Ambetter from MHS

6/9/2014

FROM mhs Your Choice for Better Healthcare

AGENDA

1. Ambetter by MHS
2. Verification of Eligibility, Benefits and Cost Shares
3. Specialty Referrals
4. Prior Authorization
5. Claim Submission
6. Claim Payment
7. Complaints/Grievances and Appeals
8. Specialty Companies/Vendors
9. Public Website
10. Contact Information

WHAT YOU NEED TO KNOW…

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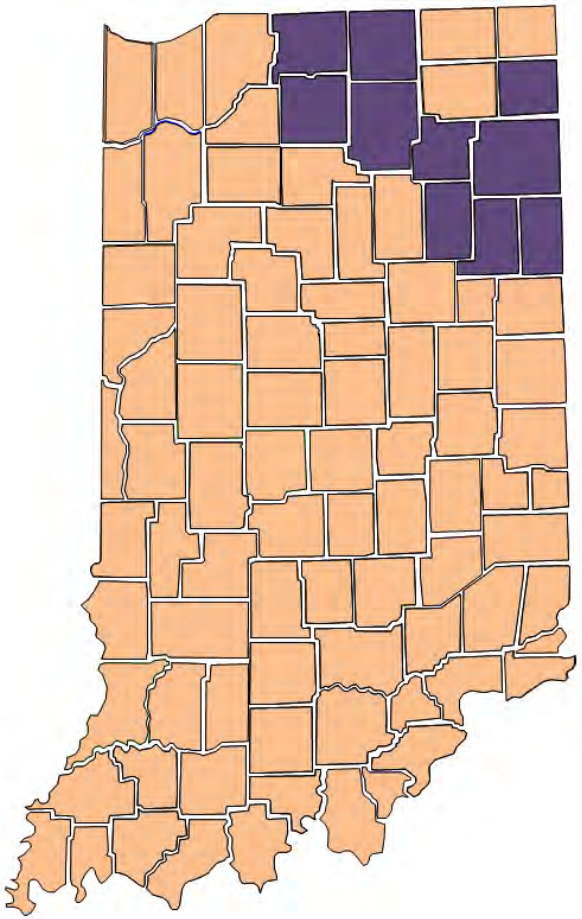
ambetter.™

