Ambetter 101

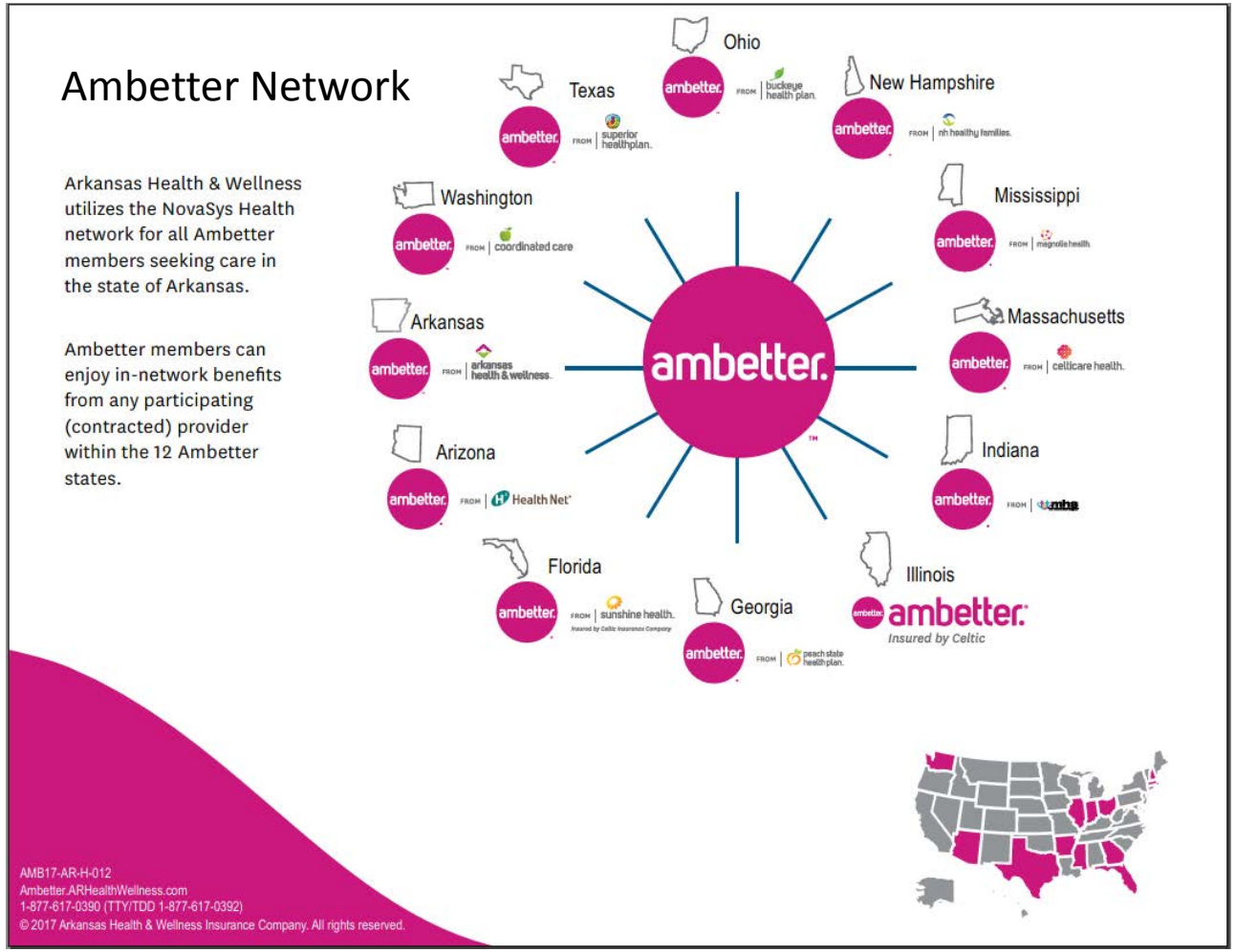
Quarterly Provider Webinar
February 23, 2017

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



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)

