



Ambetter 101

Quarterly Provider Webinar
February 23, 2017

AGENDA

1. What is Ambetter?
2. The Health Insurance Marketplace
3. Public Website and Secure Portal
4. Verification of Eligibility, Benefits and Cost Shares
5. Prior Authorization
6. Claims
7. Complaints/Grievances and Appeals
8. Provider Relations
9. Specialty Companies/Vendors
10. Contact Information
11. Questions



What is Ambetter?



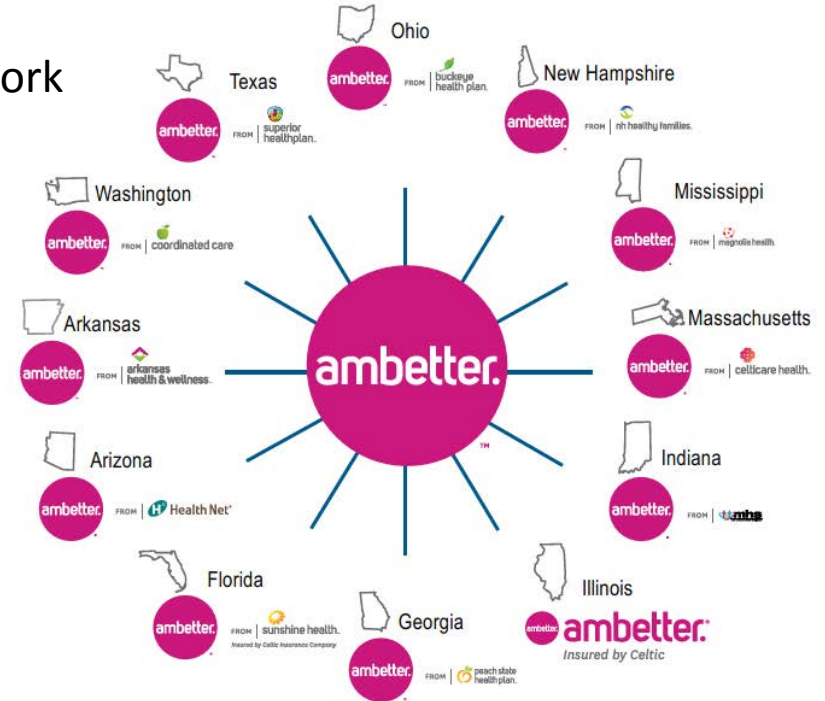
- **Ambetter is:**

- A health insurance plan offered by Arkansas Health & Wellness through the Health Insurance Marketplace
- Affordable, quality healthcare solutions that help Arkansans live better
- Offered statewide with approximately 100,000 members
- A plan that utilizes an extensive network of quality healthcare practitioners and providers

Ambetter Network

Arkansas Health & Wellness utilizes the NovaSys Health network for all Ambetter members seeking care in the state of Arkansas.

Ambetter members can enjoy in-network benefits from any participating (contracted) provider within the 12 Ambetter states.



Health Insurance Marketplace in Arkansas



ARWorks – formally known as Private Option or Healthcare Independence Program

- Medicaid Expansion Eligible
- Enroll through local DHS office or www.insureark.org

Federally Facilitated Marketplace (FFM)

- Marketplace Eligible
- Enroll through www.healthcare.gov

Benefit Plans may have cost shares in the form of copays, coinsurance and deductibles, therefore verification of benefits is important.



WHAT YOU NEED TO KNOW...

Public Website



ambetter.arhealthwellness.com

The screenshot shows the public website interface for Ambetter Arkansas Health & Wellness. At the top left is the logo with the text "ambetter. FROM arkansas health & wellness.". To the right are navigation links: Home, Find a Doctor, Login, Contact, and a search bar. Further right are accessibility options: "a a a" and "language". Below the navigation is a horizontal menu with three tabs: "FOR MEMBERS", "FOR PROVIDERS", and "HOW TO ENROLL". The main content area features a prominent pink banner with the text "Enroll in an Ambetter health plan today! Call us at 1-877-617-0390 (TTY/TDD 1-877-617-0392)." and an "Enroll Today" button. Below the banner are three image-based sections: "Find the Right Health Plan" (with a photo of a woman and child), "For Members" (with a photo of a woman and child on a bicycle), and "My Health Pays™ Rewards Program" (with a photo of two women). At the bottom, a small text block provides information about the Affordable Care Act and a link to the FAQ page.

ambetter. FROM arkansas health & wellness.

