Billing Guidelines for Providers of Intellectual/Developmental Disability Waiver Services

Claim Submission Options

You may submit claims through a variety of channels:

- Electronically through an established claim clearinghouse. Use these electronic payer IDs:
  - Emdeon: 27514
  - Capario: 28804
  - Availity: 26375
- Through the KanCare Front-End Billing option
- Through our web portal. Amerigroup Kansas, Inc. schedules weekly webinars to present the process to properly use the portal for claims submission* along with other advantages. In addition, we will be available for large groups to attend your meetings for a similar presentation. Call **1-877-434-7579 and ask for Provider Relations.** Our provider relations representative can give your provider identification number needed to get registered on the system. Tutorials are available on our provider website to guide you through the process at providers.amerigroup.com/ks
- On paper — submit your paper claims to:

  KanCare
  P.O. Box 3571
  Topeka, KS 66601-3571
- Some home and community-based services require Electronic Visit Verification (EVV) and are billed via AuthentiCare

***NOTE: Third Party Liability/Coordination of Benefits claims should not be submitted via our web portal. These claims should continue be submitted through the current process.**

National Provider Identification (NPI) Billing Requirements

Amerigroup follows state of Kansas and Federal guidelines to determine the provider types that are required to have a NPI for claim filing purposes, please refer to KMAP General Bulletin 13065 at https://www.kmap-state-ks.us/Documents/Content/Bulletins/13065%20-%20General%20-%20MCO%20NPI.pdf.

Electronic Funds Transfer- EFT

You will need to request a Registration Code for one of these two EFT services providers. To register, have your Amerigroup provider ID (or Group ID, if applicable), NPI number and Taxpayer Identification Number ready and visit either:
The Payspan Health website at www.payspanhealth.com
The Emdeon website at www.emdeon.com/eftsignup

Billing Codes and Limitations

Service Description	Billing Code	Modifier	Billing Method
Assistive Services	S5165		Per Service
Day Supports	T2021		Per 15 minute unit (maximum of 32 units per 24 hour period, 100 units per week, and 460 units per month)
Medical Alert	S5161		Per Month
Overnight Respite	H0045		Per Diem

Personal Assistive Services	T1019		Per 15 minute unit
Residential Support	T2016		Per Diem
Sleep Cycle Support	T2025		Per Service (One unit = minimum of 8 hours up to maximum of 12 hours)
Specialized Medical Care -LPN	T1000		Per 15 minute unit
Specialized Medical Care -RN	T1000	TD	Per 15 minute unit
Supported Employment	H2023		Per 15 minute unit
Supported Home Care	S5125		Per 15 minute unit
Wellness Monitoring	S5190		Per Service (One unit equals one visit per 60 days)
Financial Management Services	T2040	U2	Per Month
Respite Care, in home	S5150		Per Diem. NOTE: This is a value-added benefit through Amerigroup

All acute services billed must be submitted on a CMS-1500 or CMS-1450 (or its successor) form or by corresponding electronic format.

Date Span Billing

Span billing is permitted in the Amerigroup system. When billing using span dates:

- Dates of service must be within the same month
- Dates of service with the span cannot overlap (e.g. 10/1/13- 10/15/13 then 10/15/13 – 10/31/13). The claim will be seen as a duplicate and be denied.
- Units billed must be equal to or less than units authorized for that month — any units in excess of the authorized amount will be denied.
- To correct a billing error (e.g. billed 21 units from 10/1-10/31/13 but provided 22 units; you must submit a corrected claim. Claims for a single date of service within the span will be denied based upon a duplicate request.

Client Obligation

Amerigroup service coordinators/administrators will designate a specific provider on the member's plan of care who will assess and bill the member for all client obligation amounts. This designation will remain a part of the member's record and claim payment until services are discontinued or the designated provider changed by the service coordinator. Designated claims will be reduced by the specified CO amounts until the obligation is exhausted. In the unusual case where the member's obligation exceeds the amount billed by the designated provider; the claim system will default to assessing obligation to the next provider with obligation eligible claims. Amerigroup follows the state guidelines on services against which obligation can be assessed.

Third Party Liability (TPL)

Amerigroup follows state and federal guidelines in determining which services must be coordinated prior to payment. We use state resources (i.e., the Third-Party Liability Noncovered List) as the reference for specific procedures, by carrier, for which TPL coordination will not be made. For payor and/or procedures not listed on the state's NCC listing, you have the option of billing the other carrier and receiving a denial; or alternatively obtaining a blanket denial letter from the other carrier. Blanket denial letters are valid for one year from the date of the letter. Amerigroup does not require providers to bill Medicare first for any code that Medicare does not cover.

Corrected Claims and Claim Appeals

Claims can be corrected online through our provider website. Contact Nina Kidd for provider website training on easy claims corrections at nina.kidd@amerigroup.com or by phone at **1-877-434-7579, ext. 50551**.

Our Provider Experience program helps you with claims payment appeals. Call **1-800-454-3730 and select Claims.** You will be connected with a dedicated resource team to answer any questions about your appeal.

Website Resources

The following services are available to you through our website at providers.amerigroup.com/ks:

- Claims submission
- Claims status check
- Preauthorization submission, review, and determining the necessity of an authorization for specific codes
- Needed forms
- Updates specific to Intellectual/Developmental Disability providers