Ambetter Provider Claims & Payments FAQ

Quick links (questions are grouped into the following categories):

Submitting a Claim or Claim Reconsideration/Dispute Questions

What do I do if I do not understand the denial reason code or response to a reconsideration/dispute?

Call Provider Services 1-877-687-1197 for clarification.

What is the Ambetter Medical claims mailing address?

Ambetter Claims Processing
PO Box 5010
Farmington, MO 63640-5010

How do I submit Medical Records?

Medical records may be submitted via the Secure Portal **Correct Claim** function or by following the Reconsideration or Dispute process either electronically or via the form available on our website: Reconsideration and Dispute form. Submit forms to the address printed on the form.

If a Reconsideration has been upheld, what is the next step?

1. Submit a corrected claim if you have updated information*, or
2. Submit a Dispute with additional documentation in direct support of your position.

**Ensure the denial letter is included the corrected claim. If a paper claim is filed it must be sent on the standard 1500 red and white form or the UB 1450 (UB-04). All other claims submitted will be denied. Refer to the Ambetter Provider Billing manual for all instructions on filing a corrected claim.*

If a Provider Dispute has been upheld, what is the next step?

If you have exhausted the claims reconsideration and dispute process, a provider complaint can be filed. Please see Complaint Process, page 83 in the Provider Manual and/or contact your Provider Network Specialist.

Who should I contact for information regarding Reconsiderations/Disputes?

If the Reconsideration/Dispute was submitted electronically through the Secure Provider Portal, you can check the status there. For all other requests, allow 30 business days for processing before contacting Provider Services for status updates.

What is the difference between an Appeal and Reconsideration/Dispute?

An "Appeal" is regarding a member-driven inquiry related to an authorization/medication. An inquiry related to any disagreement with the way a claim processed after a service was rendered is a Reconsideration or Dispute (a second level reconsideration).

What is the timeline for response to a Member Appeal?

A member has 180 calendar days from Ambetter's notice of action to file the appeal. Ambetter shall acknowledge receipt of each appeal within ten (10) business days after receiving an appeal. Ambetter shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed thirty (30) calendar days from the date Ambetter receives the appeal. For additional appeal timelines, consult the Provider Manual.

Why are there additional line items added to the claim when that is not what we billed?

As a part of our normal claim processes, lines may be added to allow a breakdown in units or other measurements to adjudicate the claim.

Claim Denial Questions

Why does the claim deny when it is a covered service?

Review the Remark Codes to verify the claim adjudication reason. Re-verify the billing code does not need an authorization. If you disagree with the manner in which the claim paid/denied follow the Reconsideration/Dispute process.

Why did the claim deny for taxonomy/modifier/CLIA when it is clearly on the claim?

This can happen if the Qualifier prefix is not included, meaning the claims system cannot see it even though a human can.

1. Review your claims to ensure the required Qualifier is included (as outlined in the Provider Manual). If it is not included, then submit a corrected claim.
2. Otherwise, contact Provider Services to request review and submit the claims for reprocessing if it is determined no changes are required. If the claim denied for missing modifier please add the appropriate modifier. For additional information please visit the provider billing manual. For claim denying for missing CLIA. The claim must contain the CLIA number when CLIA waived or CLIA certified services are provided. For more information please visit the provider billing manual.

Why is the claim denying EXya DENIED AFTER REVIEW OF PATIENTS CLAIM HISTORY when we only billed once?

Services may have been rendered by another provider/practitioner on the same day. This denial requires a review of the claim with medical records to verify medical necessity to prevent incorrect billing.

Why is the claim denying for no authorization when there is an authorization listed on the claim?

There can sometimes be a discrepancy between the setup of the authorization and what is billed on the claim (dates, Rev/CPT codes, modifiers).

1. Please verify the claim matches the information on the authorization and submit a corrected claim, if needed.
2. If the claim matches the authorization, then contact Provider Services to assist with verifying the data elements on the set up of the authorization to enable reprocessing of the claim.

Why have I received a claim Remark Code EXys - reimbursement is included in another code per CMS/AMA/Medical Guidelines (or HIPAA code COA1, M15) and what are my next steps?

This explanation code is appended when a provider bills with modifiers 25 or 59 in order to unbundle procedures included in NCCI bundling edits. Coordinated Care does not automatically make additional payment when modifiers 25 or 59 are used. See Payment Policy CC.PP.031. Providers

must send in a Claim Reconsideration/Dispute with medical records that directly support their unbundling in order for additional reimbursement to be considered.

How do I locate information related to bundled denials or what the claim is bumping against?

Ambetter follows all Medicare NCCI Procedure to Procedure (PTP-bundling edits) and Medically Unlikely Edits (MUE-quantity limitations). These can be viewed at:

- **https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits** are the procedure to procedure edits (unbundling)
- **https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index?redirect-/nationalcorrectcodinited/** are the CMS NCCI Edits

Ambetter does not automatically make additional payment when modifier 25 or 59 are billed in order to attempt to unbundle procedures.

Who should I contact to assist with claim denials Exy1 Denied Out of Network when my provider is in network and contracted?

If you have not added your new practitioner through an "Add" request to our Contracting Department, or included the practitioner on your last provider roster submission, the individual practitioner may not yet be credentialed and enrolled with us. Please go to our Provider Update page at: **https://www.coordinatedcarehealth.com/providers/resources/provider-update-tools.html** to enroll your new practitioner. Otherwise, there may be a set-up issue with the individual servicing practitioner. Please contact Provider Services at 1-877-687-1197 and ask them to review the network status of the servicing practitioner.

