Ambetter
from Magnolia Health

Provider Orientation 2014

12/15/2014

FROM magnolia health

AGENDA

- Affordable Care Act Overview
- The Health Insurance Marketplace
- Verification of Eligibility, Benefits and Cost Shares
- Specialty Referrals
- Prior Authorization
- Claims
- Complaints/Grievances and Appeals
- Specialty Companies/Vendors
- Web Portal
- Provider Tool Kit
- 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
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

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

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, federally facilitated or State Partnership – *Mississippi is a Federally Facilitated Marketplace*

Subsidies come in the form of:

- **Advanced Premium Tax Credits (APTC)**
- **Cost Share Reductions (CSR)**

All Benefit Plans have cost shares in the form of copays, coinsurance and deductibles:

- **Some members will qualify for assistance with their cost shares based on their income level**
- **This assistance will be paid directly from the government to the member's health plan**

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The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies

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WHAT YOU NEED TO KNOW…

Verification of Eligibility, Benefits and Cost Share

Member ID Card:

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

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Verification of Eligibility, Benefits and Cost Share

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

The Ambetter secure portal found at: Ambetter.MagnoliaHealthPlan.com	24/7 Interactive Voice Response system:	Contact Provider Service at 1-877-687-1187
If you are already a registered user of the Magnolia Health Plan secure portal, you do NOT need a separate registration	Enter the Member ID Number and the month of service to check eligibility	

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Verification of Eligibility

Eligibility Check

Date of Service 05/15/2014 | Member ID or Last Name 123456789 or Smith | DOB mm/dd/yyyy | Check Eligibility | Print

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS		
	05/15/2014		05/15/2014	No PAP in past 36 months. DM - No retinal eye exam in past 12 mos Due for annual adult physical Risk Category Alerts: Diabetes	Emergency Room Visit?	Remove

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Verification of Eligibility

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Back to Eligibility Check

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

Patient Information

Name	
Gender	F
Birthdate	Apr 13, 1976
Age	38 years old
Member #	
Address	

PCP Information

Name	
Address	
Practice Type	
Phone Number	

Eligibility History

Start Date	End Date	Product Name
Jan 1, 2014	Dec 31, 9999	TANF

View PCP History

Care Gaps

No PAP in past 36 months.
DM - No retinal eye exam in past 12 mos
Due for annual adult physical
Risk Category Alerts: Diabetes

FROM

Summary of Benefits

Back to Eligibility Check

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

Summary of Benefits

Summary of Benefits

Ambetter Silver 5 + Vision + Adult Dental — Coverage Period: 5/15/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs — **Coverage for: Individual/Family | Plan Type:HMO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **http://ambetter.magnolia healthplan.com/** or by calling **877-687-1187, TTY/TDD 877-941-9235**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,000** family. Does not apply to preventive care and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy plan or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, **$100** individual / **$200** family for prescription drug expenses.	You must pay all of the costs for these services up to the specific **deductibles** amount before this plan begins to pay for these services.
Is there an out-of-pocket-limit on my expenses?	Yes, for in-network providers **$2,250** individual/**$4,500** family. No, for out-of-network providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and out-of-network services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **http://ambetter. magnoliahealthplan.com/ findadoc** or call **1-877-687-1187** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, you don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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12/15/2014

Verification of Cost Shares

- Overview
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Medical | Drugs | Dental | Vision

This patient is eligible as of today, May 15, 2014.

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	Meet Year To Date*	Remaining
Family	$1,000	$73.85	$926.15
Person	$500	$73.85	$426.15

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 0% of the allowed amount for the service

Co-payment

Drug Type	Your Cost
Primary Care	$10
Specialist	$20
Emergency Room	$100 Copay after 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	Meet Year To Date*	Remaining
Family	$4,500	$73.85	$4,426.15
Person	$2,250	$73.85	$2,176.15

Specialty Referrals

Members are educated to first seek care or consultation with their Primary Care Provider

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*

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 except those rendered by perinatologists. Urgent/emergent ultrasounds will be reviewed retrospectively
- Pain Management

** This is not meant as an all-inclusive list and ALL are subject to Medical Necessity review*

Prior Authorization

ambetter.

