



Ambetter Provider Orientation 2020

12/10/2019

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. Provider Relations
6. Public Website and Secure Portal
7. Prior Authorization
8. Claims
9. Complaints/Grievances and Appeals
10. Specialty Companies/Vendors
11. Provider Manual and 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

Additional Parameters:

- 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
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL)



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
- Exchanges may be State-based or federally facilitated or State Partnership – *New Hampshire 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 would 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:

		IN NETWORK COVERAGE ONLY	INSURED Under the Jurisdiction of the New Hampshire Insurance Commissioner
Subscriber:	[Jane Doe]	Effective Date of Coverage:	[XX/XX/XX]
Member:	[John Doe]	RXBIN:	004336
Policy #:	[XXXXXXXXXX]	RXPCN:	ADV
Member ID #:	[XXXXXXXXXXXXXX]	RXGROUP:	RX5452
Plan:	[Ambetter Balanced Care 1]		

COPAYS	PCP: \$5 coin. after ded.	Deductible (Med/Rx):	[\$500/\$250]
	Specialist: \$10 coin. after ded.	Coinurance (Med/Rx):	[50%/30%]
	Rx (Generic/Brand): \$5/\$25 after Rx ded.		
	Urgent Care: 20% coin. after ded.		
	ER: \$250 copay after ded.		

AMB17-NH-C-00036

Ambetter.NHhealthyfamilies.com

Member/Provider Services: 1-844-265-1278 TTY/TDD: 1-855-742-0123 24/7 Nurse Line: 1-844-265-1278	Medical Claims: NH Healthy Families Attn: CLAIMS PO Box 5010 Farmington, MO 63640-5010
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Numbers below for providers:
Pharmacy Help Desk: 1-800-594-5804
EDI Payor ID: 68069
EDI Help Desk: Ambetter.NHhealthyfamilies.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.NHhealthyfamilies.com.

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



Verification of Eligibility, Benefits and Cost Share

Providers should always verify member eligibility:

- Every time a member schedules an appointment
- When the member arrives for the appointment

Eligibility verification can be done via:

- Secure Provider Portal
- Calling Provider Services, **1-844-265-1278**

Panel Status

- PCPs should confirm that a member is assigned to their patient panel
- This can be done via our Secure Provider Portal
- PCPs can still administer service if the member is not and may wish to have member assigned to them for future care



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.nhhealthyfamilies.com If you are already a registered user of the Ambetter from NH Healthy Families 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: 1-844-265-1278

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	Start Date	End Date	Program	Product Name
Cost Sharing	Mar 1, 2011	Ongoing	Ambetter	Gold 1
Assessments	Nov 15, 2010	Feb 28, 2011	Hoosier Healthwise	TANF
Health Record				
Care Plan				
Authorizations				
Coordination of Benefits				
Claims				
Summary of Benefits				
Pharmacy PDL				

Verification of Cost Shares



Viewing Patient: Fel: 261022160 Add 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)	\$1,300	\$500	\$1,300
Deductible Family (2013)	\$2,600	\$1,300	\$2,350
Out-of-Pocket Limit Individual (2013)	\$8,300	0	\$8,300
Out-of-Pocket Limit Family (2013)	\$16,600	\$0,000	\$6,400

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

Co-insurance	
Patient	ambetter
80%	20%

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

* Allow visit includes only the visit code provided by your Primary Care Provider. Any lab, radiology (x-rays), minor surgeries, or other services provided during the visit will be subject to deductibles and co-insurance. Please note that preventative care visits, such as an annual well-visit, are not included as part of the free visits. Preventative care visits are covered, separately, at 100% by ambetter.

Specialty Referrals



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

Provider Relations



- **Ambetter from NH Healthy Families** Member/Provider Services department includes trained Provider Services staff 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 **Ambetter from NH Healthy Families** Member/Provider Services number at **1-844-265-1278**, providers will be able to access real time assistance for all their service needs.

