Ambetter from MHS
Provider Orientation Presentation

2/11/2015

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AGENDA

1. Overview of the Affordable Care Act
2. The Health Insurance Marketplace
3. Verification of Eligibility, Benefits and Cost Shares
4. Specialty Referrals
5. Prior Authorization
6. Claim Submission
7. Claim Payment
8. Complaints/Grievances and Appeals
9. Care Management
10. Specialty Companies/Vendors
11. Public Website
12. Need to Know
13. Contact Information

The Affordable Care Act

Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Changes already in place (pre 2014):

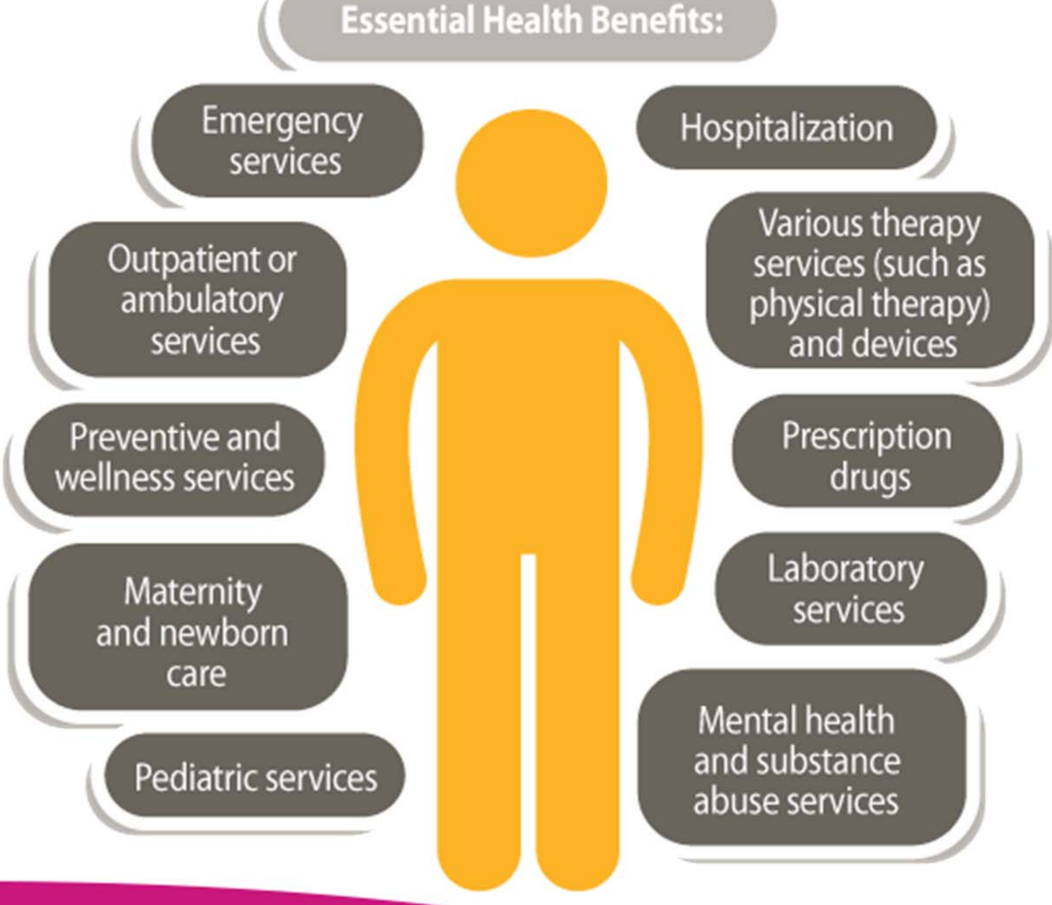
- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventive care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

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 premium and cost shares depending on income level

Benefits Overview: Essential Health Benefits



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
- Marketplaces may be State-based or federally facilitated or State Partnership – **Indiana is a Federally Facilitated Marketplace**