Home Find a Doctor Login Contact search

a a a language

FOR MEMBERS FOR PROVIDERS HOW TO ENROLL

Login

Find a Provider +

Pay My Premium

How to Enroll

Learn More +

Our Health Plans +

Health & Wellness +

For Members +

For Providers +

For Brokers +

For Navigators

Newsroom

Community Events

Enroll in an Ambetter health plan today! Call us at 1-877-617-0390 (TTY/TDD 1-877-617-0392). Enroll Today

Find the Right Health Plan

For Members

My Health Pays™ Rewards Program

If you have questions about recent coverage regarding the Affordable Care Act, plans on the Health Insurance Marketplace (Healthcare.gov), or your Ambetter health insurance in 2017, please visit our FAQ page. You'll find helpful information and answers to your questions. [Learn More.](#)

Public Website

Information contained in the FOR PROVIDERS section of our public website:

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

The screenshot displays the website's interface. At the top right, the Ambetter logo is accompanied by the text 'FROM arkansas health & wellness'. Below this, a navigation bar contains links for 'Home', 'Find a Doctor', 'Login', and 'Contact', along with a search bar and a language selector. A prominent red arrow points to the 'FOR PROVIDERS' tab in the main navigation bar. On the left side, a sidebar menu lists various services, with the 'FOR PROVIDERS' section highlighted by a red circle. The main content area features a purple banner stating 'Open Enrollment is closed. Have a Special Enrollment need? Call us at 1-877-617-0390 (TTY/TDD 1-877-617-0392)'. Below the banner are three featured articles: 'Find the Right Health Plan', 'For Members', and 'My Health Pays Rewards Program'. At the bottom, there is a section titled 'Ambetter from Arkansas Health & Wellness' with a brief description of the services provided.



Secure Provider Portal

Information contained on our Secure Provider Portal:

- Member Eligibility
- Patient Listings
- Health Records & Care Gaps
- Authorizations
- Case Management Referrals
- Claims Submissions & Status
- Corrected Claims & Adjustments
- Payments History
- PCP Reports

Secure Provider Portal



Registration is free and easy.


Click the orange “Create an Account” button to get started.

A screenshot of the Secure Provider Portal registration page. The page has a dark blue header with navigation links for "Features", "Join Our Network", and "CREATE ACCOUNT". Below the header is a section titled "The Tools You Need Now!" with a subtext "Our site has been designed to help you get your job done." To the right of this section is a "Login" form with fields for "User Name (Email)" (containing "name@domain.com") and "Password", and a green "Login" button. Below the login form is a link for "Forgot Password / Unlock Account". The main content area is divided into three columns. The left column contains three service icons: a thumbs up for "Check Eligibility", a checkmark for "Authorize Services", and a dollar sign for "Manage Claims". The middle column features a red circle around the text "Need To Create An Account?" and an orange "Create An Account" button. A red arrow points from the right side of the page towards this button. Below this section is a "How to Register" section with two blue buttons: "Provider Registration Video" and "Provider Registration PDF".



Verification of Eligibility, Benefits and Cost Share

Member ID Card:

| | |
|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
|  | |
| Subscriber: Member: Policy #: Member ID #: Plan: | Effective Date of Coverage: RXBIN: RXPCN: RXGROUP: |
| Copays: PCP: Specialist: ER: | Coinsurance (Med/Rx): Deductible (Med/Rx): Rx (Generic/Brand): |

Ambetter.ARhealthwellness.com


| | |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| Member/Provider Services: [1-877-617-0390] TDD/TTY: [1-877-617-0392] 24/7 Nurse Line: [1-877-617-0390] | Medical Claims: Ambetter from Arkansas Health & Wellness Attn: CLAIMS PO Box 5010 Farmington, MO 63640-5010 |
|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|

Numbers below for providers:

Pharmacy Help Desk: [1-844-432-0698] 63640-5010

EDI Payor ID: [68069]

EDI Help Desk: [Ambetter.ARhealthwellness.com]



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.ARhealthwellness.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.arhealthwellness.com**
 - If you are already a registered user of the Ambetter from Arkansas Health and Wellness 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: 1-877-617-0390**



Verification of Eligibility


Eligibility Check

Date of Service: 02/25/2017 Member ID or Last Name: [REDACTED] DOB: 09/04/1982 [Check Eligibility](#) [Print](#)

| ELIGIBLE | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | CARE GAPS |
|----------|-----------------|--------------|--------------|-----------|
|----------|-----------------|--------------|--------------|-----------|