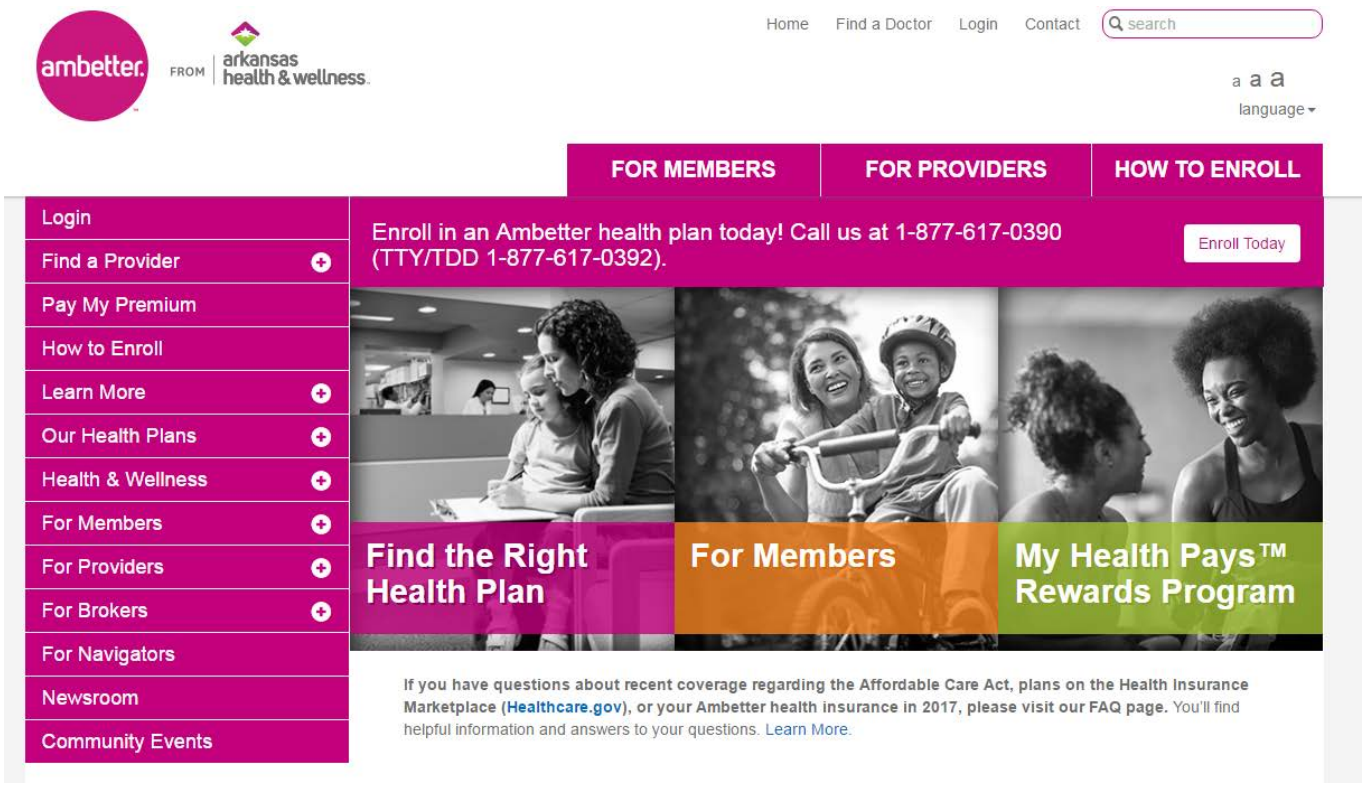
- Marketplace Eligible
- Enroll through www.healthcare.gov