Inpatient Authorization

All elective/scheduled admission notifications requested at least 5 business days prior to the scheduled date of admit	Observation stays exceeding 23 hours	Urgent/Emergent Admissions • Within **1 business day** of admission • Newborn Deliveries must include birth outcomes	Partial Inpatient, Psychiatric Residential Treatment Facilities (PRTF) and/or Intensive Outpatient Programs

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

Prior Authorization

Ancillary Services

Air Ambulance Transport (non-emergent fixed wing airplane)	DME (Durable Medical Equipment)	Home Health Care services • Home Infusion • Skilled Nursing • Therapy • Hospice • Adult Medical Day Care	Orthotics/ Prosthetics • Therapy (PT/OT/ST)	Hearing Aid Devices • Including Cochlear Implants	Genetic Testing	Quantitative Urine Drug Screen

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

Prior Authorization Request Timeframes

Service Type	Timeframe
Elective/Scheduled Admissions	**5 business days** prior to the scheduled admission date
Emergent inpatient admissions	Notification **required** within **1 business day**
Emergency room and post stabilization, urgent care, and crisis intervention	Notification **requested** within **1 business day**
Maternity admissions	Notification **requested** within **1 business day**
Newborn admissions	Notification **requested** within **1 business day**
NICU admissions	Notification **required** within **1 business day**
Outpatient dialysis	Notification **required** within **1 business day**

Prior Authorization Request Turn-Around Timeframes

Prior Authorization Type	Timeframe
Prospective/Urgent	Two (2) business days of 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	One (1) business day from receipt of necessary information and no later than fifteen (15) calendar days
Retrospective	Thirty (30) calendar days

Prior Authorization

Prior Authorization Pre-Screen Tool:

Emergency Services do NOT require prior authorization

Type of Service	Authorization Required?
The information below supersedes responses by the code lookup tool.	
All inpatient admissions and associated physician services	YES
Observation Services	YES
Anesthesia Provider Outpatient services only requires an auth for pain management and oral surgery	YES
Hospice	YES
Services rendered in the home	YES
Services from an Ophthalmologist, Optometrist or Optician are only covered if the member has elected the Vision Rider	CONDITIONAL

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

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

Check

Prior Authorization

Prior Authorization can be requested in 3 ways:

The Ambetter Provider Portal	Fax Requests to: **1-855-300-2618**	Call for Prior Authorization at **1-877-687-1187**
• Ambetter.MagnoliaHealthPlan.com	• Authorization forms are located on our website at **Ambetter.MagnoliaHealthPlan.com**	

If you are already a registered user of the Magnolia Health Plan portal, you do NOT need a separate registration

Claim Submission

Claims may be submitted in 3 ways:

The Ambetter secure portal found at: Ambetter.MagnoliaHealthPlan.com If you are already a registered user of the Magnolia Health Plan secure portal, you do NOT need a separate registration	**Electronic Clearinghouse** • Payor ID 68069 • Clearinghouses currently utilized by Ambetter from Magnolia Health will continue to be utilized • For a listing our the Clearinghouses, please visit out website at Ambetter.MagnoliaHealthPlan.com	Paper claims may be submitted to PO Box 5010 Farmington, MO 63640-5010

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The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Corrected Claim, Reconsideration, Claim Disputes

Corrected Claim

- Change or Adjustment to the original claim

Reconsideration

- Disagree with the original claim outcome (payment amount, denial reason, etc.)

Claim Dispute

- Disagree with the outcome of the Reconsideration request

Corrected Claim, Reconsideration, Claim Disputes

All Requests for corrected claims, reconsiderations or claim disputes must be received within **180 days** of the original Plan notification (ie. EOP). Original Plan determination will be upheld for requests received outside of the 180 day timeframe, unless justification is provided to the Plan to consider

Corrected Claims

- Submit via Secure Web Portal
- Submit via an EDI Clearinghouse
- Submit via paper claim:
  - **Ambetter from Magnolia Health**
  - **PO BOX 5010**
  - **Farmington, MO 63640-5010**
  - **(Include original EOP)**

Reconsideration

- Written communication (i.e. letter) outlining disagreement of claim determination
- Indicate "Reconsideration of (original claim number)"
- Submit reconsider to:
  - **Ambetter from Magnolia Health**
  - **Attn: Reconsideration**
  - **PO BOX 5010**
  - **Farmington, MO 63640-5010**

