
ia
health
link


AmeriHealth Caritas
Iowa

Claims and Billing

Ways to File Claims with AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa accepts claims in the following method:

- Electronically through a Clearinghouse
- Through the AmeriHealth Caritas Iowa Provider Portal (participating providers only)
- Paper Claims via mail

AmeriHealth Caritas Iowa accepts the following claims forms:

- Institutional (UB-04)
- Professional (CMS-1500)
- AmeriHealth Caritas Iowa Targeted Medical Care Claim (for Waiver Providers and Individual CDAC providers in addition to the CMS-1500)

Electronic Claims Submission

AmeriHealth Caritas Iowa participates with Change Healthcare (formerly Emdeon).

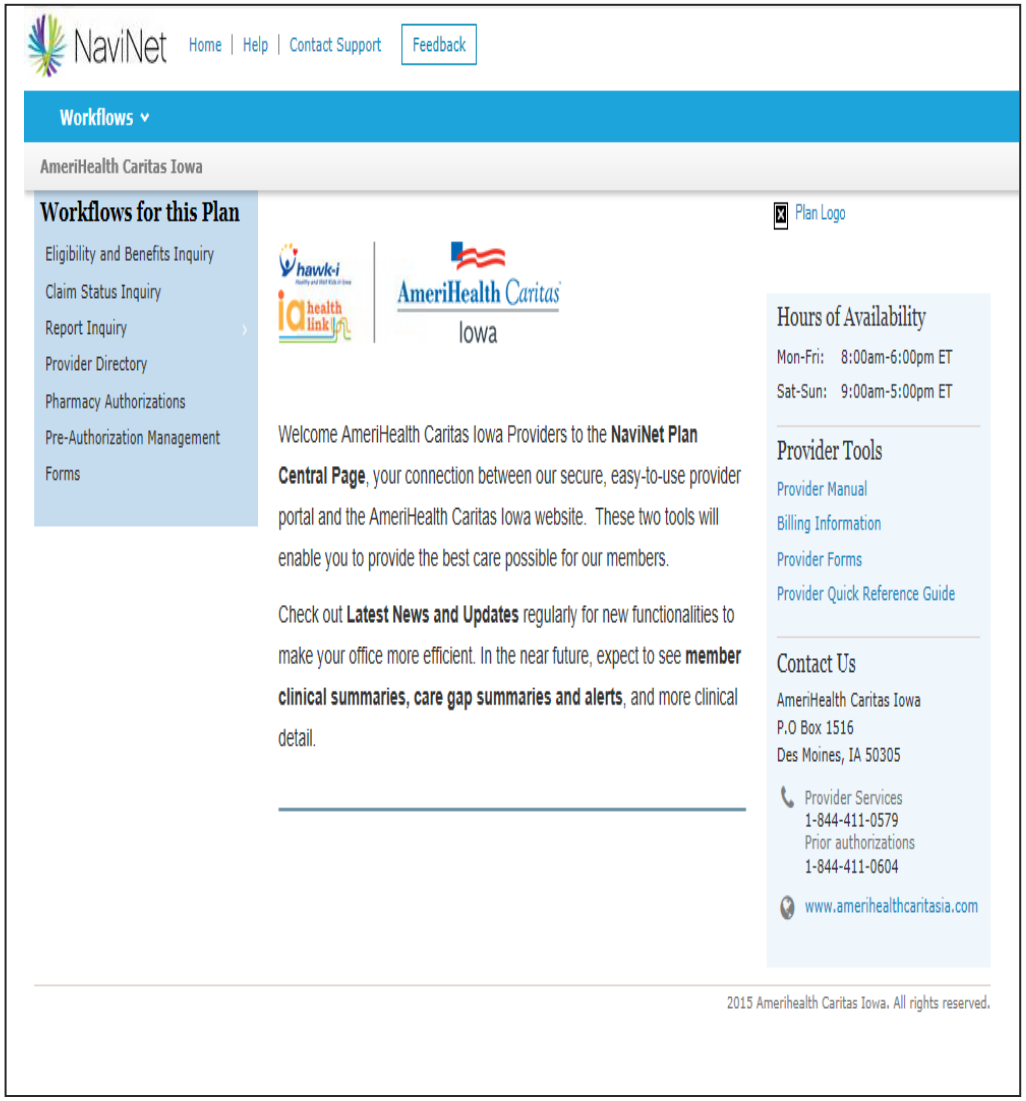
- To enroll, contact Change Healthcare (Emdeon) at **1-877-363-3666** or

- www.changehealthcare.com → resources → enrollment

- You can directly submit your Electronic Data Interchange (EDI) claims to Change Healthcare (Emdeon) or you can utilize another clearing house/vendor.
  - Inform your vendor of AmeriHealth Caritas Iowa's EDI Payer ID#: **77075**

- If you utilize a clearing house other than Change Healthcare (Emdeon), the clearing house will transmit the claim to Change Healthcare (Emdeon).