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

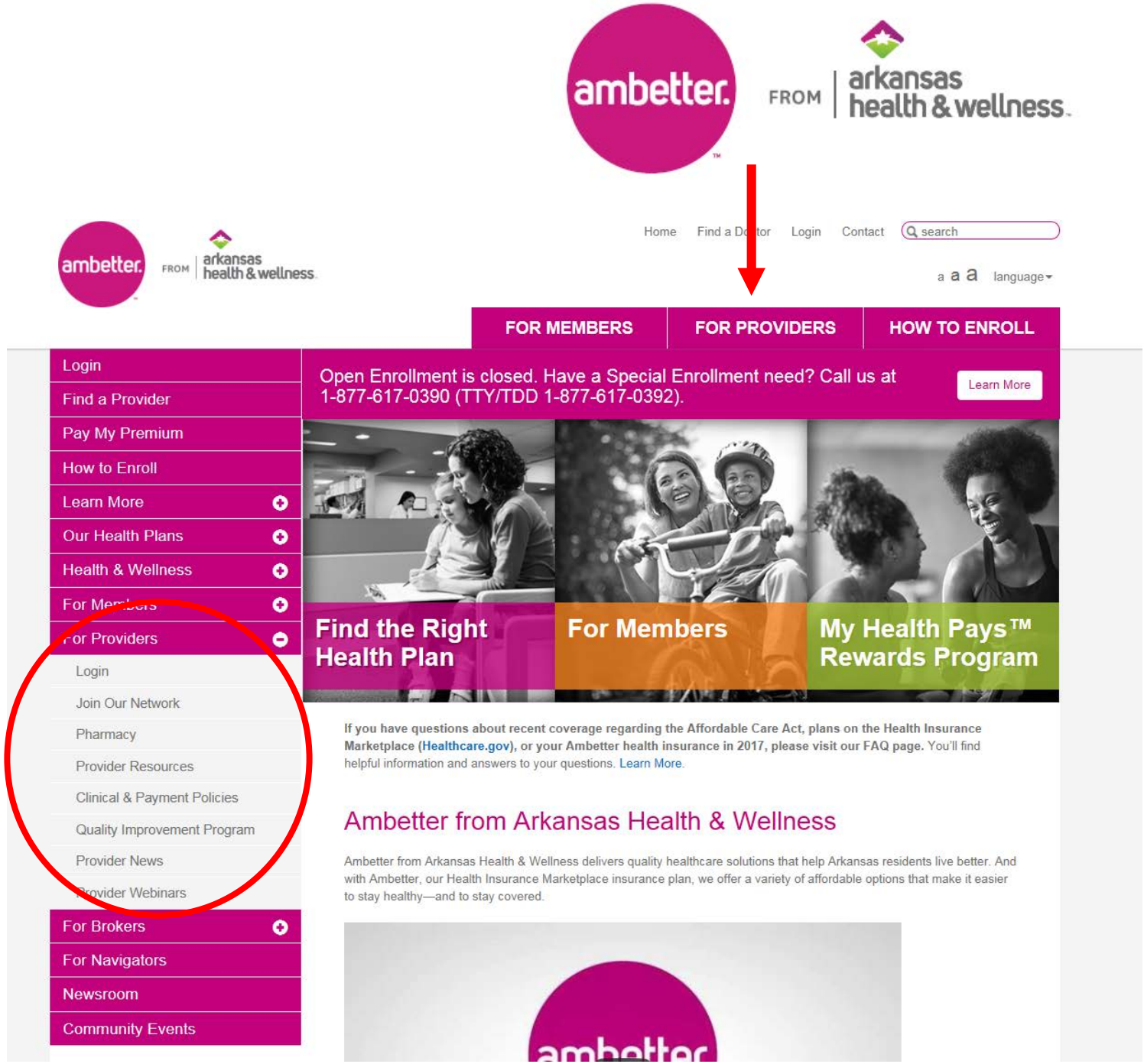
ambetter.arhealthwellness.com



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…



Secure Provider Portal

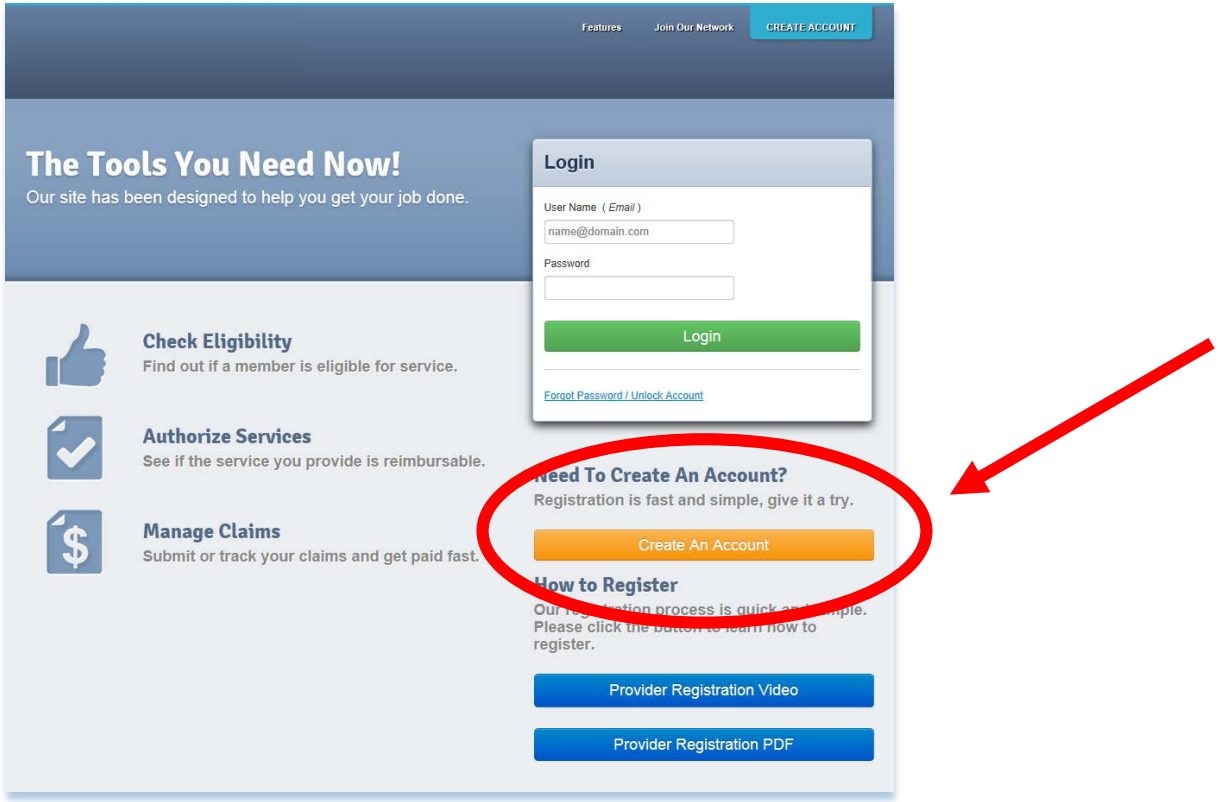
Information contained on our Secure Provider Portal:

- 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

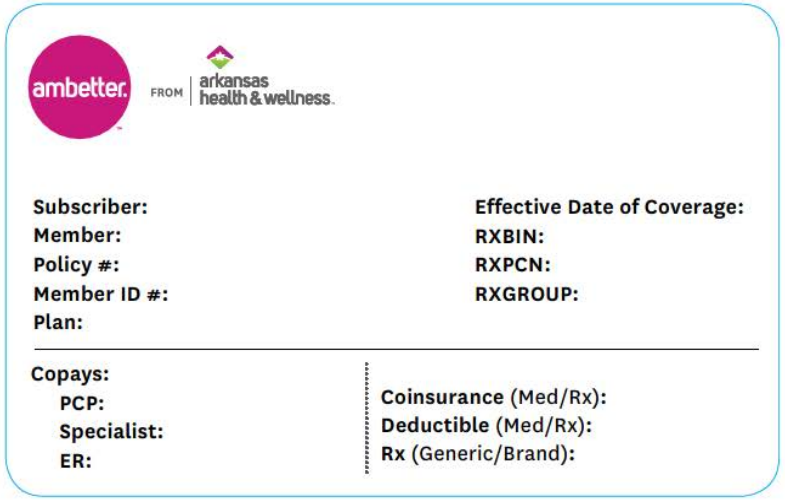
Registration is free and easy.

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



Verification of Eligibility, Benefits and Cost Share

Member ID Card:

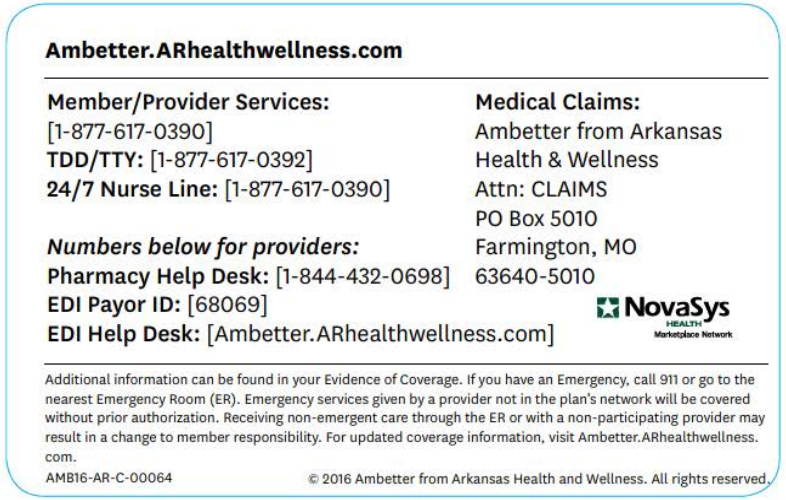

ambetter. FROM arkansas health & wellness.

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]

Numbers below for providers:
Pharmacy Help Desk: [1-844-432-0698]
EDI Payor ID: [68069]
EDI Help Desk: [Ambetter.ARhealthwellness.com]

Medical Claims:
Ambetter from Arkansas Health & Wellness
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

NovaSys HEALTH Marketplace Network

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.

AMB16-AR-C-00064

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

Verification of Eligibility, Benefits and Cost Share

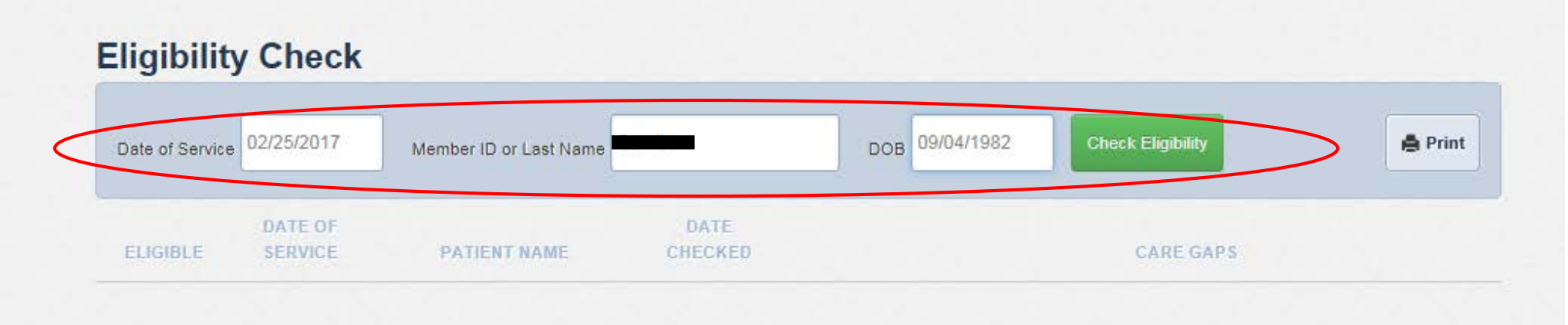
Eligibility, Benefits and Cost Shares can be verified in 3 ways:

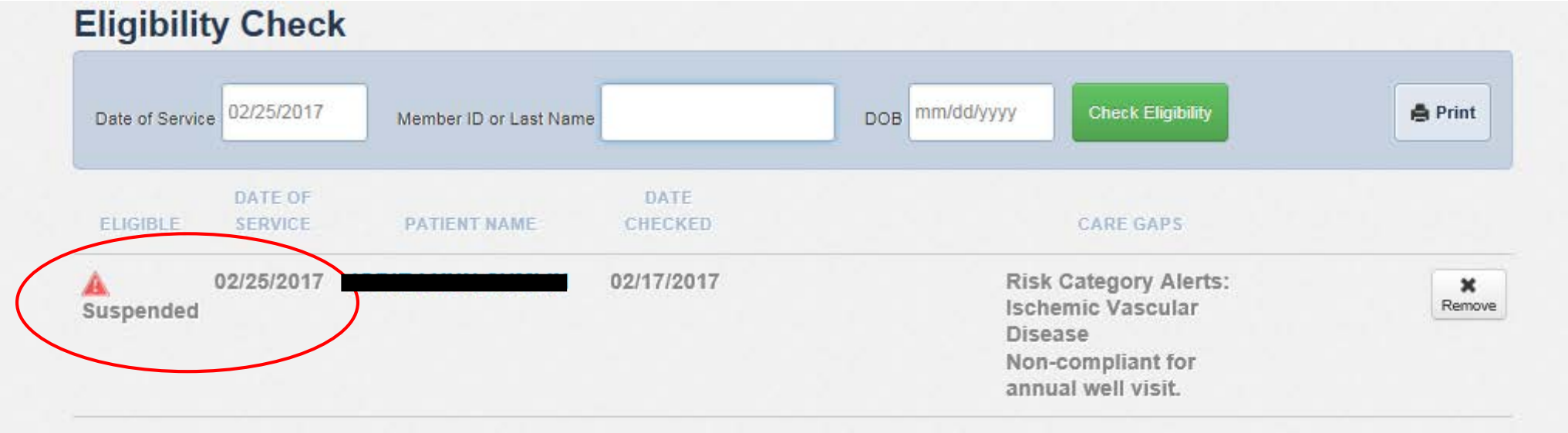
1. **The Ambetter secure portal found at: ambetter.arhealthwellness.com**
   - If you are already a registered user of the Ambetter from Arkansas Health and Wellness secure portal, you do NOT need a separate registration!

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





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.

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	
 Ineligible	07/21/2016	JOHN DOE	07/21/2016	Member is not eligible for services performed on this date of service.

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	
 Suspended	07/21/2016	JOHN DOE	07/21/2016	Member premium payment is past due. Claims may be denied.

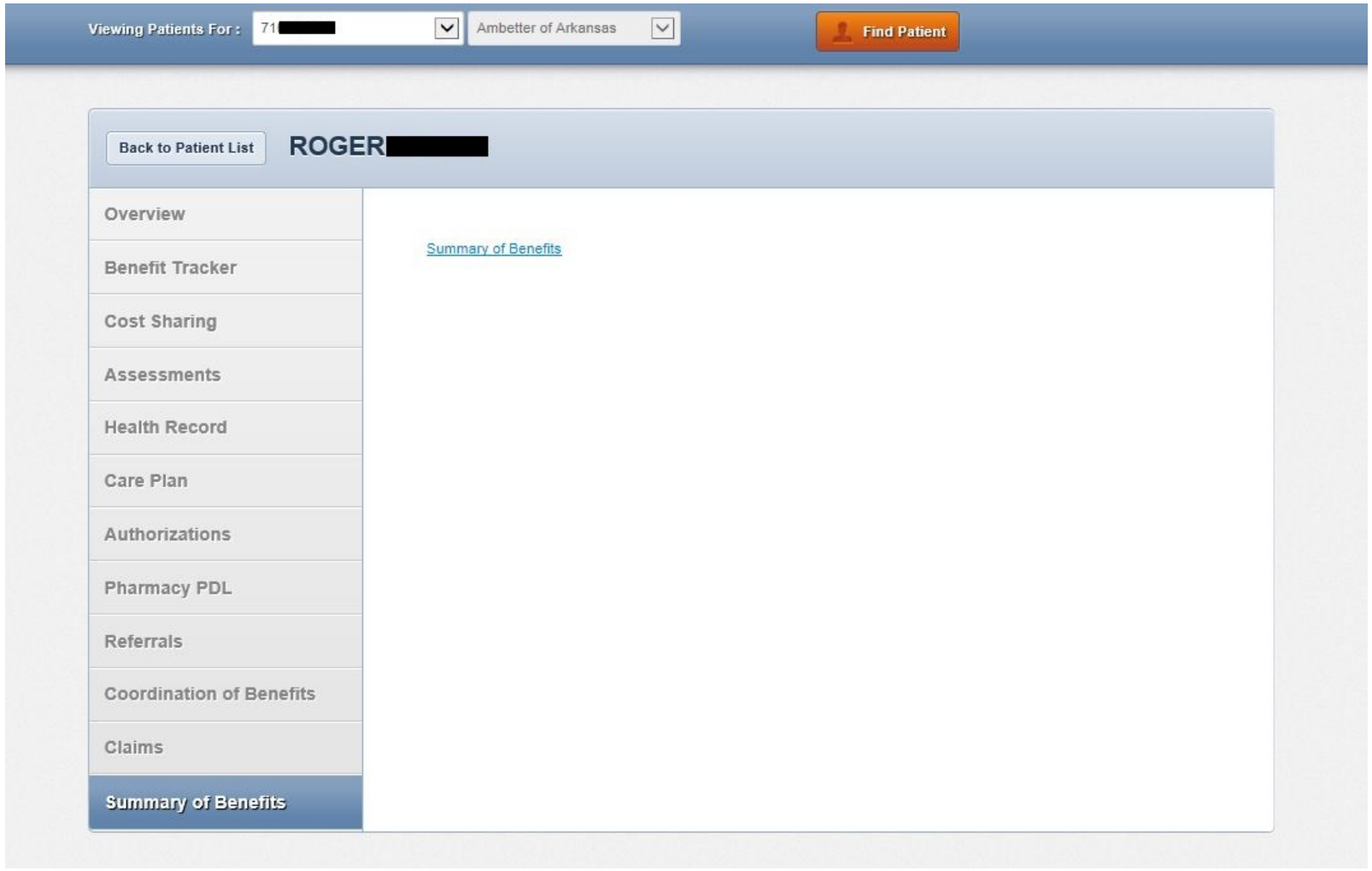
ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	
 Delinquent	07/21/2016	JOHN DOE	07/21/2016	Member's premium payment is in delinquent status. Claims will be processed.