Eligibility Check

Date of Service: 02/25/2017 Member ID or Last Name: [REDACTED] DOB: mm/dd/yyyy [Check Eligibility](#) [Print](#)

| ELIGIBLE | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | CARE GAPS |
|------------------------------------------------------------------------------------------------------|-----------------|--------------|--------------|--------------------------------------------------------------------------------------------------------------------------|
|  Suspended | 02/25/2017 | [REDACTED] | 02/17/2017 | Risk Category Alerts: Ischemic Vascular Disease Non-compliant for annual well visit. Remove |

Verification of Eligibility



When searching for eligibility on the secure provider portal, you will see one of the following statuses:

| ELIGIBLE | DATE OF SERVICE | PATIENT NAME | DATE CHECKED | |
|----------------|-----------------|--------------|--------------|-------------------------------------------------------------------------------------|
| | 07/21/2016 | JOHN DOE | 07/21/2016 | Member is eligible for services performed on this date of service. |
| Ineligible | 07/21/2016 | JOHN DOE | 07/21/2016 | Member is not eligible for services performed on this date of service. |
| Suspended | 07/21/2016 | JOHN DOE | 07/21/2016 | Member premium payment is past due. Claims may be denied. |
| Delinquent | 07/21/2016 | JOHN DOE | 07/21/2016 | Member's premium payment is in delinquent status . Claims will be processed. |

Verification of Eligibility



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.
- Claims will be paid during the first month of the grace period. After the first 30 days, the member is placed in a suspended status. While the member is in a suspended status, claims will pend and the Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- 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 denied and the provider may bill the member directly for services.
- Claims for members in a suspended status are not considered “clean claims”.

Verification of Benefits



Viewing Patients For : 71 [redacted] [v] Ambetter of Arkansas [v] [Find Patient](#)

[Back to Patient List](#) **ROGER [redacted]**

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

[Summary of Benefits](#)

Verification of Cost Shares



[Back to Eligibility Check](#)
[REDACTED]

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

Medical
Drugs

This patient is eligible as of today, Feb 17, 2017.

Deductible
 The fixed amount of money that you are responsible for paying before your insurance starts to pay. Whether or not you meet your deductible depends on how much healthcare you need throughout the year.

| Type | Total Amount | Met Year To Date* | Remaining |
|--------|--------------|-------------------|-----------|
| Family | \$200.00 | \$200.00 | \$200.00 |
| Person | \$250.00 | \$250.00 | \$0.00 |

Co-insurance
 The portion of your medical bill you pay, for certain services, after you meet your deductible. Think of coinsurance as splitting your healthcare costs with your insurance company.

Once you have reached your deductible, your share of the cost for a covered health care service will be 30% of the allowed amount for the service.

Co-payment:

| Drug Type | Your Cost |
|----------------|-------------------------------|
| Primary Care | No charge |
| Specialist | \$5 |
| Emergency Room | \$100 Copay before deductible |

Out-Of-Pocket Limit
 The total amount you will spend for healthcare, after which the insurance company pays for all your medical care until the year ends.

| Type | Total Amount | Met Year To Date* | Remaining |
|--------|--------------|-------------------|------------|
| Family | \$3,500.00 | \$325.67 | \$3,174.33 |
| Person | \$1,750.00 | \$325.67 | \$1,424.33 |

* These values will start at zero on January 1st. The following amounts towards your deductible: medical costs, physician services, hospital services, EHB covered services, including pediatric, vision and mental health services, drug benefits.

PCP Reports



PCP Reports

- PCP reports available on Ambetter's 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 Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- Members flagged for Disease and Case Management

Case Management Referrals



[Back to Patient List](#) [Redacted]

Overview

Benefit Tracker

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Pharmacy PDL

Referrals

Coordination of Benefits

Claims

Summary of Benefits

*Source: Case Management

*Date: 02/21/2017 9:28 AM

Last Name, First Name: [Redacted] [Redacted]