Claim Dispute

- ONLY used when disputing determination of Reconsideration request
- Must complete Claim Dispute form located on **Ambetter.MagnoliaHealthPlan.com**
- Include original request for reconsideration letter and the Plan response
- Send Claim Dispute form and supporting documentation to:
  - **Ambetter from Magnolia Health**
  - **Attn: Claim Dispute**
  - **PO BOX 5000**
  - **Farmington, MO 63640-5000**

Claim Submission

Member in Suspended Status:

Following initial premium payment, a grace period of 3 months from the premium due date is given	Coverage will remain in force during the grace period	Coverage will be terminated if no payment of premium is received following the grace period retroactive to the last day of the 1st month of the grace period	During months 2 and 3 of the grace period, claims will be pended. The EX code on the EOP will state: "LZ-Pend: Non-Payment of Premium". During the 1st month, claims may be submitted and paid

Members receiving APTCs

For members who are in a suspended status and seeking services from providers:

1. Providers may advise the member that services may not be delivered due to the fact that the member is in a suspended states. (Status must be verified through our Secure Web Portal or by calling Provider Services). Providers should follow their internal policies and procedures regarding this situation.
2. Should a provider make the decision to render services, the provider may collect from the member. Providers must submit a claim to Ambetter.
   - If the member subsequently pays their premium and is removed from a suspended status, claims will be adjudicated by Ambetter. The provider would then be responsible to reconcile the payment received from the member and the payment received from Ambetter. The provider may then bill the member for any underpayment or return to the member any overpayment.
   - If the member does not pay their premium and is terminated from their Ambetter plan, providers may bill the member for their full billed charges

Claim Submission

Member in Suspended Status – Example:

** Note: When checking Eligibility, the Secure Portal will indicate that the member is in a suspended status.*

January 1st
- Member pays premium

February 1st
- Premium due – Member does not pay – Claims may be submitted and paid

March 1st
- Member placed in suspend status

April 1st
- Member remains in suspend status

May 1st
- If premium remains unpaid, member is terminated. Provider may bill member directly for services provided in months 2 and 3

Claim Submission

Taxonomy Code Requirement:

- CMS 1500 - If the rendering NPI and billing NPI are different, claims must be submitted with the rendering provider's Taxonomy Code in the **shaded** portion of Box 24J and Taxonomy Qualifier "ZZ" in the **shaded** portion of Box 24I. The group Taxonomy utilizing the "ZZ" must be filed in 33b
- CMS 1500 - If the rendering NPI and billing NPI are the same, the applicable Taxonomy Code utilizing the Taxonomy Qualifier "ZZ" must be filed in Box 33b
- CMS 1450 form – The Taxonomy Code with Taxonomy Qualifier "B3" is required in Box 81 CC
- **Claims will reject if the Taxonomy Code is not present – Reject Code 06**
- This is necessary in order to accurately adjudicate the claim
- The following website can be utilized to verify a taxonomy code: www.findacode.com/tools/taxonomy-codes.html

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

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 with 45 days

Complaints/Grievances

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Ambetter's policies, procedures, or any aspect of Ambetter's functions. Ambetter logs and tracks all Complaints/Grievances. A provider has **thirty (30) calendar days** from the date of the incident, such as the date of the EOP, to file a Complaint/Grievance. Ambetter shall provide a written determination to the provider within **thirty (30) calendar days** upon receipt of complete documentation.

The Reconsideration and/or Claim Dispute process must be followed first for Complaint/Grievance related to a claim determination.

Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at: Ambetter.MagnoliaHealthPlan.com

Authorization Complaints

Authorization and coverage complaints must follow the Appeal process. **Claim decisions are NOT Appealable and must follow the Reconsideration and/or Claim Dispute process.**

An Appeal allows providers to challenge the determination of a Prior Authorization request. A Provider has **thirty (30) calendar days** from Ambetter's notice of action to file an Appeal. Ambetter shall resolve and provide a written notice of the Appeal request within **thirty (30) calendar days** upon receipt of all Appeal documentation or as required dependent on members health condition. Ambetter may extend resolution timeframe to **fourteen (14) calendar days** upon member request or need for additional information.