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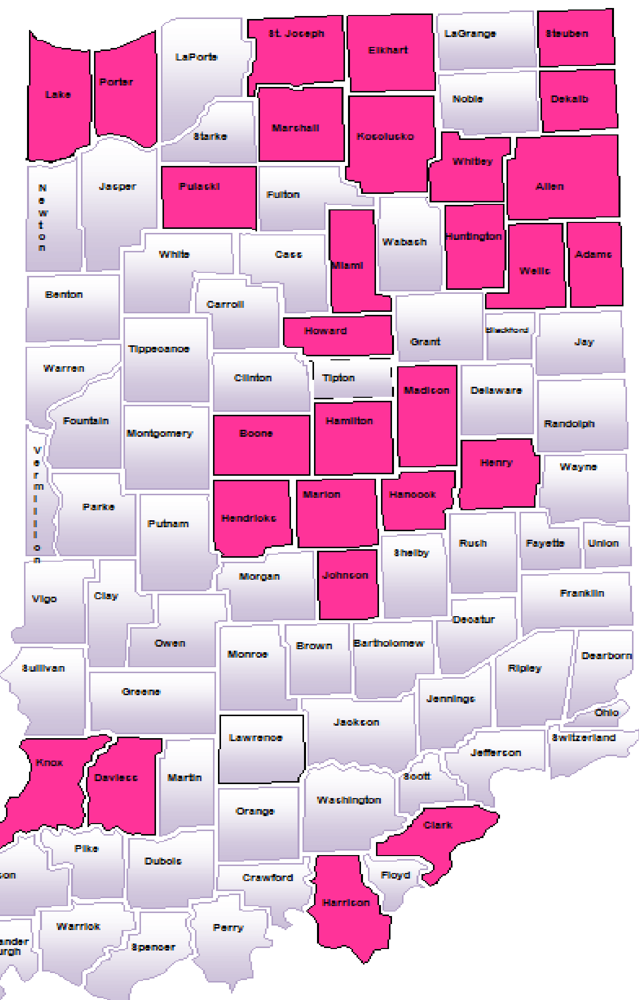
WHAT YOU NEED TO KNOW…

Coverage available in:
Adams, Allen, Dekalb, Elkhart, Huntington, Kosciusko, Marshall, St. Joseph, Wells, Whitley, Boone, Clark, Daviess, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Johnson, Knox, Lake, Madison, Marion, Miami, Porter, Pulaski, Steuben



Verification of Eligibility, Benefits and Cost Share

Member ID Card:

IMPORTANT CONTACT INFORMATION

Member/Provider Services:
1-877-687-1182

TDD/TTY: 1-877-941-9232

24/7 Nurse Advice: 1-877-687-1182

Pharmacy Help Desk: 1-855-339-4810

EDI Payor ID: 68069

EDI Help Desk: 1-800-225-2573

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

Additional information can be found in your Member Contract.

If you have an emergency, call 911 or go to the nearest emergency room (ER). Emergency services by a provider not in the plan's network will be covered without prior authorization. For updated coverage information, visit mhsindiana.com.

