Ambetter in 2021:

Better for Members, Better for Providers

ambetter. FROM mhs

ACCREDITED NCQA HEALTH PLAN

Agenda

1. Overview of the Affordable Care Act
2. The Health Insurance Marketplace
3. What You Need to Know
4. Public Website and Secure Portal
5. Provider Analytics
6. Utilization Management
7. Claims
8. Complaints/Grievances and Appeals
9. Ambetter from MHS Partnership

What You Will Learn

1. Important coverage deadline dates
2. Indiana counties where Ambetter coverage is sold
3. How to verify Ambetter coverage
4. Authorization process
5. Claim tips for successful processing
6. What to do if you disagree with claim payment
7. Partnership opportunities

The Affordable Care Act

Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Additional Parameters:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

The Affordable Care Act

Reform the commercial insurance market – Marketplace or Exchanges

- No more underwriting – guaranteed issue
- Tax penalties for not purchasing insurance
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL)

Health Insurance Marketplace

Online marketplaces for purchasing health insurance

Potential members can:

- Register
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be State-based or federally facilitated or State Partnership – ***Indiana is a Federally Facilitated Marketplace***

The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies.

Health Insurance Marketplace

Subsidies come in the form of:

- Advanced Premium Tax Credits (APTC)
- Cost Share Reductions (CSR)

All Benefit Plans have cost shares in the form of copays, coinsurance and deductibles

- Some members will qualify for assistance with their cost shares based on their income level
- This assistance would be paid directly from the Government to the member's health plan

What You Need to Know

New Ambetter Rates

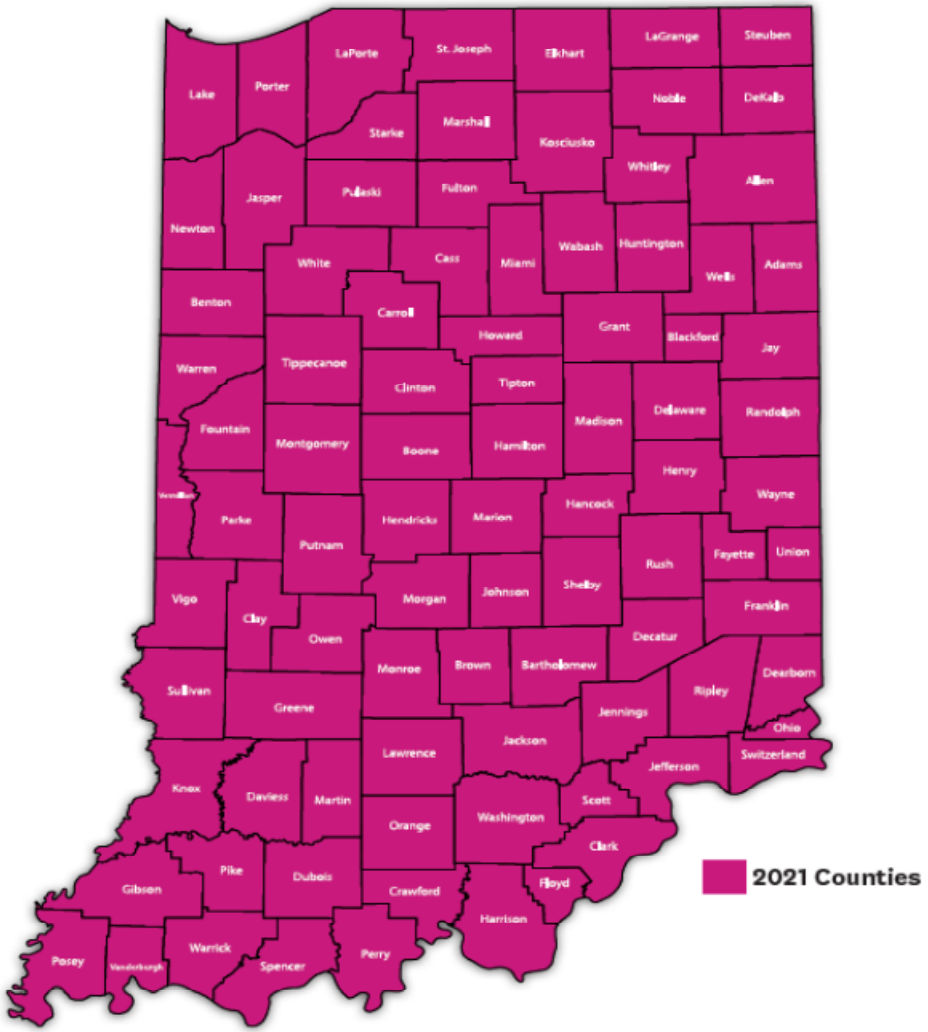
Re-basing Ambetter rates to current Medicare fee schedule based on the date of service

- Contractual guidelines apply as it pertains to % of reimbursement

This affects Professional services only at this time

- Lab, Durable Medical Equipment, Prosthetics and Orthotics - no change
- Radiology will be reimbursed at 85% of Payer Fee Schedule
- Therapy (Physical, Speech, Occupational) will be reimbursed at 80% of Payer Fee Schedule

2021 Ambetter Network



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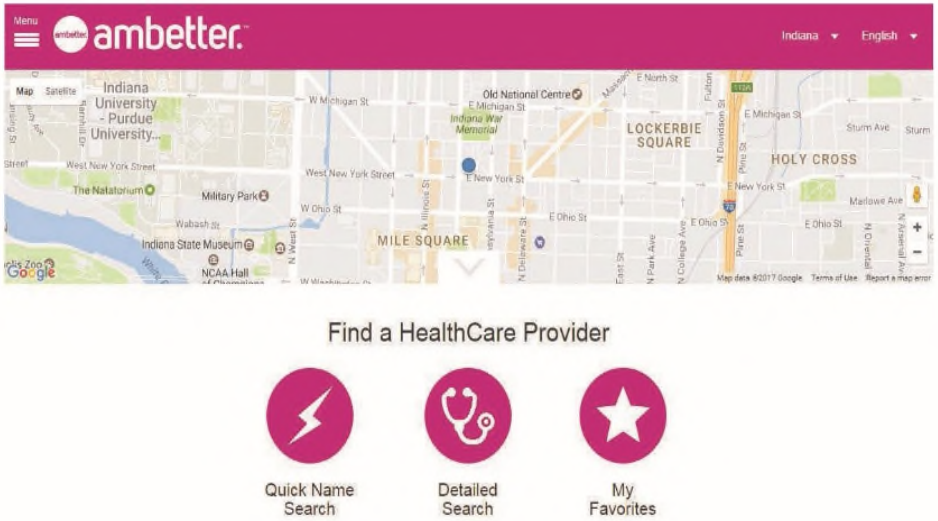
Ambetter from MHS is an Exclusive Provider Network Benefit Plan

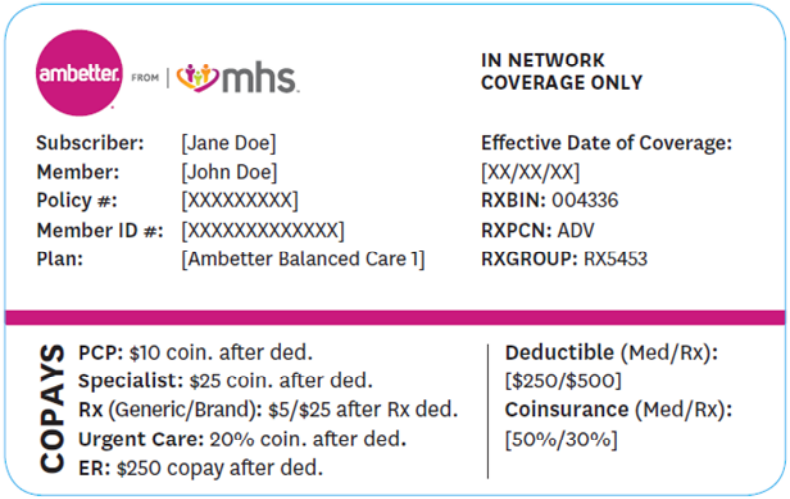
- Members enrolled in Ambetter must utilize in-network participating providers and practitioners except in the case of emergency services.
- When referring a member to another provider or practitioner, please make sure that the referral is contracted with Ambetter.
- If a non-contracted provider or practitioner is utilized, except in the case of emergency services, the member will be responsible for charges that exceed the allowed amount. ***This could mean hundreds of dollars in out-of-pocket expenses for the member.***
- Contracted providers and practitioners can be identified by visiting our website at **ambetter.mhsindiana.com** and clicking on Find a Provider.



Thank you for protecting our members from unnecessary out-of-pocket expenses!

Verification of Eligibility, Benefits and Cost Share

Member ID Card:



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IN NETWORK COVERAGE ONLY

Subscriber:	[Jane Doe]	**Effective Date of Coverage:**
Member:	[John Doe]	[XX/XX/XX]
Policy #:	[XXXXXXXXX]	**RXBIN:** 004336
Member ID #:	[XXXXXXXXXXXXX]	**RXPCN:** ADV
Plan:	[Ambetter Balanced Care 1]	**RXGROUP:** RX5453

COPAYS

PCP: $10 coin. after ded.
Specialist: $25 coin. after ded.
Rx (Generic/Brand): $5/$25 after Rx ded.
Urgent Care: 20% coin. after ded.
ER: $250 copay after ded.

Deductible (Med/Rx): [$250/$500]
Coinsurance (Med/Rx): [50%/30%]

Ambetter.mhsindiana.com

Member/Provider Services:
1-877-687-1182
TTY/TDD: 1-800-743-3333
24/7 Nurse Line: 1-877-687-1182

Numbers below for providers:
Pharmacy Help Desk: 1-866-270-3922
EDI Payor ID: 68069
EDI Help Desk: Ambetter.mhsindiana.com

Medical Claims:
Managed Health Services
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.mhsindiana.com.

