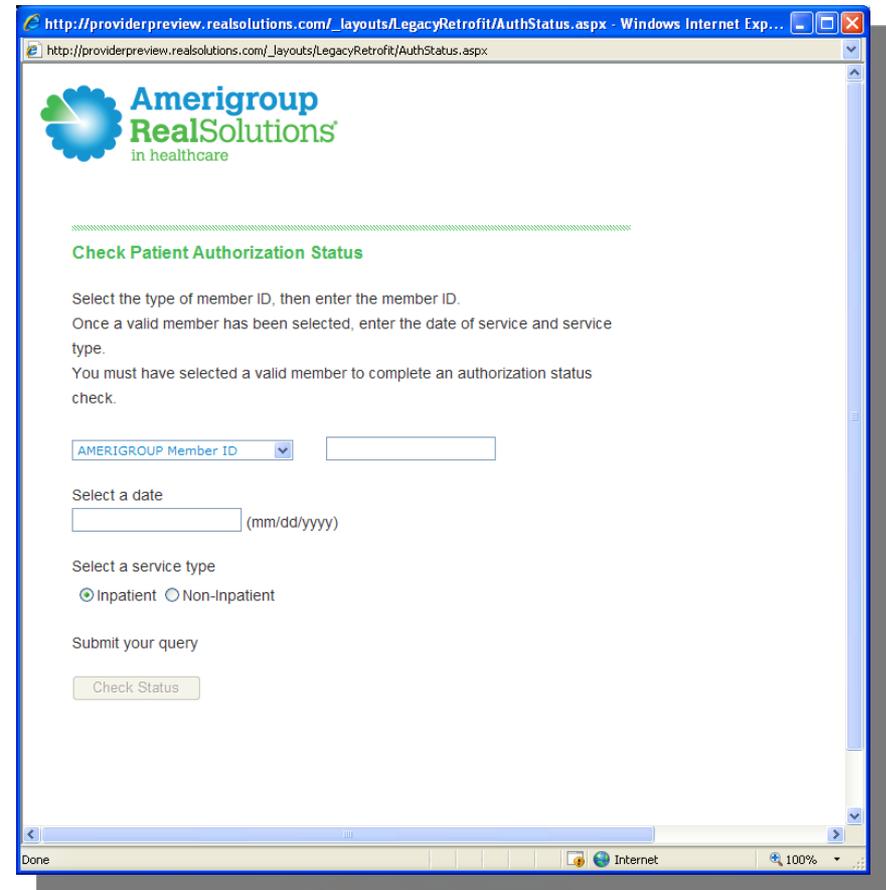
[FIND A CODE](#)

Precertification Requests

- Submit requests for precertification via fax, through the provider website or by phone by calling Provider Services toll free at 1-800-454-3730.
- Must provide the precertification nurse with appropriate Amerigroup member information.
- The servicing provider or the hospital must provide clinical documentation for medical necessity review.

Check status of precertification

- Two options:
 - Provider Website
 - Contact Provider Services



The screenshot shows a web browser window with the URL http://providerpreview.realsolutions.com/_layouts/legacyRetrofit/AuthStatus.aspx. The page features the Amerigroup RealSolutions logo and the heading "Check Patient Authorization Status". Below the heading, there are instructions: "Select the type of member ID, then enter the member ID. Once a valid member has been selected, enter the date of service and service type. You must have selected a valid member to complete an authorization status check." The form includes a dropdown menu for "AMERIGROUP Member ID", a text input field for the member ID, a date selection field labeled "Select a date" with a "(mm/dd/yyyy)" format, and radio buttons for "Inpatient" (selected) and "Non-Inpatient". A "Check Status" button is located at the bottom of the form.

Pharmacy Precertification

- Amerigroup contracts with Caremark to process prescription drug claims using a computerized point-of-sale system.
- The preferred drug list and formulary are available on our provider portal as well as through ePocrates and electronic prescribing applications
- Submit prior authorization requests by fax, phone or through the Amerigroup web portal
- Prior authorizations are processed by pharmacy technicians and pharmacists. Approvals and denial notifications are sent to providers and members
- Examples of medications that require prior authorization are as follows:
 - Drugs not listed on the formulary or Preferred Drug List (PDL) or drugs that require clinical prior authorizations
 - Most specialty drugs
 - Certain self-administered injectable products
 - Drugs that exceed certain cost and/or dosing limits

Timelines for Authorizations

Type of Request	Decision and Notification Timeframe
Post Stabilization Care Services	Within 1 hour of request
Pre-service (Prospective) non-urgent	14 calendar days from receipt of request
Pre-service (Prospective) urgent	72 hours (3 calendar days) from receipt of request
Post-service (Retrospective)	30 calendar days from receipt of request
Concurrent	24 hours (1 calendar day) from receipt of request

Precertification Process

- Amerigroup receives the authorization request. Verifies if there is an existing authorization.
- Perform the necessary verifications, such as HIPAA, enrollment, and provider status.
- Determine medical necessity by applying criteria or guidelines.
- If criteria is met, approve the authorization request.
- If criteria is not met, forward the request to the Medical Director.
- If unable to determine whether criteria is met, the request is placed in a pending status and additional clinical information is requested from the provider.
- If the auth request is approved for an outpatient service, auth process is complete.