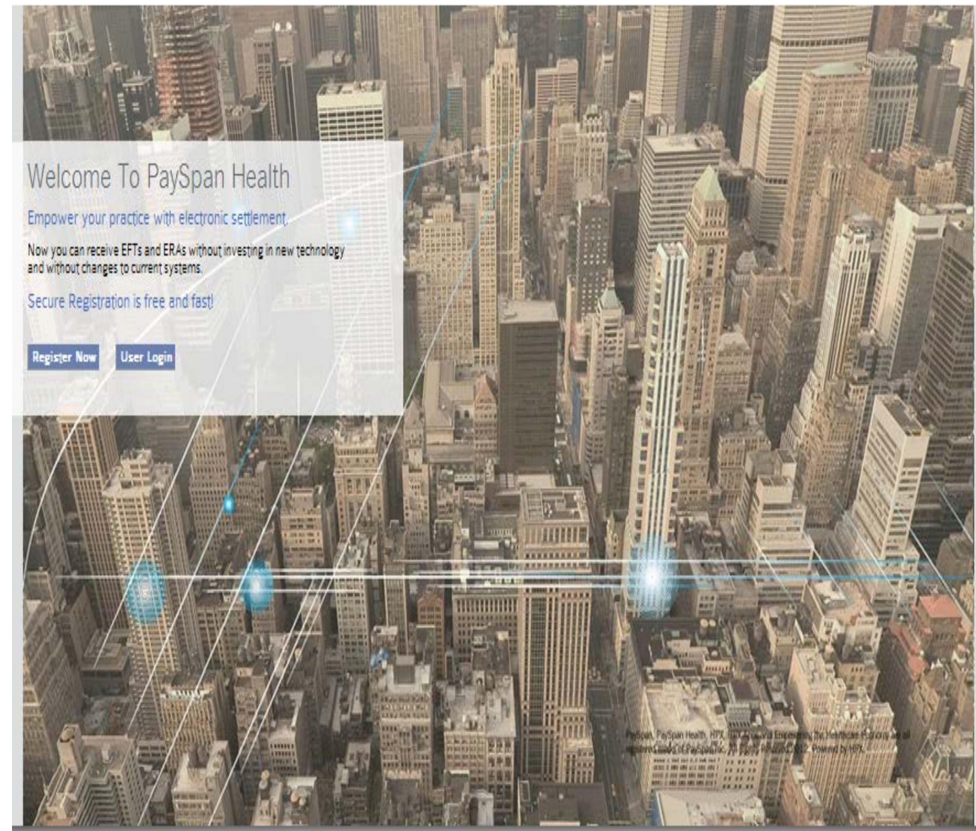
Expedited Appeal requests are resolved as expeditiously as the members health condition requires, not to exceed **seventy-two (72) hours** form the initial Appeal receipt. Ambetter may extend resolution timeframe to **fourteen (14) calendar days** upon member request or need for additional information that is in the members best interest.

Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at: Ambetter.MagnoliaHealthPlan.com

PaySpan Health

EMPOWERING THE HEALTHCARE ECONOMY™

- Ambetter has partnered with PaySpan Health to offer expanded claim payment services
- Electronic Claim Payments (EFT)
- Online remittance advices (ERA's/EOPs)
- HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: **www.PaySpanHealth.com**
  - **If currently utilizing PaySpan for the Magnolia MSCAN product, you will NOT be required to register specifically for Ambetter and will be automatically enrolled**



- For further information contact 1-877-331-7154, or email **Providerssupport@PAYSPANHEALTH.COM**

Specialty Companies/Vendors

Service	Specialty Company/Vendor	Contact Information
Behavioral Health	Cenpatico Behavioral Health	1-877-687-1187 www.cenpatico.com
High Tech Imaging Services	National Imaging Associates	1-877-687-1187 www.radmd.com
Home Health, Home Infusion and DME	Univita	1-877-687-1187 www.univita.com www.univita.com
Vision Services	OptiCare	1-877-687-1187 www.opticare.com
Dental Services	DentaQuest	1-877-687-1187 www.dentaquest.com
Pharmacy Services	US Script	1-877-687-1187 www.usscript.com

Public Website

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

Magnolia Health Plan
Contact Us | Newsroom | Events | Careers | Search
Login | Find a Provider | For Members | For Providers
A health insurance company for Mississippi's Medicaid population, and now participating in the new healthcare Market Place Exchanges.

For Members
- Login
- Your Benefits
- Find a Provider
- CentAccount®
- Pharmacy
- Member Resources

For Providers
Login
Become a Provider

ambetter. from Magnolia Health
Make Ambetter Your Health Insurance Partner Today!
Learn More

1. Go to MagnoliaHealthPlan.com and click on Ambetter

Go Back to Magnolia Health
ambetter. from Magnolia Health | Learn More | Our Health Plans | Health and Wellness | For Members | For Providers
Enroll in an Ambetter Health Plan Today! Call us at 1-877-687-1187 or Get Started! | Get Started ›
Login | Find A Provider | Contact Us

- Join Our Network
- Pharmacy Program
- Provider Resources

For Providers

Healthy partnerships are our specialty.