AMB17-IN-C-00036

**** Possession of an ID Card is not a guarantee of eligibility and benefits***

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Verification of Eligibility, Benefits and Cost Share

Providers should always verify member eligibility:

- Every time a member schedules an appointment
- When the member arrives for the appointment

Eligibility verification can be done via:

- Secure Provider Portal, ambetter.mhsindiana.com
- Calling Provider Services, 1-877-687-1182

Panel Status

- PCPs should confirm that a member is assigned to their patient panel
- This can be done via our Secure Provider Portal
- PCPs can still administer service if the member is not and may wish to have member assigned to them for future care

Verification of Eligibility, Benefits and Cost Share

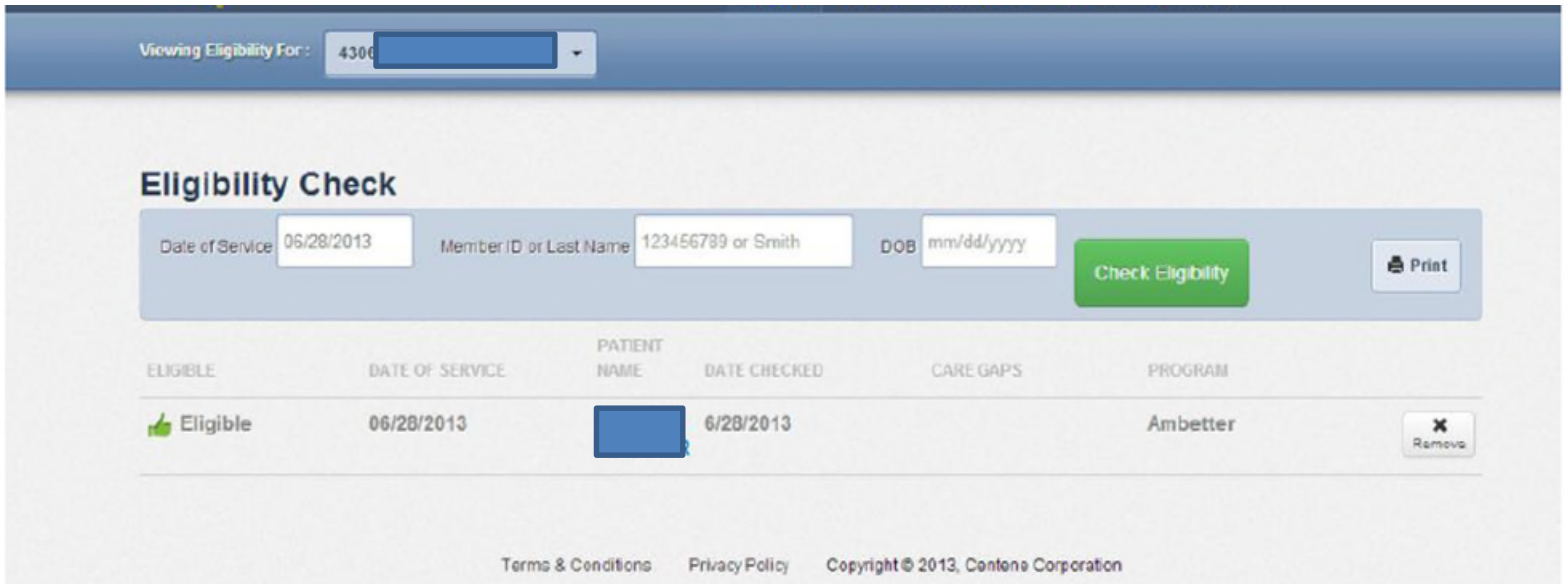
Eligibility, Benefits and Cost Shares can be verified in 3 ways:

- **The Ambetter secure portal found at:** ambetter.mhsindiana.com
  - If you are already a registered user of the Ambetter from MHS secure portal, you do NOT need a separate registration!

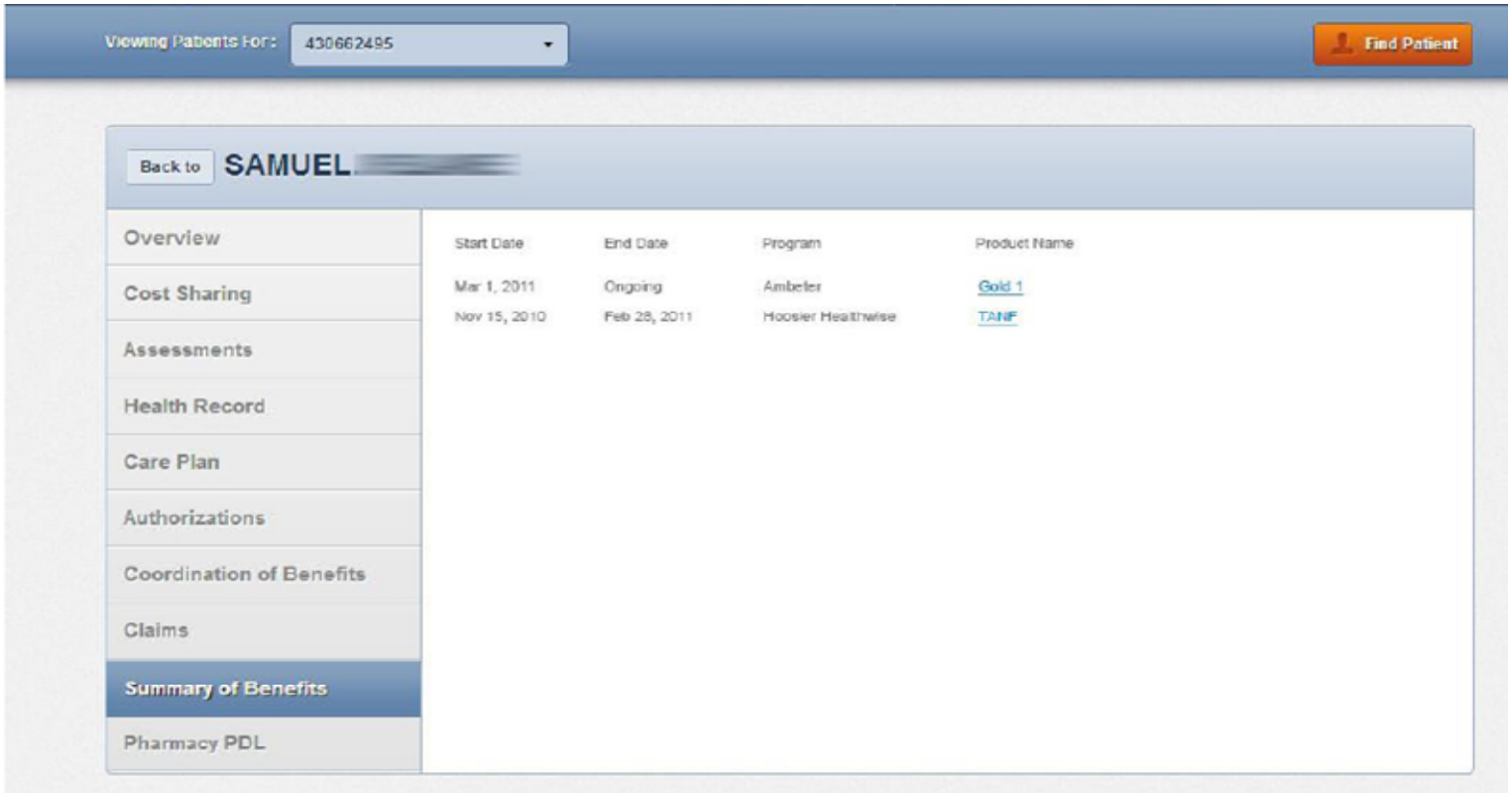
- **24/7 Interactive Voice Response system**
  - Enter the Member ID Number and the month of service to check eligibility