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

Verification of Eligibility, Benefits and Cost Share

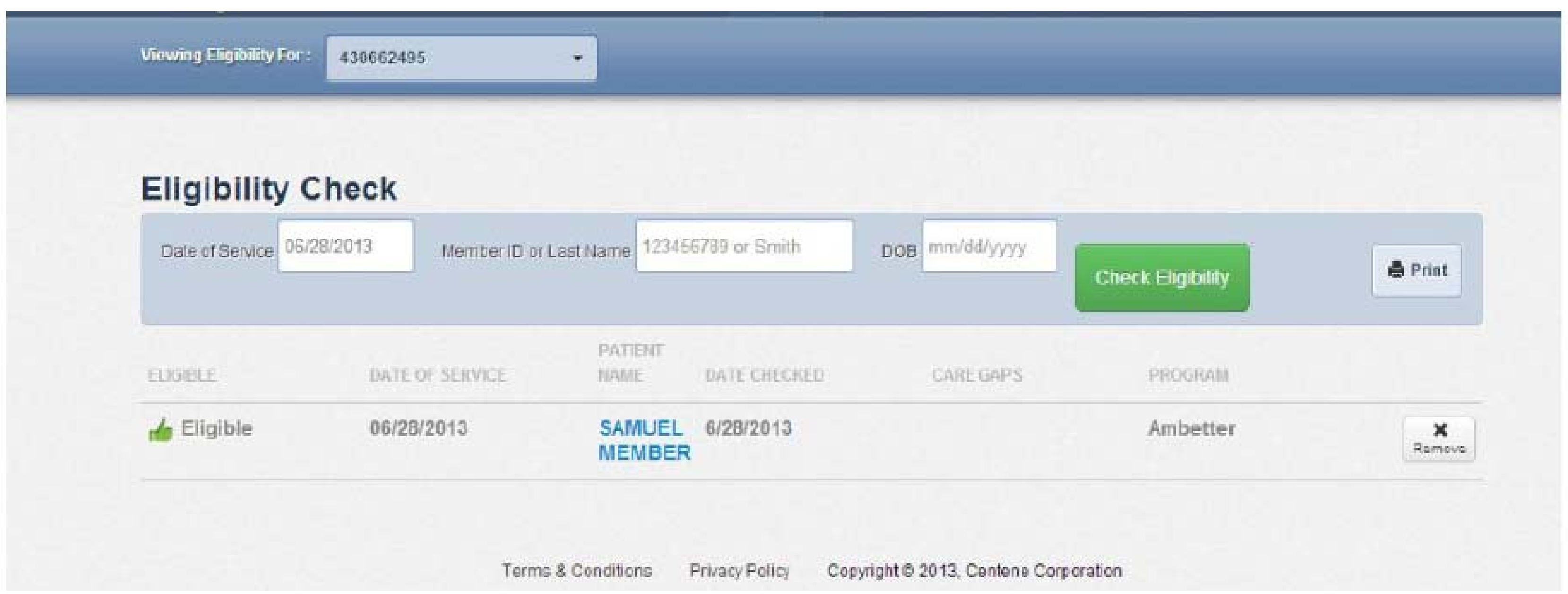
Eligibility, Benefits and Cost Shares can be verified in 3 ways:

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

2. **24/7 Interactive Voice Response system**
   - Enter the Member ID Number and the month of service to check eligibility

3. **Contact Provider Service at: 1-877-687-1182**

Verification of Eligibility



Verification of Benefits

Back to Eligibility Check

- **Overview**
- Benefit Tracker
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Pharmacy PDL
- Coordination of Benefits
- Claims
- Summary of Benefits

This patient is eligible as of today, Oct 3, 2014.

Patient Information

Name
Gender F
Birthdate Sep 2, 1982
Age 32 years old
Member # U9002549401
Address

