Ambetter Best Practices

ambetter. FROM mhs

ACCREDITED NCQA HEALTH PLAN

AGENDA

1. The Health Insurance Marketplace
2. Need To Know
3. Ambetter Website and Secure Portal
4. Utilization Management
5. Claims
6. Ambetter Partnership
7. Questions

WHAT YOU WILL LEARN

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

WHAT YOU NEED TO KNOW…

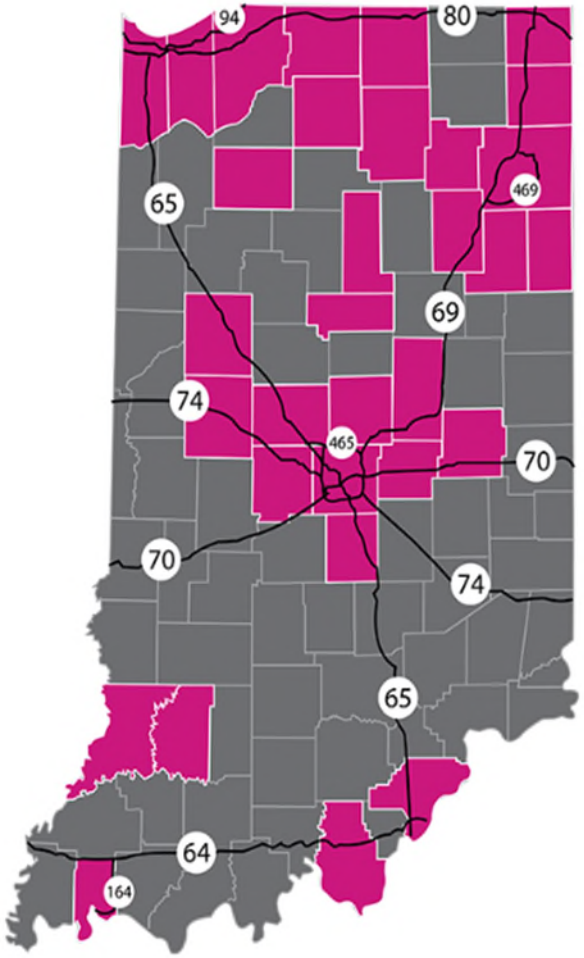
What is “EPO”?

Ambetter is an **Exclusive Provider Network (EPO)**

- **EPO** stands for "**Exclusive Provider Organization**" plan.
- Members of an **EPO**, can use the doctors and hospitals within the **EPO network**, but cannot go outside the **network** for care.

Important Note: There are no out-of-network benefits

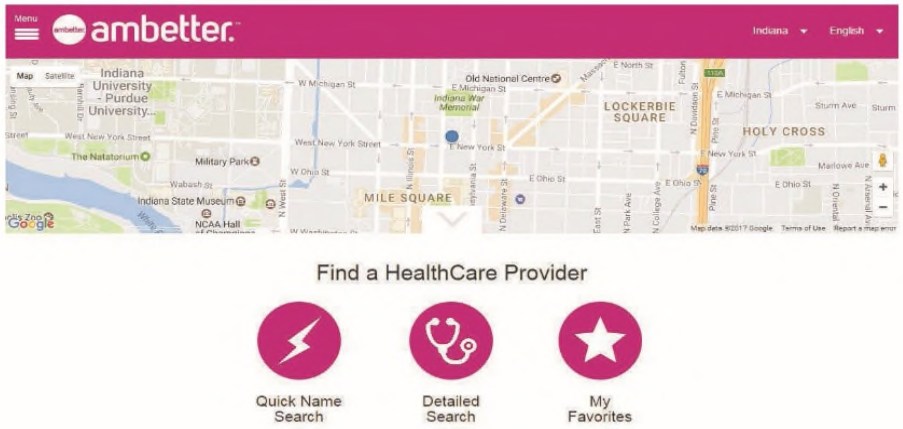
Ambetter Service Areas



- Adams
- Allen
- Boone
- Clarke
- Daviess
- DeKalb
- Elkhart
- Hamilton
- Hancock
- Harrison
- Hendricks
- Henry
- Howard
- Huntington
- Johnson
- Knox
- Kosciusko
- Lake
- LaPorte
- Madison
- Marion
- Marshall
- Miami
- Montgomery
- Porter
- Pulaski
- St. Joseph
- Steuben
- Tippecanoe
- Vanderburgh
- Wells
- Whitley