- **Contact Provider Services at:** 1-877-687-1182

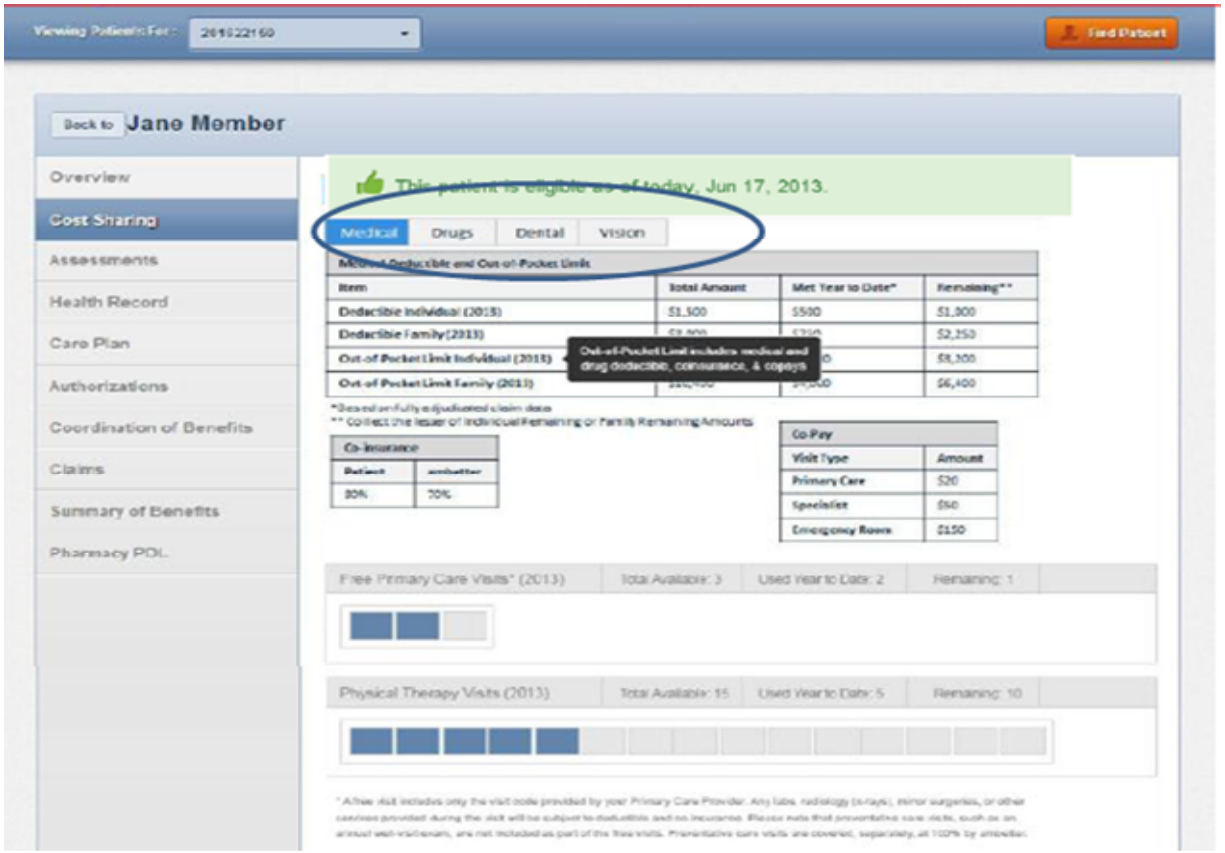
Verification of Eligibility



Verification of Benefits



Verification of Cost Shares



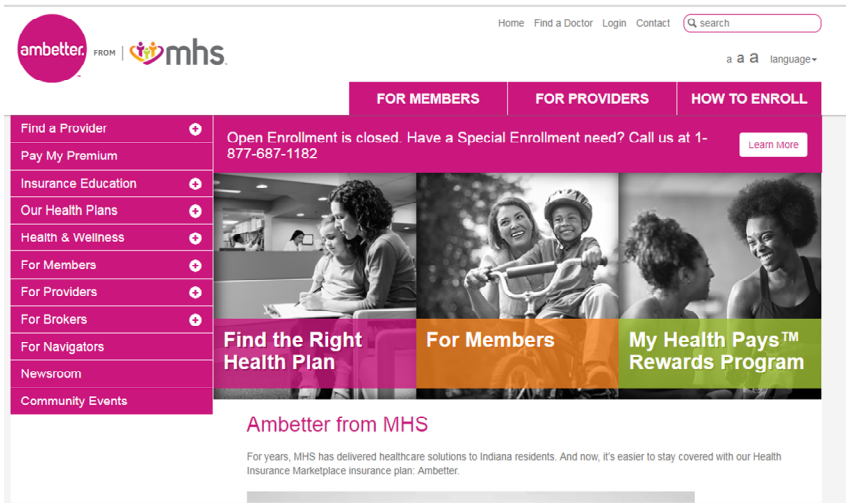
Specialty Referrals

- Members are educated to seek care or consultation with their Primary Care Provider first
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers
- PAPER REFERRALS ARE NOT REQUIRED FOR MEMBERS TO SEEK CARE WITH IN-NETWORK SPECIALISTS

Ambetter Website

Ambetter Website

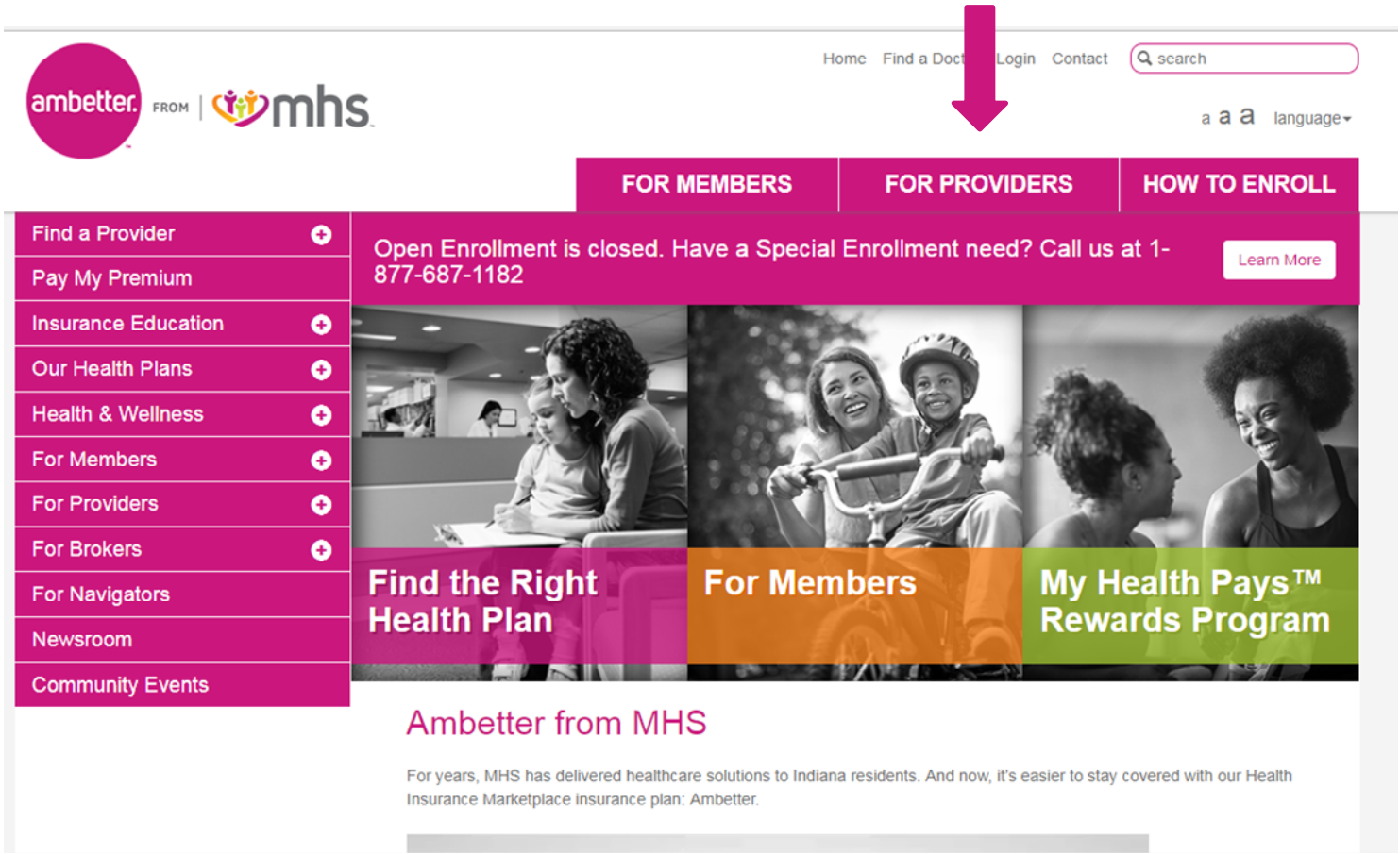
You may access the Public Website for Ambetter in two ways:



1. Go to **mhsindiana.com** and click on Ambetter

2. Go to **ambetter.mhsindiana.com**

Utilizing Our Website



Public Website

Information contained on our Website

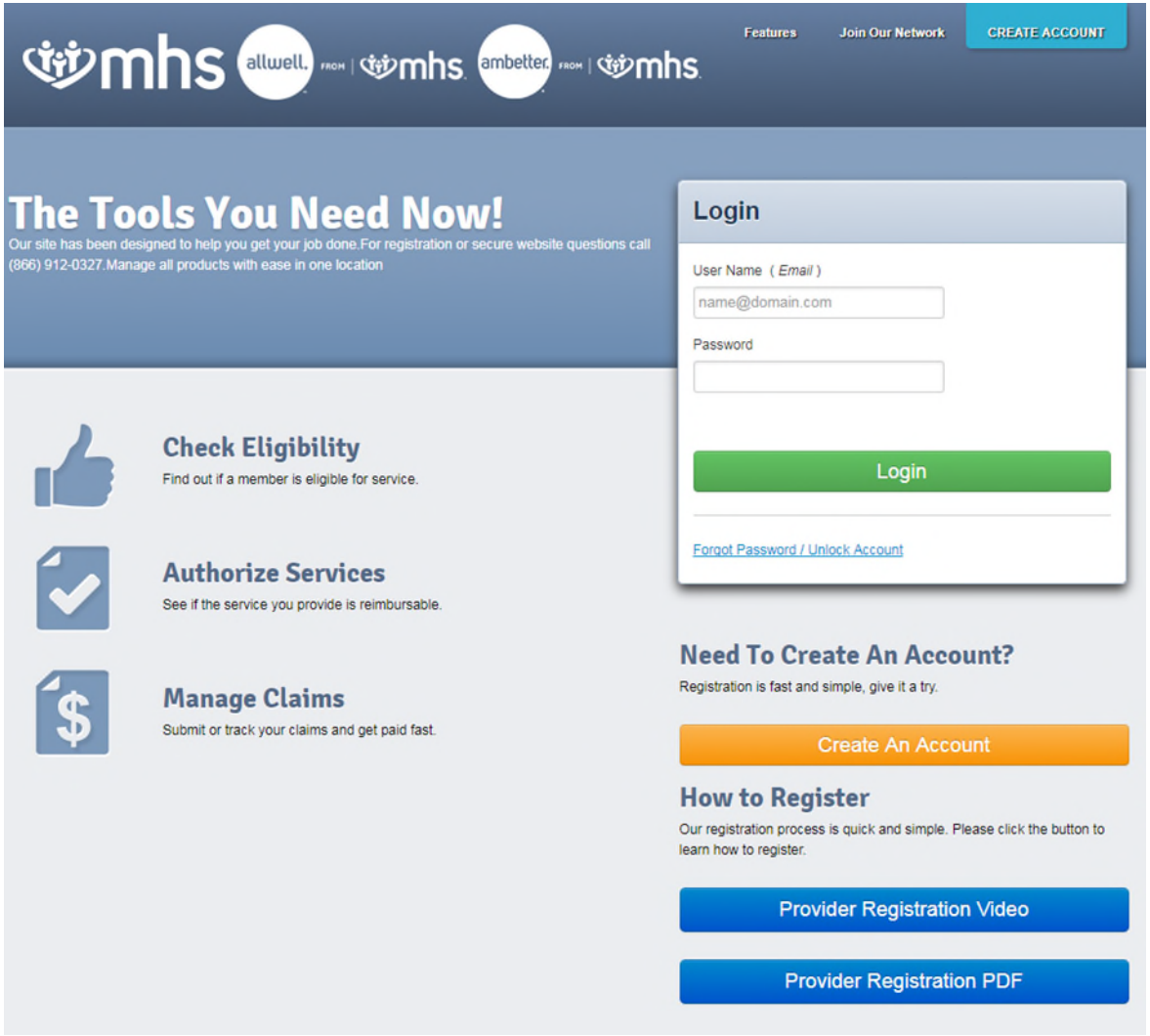
- The Provider and Billing Manual
- Quick Reference Guides
- Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- And much more…