Verification of Eligibility

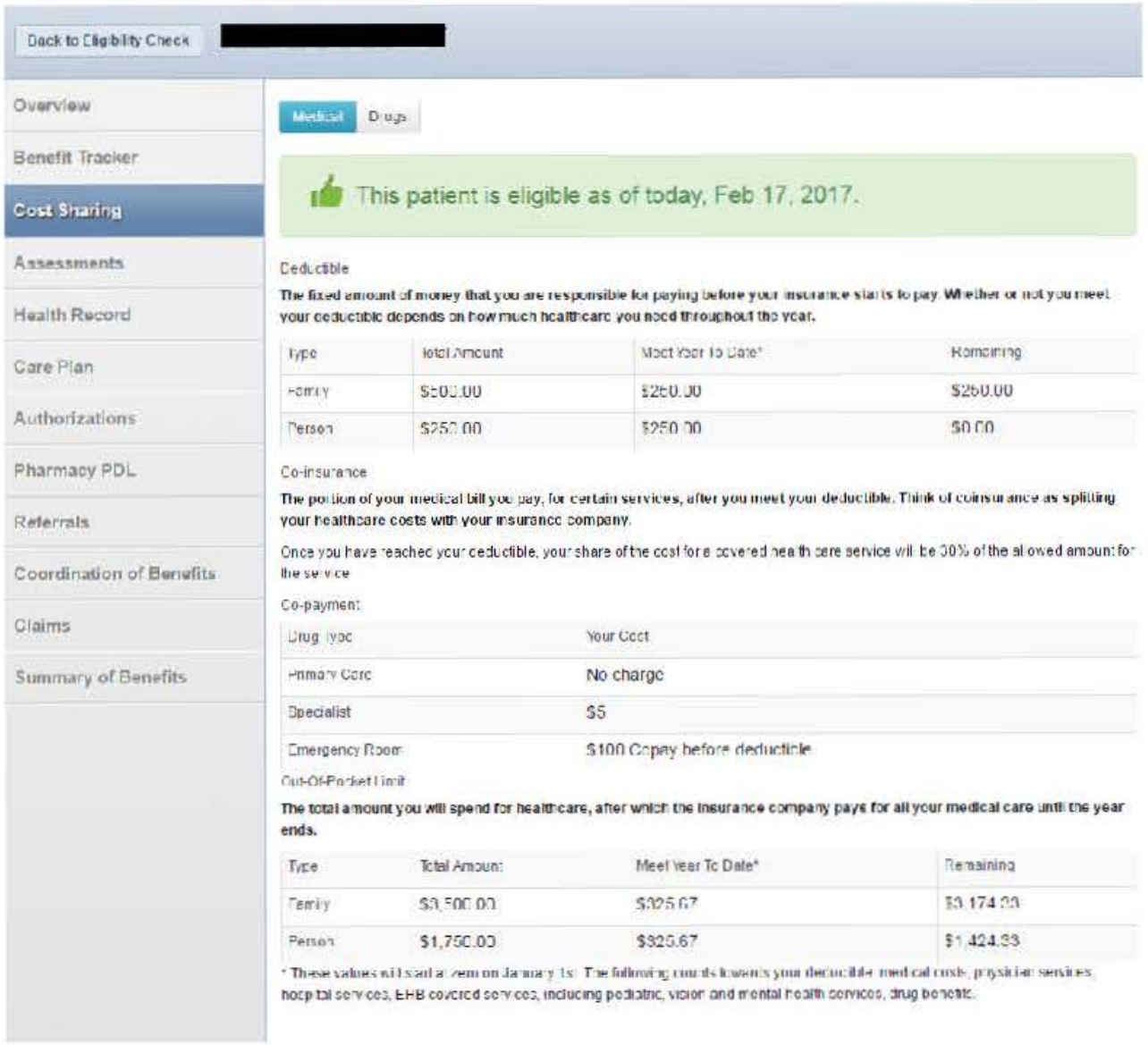
Member in Suspended Status

- 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



Verification of Cost Shares



PCP Reports