Claim Inquiries, Projects and Claims Research Questions

What is the standard turnaround time for requests related to claims? (Example: Reference # S-12345678)

30 business days

How do we get information on claim projects?

Allow 30 business days for research. If a project is deemed necessary, the project can take up to 30 days to process through the claims project center. If you have not received a response after 60 business days, contact Provider Services at 1-877-687-1197.

What is the standard turnaround time to Provider Data updates? (E.g. TIN, NPI, W9 changes. Example: Ticket # SPT-1234 or PVDM-1234)

The turnaround time is up to 30 days once all the requested documents are received.

What should I do if my request (Example: reference #S-12345678) was completed without resolution of all claims?

Contact your Provider Network Specialist for review and possible escalation.

If I suspect a contract or credentialing set up related issue is affecting my reimbursement, what should I do?

Send an email to **Contracting@CoordinatedCareHealth.com**. If you are not certain if it is a set up issue, contact Provider Services at 1-877-687-1197

Why do I have to contact both the Provider Services Team and my Provider Network Specialist in order to resolve some concerns?

Provider Services is a provider's first resource for questions. Some questions require deeper research or discussion, thus requiring outreach to your Provider Network Specialist. Complex issues that require outreach to your Provider Network Specialist include provider credentialing and claims projects, among others.

Payment and Recoup Questions

How do I obtain a copy of my Explanation of Payment/Remittance Advice?

If you are registered with PaySpan to receive an electronic remittance contact PaySpan at **ProviderSupport@payspanhealth.com** call 1-877-331-7154.

- If you are not set up to receive an electronic remittance you may review claim status via the Secure Portal and view the Explanation of Payment detail online or download the Explanation of Payment (EOP) in Excel Format.
- For additional EOP/Remittance questions contact Provider Services or access the Secure Provider Portal.
    - There is an instruction manual link located on each page that is searchable by selecting 'Ctrl F' and typing in a key word.
    - Type in "Explanation of Benefit" in the search field for instructions on downloading an EOP.

Provider Services said my claim was paid but I did not receive a payment; what should I do to get paid?

Review claim status via the Secure Portal.

- If it shows paid and you have not received payment, contact your Provider Network Specialist (PNS) to verify how the claim was paid and or to verify the correct billing address (W-9) is on file.
    - **Please provide the following information with your inquiry:** Bank code, check number, amount, date issued, claim number, and correct payment address.
- *To help ensure prompt and accurate payment we encourage registering for EFT via PaySpan to avoid payment issues. Please review the PaySpan PDF.*

Why does the claim say 'Paid' but the amount is 0.00?

Review the Remark Code to verify the adjudication reason. If you disagree with the way the claim processed you may submit a Reconsideration and or Dispute: Reconsideration and Dispute form.

What should I do if I receive a check and cannot identify what it is for?

Email an image of the check to your Provider Network Specialist for review and next steps.

Why did I receive a letter regarding a recoupment?

Prior to claim recoupments, a letter is mailed to the provider to give notification of the expected recoupment and the reason associated with the recoup. Providers are given the opportunity to dispute the request if they do not agree; otherwise, the recoupment will be taken from the same remittance advice it is applied to originally. If there are insufficient funds to cover the recoupment the remittance advice will result in a Negative Balance and zero check offsetting the payment of future claims.

I received a zero balance check with a Remittance Advise. What should I do to obtain the documentation to post the associated claim transactions?

Request a Negative Balance Report from Provider Services by either sending a Secure Message via the Secure Provider Portal or calling Provider Services at 1-877-687-1197. If you send a Secure Message via the Provider Portal, please add your fax number.

Who do I contact to request a Negative Balance Report?

Contact Provider Services at 1-877-644-4613 or send a Secure Message via the Secure Portal. If you send a Secure Message via the Secure Portal please add your fax number.

If I have questions about the Negative Balance Report who may I contact?

Contact Provider Services at 1-877-687-1197 or send a Secure Message via the Provider Portal. If you send a Secure Message via the Provider Portal please add your fax number.

Where should I mail checks for refunds & overpayments of Ambetter claims?

Ambetter from Coordinated Care Corporation
PO Box 741033
Los Angeles, CA 90074

Or for behavioral health:
Ambetter from Coordinated Care Corporation
Attn: Claims Recovery Team
PO Box 741033
Los Angeles, CA 90074

Other Claims Questions

How do I verify whether the Prior Auth Tool is correct?

If you suspect an error you may contact Provider Services to submit an inquiry to Medical Management. If you have a claim denial please submit a Reconsideration and/or Dispute via the provider portal or by mail: Reconsideration and Dispute form

How are newborn claims affected by the Erin Act?

Washington State's Erin Act requires a mother's health plan cover her newborn child for the first 21 days of life, including any continuous health events that begin in the first 21 days of life, regardless of whether the child is ultimately enrolled in the plan.

How should I bill claims for newborns when the newborn has not been assigned their own ID?

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. A separate claim needs to be submitted for the mother and their newborn. Newborn services claims should be billed with their own ID/U number, until the newborn's U# is obtained, bill with mother's U#/ID#, mother's last name, baby's first name (or 'baby boy'/baby girl') and newborn's date of birth (DOB). See Provider Manual for additional information.