Provider Relations

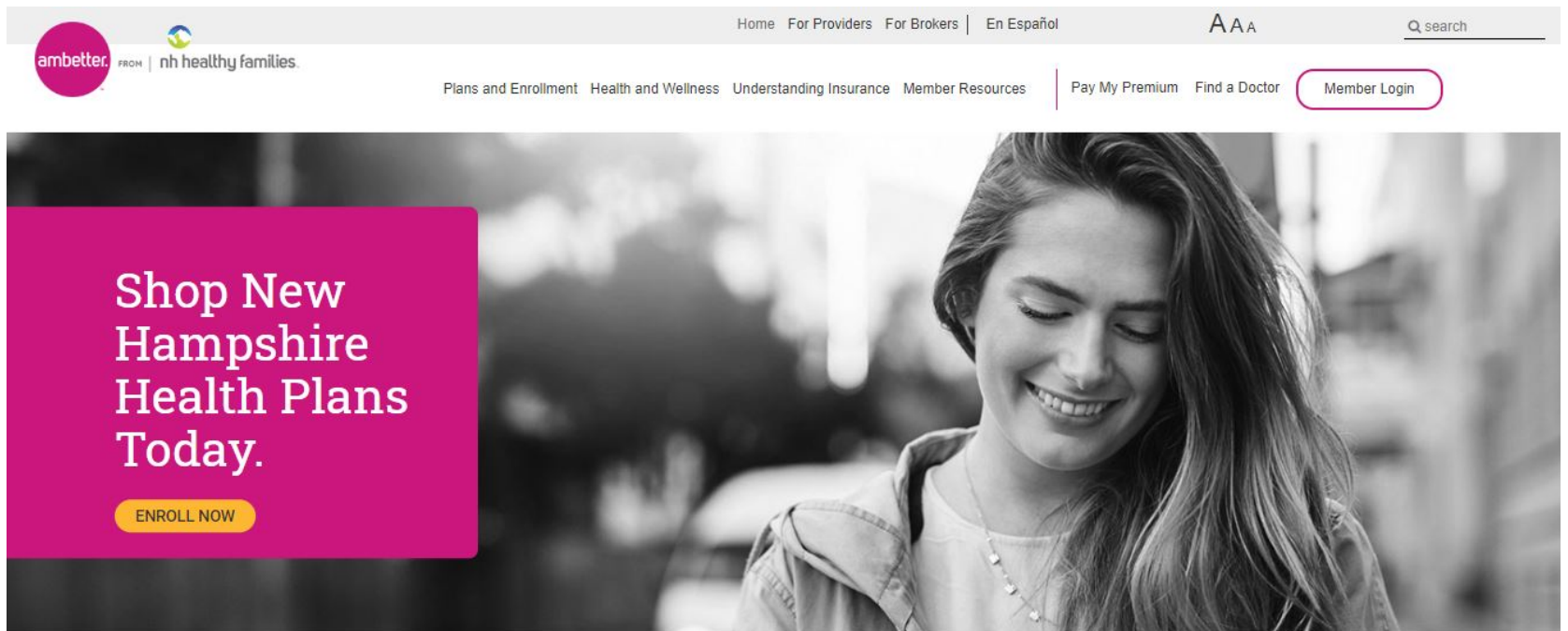


- Each provider will have an **Ambetter from NH Healthy Families** Provider Network Specialists assigned to them. This team serves as the primary liaison between the Plan and our provider network and is responsible for:
 - Provider Education
 - Facilitate HEDIS/Care Gap Reviews
 - Assisting Providers with EHR Utilization
 - Demographic Information Update
 - Facilitate to inquiries related to administrative policies, procedures and operational issues
 - Monitor performance patterns
 - Contract clarification
 - Membership/Provider roster questions
 - Assist in Provider Portal registration and Payspan

Public Website



ambetter.nhhealthyfamilies.com



Public Website



Information contained on our Website

- The Provider and Billing Manual
- Quick Reference Guides
- Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- 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
- Claims Submissions & Status
- Corrected Claims & Adjustments
- Payments History
- Monthly PCP Cost Reports

Secure Provider Portal



Registration is free and easy. Contact your Provider Network Specialist to get started.

The screenshot shows the Secure Provider Portal interface. At the top right, there are navigation links for 'Features', 'Join Our Network', and a 'CREATE ACCOUNT' button. The main heading is 'The Tools You Need Now!' with the subtext 'Our site has been designed to help you get your job done.' Below this, there are three main service areas: 'Check Eligibility' (with a thumbs up icon), 'Authorize Services' (with a checkmark icon), and 'Manage Claims' (with a dollar sign icon). On the right side, there is a 'Login' form with fields for 'User Name (Email)' and 'Password', a 'Login' button, and a link for 'Forgot Password / Unlock Account'. Below the login form, there is a section titled 'Need To Create An Account?' with a 'Create An Account' button and a 'How to Register' section with links for 'Provider Registration Video' and 'Provider Registration PDF'.

Secure Provider Portal



PCP Reports

- PCP reports available on **Ambetter from NH Healthy Families** 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 HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High Cost Claims

Secure Provider Portal



Procedures / Services*

- Potentially Cosmetic
- Experimental or Investigational
- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility *Covered services* for infertility treatment are limited to diagnostic testing to find the cause
- Pain Management
- OB Ultrasounds - *Coverage is provided for 2 standard ultrasounds per member, per pregnancy.*

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

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 48 hours require Inpatient Authorization

(Continued on next slide)

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

Prior Authorization



Inpatient Authorization, cont.*

- Urgent/Emergent Admissions
 - Within 1 business day following the date of admission
 - Newborn deliveries must include birth outcomes
- Partial Inpatient, 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

(Continued on next slide)

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

Prior Authorization



Ancillary Services, cont.