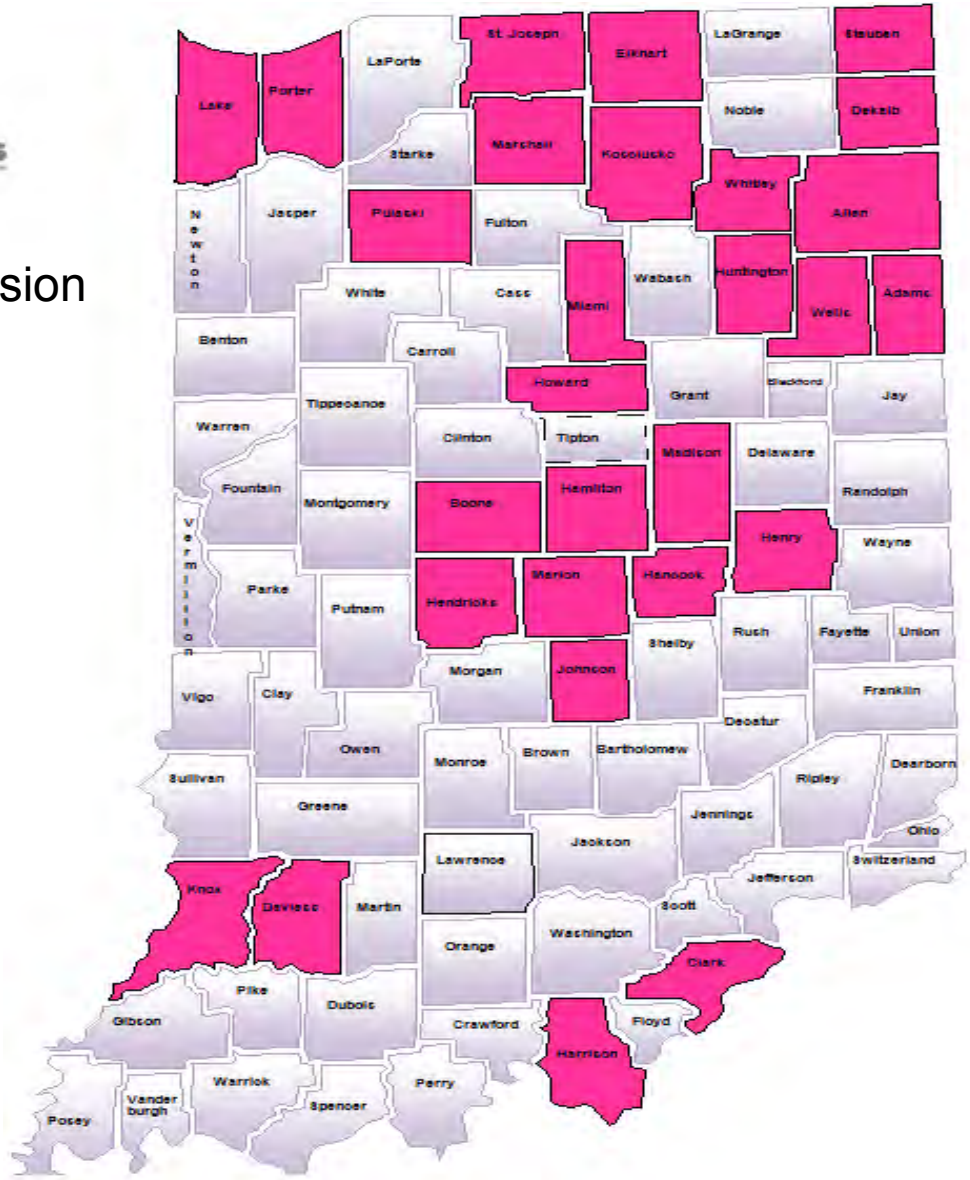
FROM mhs™

1. St. Joseph
2. Elkhart
3. Marshall
4. Kosciusko
5. Whitley
6. DeKalb
7. Allen
8. Huntington
9. Wells
10. Adams



ambetter. FROM mhs

2015 Network Expansion



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Verification of Eligibility, Benefits and Cost Share

Member ID Card:

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

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Verification of Eligibility, Benefits and Cost Share

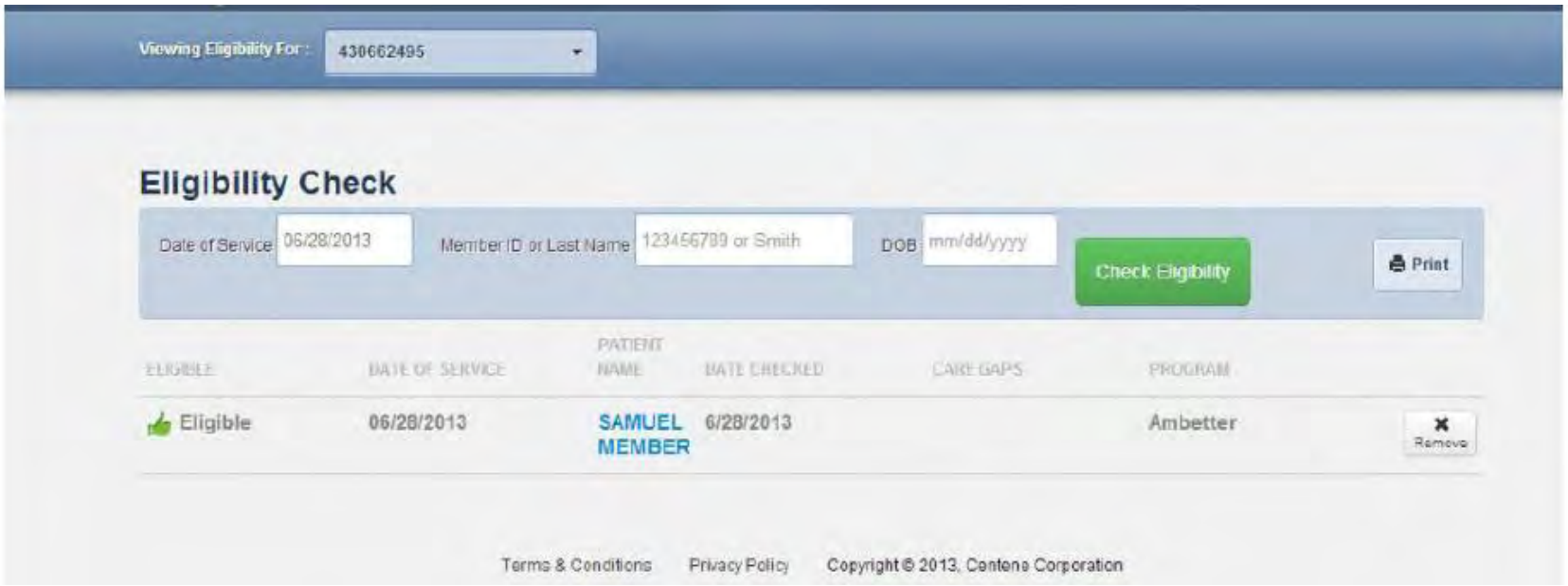
Eligibility, Benefits and Cost Shares can be verified in 3 ways:

1. **The Ambetter secure portal found at: Ambetter.mhsindiana.com**
   - If you are already a registered user of the MHS-Indiana 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: 1-877-687-1182**

Verification of Eligibility



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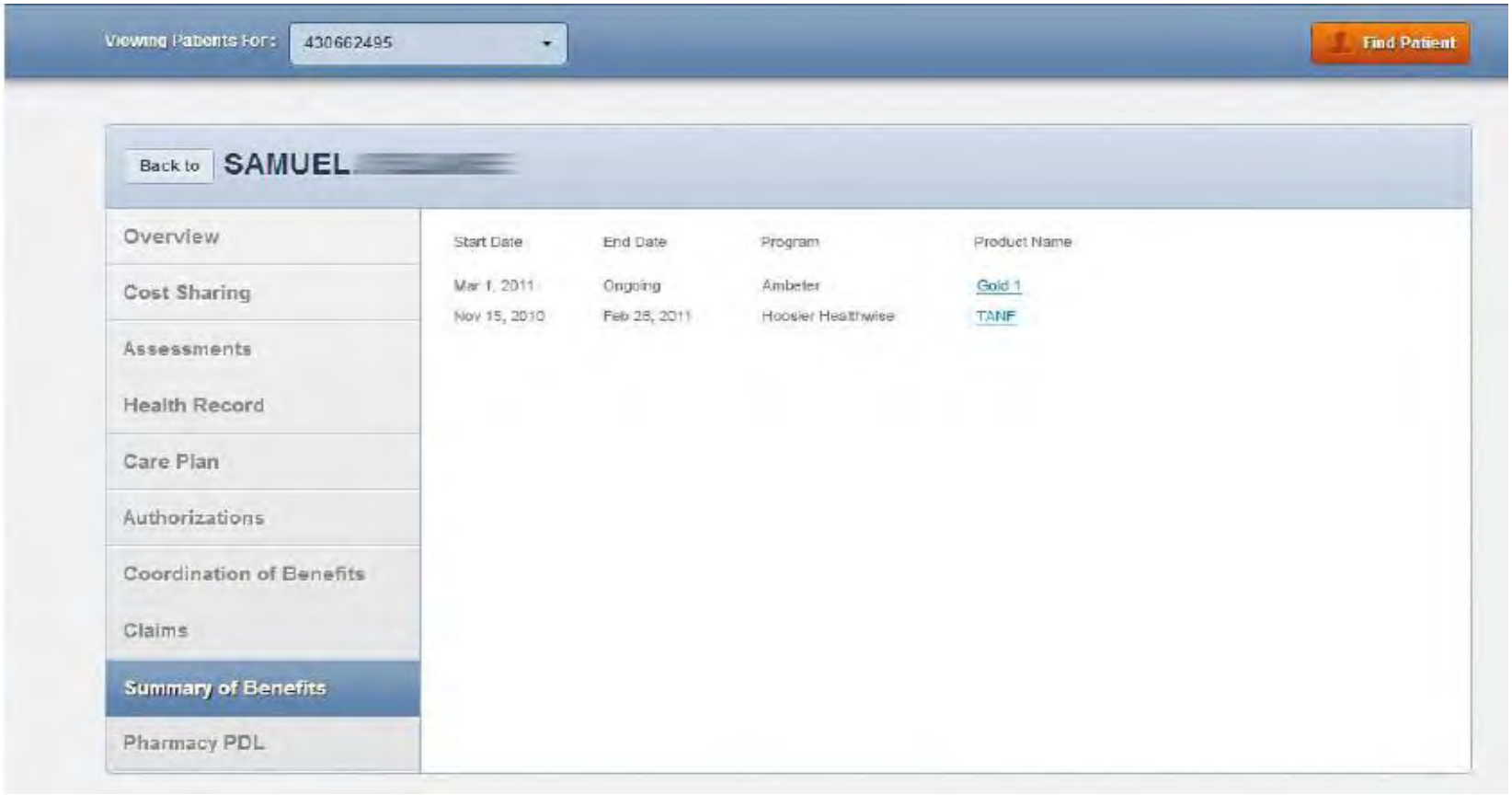