Precertification Process

- **If the auth request is approved for an inpatient stay, a Utilization Management (UM) clinician will perform concurrent review.**
- **The clinician will approve each day of the stay as long as criteria is met, and the clinician will begin discharge planning upon admission.**
- **The UM clinician may also have to forward the request to the Medical Director for review if criteria is not met at any point, or if other issues arise.**
- **The UM clinician will finish discharge plans.**

BH UM Process

- **Mental Health Authorization Requests For Services Requiring Authorization:**
 - Request received via the Provider Services number, fax, or through the provider website
 - Member services staff perform the necessary verifications, e.g. HIPAA, enrollment, provider status, status of the authorization
 - Staff obtain clinical information necessary to review the request using the Kansas medical necessity definition InterQual Level of Care criteria for most services
 - If criteria appear not to be met, the BH clinician forwards the request to the BH Medical Director for review.
 - Decision and required notifications are made within timeliness standards
 - Clinical staff review continued stay requests and monitor discharge planning and plans for any necessary care coordination

BH UM Process

- **Substance Abuse Disorder (SUD) Authorization Requests For Services Requiring Authorization:**
 - Request received via the KCPC system
 - Staff verify necessary information, e.g. HIPAA, enrollment, provider status, status of the authorization
 - Clinical staff review clinical information utilizing the Kansas medical necessity definition and KCPC ASAM criteria
 - If criteria appear not to be met, the BH clinician forwards the request to the BH Medical Director for review.
 - Decision and required notifications made within timeliness standards
 - Clinical staff review continued stay requests and monitor discharge planning and plans for any necessary care coordination

Claims Operations

Operational Commitments

- **AGP will meet performance guarantees**
 - Real-time claim inventory monitoring system
 - Reporting capabilities for weekly, monthly and quarterly
 - Staff relative to performance requirements

- **Dedicated claim team**
 - Delivers accuracy and consistency with handling of claims
 - Specific Processing Instructions are created for the market rules

- **Focus on quality and process improvement**
 - Dedicated team, Internal Resolution Unit to resolve claim issues and respond timely
 - Error identification with root cause solutions



Claims Processing Standards

■ Timely Claims Filing

- 90 day for PCPs, specialists, FQHCs, RHCs, medical ancillary, HCBS/LTSS
- 180 days for nursing facilities, hospitals and Indian Health providers

■ Clean Claim Definition

- Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

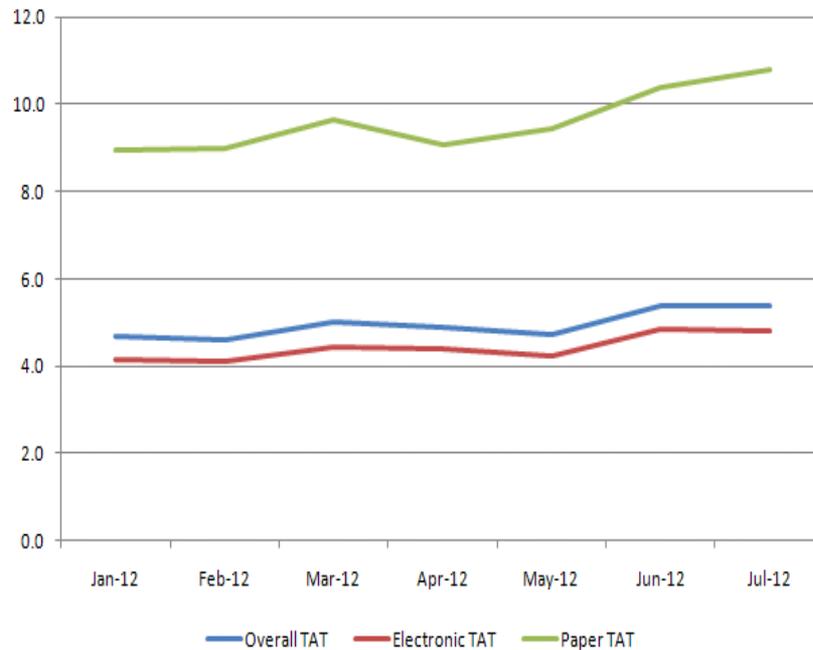
Claims Processing Standards con't

- **Clean Claim Processing Standards**
 - 100% of clean claims w/n 30 days
 - 99% of non clean claims w/n 60 days
 - 100% of all claims w/n 90 days
 - 90% of clean nursing facility (NF) and Frail Elderly (FE) claims w/n 14 days
 - 99.5% of clean NF/FE claims w/n 21 days
 - 100% of valid NF/FE claims w/n 60 days