NaviNet (AmeriHealth Caritas Iowa Provider Portal)



- Providers can also access the Web Connect feature through our provider portal, NaviNet, and submit CMS -1500 claims to AmeriHealth Caritas Iowa one claim form at a time.

- NaviNet is a web-based solution for electronic transactions and information through a portal.

Paper Claims

Paper Claims

- Claims with dates of service on or after March 1, 2016 may be submitted to:

  AmeriHealth Caritas Iowa

  Attn: Claims Processing Department

  P.O. Box 7113

  London, KY 40742

Claim Filing Deadlines

- **Original Paper and Electronic Claims**
  - Must be submitted within 180 calendar days from the date of service or date of discharge(for inpatient).
  - Non-par providers must submit claims within 365 days of the date of service

- **Rejected Claims (i.e. missing NPI)**
  - These claims are considered NOT received and will be sent back to the provider for missing or invalid data elements. The plan does not keep a record of rejected claims. These must be corrected and resubmitted within 180 days from the date of service.

- **Denied Claims (i.e. duplicate claim)**
  - These claims have processed through our claims system, but did not meet requirements for claim payment. These must be re-submitted as a corrected claim within 365 days from the original date of service.

- **Claims with Explanation of Benefits (EOBs)**
  - Primary insurers, including Medicare, must be submitted within 60 days of the date on the primary insurer's EOB (claim adjudication).

- **Refunds for Improper or Over Payment of Claims**:
  - Please include the member's name and ID, date of service and claim ID.

AmeriHealth Caritas Iowa

Attn: Provider Refunds

P.O. Box 7113

London, KY 40742

Payment Timelines for Clean Claims

AmeriHealth Caritas Iowa will pay or deny all clean claims as follows:

- 90% within 14 calendar days of receipt
- 99.5% within 21 calendar days of receipt
- 100% within 90 calendar days of receipt.

Timely Claims Payment

- It will typically take 14 days for claims to process upon receipt.
- We generate payments on Monday, Wednesday, and Friday each week.
- You will receive a remittance advice along with the payment.

Tips for Timely Claims Payment

- Note: Claims must be received by the EDI vendor by 9:00 p.m. CST in order to be transmitted to the Plan the next business day.

- If you have questions or concerns regarding any claim issue, claims status information is available by:
  - Calling Provider Services at 1-844-411-0579.
  - Visiting the provider area of AmeriHealth Caritas Iowa's website, www.amerihealthcaritasia.com, to access NaviNet.

Common Causes of Claim Delays, Rejections, and Denials

Here are a few examples for paper claims:

- EOBS (Explanation of Benefits) from Primary Insurers Missing or Incomplete
- Future claim dates
- Handwritten claims
- Highlighted claim fields
- Illegible claim information
- Incomplete forms
- Member plan identification number missing or invalid

Common Electronic Rejections from Change Healthcare (Emdeon):

- Missing or invalid batch level records
- Missing or invalid required fields
- Claim records with invalid codes (CPT-4, HCPCS, or ICD-10, etc.)
- Claims without member numbers

Common Electronic Rejections from AmeriHealth Caritas Iowa:

- Invalid provider numbers
- Invalid member numbers
- Invalid member date of birth

Certain fields are required to be completed for the claim to process correctly. Claim form instructions can be found in the Claims and Billing Manual located at http://www.amerihealthcaritasia.com/provider/manual-forms/index.aspx

Submitting Claims Adjustments

Requests for adjustments may be submitted electronically (via EDI), on paper or by telephone.

Electronically:

- Please mark claim frequency code “6” and use CLM05-3 to report claim adjustments electronically.
- If submitting via paper or EDI, please include the original claim number.

On paper:

- Please be sure to write “corrected” or “re-submission” on the claim and address the letter to:

AmeriHealth Caritas Iowa
Attn: Claims Processing Department
P. O. Box 7113
London, KY 40742

By phone:

- Provider Claims Services 1-844-411-0579

Non-Participating Providers

- **Safe Harbor:** For dates of service March 1, 2016 through March 31, 2016, AmeriHealth Caritas Iowa will pay claims for covered services to existing Medicaid providers at 100% of the established floor whether a provider is in-network or out-of-network.
- Beginning April 1, 2016, providers must participate with the MCO to receive 100% of the Medicaid fee schedule for providing covered services to members of the health plan. Non-participating providers will receive 90% of the Medicaid fee schedule.
- When an out-of-state or other non-participating provider renders services, providers must follow the steps below to bill:
  - Complete the non-participating provider form.
  - Return the completed form by faxing to Provider Data Management.
  - Receive your unique AmeriHealth Caritas Iowa non-participating provider ID number from the plan.
  - Use your national provider identification number and AmeriHealth Caritas Iowa non-participating provider ID to submit your claim to the plan.
- Timely filing for non-participating providers is 365 days from the date of service.