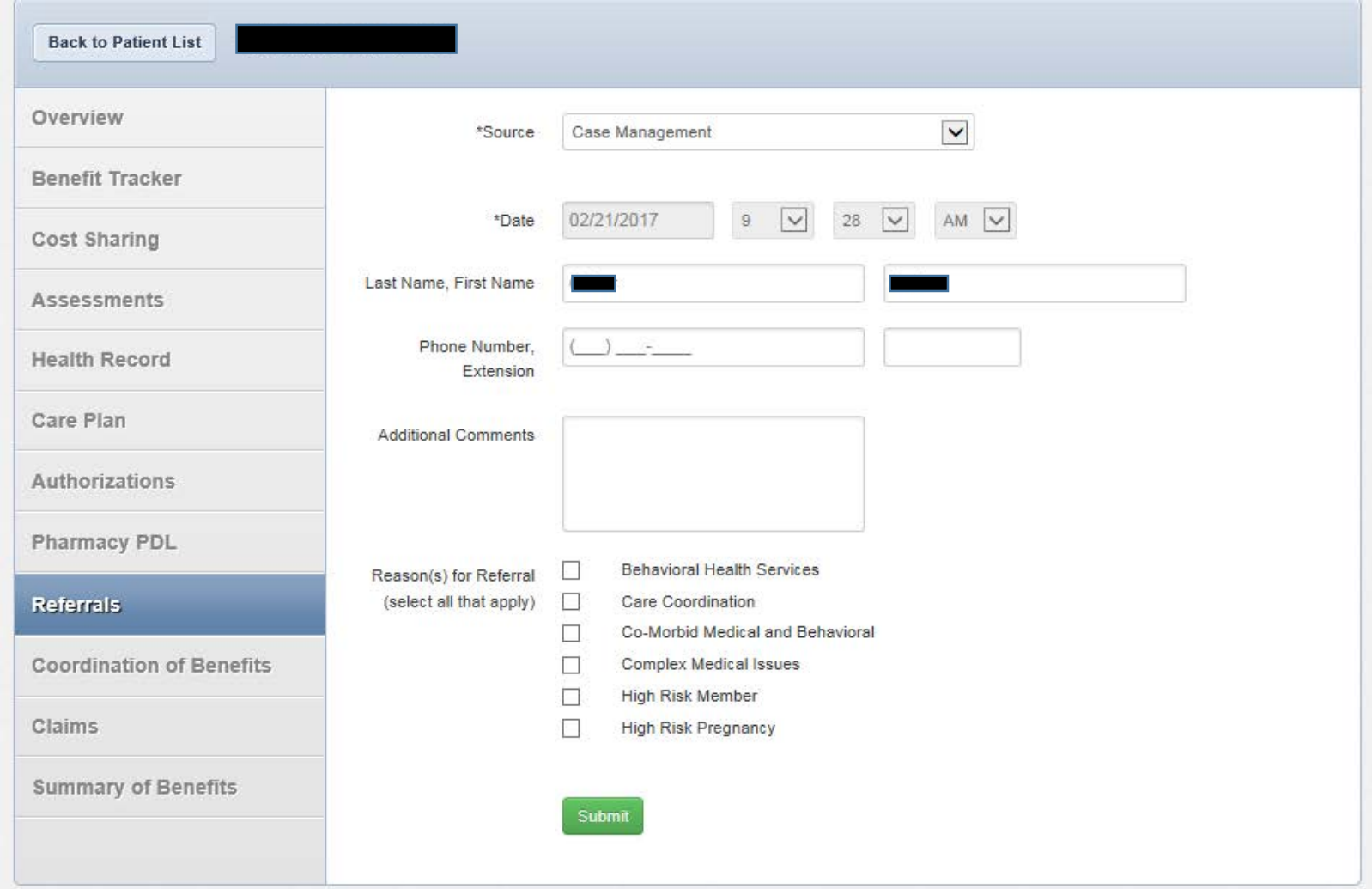
PCP Reports

- PCP reports available on Ambetters' secure provider web portal are generated on a monthly basis and can be exported into a PDF or Excel format.