- **Clean Claim Processing Timelines (P4P Incentives)**
 - 100% of all clean claims processed w/n 20days
 - 99% of all non clean claims w/n 45 days
 - 100% of all claims processed w/n 60 days

2012 Overall Turn Around Time Results

Turn Around Time In Days By Claim Type



Average days turnaround time at 5.0 days - Paper 9.6 days and EDI 4.4 days

Encourage providers to use electronic as primary method and EDI Hotline available to assist providers

Reporting capabilities to monitor activity daily, weekly, monthly and quarterly

System Adjudication finalizes 75% of the claim volume producing quick turnaround

Multiple check writes during the week along with EFT capabilities to improve cash flow

Life Cycle of a Claim

- **Claims received by multiple methods using industry standard formats - Direct paper, Electronic clearinghouses, Web (individual and batch)**
- **Compliance Check Edits - HIPAA requirements applied, Identify clean vs. non-clean claims**
- **System selection of Member and Provider**
- **Front-End Business Edits - Customization of Logic by state (i.e., NDC, NPI, etc...)**

Life Cycle of a Claim Cont'd

- System will attempt to adjudicate claims – edits configured in claim system (timely filing, duplicates, etc...)
- Remainder of claims edit for manual review. Primary reasons requiring review are: authorization, coordination with primary insurance
- Medical Code Editing (Claim Check) occurs prior to check write
- Final claim disposition – paid/denied and EOP generated

Provider Experience Program - PSU

- Program goal is to ensure provider claim inquiries are handled efficiently and in a timely manner while maximizing resolution at the point of call.
- Claim inquiry calls to our National Customer Care center will be handled by a specially trained call agent in our Provider Services Unit (PSU). These agents have:
 - Been trained to ensure your claim issues are addressed on the phone, and when that isn't possible, to coordinate resolution with the appropriate departments.
 - The ability to both answer your claims-related questions as well as adjust a small set of routine claim types.



Provider Experience Program - IRU

- Claim inquiries resulting in extensive research will be forwarded to our Internal Resolution Unit (IRU)
- IRU agents coordinate the research, error correction and adjustment of claims as appropriate.
- If a delay is anticipated due to the complexity of a claim, providers receive notification of the delay and a target date for resolution.

Member and Provider Service Call Center



Services & Hours of Operation

24/7 / 365 Services

12:00am to
7:00pm

8:00 am

9:00 am

10:00 am

11:00 am

12:00 Noon

1:00 pm

2:00 pm

3:00 pm

4:00 pm

5:00 pm

6:00 pm to
12:00 am

Member

- General Member info – benefits, policy & procedures
- Access to care
- Material requests
- Provider lookup
- PCP
- Eligibility
- Web support

Provider

- Claim status
- Benefits
- Eligibility
- Provider Policy & Procedures
- Web Support

Live Agent:

- Clinical Authorizations

Web & IVR Self-Service:

- PCP search and Change
- Address & telephone number updates
- Requests for ID cards, handbooks, and directories
- Eligibility check

Amerigroup On Call (Live Agent):

- Self care
- Schedule an appointment with PCP
- Refer member to Urgent Care Centers or clinics within AGP network
- Schedule phone consultations with a Physician
- Assist with transportation
- Schedule an appointment online with network providers
- Refer to ER if emergency services are required

Member/Provider Service – 8:00 to 5:00 pm, M-F
Clinical/Amerigroup on Call 24/7 / 365
Voice Portal / Web Services 24/7 / 365 (Including Holidays)



* In addition, during core hours, callers will have the option to select a call back using our Virtual Hold technology. Voice mail will be an option 24/7.

Customer Service Training

CCR1 Curriculum

Training includes:

- HIPAA and Compliance
- Cultural Competencies, such as:
 - Way of life in Kansas
 - Effectively service members with Autism, physical disabilities, emotionally disturbed, elderly/frail
- Appeals and Grievances
- Fraud and Abuse
- Code of Conduct and Business Ethics
- Kansas Benefits/Services and Markets specifics
- Systems and related tools
- Customer Service/professional skills
- How to leverage knowledge management tools (ATLAS)

CCR2 Curriculum

- Authorization/Precertification training
- Web Support
- Pharmacy Support

CCR3 Curriculum

- Provider Recruitment and Credentialing
- Medical Terminology
- Introduction to Claims: Lifecycle of a Claim, claim forms
- Claims status Inquiries
- Provider Appeals

New hire training lasts for a total of 30 days and includes classroom, observation, on-the-job (OJT) training, and performance monitoring.