PCP Information

UNASSIGNED PCP

View PCP History

Care Gaps

Due for annual adult physical

Eligibility History

Start Date	End Date	Product Name
Mar 1, 2014	Dec 31, 9999	

Verification of Benefits

Viewing Patients For: 430662495

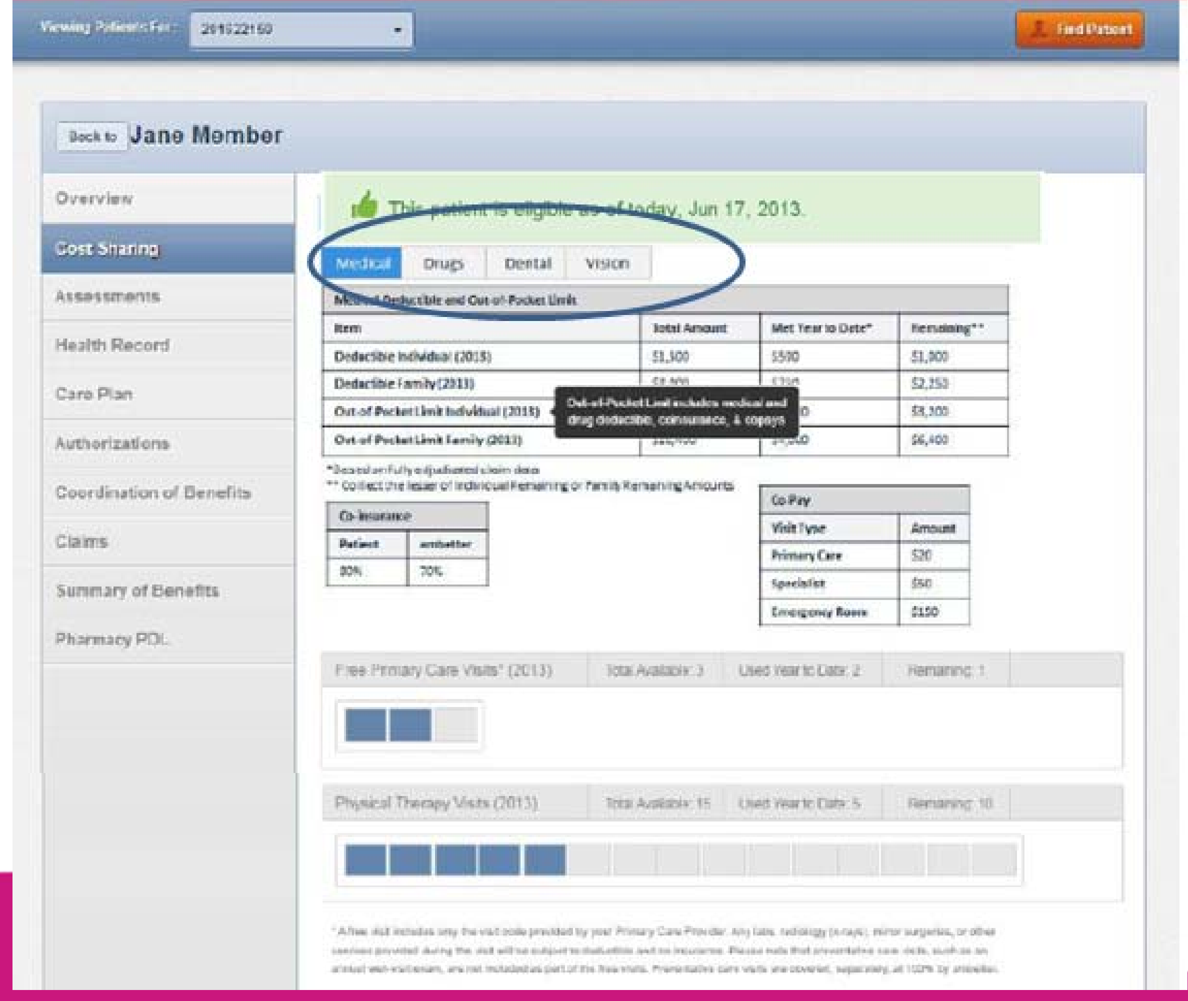
Find Patient

Back to SAMUEL

- Overview
- Cost Sharing
- Assessments
- Health Record
- Care Plan
- Authorizations
- Coordination of Benefits
- Claims
- **Summary of Benefits**
- Pharmacy PDL

Start Date	End Date	Program	Product Name
Mar 1, 2011	Ongoing	Ambetter	Gold 1
Nov 15, 2010	Feb 28, 2011	Hoosier Healthwise	TANF

