High Impact Stakeholder Issues Log

Date Identified	Issue Log #	Affected Stakeholder Group	Issue Title	Comments	Estimated Resolution Date	Issue Status	Resolution Date
1/2/2013	19	General Providers	EVV Transition Issue	**Issue:** Over the next 24-48 hours, providers may see some claims in a critical exception status in AuthentiCare, related to missing authorization. This event is a one-time occurrence as part of the transition being resolved by Authenticare, the State, and the MCOs. State resolution & coordination with MCOs projected for 24-48 hrs **Response:** 2013 claim export was created and had over 70,000 claim records that were being checked on Friday, 1/4/2013 and a second export was being generated at noon. EVV/AuthentiCare claims have automatically been processed to match the January authorizations with the correct Payer assignment. On 1/4/13 state confirmed claims are now being successfully submitted with the payer information.	1/4/2013	Closed	1/4/2013
1/3/2013	20	Pharmacy	Auto-Refill Policy	**Question:** AGP was asked whether or not our pharmacy benefit included an auto-refill option for beneficiaries; if auto-refill is an option to describe our policy for using this service. **Response:** Neither AGP nor CAREMARK have a policy authorizing auto-refill. A beneficiary	1/4/2013	Closed	1/4/2013

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				may participate in a pharmacy's auto-refill program independent of the MCO provided the program conforms to the Kansas Pharmacy Benefit rules (e.g. 31 day supply, etc ...)			
1/3/2013	21	Home Health	Third Party Claim Denial Process	**Question:** A question was raised on today's stakeholder call to the use and requirement to provide a denial code for third party liability in the submission of a claim. **Response:** AGP requires the provider to submit a paper EOP showing the denial. Each claim will be reviewed against the non-covered list provided by the State. A future (date TBD) enhancement will include the ability to submit TPL information on an electronic claim.	1/3/2013	Closed	1/3/2013
1/4/2013	22	Mental Health	Out-Patient Mental Health - Dual Eligible Pre-Auth Requirement	**Question:** Inquiry regarding whether dual eligibles require pre-authorization for outpatient mental health services when pre-specified limits have been reached. **Response:** Amerigroup does not require pre-authorization for traditional outpatient mental health services (e.g., individual therapy, group therapy, family therapy), nor are there limits for these services – dual eligibility is not a factor.	1/3/2013	Closed	1/3/2013
1/4/2013	23	General Providers	Credentialing – Locum Tenens (LT)	**Question:** Does AGP require the credentialing of LT providers? **Response:** AGP does not require credentialing of LT working within a facility and billing under the facility's NPI. LT substituting for a sole	1/3/2013	Closed	1/3/2013

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				practitioner may bill under the practice's NPI (and paid according to the practice's PAR status) or bill under their provider NPI and paid as Non-PAR, if not contracted and credentialed directly.			
1/8/2013	24	Multiple Stakeholders	Faxing Issue	**Issue:** Amerigroup is experiencing technical difficulties with some of our FAX II options and specifically, faxes coming in that we route to Case Management, Behavioral Health and Pharmacy. The first problem is that providers may receive no pick-up and the line just keeps ringing. The second is as we attempt to route faxes internally, it appears all or a portion of the faxes (it is unknown whether some or all) are not routing to these queues and are sitting in our No Go queue with error messages. Information Technology and the RightFax / FAX II players are engaged and working with the vendors. **Response:** We are working the issue around the clock with all parties to try to get to a resolution; we do not have an ETA on resolution at this time. **Update:** Roll back of software implemented during the previous weekend has addressed the "no answer" issue and test faxes sent in are going through as expected. **Update:** The 2 critical issues were resolved late Tuesday night. So, over the past day and today, providers should be able to fax	1/11/2013	Closed	1/10/2013

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				documents in uninterrupted.			
1/7/2013	25	General Providers	Dual Member Denied Claims	**Question:** Dual eligible member; when get denial from Medicare (very limited benefit) --- will all three MCOs continue the practice of paying those denied claims? **Response:** Yes. As we process claims, if there are any questions or issues, let us know and we will work it through together. Item will be monitored for 30 days for any issues with paying these claims.	2/9/2013	Pending	
1/8/2013	26	Clinics	PreCertification	**Issue:** Getting precertification via Amerigroup: This is difficult and physician has to participate in the call – office staff not able to do this. Doctors do not have the time to be on the phone like that, and especially if an urgent issue. **Response:** If an emergent situation, provide the care. We are addressing the specific situation that arose yesterday with you separately, and will finish that with you directly. AGP continues to reinforce associate training on our pre-certification process to make this a timely and efficient service.	1/11/2013	Closed	1/9/2013
1/7/2013	27	Clinics / Behavioral Health	Claims billing	**Question:** Question came up from a Behavioral Health provider regarding which modifier to use when T1017, targeted case management, is provided to a member both in the	1/10/2013	Closed	1/15/2013