Secure Provider Portal

Information Contained on Our Secure Provider Portal

- Member Eligibility & Patient Listings
- Health Records & Care Gaps
- Authorizations
- Claims Submissions & Status
- Corrected Claims & Adjustments
- Payments History
- Monthly PCP Cost Reports
- Member Analytics
- Provider Analytics

Secure Provider Portal



Registration is free and easy

Secure Provider Portal

PCP Reports

- PCP reports available on the **Ambetter** secure provider web portal are generated on a monthly basis and can be exported into a PDF or Excel format

PCP Reports Include

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High Cost Claims

Provider Analytics

Provider Analytics

What is Provider Analytics?

Provider Analytics is an intelligent health platform that enables providers to make better-informed decisions about healthcare costs and quality metrics using standardized cost, utilization and quality data.

Provider Analytics provides 6 dashboards including: cost, utilization and quality to help providers understand trend performance in key areas where they may have the opportunity to impact and improve health outcomes, better support patient care and provider performance in value-based arrangements.

Dashboard views:

- Key Performance Indicators (summary): high level summary statistics to help providers identify specific care management opportunities
- Cost and Utilization: categorization and trending of costs and utilization of services by disease category and type of service
- Emergency Room: cost and trending of emergency room utilization and identification of potentially preventable visits
- Pharmacy: comparison and trending of generic vs brand cost and utilization
- Quality: identification and trending of quality performance and gaps in care
- VBC: Houses quarterly reports that include performance summaries and identifies number of members needed to meet care gap targets and potential dollars to earn

Provider Analytics

Features

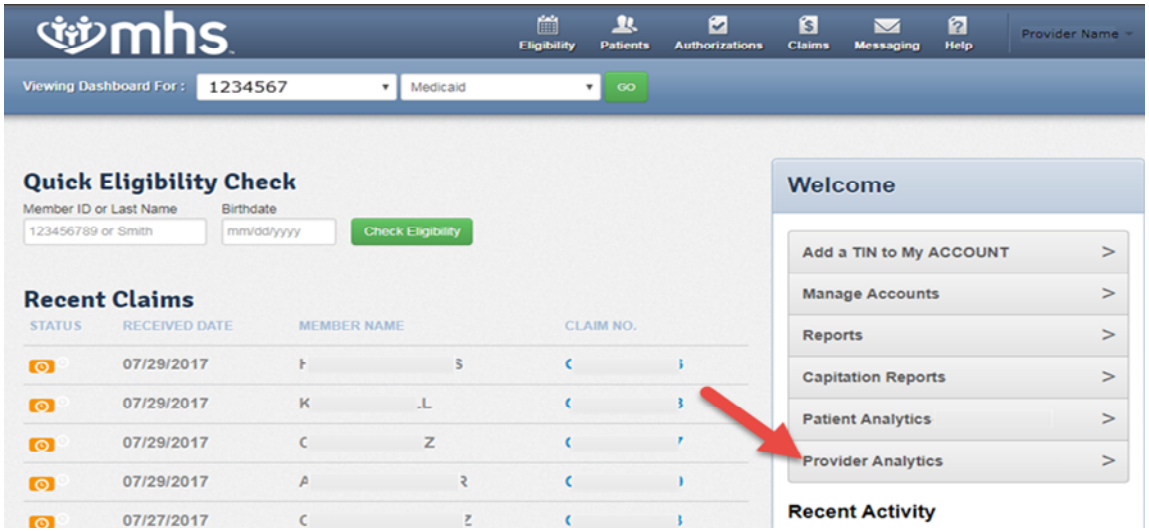
Monthly Quality reports display easy to read gaps-in-care graph

- Can be organized by HEDIS measure or provider (assigned provider, not imputed)
- Loyalty display shows percentage of members in 5 engagement categories to determine how frequently members are seeing their assigned PCP
- Gaps Member Detail report allows users to create a custom report with member detail including: NPI, HEDIS measure, member compliancy, and loyalty
- Tax Identification Number (TIN) to Plan Comparison graph that displays the TIN's complaint rate compares to the rest of the plan

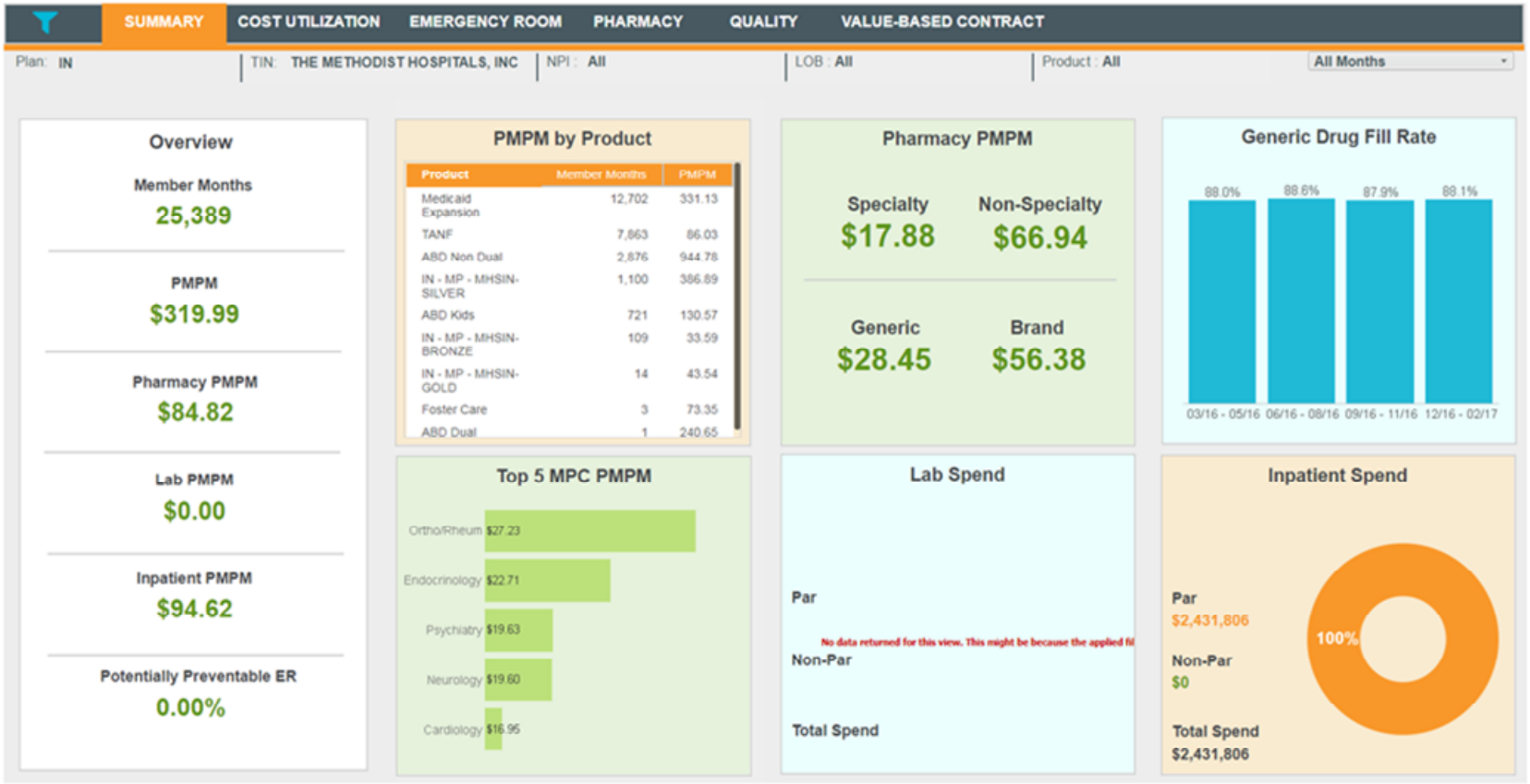
Accessing Provider Analytics

To navigate to the Quality and Pay for Performance Dashboards:

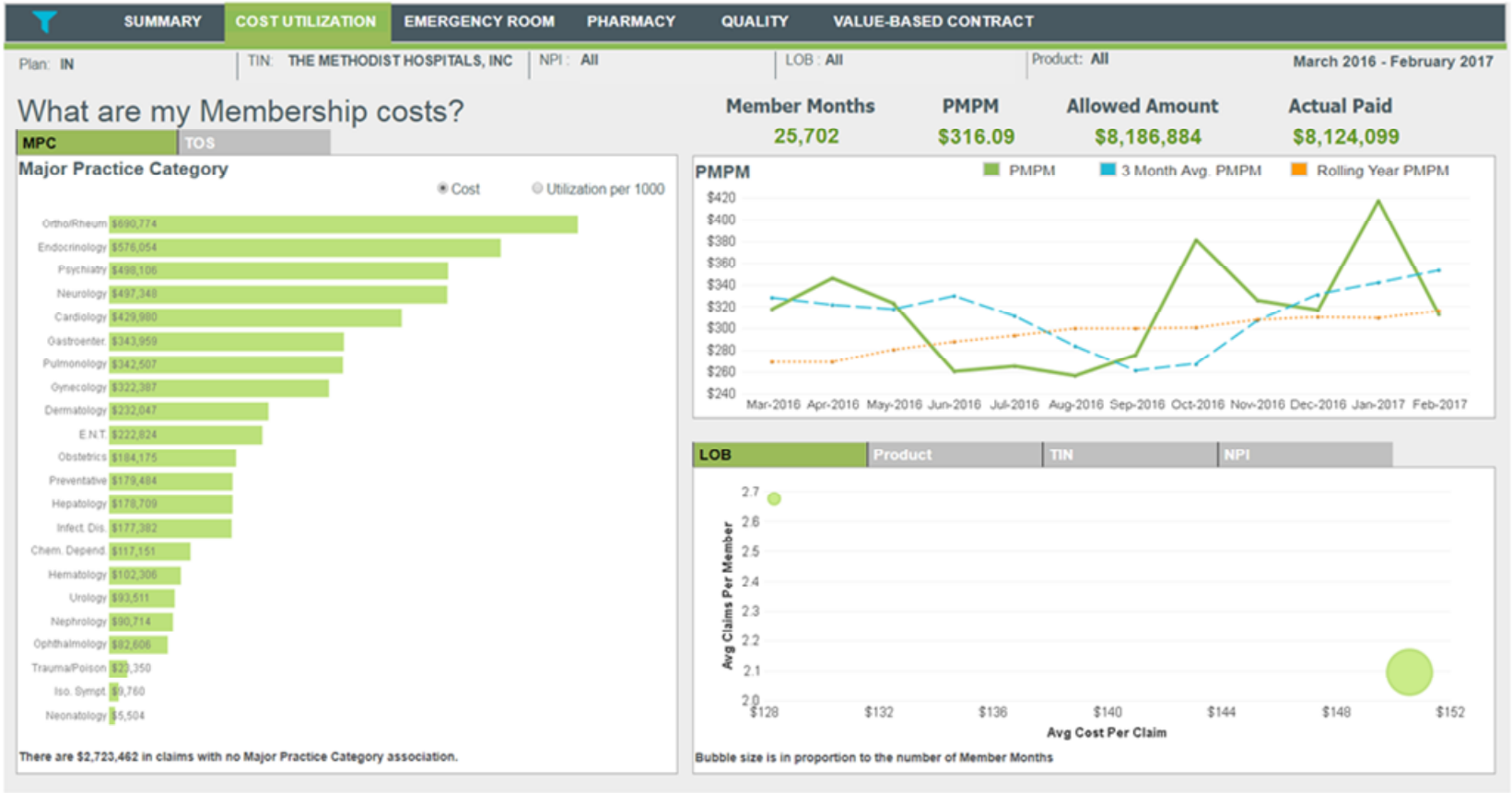
1. From the Provider Portal click on the ***Provider Analytics*** link to be directed to the launch page.
2. Select one of the following dashboards to get started:
    - Summary
    - Cost & Utilization
    - Emergency Room
    - Pharmacy
    - Quality
    - Value-Based Contract



Summary


SUMMARY
COST UTILIZATION
EMERGENCY ROOM
PHARMACY
QUALITY
VALUE-BASED CONTRACT
Plan: IN
TIN: THE METHODIST HOSPITALS, INC
NPI : All
LOB : All
Product : All
All Months
Overview
Member Months
25,389
PMPM
$319.99
Pharmacy PMPM
$84.82
Lab PMPM
$0.00
Inpatient PMPM
$94.62
Potentially Preventable ER
0.00%
PMPM by Product
Product
Member Months
PMPM
Medicaid Expansion 12,702 331.13
TANF 7,863 86.03
ABD Non Dual 2,876 944.78
IN - MP - MHSIN-SILVER 1,100 386.89
ABD Kids 721 130.57
IN - MP - MHSIN-BRONZE 109 33.59
IN - MP - MHSIN-GOLD 14 43.54
Foster Care 3 73.35
ABD Dual 1 240.65
Pharmacy PMPM
Specialty
$17.88
Non-Specialty
$66.94
Generic
$28.45
Brand
$56.38
Generic Drug Fill Rate
88.0%
88.6%
87.9%
88.1%
03/16 - 05/16
06/16 - 08/16
09/16 - 11/16
12/16 - 02/17
Top 5 MPC PMPM
Ortho/Rheum $27.23
Endocrinology $22.71
Psychiatry $19.63
Neurology $19.60
Cardiology $16.95
Lab Spend
Par
No data returned for this view. This might be because the applied fil
Non-Par
Total Spend
Inpatient Spend
Par
$2,431,806
Non-Par
$0
Total Spend
$2,431,806
100%

Cost Utilization



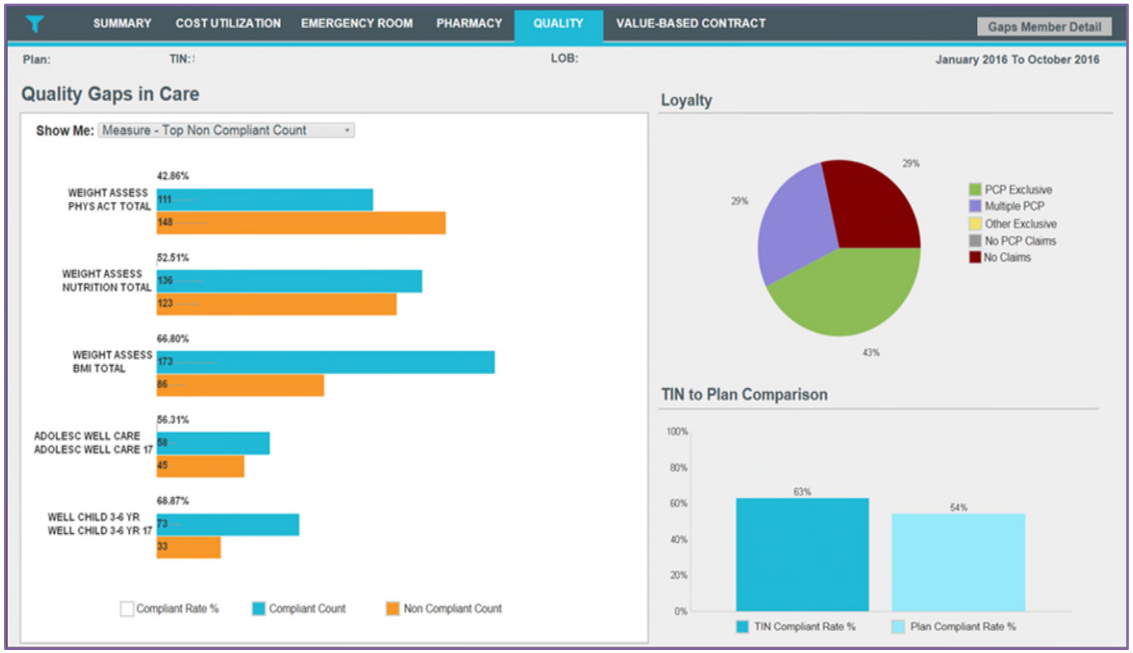
Provider Analytics: Quality

1. **Quality Gaps in Care:** Shows the compliant count and rate by HEDIS measure or provider.

2. **Loyalty:** Displays the number of members in each of the five engagement categories to determine how frequently the members are visiting their assigned PCP. The five categories are PCP Exclusive, Multiple PCP, Other Exclusive, No PCP Claims, and No Claims.

3. **Tax Identification Number (TIN) to Plan Comparison:** Displays the TIN's average compliant rate and the plan's compliant rate as a percentage.

4. **Gaps Member Detail:** The build a report feature allows users to create a custom report with member detail including line of business, NPI, HEDIS measure, HEDIS sub-measure, member compliancy, and loyalty.