Verification of Cost Shares

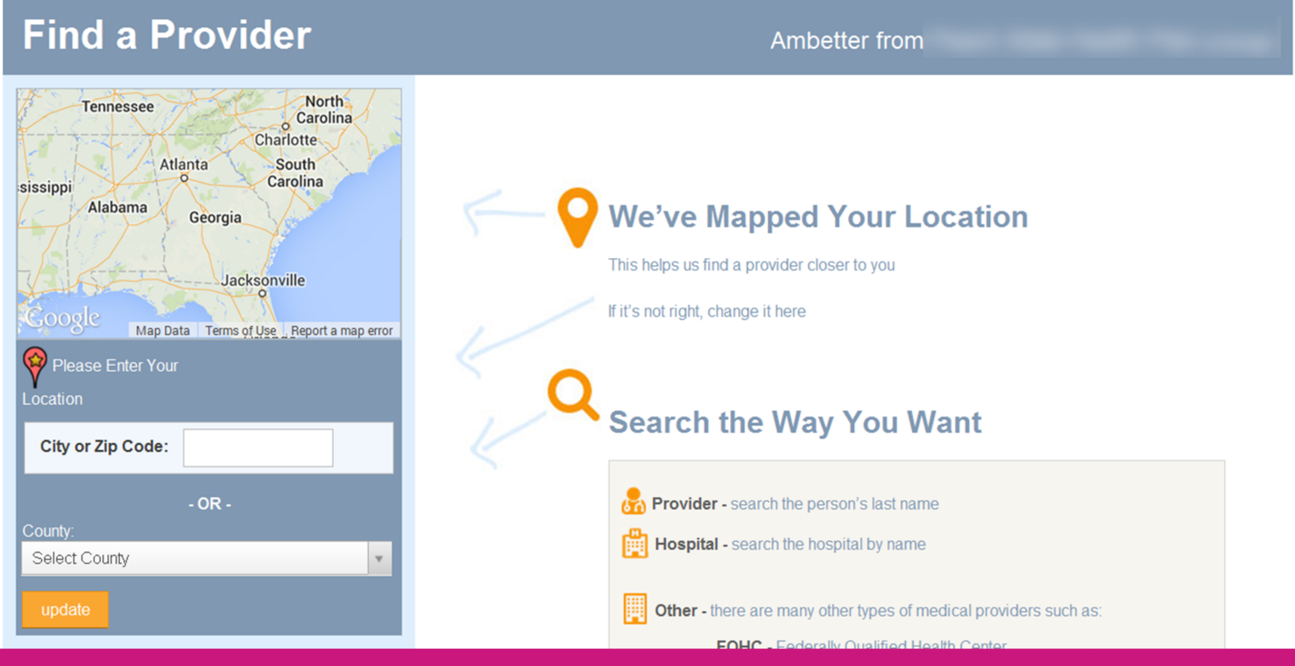


Ambetter from Indiana is an HMO Benefit Plan.

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

Members and You can identify other participating providers by visiting our website and clicking on Find a Provider.

If an out of network provider is utilized, (except in the case of emergency services), the Member will be 100% responsible for all charges.



Specialty Referrals

- Members are educated to first seek care or consultation with their Primary Care Provider (PCP).
- 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.

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

All Out of Network (Non-Par) service require prior authorization excluding emergency room services.

Prior Authorization

Procedures / Services

- Potentially Cosmetic
- Experimental or Investigational
- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound – two allowed in 9 month period, any additional will require prior authorization
- Quantitative Urine Drug Screens – except for Urgent Care, ER and Inpatient place of service
- Pain Management – must be prior authorized except if performed on the same date as surgery

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

All Out of Network (Non-Par) services require prior authorization excluding emergency room services.

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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**
- **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 as an all-inclusive list*

All Out of Network (Non-Par) services require prior authorization excluding emergency room services.

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
- **Orthotics/Prosthetics**
- **Hearing Aid devices (including cochlear implants)**
- **Genetic Testing**
- **Quantitative Urine Drug Screen**

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

All Out of Network (Non-Par) services require prior authorization excluding emergency room services.

Pre-Auth Needed?

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by Opticare
Dental services need to be verified by DentaQuest
Behavioral Health/Substance Abuse need to be verified by Cenpatico
Home Health and Durable Medical Equipment need to be verified by Univita
Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by NIA

Services provided by Out-of-Network providers are not covered by the plan. Join Our Network

Note: Services related to an authorization denial will result in denial of all associated claims.

Are Services being performed in the Emergency Department?