Phone Number, Extension: () - -

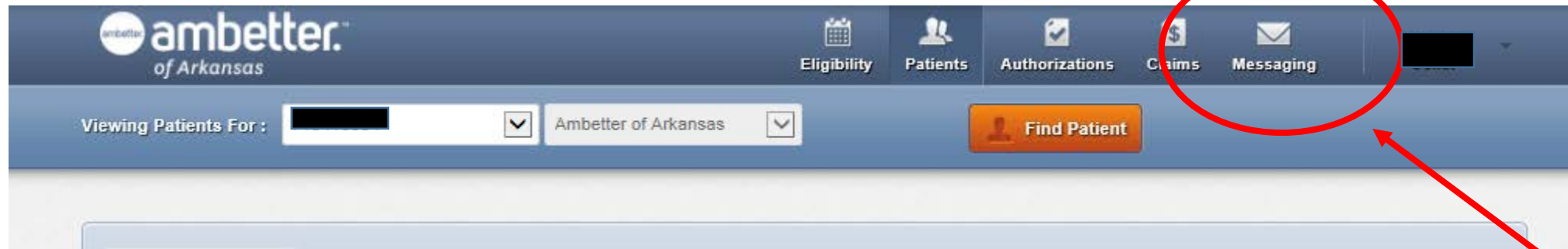
Additional Comments:

Reason(s) for Referral (select all that apply)

- Behavioral Health Services
- Care Coordination
- Co-Morbid Medical and Behavioral
- Complex Medical Issues
- High Risk Member
- High Risk Pregnancy

[Submit](#)

Send a Secure Message





Prior Authorizations

Prior Authorization



Prior Authorization can be requested in 3 ways:

1. The Ambetter secure portal found at ambetter.arhealthwellness.com
2. Fax Requests to: 1-866-884-9580
The fax authorization forms are located on our website at ambetter.arhealthwellness.com.
3. Call for Prior Authorization at 1-877-617-0390

Prior Authorization



Inpatient Authorization*

- We request that you call for authorization for all elective or scheduled inpatient admission at least 5 business days prior to the scheduled date of admit including:
 - Behavioral health/substance use
 - Hospice care
 - Rehabilitation facilities
 - Transplants, including evaluation
- Urgent/Emergent Admissions
 - Call within 1 business day following the date of admission
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs

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

Prior Authorization



Outpatient Procedures / Services*

- Potentially Cosmetic procedures
- Experimental or Investigational procedures
- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Pain Management

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

Prior Authorization



Ancillary Services*

- Air Ambulance Transport (non-emergent fixed-wing airplane)
- Home health care services including, home infusion, skilled nursing, and therapy
 - Home Health Services
 - Private Duty Nursing
 - Hospice
 - Furnished Medical Supplies & DME
- Orthotics/Prosthetics
- Hearing Aid devices including cochlear implants
- Genetic Testing
- Quantitative Urine Drug Screen

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

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 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 for a possible retrospective review.

Medical Necessity Appeals



Medical Necessity Appeals

- 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.

Pre-Auth Needed Tool



Are Services being performed in the Emergency Department?

Yes No

| Types of Services | YES | NO |
|-------------------------------------------------------------------------------------------------|-----------------------|----------------------------------|
| Is the member being admitted to an inpatient facility? | <input type="radio"/> | <input checked="" type="radio"/> |
| Are anesthesia services being rendered for pain management or dental surgeries? | <input type="radio"/> | <input checked="" type="radio"/> |
| Is the member receiving hospice services? | <input type="radio"/> | <input checked="" type="radio"/> |
| Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home? | <input type="radio"/> | <input checked="" type="radio"/> |

Enter the code of the service you would like to check:

N
No

69436 - TYMPANOSTOMY GEN ANES
No authorization required.

To submit a prior authorization [Login Here](#).



Utilization Determination Timeframes

| UM Decision Time Table | |
|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| UM Decision Type | Timeframe |
| Prospective/Urgent | Within 1 business days of receipt of all information needed to complete the review. If all information is not received by the end of the 72 hours a determination will be made based on available information. |
| Prospective/Non-Urgent | Within 2 business days of receipt of all information needed to complete the review. If all information is not received by the 14 th day of the request a determination will be made based on available information. |
| Concurrent/Urgent | Twenty-four (24) hours (1 calendar day) Extension: A onetime extension may be granted up to 3 days If all information is not received by the end of the 24 hours a determination will be made based on available information. |
| Retrospective | Thirty (30) calendar days |

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



Claims

Claims Terminology



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. An **exception** would be a claim for which fraud is suspected or a claim for which a third party resource should be responsible

Rejected Claim

A rejected claim is a front end rejection. This means that the claim did not make it into our system. If submitted electronically, the rejection will be on your rejection report from your clearinghouse. If you submit it on paper, you will get a letter in the mail. If a claim is rejected, you need to correct the problem and submit the claim as a first time claim. Do not submit it as a corrected claim.

Denied Claim

A claim contains all necessary data to make it in our system, but is denied for some reason.