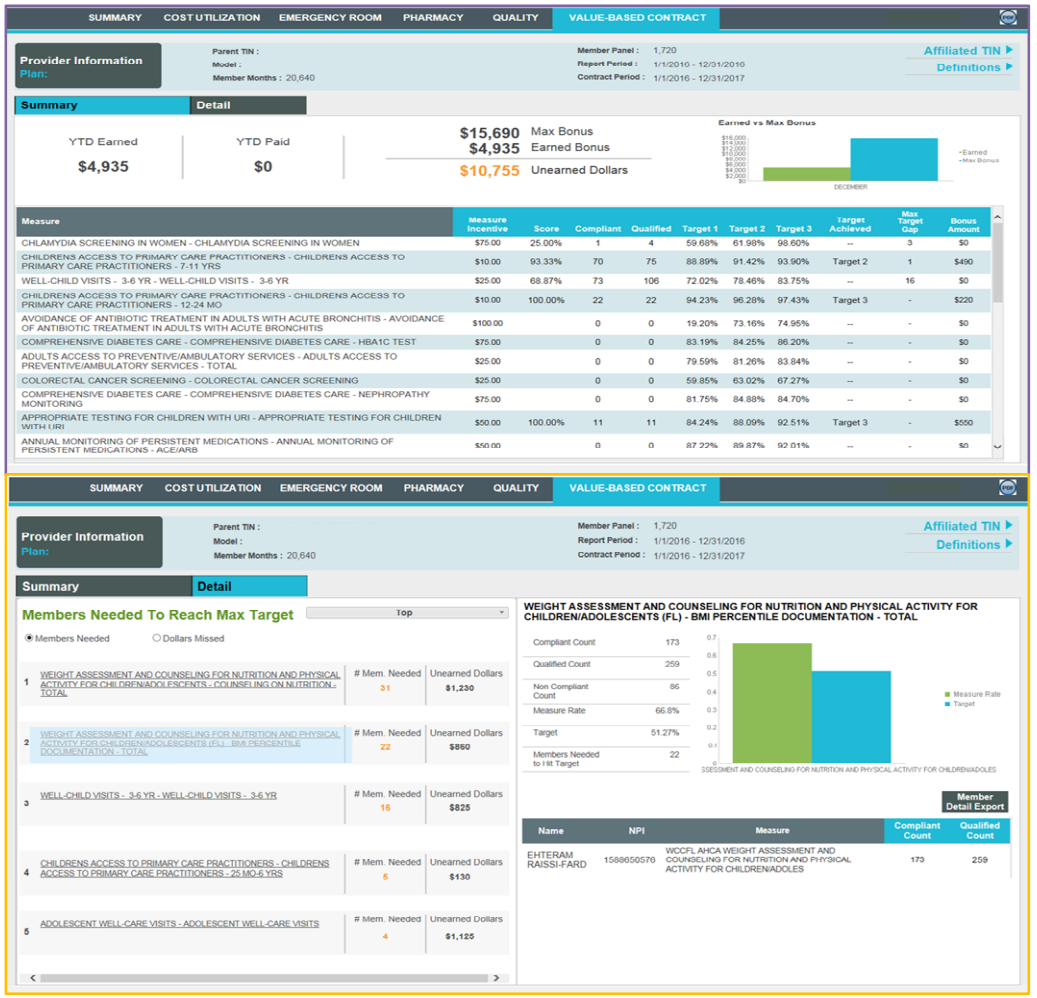
Provider Analytics: Value-Base Contract

- **Summary Tab:** Shows the earned and paid amount year to date, outlines the maximum, earned, and unearned bonus amounts in figures and graphical form. The summary includes a measures list that displays the score, compliant and qualified counts, targets, maximum target gap, and bonus amount.

- **Detail Tab:** Outlines the number of members needed to reach the maximum target. The selected views include members needed or dollars missed.

- **Provider Information:** Includes the parent TIN, model, member months, member panel, report period, and contract period.

- **Other Information:** The user has the option to view an affiliated TIN, product list, or definitions found in the report.



MyHealthDirect:
Overview

myhealth direct

MyHealthDirect is a service sponsored by MHS to schedule healthcare appointments for MHS members.

How is MyHealthDirect different from other services?

- MHS makes scheduling appointments for your members easy. We reach out to schedule appointments with your patients on your behalf.
- Together we close gaps in care.

How does MyHealthDirect work?

- MHS contacts and schedules with your patient
- Both you and the patient get a confirmation email
- You enter the appointment into your PM system
- Automatic reminder(s) are sent to patient
- Patient attends their appointment

MyHealthDirect is FREE to you and your patients. You still keep full control over your calendar and appointments. We do the rest.

Want to learn more? Contact a Provider Representative of MyHealthDirect today!

mhs@myhealthdirect.com myhealth direct

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Utilization Management

Specialty Referrals

- Members are educated to seek care or consultation with their Primary Care Provider first
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers
- Paper referrals are not required for members to seek care with in-network specialists
- **If an out of network provider is utilized, except in the case of emergency services, the member will be 100% responsible for all charges. Please help our members avoid out-of-pocket costs by referring in-network.**

How to Secure Prior Authorization

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Pre-Auth Needed Tool

Use the Pre-Auth Needed Tool at ambetter.mhsindiana.com to quickly determine if a service or procedure requires prior authorization.

Submit Prior Authorization

If a service requires authorization, submit via one of the following three ways:

PHONE
1-877-687-1182

FAX

MEDICAL	BEHAVIORAL HEALTH
1-855-702-7337	1-855-283-9094

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned phone, fax or web.

SECURE WEB PORTAL
provider.mhsindiana.com

Exclusive Provider Network Benefit Plan

PLEASE NOTE:

1. Members must utilize in-network participating providers and practitioners except in the case of emergency services.
2. Emergency and urgent care services DO NOT require prior authorization. All out-of-network (non-par) services, providers and practitioners DO require prior authorization.
3. Failure to complete the required authorization or certification may result in a denied claim.

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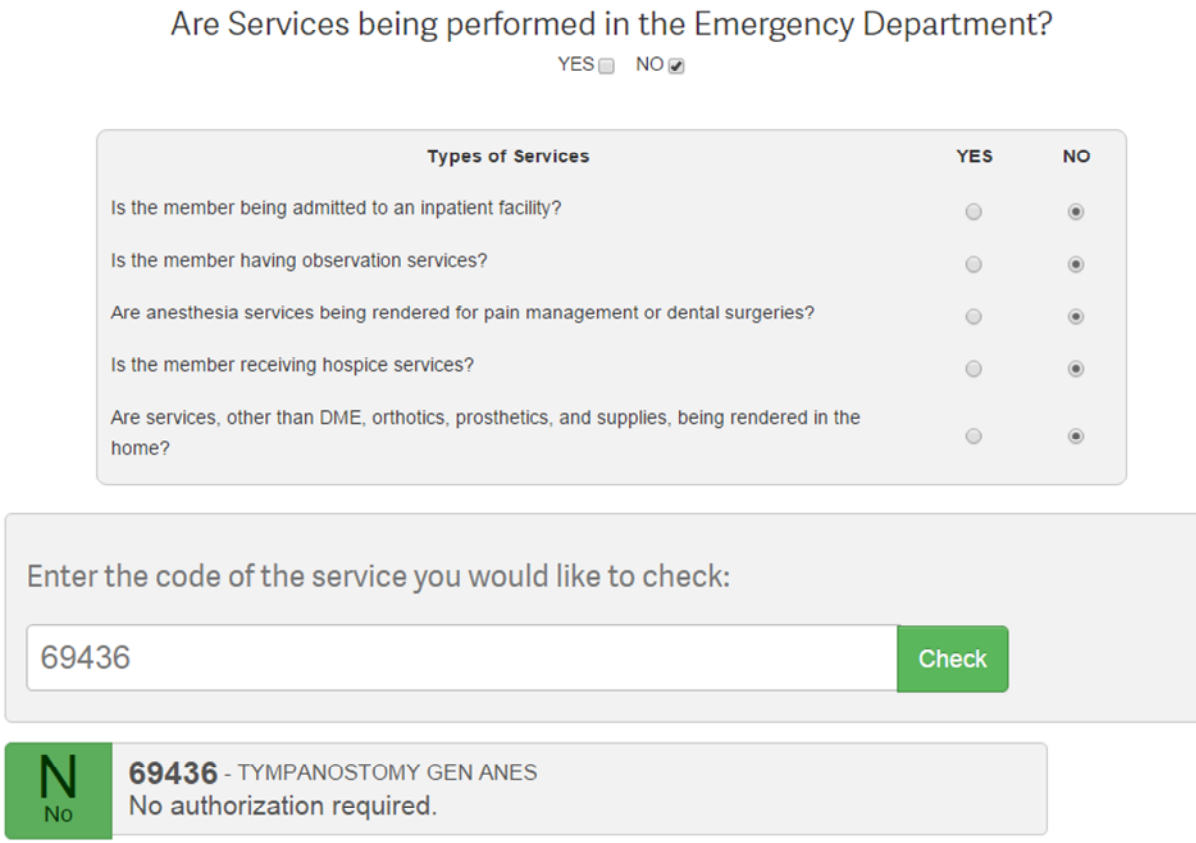
Pre-Auth Needed Tool



Prior Authorization

Procedures / Services*

- Potentially Cosmetic
- Experimental or Investigational
- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
  - One allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists
  - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively
- Pain Management

** This is not meant to be an all-inclusive list*

Prior Authorization

Inpatient Authorization*

- All elective/scheduled admission notifications requested at least **5** business days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays exceeding 23 hours require Inpatient Authorization

** This is not meant as an all-inclusive list*

Prior Authorization

Inpatient Authorization, cont.*

- Urgent/Emergent Admissions
  - Within 1 business day following the date of admission
  - Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs

** This is not meant to be an all-inclusive list*

Prior Authorization

Ancillary Services*

- Air Ambulance Transport (non-emergent fixed-wing airplane)
- DME including orthotics/prosthetics (CPT Code Specific)
- Home health care services including, home infusion, skilled nursing, and therapy
  - Home Health Services
  - Private Duty Nursing
  - Adult Medical Day Care
  - Hospice
  - Furnished Medical Supplies & DME

** This is not meant to be an all-inclusive list*

Prior Authorization

Ancillary Services, cont.

- Orthotics/Prosthetics
  - Therapy
  - Occupational
  - Physical
  - Speech
- Hearing Aid devices including cochlear implants
- Genetic Testing
- Quantitative Urine Drug Screen

** This is not meant to be an all-inclusive list*

Prior Authorization

Prior Authorization can be requested in 3 ways:

1. **The Ambetter secure portal found at ambetter.mhsindiana.com**
   - If you are already a registered user of the MHS portal, you do NOT need a separate registration!