YES ☐ NO ☐

Types of Services	YES	NO
Are the services being performed or ordered by a non-participating provider?	○	○
Is the member being admitted to an inpatient facility?	○	○
Is the member having observation services?	○	○
Are anesthesia services being rendered for pain management or dental surgeries?	○	○
Is the member receiving hospice services?	○	○
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○

To submit a prior authorization Login Here.

Prior Authorization Request Timeframes

Service Type	Timeframe
Elective/Scheduled Admissions	**5 business days** prior to the scheduled admission date
Emergent inpatient admissions	Notification within **1 business day**
Emergency room and post stabilization, urgent care, and crisis intervention	Notification within **1 business day**
Maternity admissions	Notification within **1 business day**
Newborn admissions	Notification within **1 business day**
NICU admissions	Notification within **1 business day**
Outpatient dialysis	Notification within **1 business day**
Update current authorization	**Within 30 days of the original auth request date**

Prior Authorization Request Turn-Around Timeframes

Prior Authorization Type	Timeframe
Prospective/Urgent	Two (2) business days from receipt of necessary information or three (3) calendar days, whichever is earlier
Prospective/Non-Urgent	Two (2) business days from receipt of necessary information and no later than fifteen (15) calendar days
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Concurrent/Non-Urgent	Two (2) business days from receipt of necessary information and no later than fifteen (15) calendar days
Retrospective	Thirty (30) calendar days

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-Indiana 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**

Prior Authorization

Prior Authorization will be granted at the CPT code level.

1. If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
   - If during the procedure additional procedures are performed, in order to avoid a claim denial, the provider must contact the health plan to update the authorization. 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.

2. 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 submitted for reconsideration or a claim dispute.

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

- After the first premium is paid, a grace period of 3 months from the premium due date is given for the payment of the premium.

- Coverage will remain in force during the grace period.

- If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period.

- During months two and three of the grace period, claims will be pended. The EX code on the Explanation of Payment will state: “LZ – Pend: Non-Payment of Premium. During the first month, claims may be submitted and paid.

Suggest replacing the Member in Suspended Status example with the following graphic:

January 1st:
Member pays their premium

February 1st:
Premium is due
Member does not pay their premium
Provider may continue to submit claims and will be reimbursed for services

March 1st:
Premium is due
Member does not pay their premium
Member is placed in a SUSPENDED status
Claims may be submitted but will be pended
The EOP will state: "LZ Pend-Non-Payment of Premium

April 1st:
Premium is due
Member does not pay their premium
Member remains in a SUSPENDED status
Claims may be submitted but will be pended
The EOP will state: "LZ Pend-Non-Payment of Premium

May 1st:
Premium is due
Member does not pay their premium
Member is terminated
Provider may bill Member directly for services provided in March and April (months 2 and 3)

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

ZZ Qualifier

Rendering Taxonomy

Rendering NPI

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

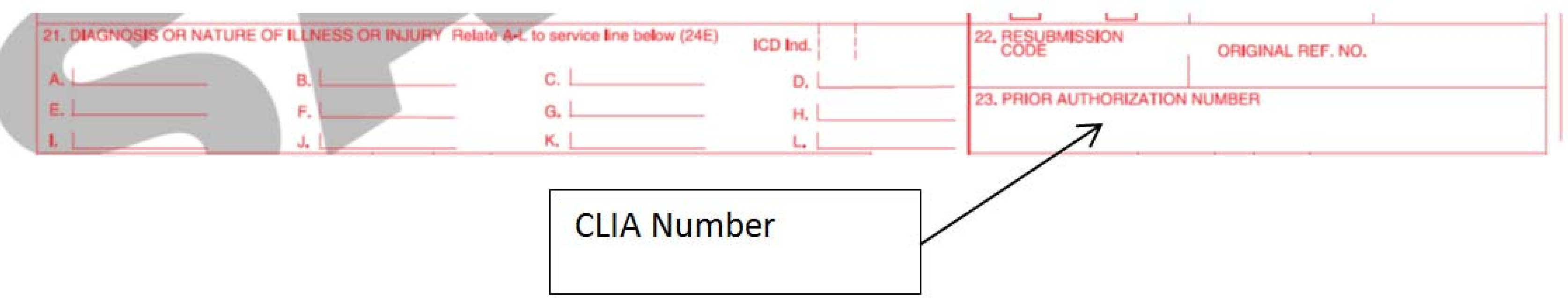
Group NPI

Group Taxonomy with ZZ Qualifier

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

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 Indiana
  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

