Ambetter
from Magnolia Health Plan
FQHC / RHC Webinar

12/15/2014

FROM magnolia health

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. Specialty Companies/Vendors
10. Public Website
11. Provider Tool Kit
12. 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)

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

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***

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

Health Insurance 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

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***

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.MagnoliaHealthPlan.com**
   - If you are already a registered user of the Magnolia Health Plan 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 1-877-687-1187**

Verification of Eligibility

Viewing Eligibility For : 430662495

Eligibility Check

Date of Service 06/28/2013 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	PROGRAM	
Eligible	06/28/2013	SAMUEL MEMBER	6/28/2013		Ambetter	Remove

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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.™

Viewing Patients For: 201522150

Find Patient

Back to **Jane Member**

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

This patient is eligible as of today, Jun 17, 2013.

Medical | Drugs | Dental | Vision

Medical Deductible and Out-of-Pocket Limit

Item	Total Amount	Met Year to Date*	Remaining**
Deductible Individual (2013)	$1,500	$500	$1,000
Deductible Family (2013)	[illegible]	[illegible]	$2,250
Out-of-Pocket Limit Individual (2013)	[illegible]	[illegible]	$3,300
Out-of-Pocket Limit Family (2013)	[illegible]	[illegible]	$6,400

Out-of-Pocket Limit includes medical and drug deductible, coinsurance, & copays

*Based on fully adjudicated claim data
** Collect the lesser of Individual Remaining or Family Remaining Amounts

Co-Insurance	
Patient	ambetter
30%	70%

Co-Pay	
Visit Type	Amount
Primary Care	$20
Specialist	$50
Emergency Room	$150

Free Primary Care Visits* (2013) | Total Available: 3 | Used Year to Date: 2 | Remaining: 1

Physical Therapy Visits (2013) | Total Available: 15 | Used Year to Date: 5 | Remaining: 10

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. For urgent/emergent ultrasounds, treat using best clinical judgment and this 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

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, 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**
- **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**
  - Therapy
  - Occupational
  - Physical
  - Speech
- **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 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**

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:

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

Check

If an authorization is required for the requested procedure, to submit an authorization Login here.

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

69436

Check

M
Maybe

69436 - Tympanostomy,general Anesthesia;unilateral

Authorization is required for non-participating providers only.

If an authorization is required for the requested procedure, to submit an authorization Login here.

Prior Authorization

Prior Authorization can be requested in 3 ways:

1. **The Ambetter secure portal found at Ambetter.MagnoliaHealthPlan.com**
   - If you are already a registered user of the Magnolia Health Plan portal, you do NOT need a separate registration

2. **Fax Requests to: 1-855-300-2618**
   The Fax authorization forms are located on our website at Ambetter.MagnoliaHealthPlan.com

3. **Call for Prior Authorization at 1-877-687-1187**

Prior Authorization

Prior Authorization at the CPT code level:

1. If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
    - For example, if additional procedures are performed, the provider must contact the health plan to update the authorization. This should be done within 72 hours of the procedure and prior to claim submission to avoid claim denial.

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 be 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.MagnoliaHealthPlan.com**

2. **Electronic Clearinghouse**
   - Payor ID 68069
   - Clearinghouses currently utilized by Ambetter from Magnolia Health Plan will continue to be utilized
   - For a listing our the Clearinghouses, please visit out website at Ambetter.MagnoliaHealthPlan.com

3. **Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010**

Claim Submission

- **Corrected Claim:**
  - Request to adjust or correct a claim submission: A CHANGE or CORRECTION is needed for the original claim submission
  - Must be clearly indicated and submitted within 90 days of the Explanation of Payment
  - Corrected Claims may be submitted in the following ways:
    - Via the secure Provider Web Portal
    - Submission of a corrected claim electronically via a Clearinghouse:
      - Institutional Claims (UB) – Field CLM05-3=7 and Ref*8= Original Claim Number
      - Professional Claims (CMS) – Field CLM05-3=7 and Ref*8= Original Claim Number
    - Paper submission:

Magnolia Health Plan
PO Box 5010
Farmington, MO 63640-5010

- The original Explanation of Payment should accompany the corrected claim. Failure to submit the original EOP may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

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 90 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 90 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at Ambetter.MagnoliaHealthPlan.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

Claim Submission

Member in Suspended Status – Example (member receives tax credits):

- **January 1st**
  Member Pays Premium
- **February 1st**
  Premium Due – Member does not pay – Claims may be submitted and paid
- **March 1st**
  Member placed in suspended status
- **April 1st**
  Member remains in suspended status
- **May 1st**
  If premium remains unpaid, member is terminated. Provider may bill member directly for services provided in months two and three

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

Claim Submission

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
  - CMS 1500 form – Box 33b
  - CMS 1450 form – Box 3b
- This is necessary in order to accurately adjudicate the claim
- The following website can be utilized to verify a taxonomy code: http://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 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 need to register specifically for the Ambetter product
- **To register for PaySpan:**
  Call 1-877-331-7154 or visit www.payspanhealth.com