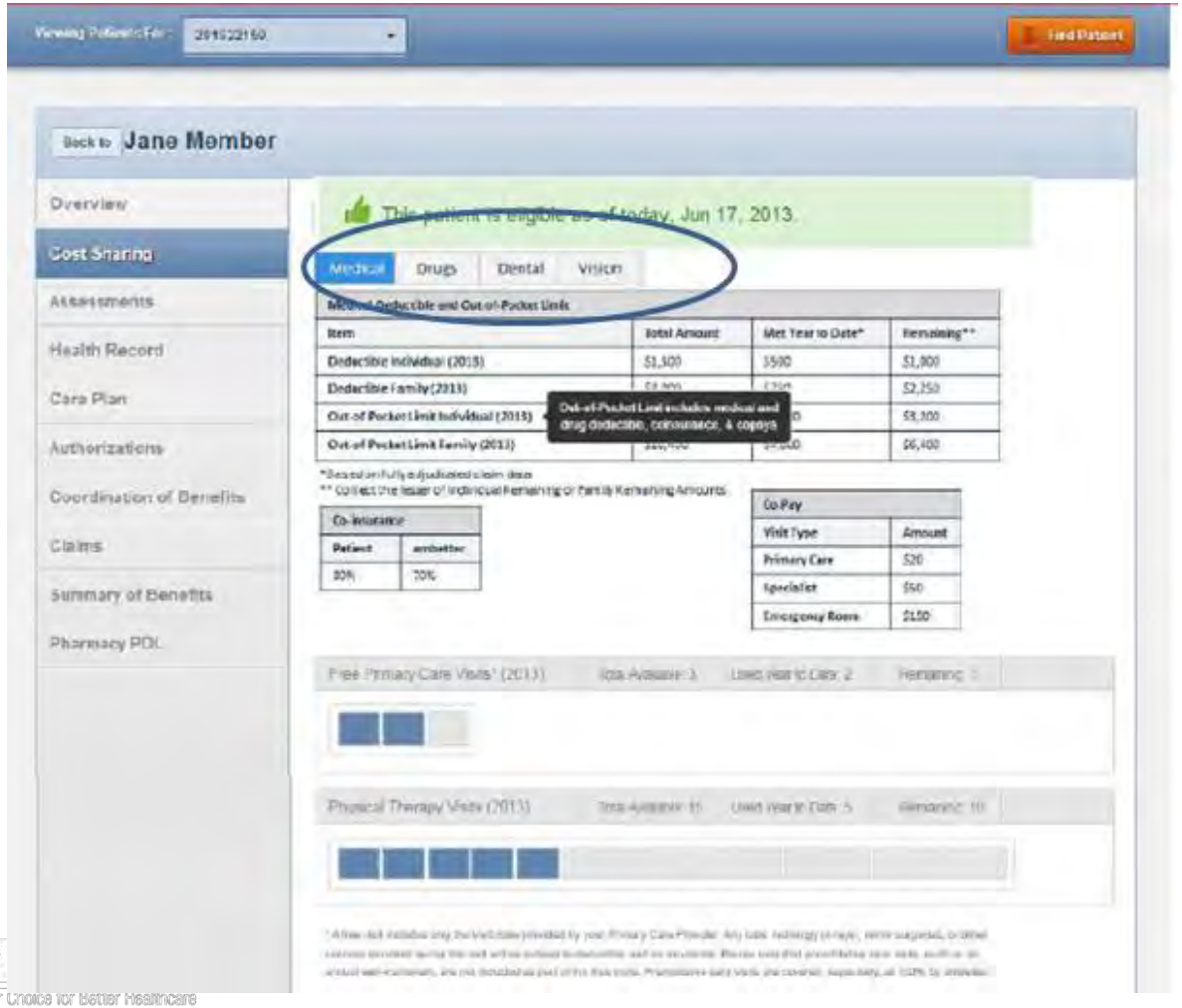
Verification of Benefits



Verification of Cost Shares



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*

All Out of Network (Non-Par) service require prior authorization excluding emergency room services.