Complaint/Grievance

- Must be filed within 30 calendar days of the Notice of Action
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days

Complaints/Grievances/Appeals

Appeals

- Claims are not appealable. Please follow the Claim Reconsideration, Claim Dispute and Complaint/Grievance process.

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

Care Management Programs

Care Management Process

Ambetter from MHS' Care Management for high risk, complex or catastrophic conditions contains the following key elements:

• Screen, identify and assess members risk factors members who potentially meet the criteria for Care Management.

• Notify the Member and their PCP of the Member's enrollment in Ambetter's Care Management program.

• Develop and implement a treatment plan that accommodates the specific cultural and linguistic needs of the member and established treatment objectives.

• Coordinate and monitor medical, residential, social and other support services.

• Track plan outcomes.

• Follow-up post discharge from Care Management.

• Referring a member to Ambetter Care Management: Providers are asked to contact an Ambetter Case Manager

Disease Management

Nurtur

Nurtur's programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions.

Programs include but are not limited to:

- Adult and Pediatric Asthma
- High Blood Pressure and High Cholesterol Management
- Coronary Artery Disease (CAD)
- Low Back Pain
- Adult and Pediatric Diabetes
- Tobacco Cessation

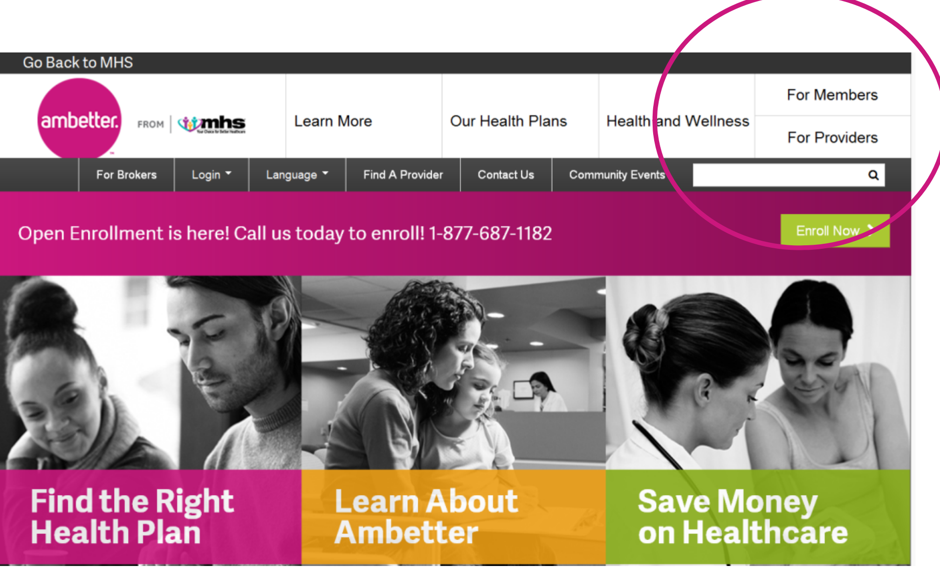
Specialty Companies/Vendors

Service	Specialty Company/Vendor	Contact Information
Behavioral Health	Cenpatico Behavioral Health	1-877-687-1182 cenpatico.com
Vision Services	OptiCare	1-877-687-1182 opticare.com
Dental Services	DentaQuest	1-877-687-1182 dentaquest.com
Pharmacy Services	US Script	1-877-687-1182 usscript.com