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:

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

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

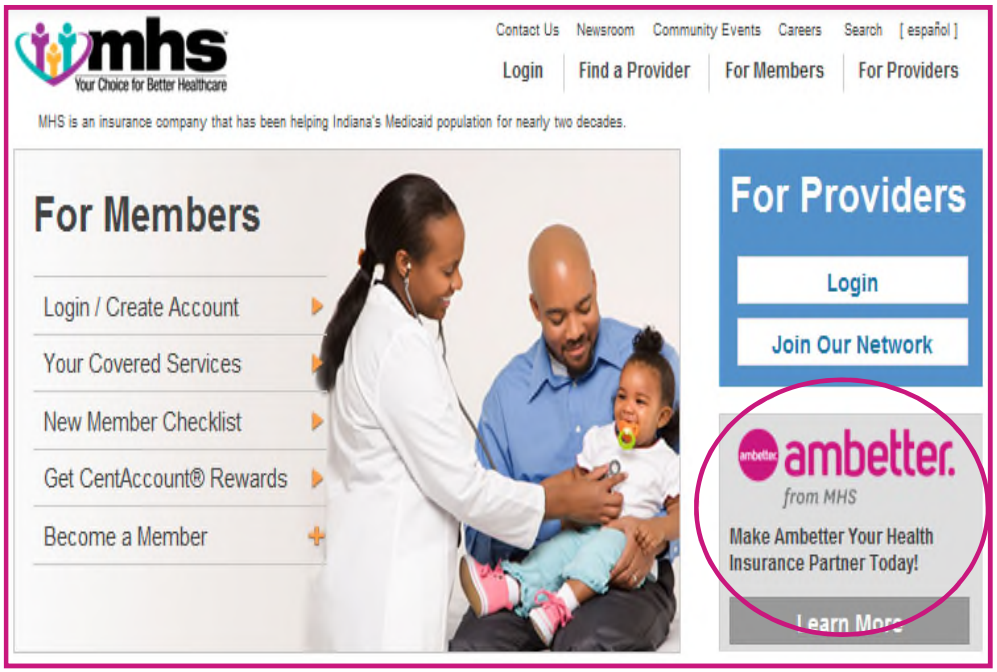
Panel Status

- 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

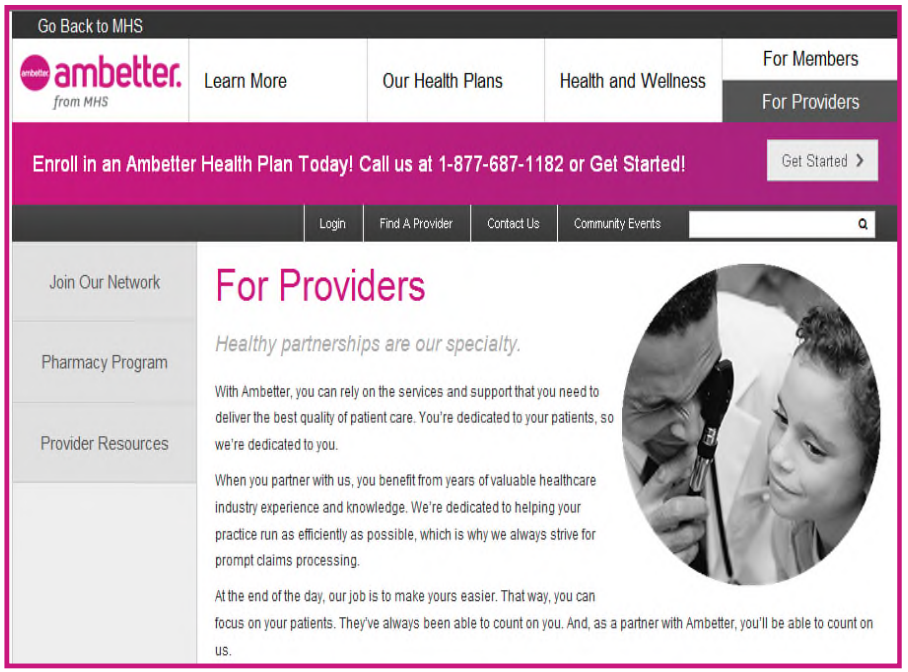
Ambetter Website

Ambetter Website

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

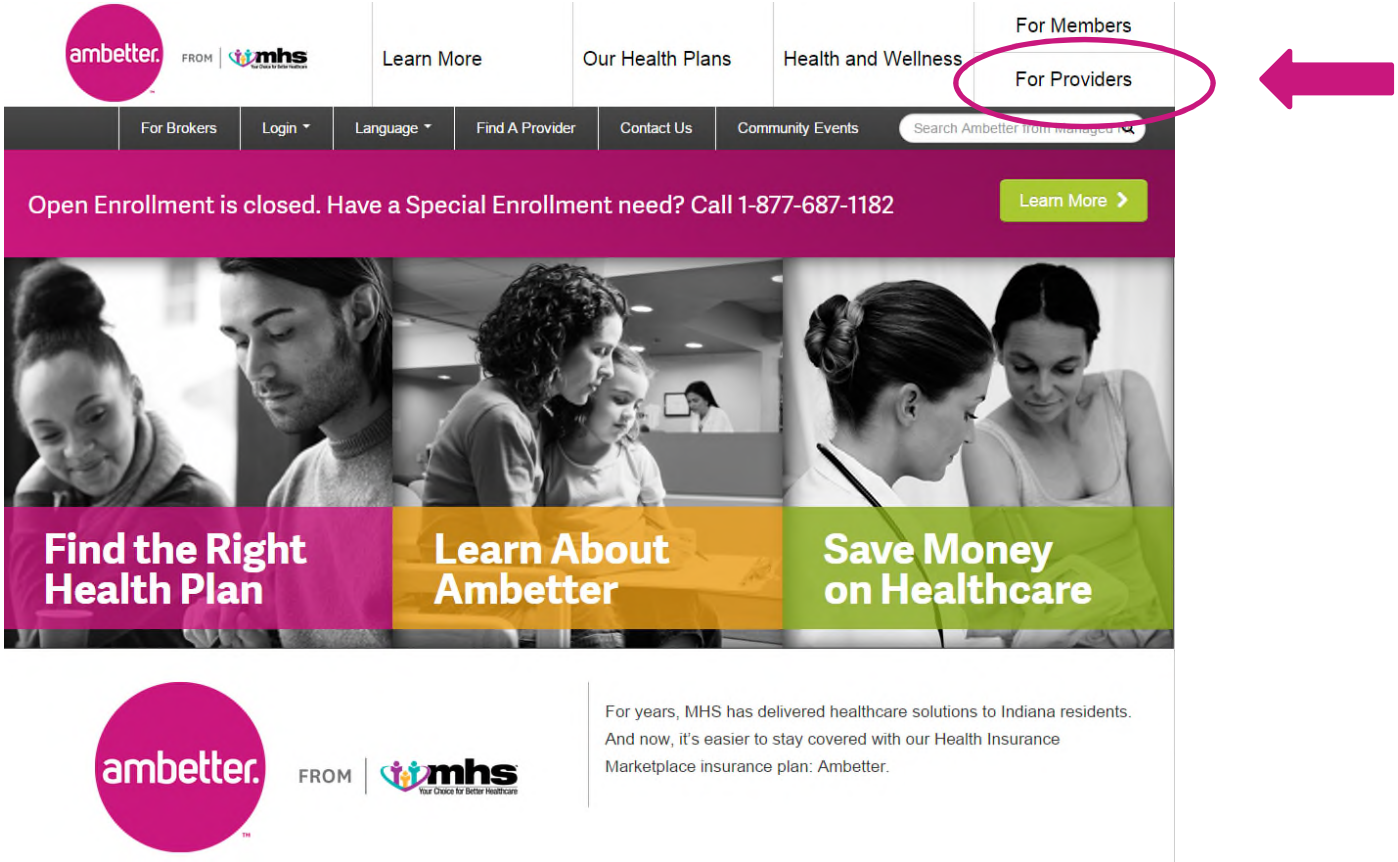


1. Go to **mhsindiana.com** and click on Ambetter



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…

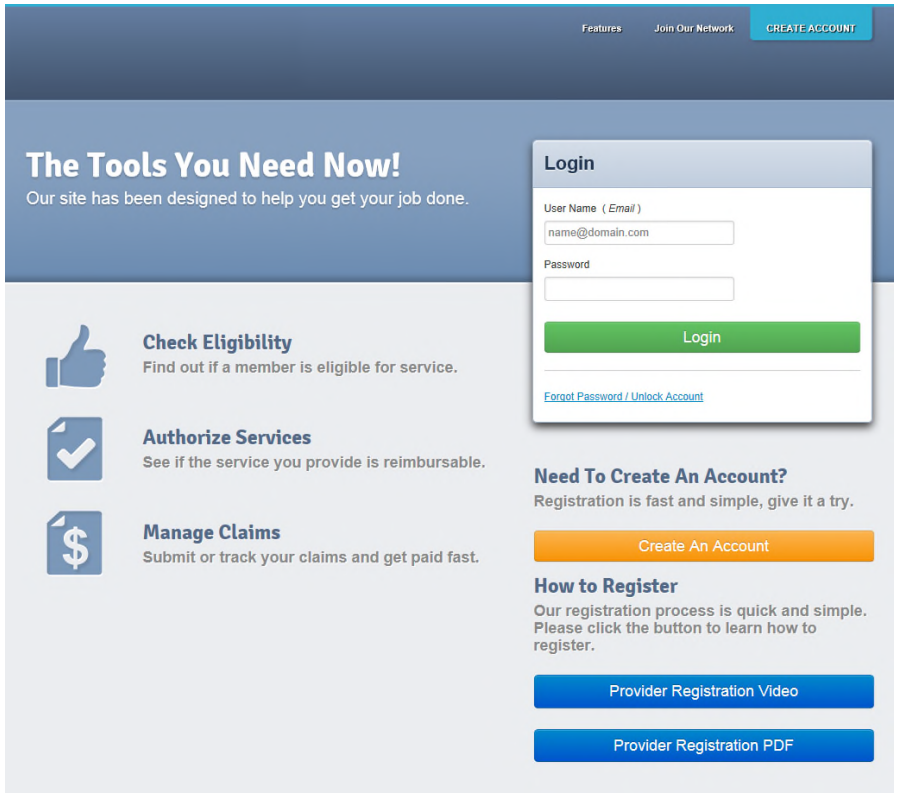
Secure Provider Portal

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

Secure Provider Portal

Registration is free and easy



Secure Provider Portal

PCP Reports

- PCP reports available on **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

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 see 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.**

How to Secure Prior Authorization

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
1-855-702-7337

BEHAVIORAL HEALTH
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.

Prior Authorization

Prior Authorization will be granted at the CPT code level

- If a claim is submitted that contains CPT codes that were not authorized, the services 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

Note: This is not a comprehensive 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

Note: This is not a comprehensive or all-inclusive list

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

Ancillary Services*

- Air Ambulance Transport (non-emergent fixed-wing airplane)
- DME
- 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*

National Imaging Associates (NIA)

Radiology benefit management program for outpatient advanced imaging services 11/1/16

- *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 will **not** be impacted:

- Inpatient advanced imaging services
- Emergency Room imaging services
- Observation imaging services
- MHS will continue to perform 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