Complaints/Grievances/Appeals

Claims:

- A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a Complaint/Grievance

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:

- Allows providers the right to appeal actions of Ambetter such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Ambetter (If an appeal is related to a claims payment, the provider must follow the process for claim reconsideration, claim dispute and the complaint process prior to filing an Appeal)

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

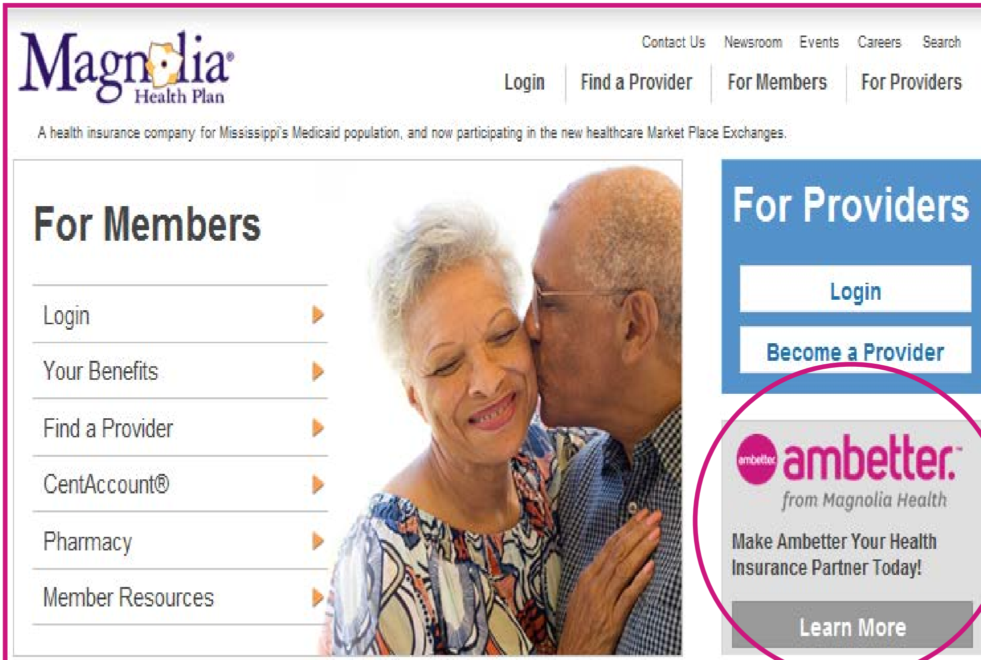
- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at: Ambetter.MagnoliaHealthPlan.com

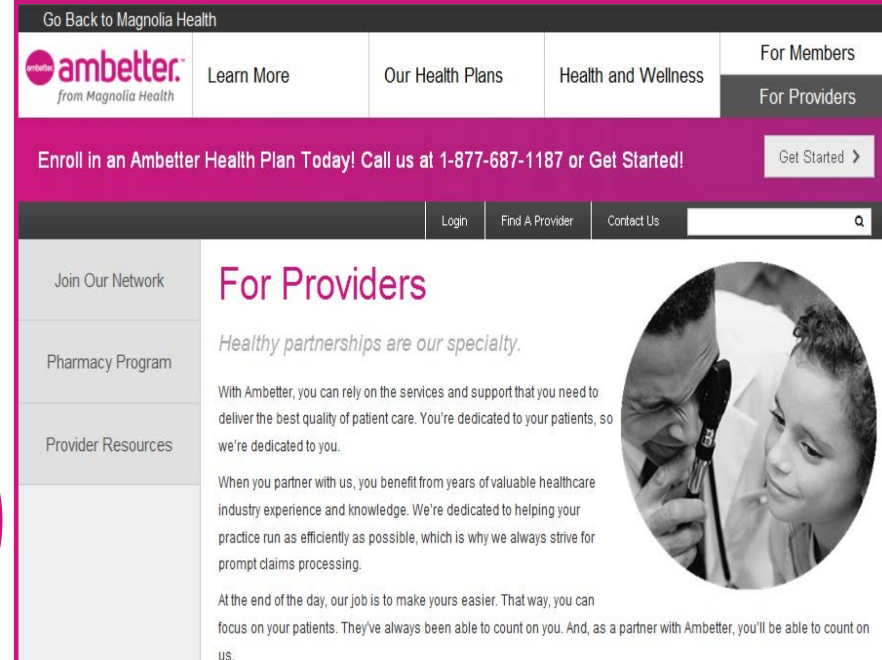
Specialty Companies/Vendors

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:





1. **Go to MagnoliaHealthPlan.com and click on Ambetter**
2. **Proceed to Ambetter.MagnoliaHealthPlan.com**

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…

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:

Ambetter from Magnolia Health Plan

Phone: 1-877-687-1187

TTY/TDD: 1-877-941-9235

Ambetter.MagnoliaHealthPlan.com

Questions