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				morning and then again in the afternoon. Hence, the member is having two separately scheduled services on the same day. Historically, the providers billed to KHS using modifier 59 and then billed HP/State of Kansas with modifier 76. **Resolution:** If the same type of service is provided in the morning and then again in the afternoon, the providers should use the following "U" modifiers which allow for billing at different times of the day. Mod Definition UF Services provided, morning UG Services provided, afternoon UH Services provided, evening UJ Services provided, night			
1/10/2013	31	Multiple Stakeholders	Faxing Issue	**Issue:** Some incoming faxes have black or blank portions of the page. The issue can impact all providers that are submitting faxes although is intermittent but we are seeing a large number received that have this issue. **Resolution:** Information Technology and the Right Fax / FAX II players are engaged and working with the vendors. Where provider information is shown we are reaching out to providers to have the documents resent. **Update:** We have confirmed over the weekend and thru Monday there are no longer issues with	1/13/2013	Closed	1/14/2013

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				faxes coming in partially blank or black.			
1/10/2013	32	Multiple Stakeholders	HIPPA 2013 HCPC's codes	**Issue:** Amerigroup has identified an issue related to the update of HIPAA compliant 2013 HCPCs codes. Our code software vendor notified us last Friday of an issue with 2013 code set up software update. The correction was implemented last night therefore all HIPAA compliant 2013 HCPCs should be recognized. Any front end billing issues should now be corrected. **Resolution:** The most extensive changes were to behavioral health codes including those on the updated KS Medicaid behavioral health fee schedule. Amerigroup has instituted a pend for these codes to insure they did not process in error. Claims with these codes will be processed for payment in the next check cycle.	1/09/2013	Closed	1/09/2013
1/15/2013	33	Multiple Stakeholders	RHC/FQHC Billing Guideline	**Question:** Inquiry on billing submission requirements to ensure proper payment of encounter. There was confusion around the need to use a revenue code for payment of the case rate for the encounter. **Resolution:** AGP adjudication routine references the submitted procedure codes to determine if the claim should include the case rate fee for the encounter. Standard rate sheets require submission on CMS 1500 unless an individual contract allows a UB92 – in which case a	1/15/2013	Closed	1/15/2013

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				revenue code of 510 should be used.			
1/15/2013	34	Multiple Stakeholders	Claims submitted thru KMAP not reflected in FACETS system	**Issue:** Providers submitting claims through KMAP on Friday 1/11/13 are receiving a batch submission acknowledgement from HP, but are not showing on in our system. **Response:** Requesting tax id/NPI on these so he can look at today's submissions.	1/18/2013	Pending	
1/15/2013	35	Home Health	Provider Access to Claims system	**Issue:** We still are trying to get logged into your systems and still struggling with all three; our contracts are still pending, so no provider #; we got an email from Sunflower saying we didn't need a provider #; Amerigroup says cannot without a provider number. We cannot bill through KMAP, because it requires separate DME/Rx billing – we were allowed to do them together under previous physical health MCOs and are hoping to be able to bill them together with the KanCare MCOs. We are billing electronically. **Response:** AGP requires providers to be contracted (and will then be given a provider number) to access and claims data. We will discuss internally and connect with you to resolve. **Update:** Provider was contacted by the Provider Relations team.	1/18/2013	Closed	1/18/2013

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1/15/2013	36	Behavioral Health	Billing	**Issue:** Similar to the issue of billing for the same service in the morning and afternoon, the same Behavioral Health provider posed the question of what modifier should be used for the targeted case management code, T1017, if the service is provided at, for example, 8 a.m. and then again at 10 a.m. for the same patient. In between those two times a bill is dropped so the provider wants to know how to identify the second appointment. **Resolution:** AGP's interpretation is that the proper modifier to submit this service is modifier 76. In this scenario, use of modifier 76 would require additional documentation to explain why the same service was repeated in the morning, but not billed as multiple units. For example if the service is performed at 8 a.m. and 10 a.m., unless a claim is submitted in between those two times, the claim should simply be submitted with 2 units.	1/15/2013	Closed	1/15/2013
1/17/2013	37	Nursing Facility	Response to Nursing Facility Claim Inquiries	**Issue:** Some Nursing Facilities have expressed concerns when they call inquiring about the status of claims submitted that they are being told by MCO's that it could be up to 30 days before they receive payment. **Response:** We are updating our	1/18/2013	Pending	1/25/2013

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				training materials and have communicated verbally with staff the processing times for claim payments for Nursing facilities.			
1/18/2013	38	County Health Departments	Claims Submission – Multi Entities	**Issue:** Provider inquired whether or not claims submitted for multiple entities would be separated for accounting purposes. **Response:** Provided each entity has a unique NPI there should be no issue identifying remittances for each entity.	1/18/2013	Closed	1/18/2013