2. **Fax Requests to 1-855-702-7337**
   The Fax authorization forms are located on our website at ambetter.mhsindiana.com

3. **Call for Prior Authorization at 1-877-687-1182**

National Imagining Associates (NIA) Training Opportunities

- Reminder: NIA will begin facilitating Ambetter authorizations for MHS 1/1/21
- Outpatient physical, occupations and speech therapy
- www.RadMD.com

Imaging Services

Radiology benefit management program for outpatient advanced imaging services

- *NIA's Guidelines for Clinical Use of Diagnostic Imaging Procedures can be found on NIA's website at RadMD.com.*
- *The NIA authorization number consists of 8 or 9 alpha/numeric characters (e.g., 1234X567)*

- For privileging application or process, contact NIA's Provider Assessment Department toll-free at 1-888-972-9642 or at RADPrivilege@Magellanhealth.com

- **The number to call to obtain a prior authorization is 1-866-904-5096 or initiate at** RadMD.com

National Imaging Associates (NIA)

The following services require authorization with NIA

- CT/CTA
- CTTA
- MRI/MRA
- PET Scan
- Stress Echo/Echo
- MUGA Scan
- Myocardial Perfusion Imaging
- Please refer to NIA's website to obtain the Billable CPT® Codes Claim Resolution Matrix for all of the CPT-4 codes that NIA authorizes on behalf of MHS

National Imaging Associates (NIA)

The following services are **not** be impacted:

- Inpatient advanced imaging services
- Emergency Room imaging services
- Observation imaging services
- Ambetter from MHS performs prior authorization of coverage for interventional imaging procedures (even those that utilize MR/CT technology)
  - Emergency room, observation and inpatient imaging procedures do not require prior authorization from NIA
  - If an urgent/emergent clinical situation exists outside of a hospital emergency room, please contact NIA immediately with the appropriate clinical information for an expedited review

Therapy Services
Speech, Occupational, Physical Therapy

- Benefit Limitations Apply
- Must follow billing guidelines (GP, GN, GO modifiers)
- National Imaging Associates, Inc. (NIA) conducts retrospective review to evaluate medical necessity:
    - If requested, medical records can be uploaded to RadMD.com or faxed to NIA at 1-800-784-6864.
    - Medical necessity appeals will be conducted by NIA:
        - Follow steps outlined in denial notification
        - NIA Customer Care Associates are available to assist providers at 1-800-424-5391

TurningPoint Healthcare Solutions

June 1, 2019 MHS entered into an agreement with **TurningPoint Healthcare Solutions, LLC,** to implement a Musculoskeletal Surgical Quality and Safety management program. This program includes prior authorization for medical necessity and appropriate length of stay (when applicable) for both inpatient and outpatient settings.

TurningPoint Healthcare Solutions will manage prior authorization for medical necessity and appropriate length of stay (when applicable) for services listed below through MHS' existing contractual relationships. Prior authorization will be required for the following musculoskeletal surgical procedures:

MUSCULOSKELETAL

Orthopedic Surgical Procedures

Including all associated partial, total, and revision surgeries

- ✓ Knee Arthroplasty
- ✓ Unicompartmental/Bicompartmental Knee Replacement
- ✓ Hip Arthroplasty
- ✓ Shoulder Arthroplasty
- ✓ Elbow Arthroplasty
- ✓ Ankle Arthroplasty
- ✓ Wrist Arthroplasty
- ✓ Acromioplasty and Rotator Cuff Repair
- ✓ Anterior Cruciate Ligament Repair
- ✓ Knee Arthroscopy
- ✓ Hip Resurfacing
- ✓ Meniscal Repair
- ✓ Hip Arthroscopy
- ✓ Femoroacetabular Arthroscopy
- ✓ Ankle Fusion
- ✓ Shoulder Fusion
- ✓ Wrist Fusion
- ✓ Osteochondral Defect Repair

Spinal Surgical Procedures

Including all associated partial, total, and revision surgeries

- ✓ Spinal Fusion Surgeries
  - ✓ Cervical
  - ✓ Lumbar
  - ✓ Thoracic
  - ✓ Sacral
  - ✓ Scoliosis
- ✓ Disc Replacement
- ✓ Laminectomy/Discectomy
- ✓ Kyphoplasty/Vertebroplasty
- ✓ Sacroiliac Joint Fusion
- ✓ Implantable Pain Pumps
- ✓ Spinal Cord Neurostimulator
- ✓ Spinal Decompression

TURNINGPOINT'S UTILIZATION MANAGEMENT & PRECERTIFICATION CONTACT INFORMATION:
Web Portal Intake: myturningpoint-healthcare.com
Telephonic Intake: 574-784-1005 | 855-415-7482 Facsimile Intake: 463-207-5864

Should you have any questions at this time, please contact MHS Provider Services at **1-877-647-4848**

Durable & Home Medical Equipment (DME)

- Members and referring providers will no longer need to search for a DME provider or provider of medical supplies to service their needs
- Order is submitted directly to Ambetter, coordinated by Medline and delivered to the member
- Availability via Medline's web portal to submit orders and track delivery
- Prior authorization required by the **ordering physician** for all non-participating DME providers
- Does not apply to items provided by and billed by physician office

Durable & Home Medical Equipment

Requests should be initiated via **Ambetter secure portal**

- **Web Portal**: Simply go to ambetter.mhsindiana.com, log into the provider portal, and click on “Create Authorization.” Choose DME and you will be directed to the Medline portal for order entry.

Prior Authorization

Prior Authorization will be granted at the CPT code level

- If a claim is submitted containing CPT codes that were not authorized, the services will be denied
- If additional procedures are performed during the procedure, the provider must contact the health plan to update the authorization in order to avoid a claim denial
- It is recommended that this be done within 72 hours of the procedure; however, it must be done prior to claim submission or the claim will deny
- Ambetter will update authorizations but will not retro-authorize services
  - The claim will deny for lack of authorization
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed

Prior Authorization

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one business day
Maternity admissions	Notification within one business day
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day
Outpatient Dialysis	Notification within one business day

** This is not meant to be an all-inclusive list*

Utilization Determination Timeframes

Type	Timeframe
Prospective/Urgent	One (1) Business day
Prospective/Non-Urgent	Two (2) Business days
Emergency services	60 minutes
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

Claims

Claims

Clean Claim

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Exceptions

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

Claim Submission

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Claims may be submitted in 3 ways:

1. **The secure web portal located at ambetter.mhsindiana.com**

2. **Electronic Clearinghouse**
   - Payor ID 68069
   - Clearinghouses currently utilized by ambetter.mhsindiana.com will continue to be utilized
   - For a listing our the Clearinghouses, please visit out website at ambetter.mhsindiana.com

3. **Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010**

Claim Submission

Claim Reconsiderations

- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 180 days of the Explanation of Payment
- Claim Reconsiderations may be mailed to PO Box 5010 – Farmington, MO 63640-5010

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at ambetter.mhsindiana.com
- The completed Claim Dispute form may be mailed to PO Box 5000 – Farmington, MO 63640-5000

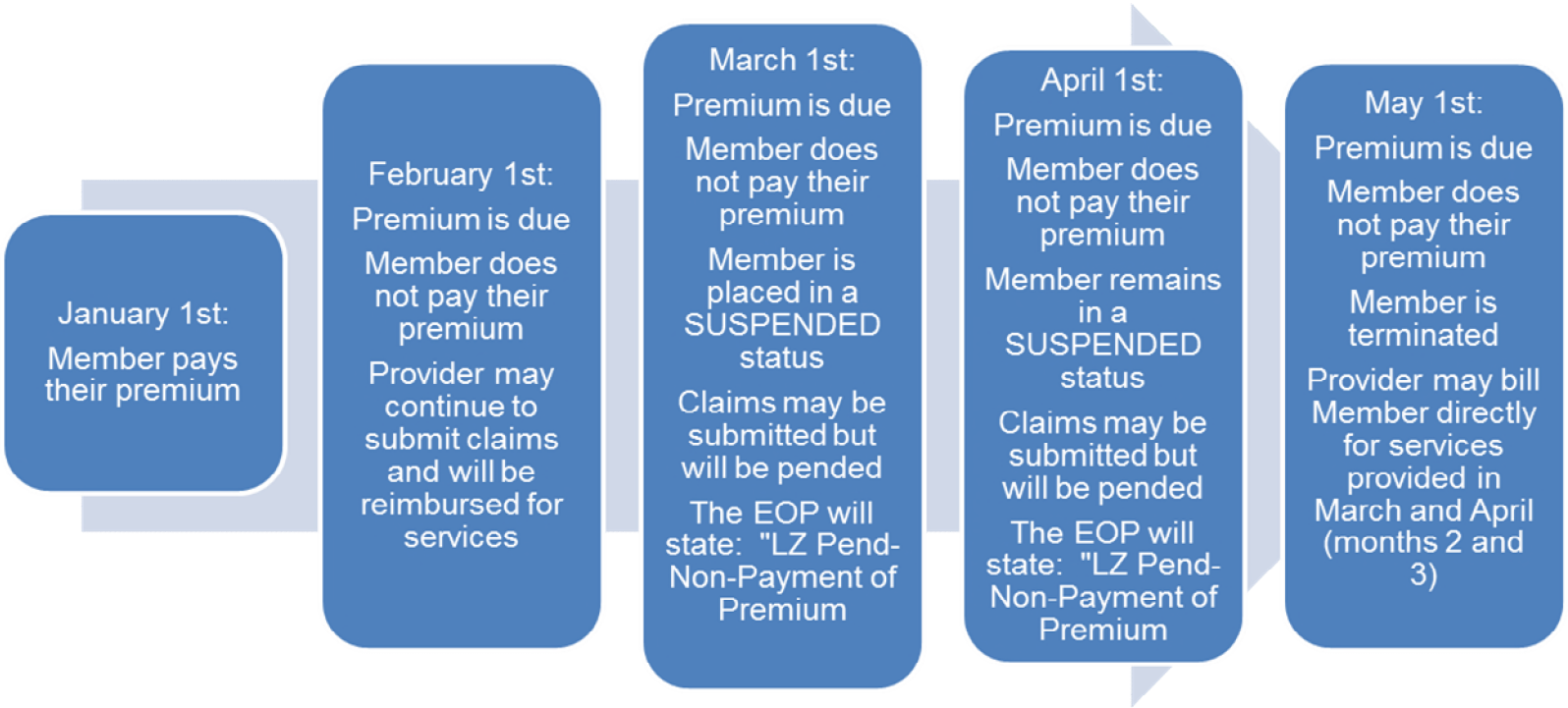
Claim Submission

Member in Suspended Status

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member is in a suspended status, claims will be pended
- When the premium is paid by the member, the claims will be released and adjudicated
- If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services