With Ambetter, you can rely on the services and support that you need to deliver the best quality of patient care. You're dedicated to your patients, so we're dedicated to you.

When you partner with us, you benefit from years of valuable healthcare industry experience and knowledge. We're dedicated to helping your practice run as efficiently as possible, which is why we always strive for prompt claims processing.

At the end of the day, our job is to make yours easier. That way, you can focus on your patients. They've always been able to count on you. And, as a partner with Ambetter, you'll be able to count on us.

2. Proceed to Ambetter.MagnoliaHealthPlan.com

FROM magnolia health™

12/15/2014

Ambetter from Magnolia Website

ambetter.

Submit:

- Claims
- Demographic Updates

Verify:

- Eligibility
- Claim Status

View:

- Provider Manual
- Billing Manual
- Quick Reference Guides
- Forms
- Prior Authorization Pre-Screen Tool
- Pharmacy Preferred Drug Listing
- Affordable Care Act Overview
- Provider Training Schedule
- And more Provider Resources….

ambetter. FROM magnolia health.
Learn More | Our Health Plans | Health and Wellness | For Members | For Providers

Open Enrollment is closed. Have a Special Enrollment need? Call 1-877-687-1187 Learn More

For Brokers | Login | Language | Find A Provider | Contact Us | Community Events

Login
Provider Training
Join Our Network
Pharmacy
Provider Resources

For Providers

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www.Ambetter.MagnoliaHealthPlan.com

Web Portal – Provider Resources

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Learn More | Our Health Plans | Health and Wellness | For Members | For Providers

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- Login
- Provider Training
- Join Our Network
- Pharmacy
- Provider Resources

Provider Resources

Ambetter provides the tools and support you need to deliver the best quality of care.

Reference Materials

- Provider Manual
- Billing Manual
- Quick Reference Guide
- FAQ — Ambetter Administrative Questions

Medical Management

- Pre-Auth-Needed?
- Inpatient Prior Authorization Fax Form
- Outpatient Prior Authorization Fax Form
- Prior Authorization Fax Back Form
- Electroconvulsive Therapy (ECT) Authorization Request Form
- Psychological or Neuropsych Testing Authorization Request Form
- SMART Goals Fact Sheet

Claims and Claim Payment

- Claim Dispute Form

Quality

Specialty Companies

National Imaging Associates (NIA)

- NIA Transthoracic Echocardiography Announcement
- Transthoracic Echocardiography (TTE) Guidelines

Other

- FAQ — Overview of the Affordable Care Act
- Creating a Secure Portal Account

FROM | magnolia health.

Secure Provider Portal

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Features | Join Our Network | CREATE ACCOUNT

The Tools You Need Now!

Our site has been designed to help you get your job done.

Manage all products with ease in one location

Check Eligibility

Find out if a member is eligible for service.

Authorize Services

See if the service you provide is reimbursable.

Manage Claims

Submit or track your claims and get paid fast.

Login

User Name (Email)

name@domain.com

Password

Login

Forgot Password / Unlock Account

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

Start Your Registration

Tax ID	XXXXXXXXXX	?
First Name	First	
Last Name	Last	
Email	name@domain.com	?
Re-enter Email	name@domain.com	
Password	••••••••	?
Retype Password	••••••••	

Register

Provider Tool Kit

Materials for You and Your Staff	Materials for your Patients
• Ambetter Provider Introductory Brochure • FAQs • Health Insurance Marketplaces and What to Expect Flyer • Provider Quick Reference Guide • Secure Website Portal Flyer	• Ambetter Consumer Introductory Brochure • Quick Guide Education Cards • Order Form

Contact Information

PHONE: 1-877-687-1187

TTY/TDD: 1-877-941-9235

Ambetter.MagnoliaHealthPlan.com

Provider Relations

Provider Education

- Provider Contract clarification
- Web Demonstration
- Initiate credentialing of new providers
- Policy and Procedure clarification
- Education and information on electronic solutions to authorizations, claims, etc.
- Schedule in-services/training for new and existing staff

Thank You!