Corrected Claim

A claim submitted using the Corrected Claim Guidelines found in the Ambetter Provider and Billing Manual with changes from the initial claim submission.

Claim Submission



Timely filing deadline for an initial claim submission:
Contracted Provider – 180 days from date of service or date of primary payment.
Non Contracted Provider – 90 days from date of service or date of primary payment.

Claims may be submitted in 3 ways:

1. The secure web portal located at ambetter.arhealthwellness.com
2. **Electronic Clearinghouse**
 - Payor ID 68069
 - For a listing of Clearinghouses we accept, please visit our website at ambetter.arhealthwellness.com
3. **Paper claims may be submitted to:**
P.O. Box 5010 Farmington, MO 64640-5010

Common Causes for Claim Rejections/Denials



- APC Contracts not following CMS billing guidelines
- Black and white claim forms
- Handwritten claims
- ID Number does not match member data
- Misaligned data on paper claims
- Mismatched member ID/ date of birth combination
- Missing NPI and/or taxonomy code and qualifier
- Missing appropriate modifiers for certain services (i.e. anesthesia, therapy, DME)
- Missing CLIA number if claim contains CLIA certified or CLIA waived services
- Missing or invalid data
- Missing or incorrect POA indicator on inpatient claims

Corrected Claims, Request for Reconsiderations or Claim Disputes



Corrected Claim

- Must be submitted within 180 days of the Explanation of Payment
- Must clearly indicate that the claim is corrected using criteria found in Ambetter Provider & Billing Manual
- ***NO HANDWRITING ON CLAIM***

Request for Reconsideration

- Disagree with original claim outcome (payment amount, denial reason, etc.)
- May be submitted via phone call, written letter, or form found on our website (preferred method)
- Must be submitted within 180 days of the Explanation of Payment
- Claim Reconsiderations may be mailed to Ambetter from Arkansas Health and Wellness, Attn: Request for Reconsideration, P.O. Box 5010, Farmington, MO 63640-5010

Claim Disputes

- Used when provider receives an unsatisfactory response to Request for Reconsideration
- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at ambetter.arhealthwellness.com
- The completed Claim Dispute form may be mailed to Ambetter from Arkansas Health and Wellness, Attn: Level II – Claim Dispute, P.O. Box 5000, Farmington, MO 63640-5000

Provider Grievance Process



Grievance

- A grievance is a verbal or written expression by the provider indicating dissatisfaction or a dispute with an Ambetter policy, procedure or any administrative aspect of Ambetter from Arkansas Health and Wellness functions.
- All grievances are logged.
- Provider has 30 days from the date of the incident to file a grievance.
- If a grievance is related to a claims payment, the provider must follow the Claims Reconsideration and Claims Dispute process.

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, Provider Grievance and Appeals processes can be found in our Provider Manual at: ambetter.arhealthwellness.com

Claim Payment



PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer
- If you currently utilize PaySpan, you will need to register specifically for the Ambetter product
- **To register for PaySpan:**
Call 1-877-331-7154 or visit www.payspanhealth.com

Provider Relations



- The Member/Provider Services Department includes trained Provider Service Representatives 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 the Member/Provider Services number at 1-877-617-0390, providers will be able to access real time assistance for all their service needs.
- Each provider will have an Ambetter from Arkansas Health and Wellness Provider Network Specialists available to them. This team serves as the primary liaison between the Plan and our provider network and is responsible for:
 - Provider Education
 - Care Gap Reviews
 - Demographic Information Update
 - Initiate credentialing of a new practitioner
 - Monitor performance patterns



Specialty Companies/Vendors

| Service | Specialty Company/Vendor | Contact Information |
|----------------------------|-----------------------------|----------------------------------------------------------------------------------------------------------|
| Behavioral Health | Envolve People Care | 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 | 1-877-617-0390 pwp.dentalhw.com |
| Pharmacy Services | Envolve Pharmacy Solutions | 1-877-617-0390 www.usscript.com |

Contact Information



Ambetter from Arkansas Health and Wellness

Provider Services

Phone: 1-877-617-0390

TTY/TDD: 1-877-617-0392

Credentialing

Phone: 1-844-263-2437

Fax: 1-844-357-7890

Email: arkcredentialing@centene.com

ambetter.arhealthwellness.com



Contact Information

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Va'Linda Perkins, Provider Network Specialist

vperkins@centene.com



Questions?

Please submit an additional using ‘Provider Webinar’ in the subject line to
Contact_Us_Provider_AR@centene.com

Thank you.