Claim Submission

Member in Suspended Status



Claims for members in a suspended status are not considered “clean claims”

** Note: When checking Eligibility, the Secure Portal will indicate that the member is in a suspended status*

Claim Submission

Other helpful information:

Rendering Taxonomy Code

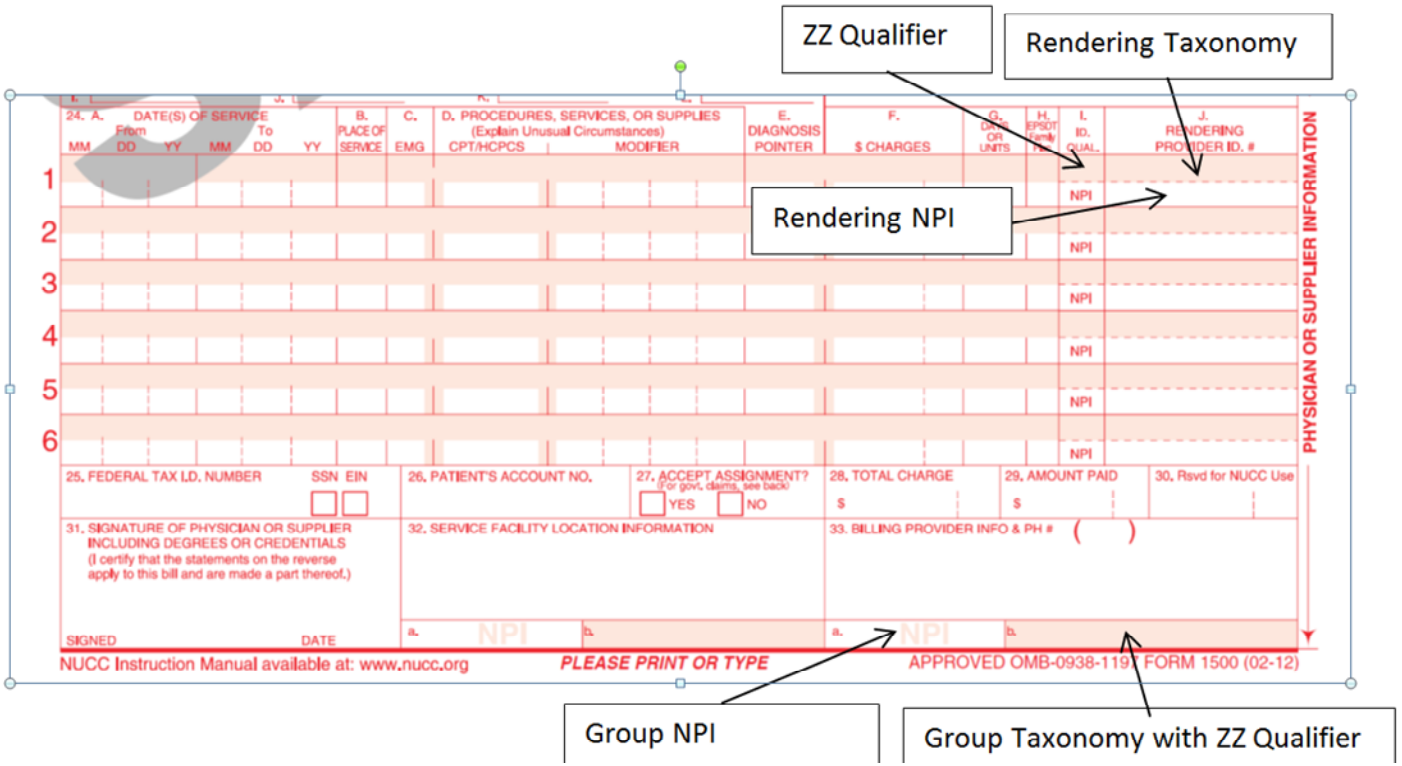
- Claims must be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

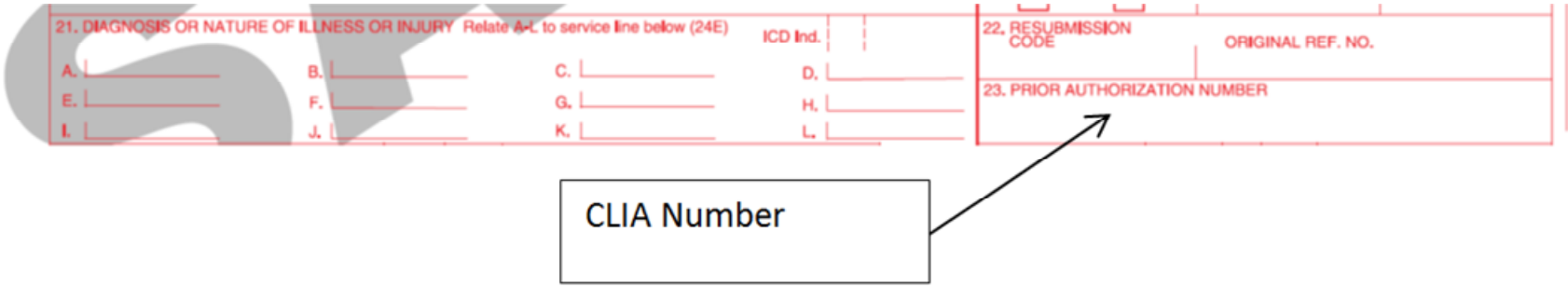
Taxonomy Code

Example of Taxonomy Code – CMS 1500



CLIA Number

- CLIA Number **is required** on CMS 1500 Submissions in Box 23
- CLIA Number **is not required** on UB04 Submissions



Claim Submission

Billing the Member:

- Copays, Coinsurance and any unpaid portion of the Deductible may be collected at the time of service
- The Secure Web Portal will indicate the amount of the deductible that has been met
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days

Claim Payment

PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer
- If you currently utilize PaySpan, you will auto-enrolled in PaySpan for the Ambetter product
- **If you do not currently utilize PaySpan: To register** call 1-877-331-7154 or visit payspanhealth.com

Complaints/Grievances/Appeals

Complaints/Grievances/Appeals

Claims

- A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a Complaint/Grievance

Corrected Claims, Requests for Reconsideration or Claim Disputes

- All claim requests for corrected claims, reconsiderations or claim disputes must be received within 180 days from the date of the original notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 180 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance.

Complaints/Grievances/Appeals

Reconsiderations

- A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records
- The documentation must also include a description of the reason for the request
- Indicate “Reconsideration of (original claim number)”
- Include a copy of the original Explanation of Payment
- Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim

The “Request for Reconsideration” should be sent to:

Ambetter from MHS
Attn: Reconsideration
PO Box 5010
Farmington, MO 63640-5010

Complaints/Grievances/Appeals

Claim Dispute

- A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration
- Providers wishing to dispute a claim must complete the Claim Dispute Form located at ambetter.mhsindiana.com
- To expedite processing of the dispute, please include the original request for reconsideration letter and the response

The Claim Dispute form and supporting documentation should be sent to:

Ambetter from MHS Indiana
Attn: Claim Dispute
PO Box 5000
Farmington, MO 63640-5000

Complaints/Grievances/Appeals

Appeals

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal

Medical Necessity

- Must be filed within 30 calendar days from the Notice of Action
- Ambetter shall acknowledge receipt within 10 business days of receiving the appeal
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 calendar days
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.

Complaints/Grievances/Appeals

- Members may designate Providers to act as their Representative for filing appeals related to Medical Necessity
    - Ambetter requires that this designation by the Member be made in writing and provided to Ambetter
- No punitive action will be taken against a provider by Ambetter for acting as a Member's Representative
- Full Details of the Claim Reconsideration, Claim Dispute, Complaints/Grievances and Appeals processes can be found in our Provider Manual at: ambetter.mhsindiana.com

Ambetter from MHS Partnership

Specialty Companies/Vendors

Service	Specialty Company/Vendor	Contact Information
Behavioral Health	Centene Corporate	1-877-687-1182 ambetter.mhsindiana.com
High Tech Imaging Services	National Imaging Associates	1-866-904-5096 radmd.com
Vision Services	Envolve Vision	1-844-820-6523 visionbenefits.envolvehealth.com
Dental Services	Envolve Dental	1-855-609-5157 dental.envolvehealth.com
Pharmacy Services	Envolve Pharmacy Solutions	1-877-399-0928 pharmacy.envolvehealth.com

Provider Services

- **Ambetter from MHS** Member/Provider Services department includes trained Provider Relations staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
  - Credentialing/Network Status
  - Claims
  - Request for adding/deleting physicians to an existing group
- By calling **Ambetter from MHS** Member/Provider Services number at 1-877-687-1182, providers will be able to access real time assistance for all their service needs

Provider Relations

- Each provider will have an **Ambetter from MHS** Member/Provider Services department includes trained Provider Relations staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
  - Provider Education
  - HEDIS/Care Gap Reviews
  - Financial Analysis
  - Assisting Providers with EHR Utilization
  - Demographic Information Update
  - Initiate credentialing of a new practitioner
  - Facilitate inquiries related to administrative policies, procedures, and operational issues
  - Monitor performance patterns
  - Contract clarification
  - Membership/Provider roster questions
  - Assist in Provider Portal registration and Payspan

By calling **Ambetter from MHS** Member/Provider Services number at 1-877-687-1182**,** providers will be able to access real time assistance for all their service needs

Provider Tool Kit

Information included in the Tool Kit:

- Welcome Letter
- Ambetter Provider Introductory Brochure
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal

Key Things to Remember

- Members enrolled in Ambetter must utilize **in-network participating providers** except in the case of emergency services
- Use the “Find a Provider” tool for patient referrals
- Provider may bill Member directly for services provided while member is in suspended status

Contact Information

Ambetter from MHS

Phone: 1-877-687-1182

TTY/TDD: 1-877-743-3333

ambetter.mhsindiana.com

Questions?