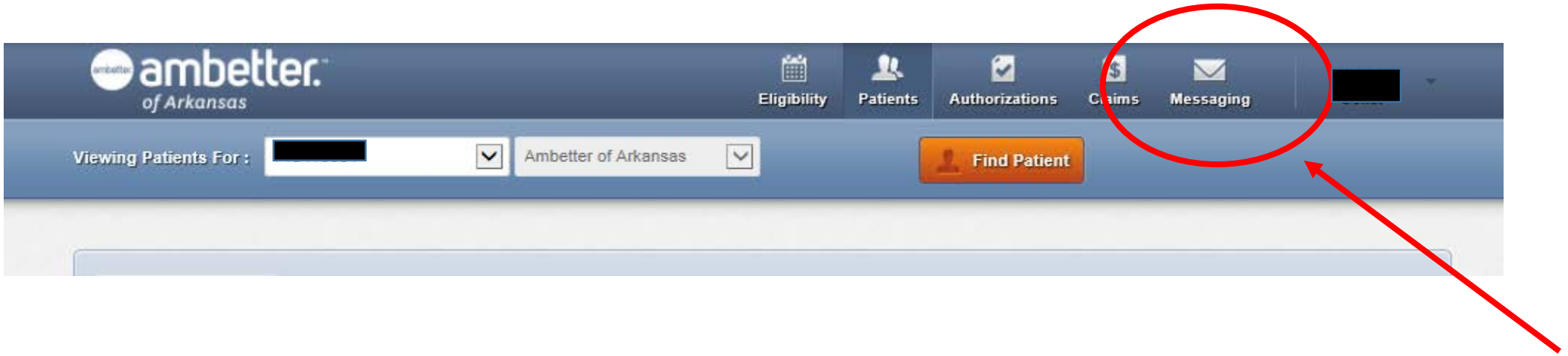
PCP Reports Include

- Patient List with Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- Members flagged for Disease and Case Management

Case Management Referrals



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.

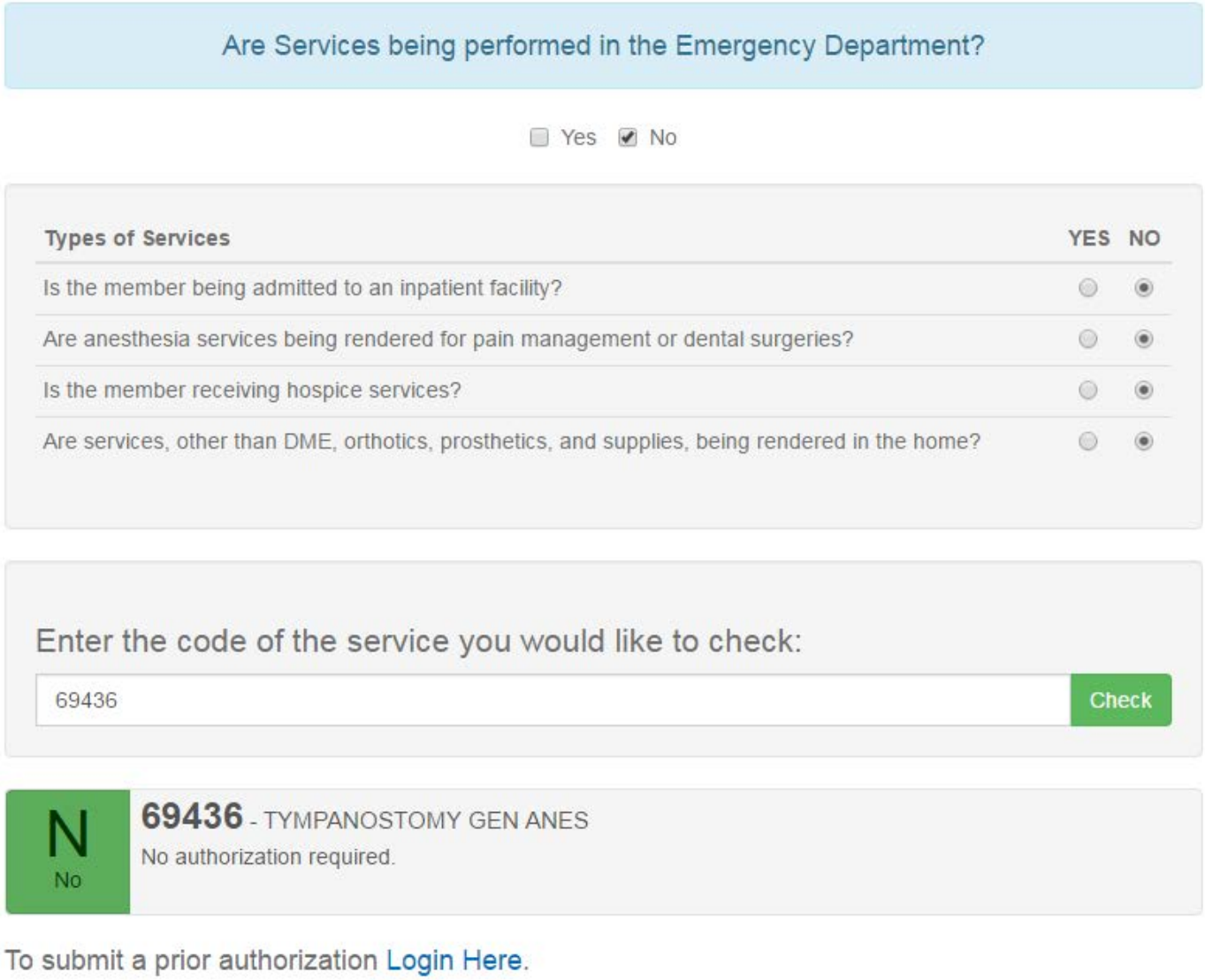
- Ambetter will update authorizations but will not retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed for a possible retrospective review.

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



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 14th 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 out 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

Kelly McArthur, Director of PDM, Credentialing & Provider Network	kmcarthur@centene.com
Rebekah Wilson, Credentialing Manager	rwilson@centene.com
Mike Hackbart, Provider Network Specialist	mhackbart@centene.com
Kari Murphy, Provider Network Specialist	kamurphy@centene.com
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.