Ambetter Website

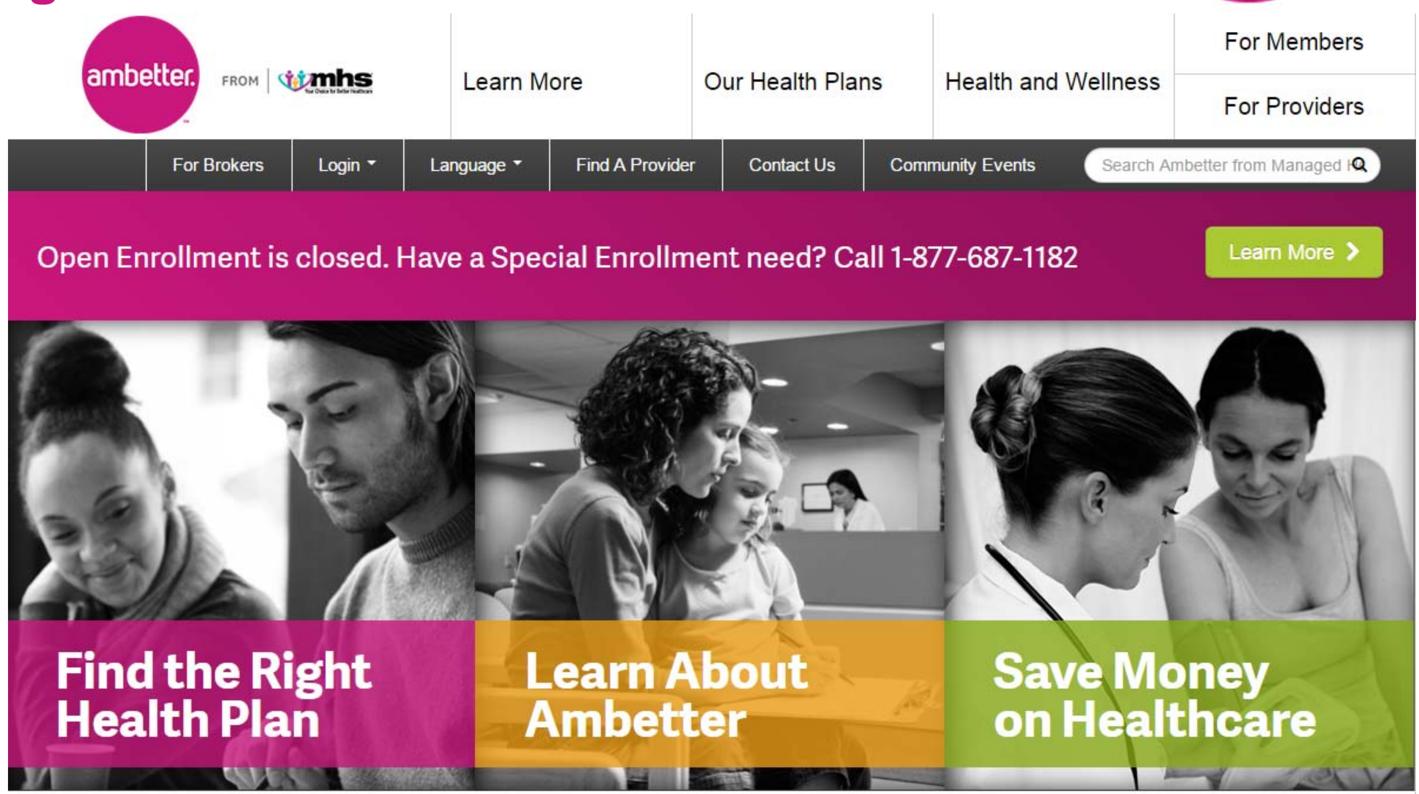
Public Website

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 Ambetter.mhsindiana.com



For years, MHS has delivered healthcare solutions to Indiana residents. And now, it's easier to stay covered with our Health Insurance Marketplace insurance plan: Ambetter.

Public Website

Information contained on our Website:

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

Key Things to Remember

- Members enrolled in Ambetter from MHS 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: 1-877-941-9232

Ambetter.mhsindiana.com

Questions