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

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

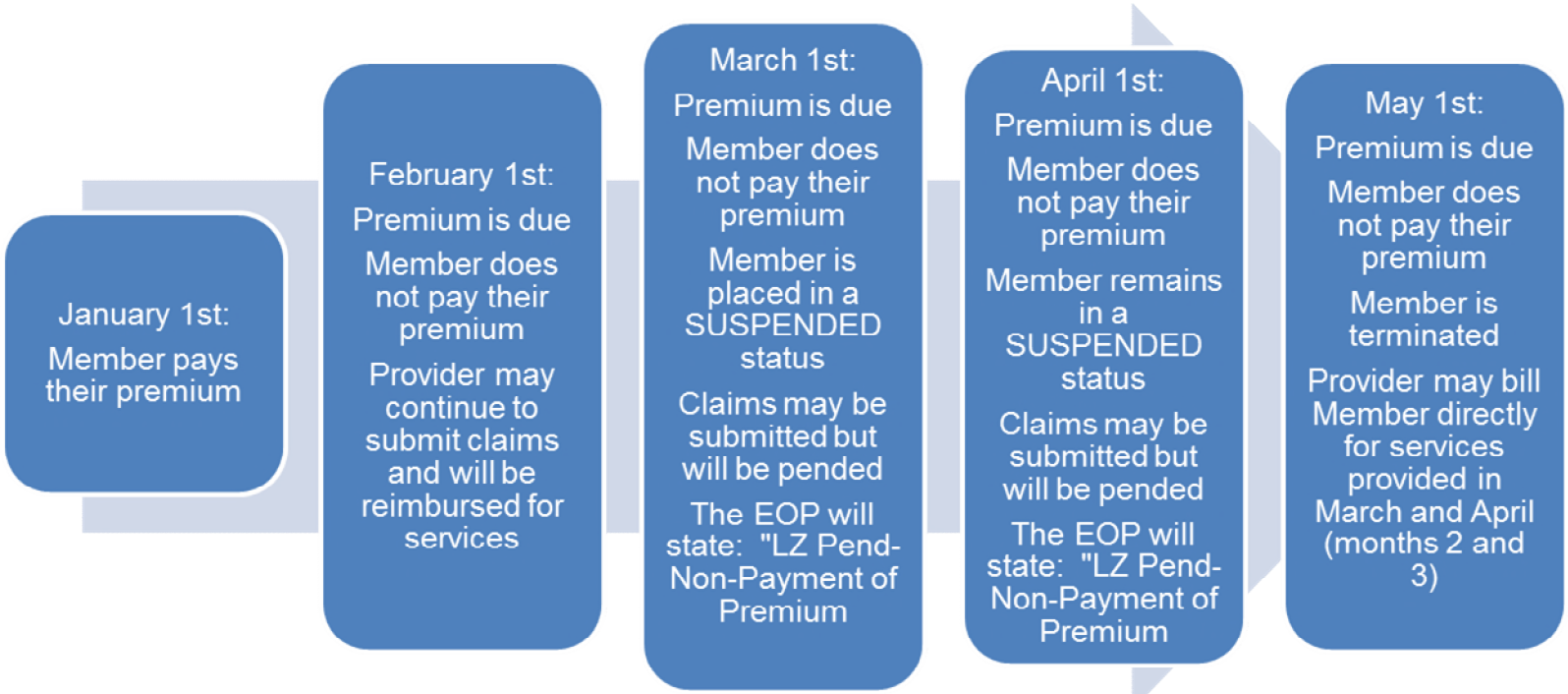
Claim Submission

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

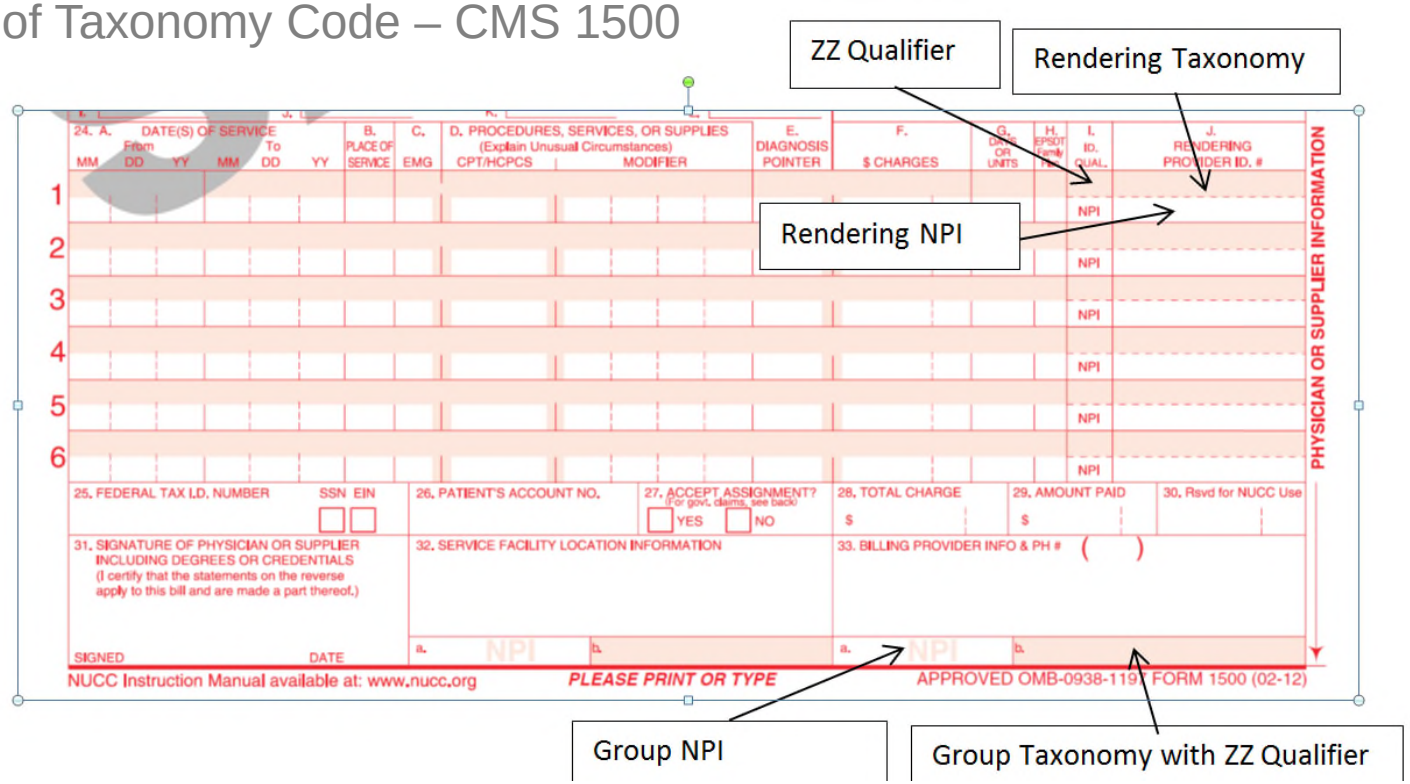
- Claims must be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