- Orthotics/Prosthetics
- Hearing Aid devices including cochlear implants
- Genetic Testing
- Quantitative Urine Drug Screen

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

Prior Authorization



Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one business day
Observation – 48 hours or less	Notification within one business day for <i>non-participating providers</i>
Observation – greater than 48 hours	Requires inpatient prior authorization within one business day
Maternity admissions	Notification within one business day
Newborn admissions	Notification within one business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day

* This is not meant as an all-inclusive list

Utilization Determination Timeframes



Type	Timeframe
Prospective/Urgent	72 hours from date of request
Prospective/Non-Urgent	14 days from date of request
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

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

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"/>
Is the member having observation services?	<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:

69436

Check

N
No

69436 - TYMPANOSTOMY GEN ANES
No authorization required.

Prior Authorization



Prior Authorization can be requested in 3 ways:

1. The Ambetter secure portal found at:
ambetter.nhhealthyfamilies.com
2. Fax Requests to: 1-877-502-7255
3. The fax authorization forms are located on our website at:
<https://ambetter.nhhealthyfamilies.com/provider-resources.html>
4. Call for Prior Authorization at: 1-844-265-1278

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 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.

Claims



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

Exceptions

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

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.nhhealthyfamilies.com

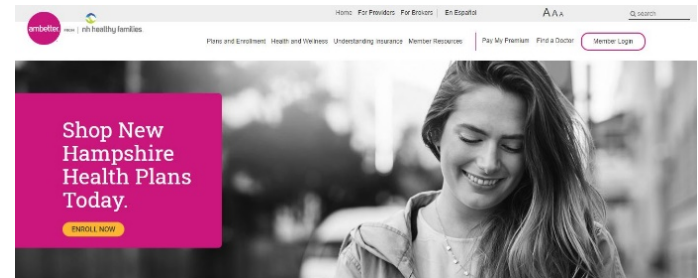
2. Electronic Clearinghouse

- Payor ID 68069

- For a listing of the Clearinghouses, please email EDIBA@Centene.com

3. Paper claims may be submitted to:

PO Box 5010 Farmington, MO 64640-5010



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 180 days of the Explanation of Payment.
- Claim Reconsiderations may be mailed to: Ambetter Attn: Request for Reconsideration, PO Box 5010 – Farmington, MO 63640-5010

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at: ambetter.nhhealthyfamilies.com
- The completed Claim Dispute form may be mailed to PO Box 5000 – Farmington, MO 63640-5000

Claim Submission



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.
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member is in a suspended status, claims will be pended.
- 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 the provider may bill the member directly for services.

Claim Submission



Member in Suspended Status – Example

- **January 1st**
Member Pays Premium
- **February 1st**
Premium Due – Member does not pay
- **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 rendered.

Claims for members in a suspended status are not considered “clean claims”.

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

Claim Submission



Other helpful information:

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
- This is necessary in order to accurately adjudicate the claim

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/Appeals process before filing a Complaint/Grievance

Provider Complaint/Grievance

- Must be filed within 30 calendar days from the date of the incident
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days

Provider Appeals

- A provider may appeal adverse credentialing determinations.
- Must be filed within 30 calendar days of the date of the notice.
- Will be reviewed by the Credentialing Committee no later than 60 days from receipt of the appeal.

Complaints/Grievances/ Appeals



Member Appeals

- Must be filed within 180 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 Ambetter requires that this designation by the Member be made in writing and provided to Ambetter to Medical Necessity.
- 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.nhhealthyfamilies.com

Specialty Companies/ Vendors



FROM



nh healthy families.

Service	Specialty Company/Vendor	Contact Information
Behavioral Health	Ambetter from NH Healthy Families	1-844-265-1278 ambetter.nhhealthyfamilies.com
High Tech Imaging Services	National Imaging Associates	1-888-899-7805 www.radmd.com
Vision Services	Involve Vision Benefits	844-258-4615 for Member Eligibility / Claims 1-800-531-2818 Network Management / Credentialing www.involvevision.com
Pharmacy Services	Involve Pharmacy Solutions	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)

Provider Tool Kit



Information included in the Tool Kit:

- Welcome Letter
- Ambetter Provider Introductory Brochure
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal

Contact Information



Ambetter from NH Healthy Families

Phone: 1-844-265-1278

TTY/TDD: 1-855-742-0123

ambetter.nhhealthyfamilies.com



FROM



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QUESTIONS?