Utilization Management
and
Prior Authorization

Utilization Management (UM)
Hours of Operation and Contact Information

Hours of operation: 8:30 a.m. to 5:00 p.m., CST, Monday-Friday

For all phone authorizations call: **1-844-411-0604**

Physical Medicine Authorizations Fax: **1-844-211-0972**

Behavioral Health Prior Authorizations Fax: **1-844-214-2469**

Long Term Services and Support Prior Authorizations Fax: **1-844-399-0479**

After Hours:

An On-Call Nurse is available after hours through member services. The member services representative will activate the On-Call process for the nurse.

Member Services Phone: **1-855-332-2440**

Prior Authorization

Services requiring prior authorization include but are not limited to :

- Inpatient admission, concurrent review and discharge planning
- DME rentals and purchases over $750
- Therapies and rehabilitation services and chiropractic care
- Pain management
- Radiology services – CT scan, PET scan, MRI, MRA, nuclear cardiac imaging
- Transplant evaluation and services
- Genetic testing
- Services that could be considered cosmetic procedures,
- Inpatient hysterectomies, gastric procedures
- Termination of pregnancy
- Hospice inpatient
- Maternity and obstetrical services and newborn deliveries
- Hyperbaric oxygen
- Home based services (via Case Manager)

Complete Prior authorization lists can be found on the provider section of the website at http://amerihealthcaritasia.com/provider/resources/prior-auth.aspx

Lists available:

Physical Health Services, Behavioral Health Services, Long-term Services and Supports, Consumer Directed Attendant Care Services, and Pharmacy Services.

Prior Authorization Process

Requests are accepted by telephone, by fax or electronically
http://www.amerihealthcaritasia.com/provider/resources/prior-auth.aspx

Information supporting the medical necessity of the requested service should be included with the request for service and can include any or all of the following:

- Medical history
- Mental health and substance use disorder (SUD) history
- History of present illness
- Presenting symptoms
- Prior treatment outcomes – including what has been tried and failed
- Current clinical status
    - Plan of care
    - Emergency room treatment
    - Current treatment
    - Discharge plan
    - Information regarding condition and instructions at prior discharge if readmission within 30 days

Prior Authorization Process - continued

The UM staff reviews the information submitted in support of the request against the definition of medically necessary and applicable UM medical necessity criteria such as :

- **McKesson InterQual Criteria** as guidelines for determinations related to medical necessity.

- The **American Society of Addictions Medicine (ASAM**) Patient Placement Criteria (PPC) will be used for determinations related to substance abuse detox.

Any request that is not addressed by, or does not meet, medical necessity guidelines is referred to the Medical Director or designee for a decision.

Prior Authorization Review Timeframes

Review Type	Timeframe
Preservice Non-urgent	As quickly as required by the member's health condition, not to exceed 7 calendar days
Preservice Urgent	As quickly as required by the member's health condition, not to exceed 3 business days

Prior Authorization During Safe Harbor Period

- Providers should continue to seek prior authorization under AmeriHealth Caritas Iowa policies to ensure timely and appropriate reimbursement.
- All claims will be processed whether or not the provider has sought a prior authorization.
- All claims submitted without a prior authorization will be subject to retrospective review by AmeriHealth Caritas Iowa to determine if services were medically necessary.
- The medically necessary definition remains the same at it is today per state and federal requirements.
- Just like today, if a claim is determined not to be medically necessary, payment may be recovered.
- Beginning April 1, 2016, all Medicaid providers whether in-network or out-of-network must follow AmeriHealth Caritas Iowa's prior authorization requirements included in our provider manual.
- AmeriHealth Caritas Iowa will honor existing authorizations for covered benefits for a minimum of 90 calendar days when a member transitions.

No Referrals

Referrals are **NOT** required when an AmeriHealth Caritas Iowa primary care practitioner (PCP) refers a member to a participating specialist or when a participating specialist refers a member to another participating specialist.

Our Mission:

We help people get care, stay well and build healthy communities.

For more information:

Visit our website: www.amerihealthcaritasia.com

Call Provider Services: 1-844-411-0579