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

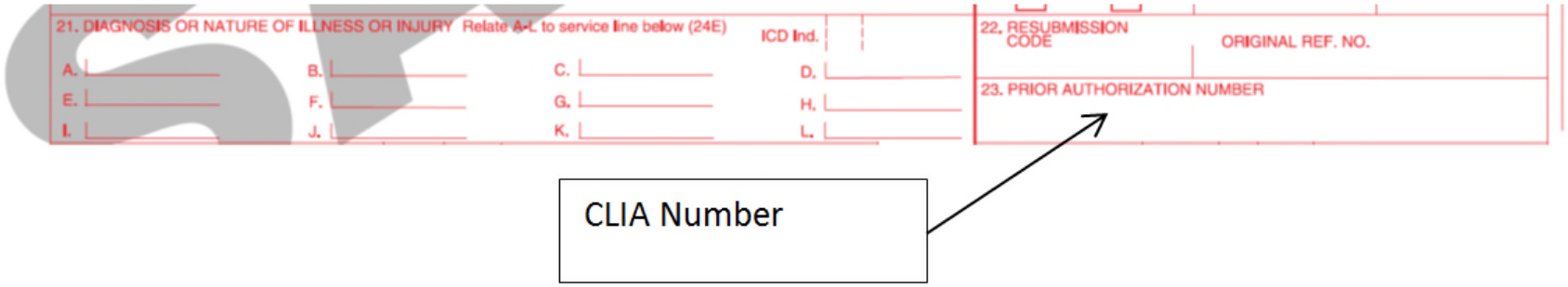
Example of Taxonomy Code – CMS 1500



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 www.payspanhealth.com

Claim Billing Tips

- Maternity Billing -Ambetter is considered a commercial plan and the claims should be billed global.

- Home Health- they should not be billed like Medicaid. Providers will need to bill with Home Health codes – not 99600

- Standard contracts are paid at “Payor Medicare” They are rebased every 3 years (updated to 2015 in 2016 – next update will in 2019 with 2018 rates). Updates made quarterly with new codes. Gap fill rates also used.

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	Cenpatico Behavioral Health	1-877-617-0390 www.cenpatico.com
High Tech Imaging Services	National Imaging Associates	1-877-617-0390 www.radmd.com
Vision Services	Envolve Vision	1-877-617-0390 Visionbenefits.envolvehealth.com
Dental Services	Envolve Dental	1-855-609-5157 Dental.envolvehealth.com
Pharmacy Services	Envolve Pharmacy Solutions	1-877-617-0390 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 a **Ambetter from MHS** Provider Network Specialists assigned to them. This team serves as the primary liaison between the Plan and our provider network and is responsible for:
  - Provider Education
  - HEDIS/Care Gap Reviews
  - Financial Analysis
  - Assisting Providers with EHR Utilization
  - Demographic Information Update
  - Initiate credentialing of a new practitioner
  - Facilitate to 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

Key Things to Remember

- Members enrolled in Ambetter must utilize in-network participating providers except in the case of emergency services
- 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?