*CCR = Customer Care Representative (Front Line Call Center Associate)

Performance/SLA Overview

- Kansas members will be serviced primarily out of the Kansas Service Center that will be located in Overland Park
- Goals include:
 - 80% of all calls answered 30 seconds or less
 - ≤1% blocked rate*
 - ≤5% abandon rate
 - >96% Quality
 - 100% call documentation
 - 90% first call resolution*
 - >95% on hold <1 minute without returning to caller*
 - 98% inquiries resolved within 2 business days*
 - 100% inquiries resolved within 8 business days*

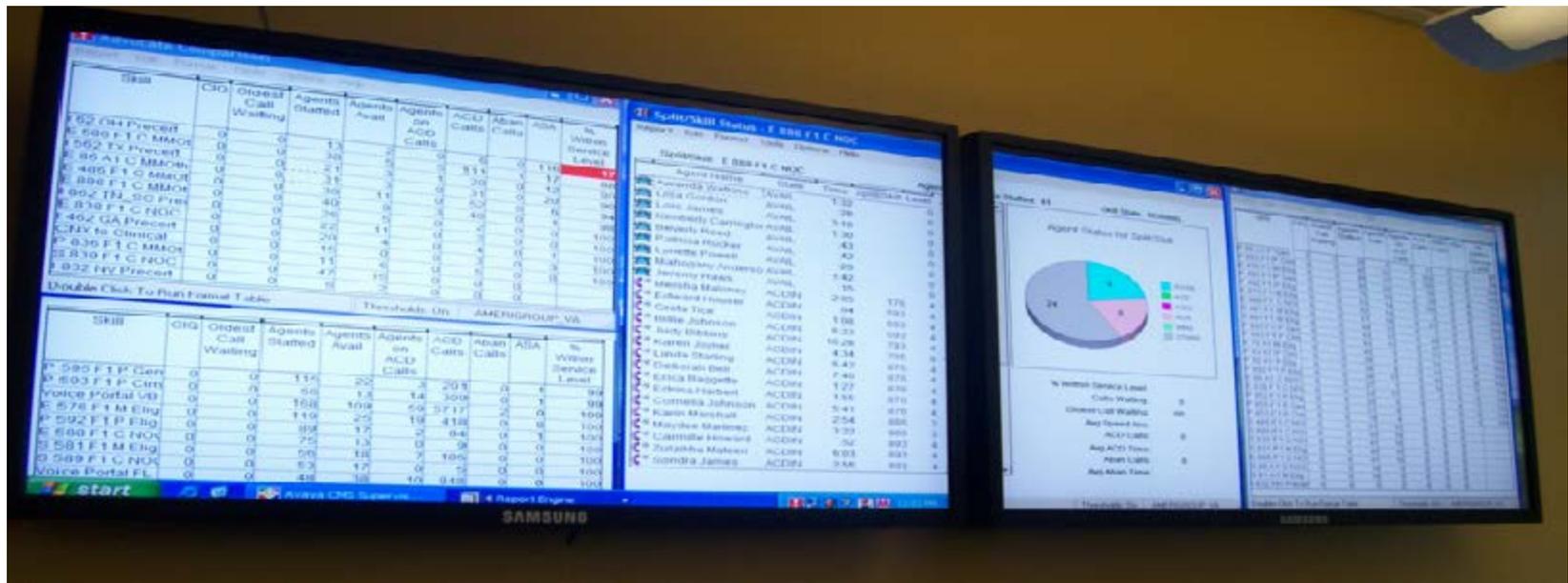
**Contractual requirements*

**2013 Pay-for-Performance measures*



Monitor Performance Strategy

- Real Time Performance Monitoring During Core Hours
 - “Traffic” analysts monitor call arrivals to make adjustments to staffing if actual calls vary from projections



Monitor Performance Strategy

- **Near Real Time Performance Monitoring**
 - Bi-hourly snapshot reports sent to key leadership
- **Historical Reports**
 - By interval, day, week, month
 - Used to modify/update future projections/staffing models
 - Used to identify trends
 - Input into future hiring and training decisions
- **Quality Assurance**
 - Random Silent Monitoring
 - Side by Side Monitoring
 - Random Monitoring Recorded Calls