Prior Authorization

Procedures / Services

- Potentially Cosmetic
- Bariatric Surgery
- 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
- Pain Management

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

All Out of Network (Non-Par) services require prior authorization excluding emergency room services.

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, PRTF and/or Intensive Outpatient Programs**

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

All Out of Network (Non-Par) services require prior authorization excluding emergency room services.

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*

All Out of Network (Non-Par) services require prior authorization excluding emergency room services.

Prior Authorization Request Timeframes

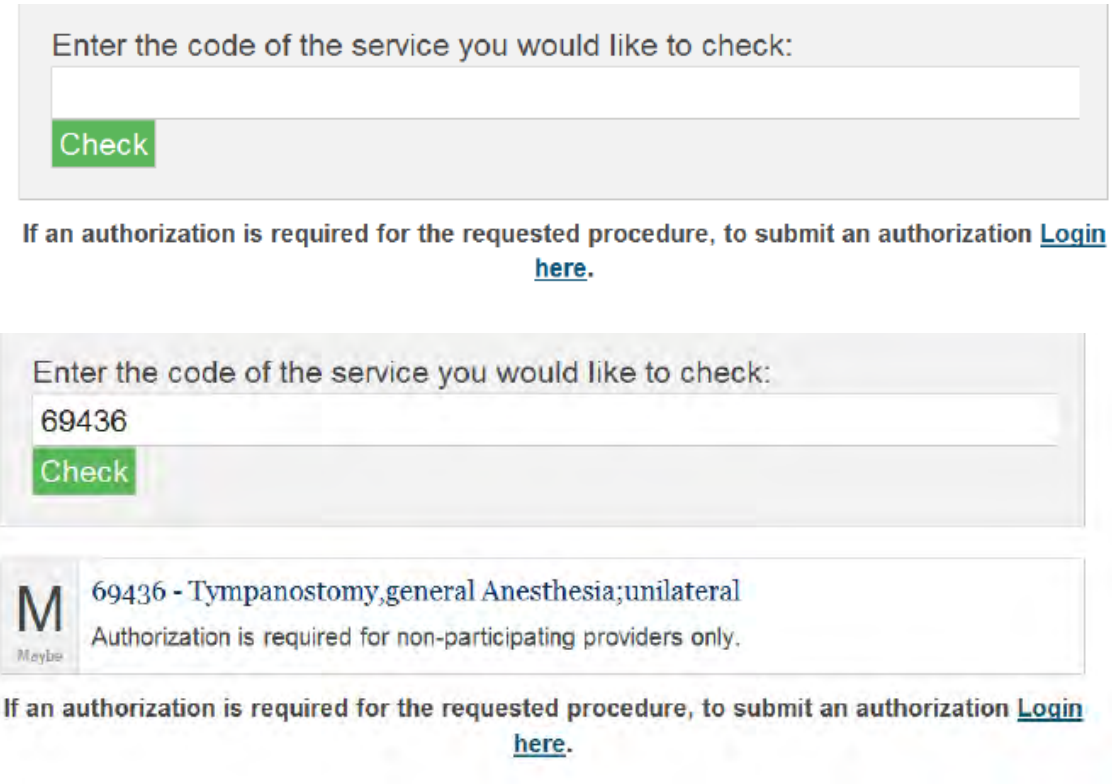
Service Type	Timeframe
Elective/Scheduled Admissions	**5 business days** prior to the scheduled admission date
Emergent inpatient admissions	Notification within **1 business day**
Emergency room and post stabilization, urgent care, and crisis intervention	Notification within **1 business day**
Maternity 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 from 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	Two (2) business days 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:



FROM imhs Your Choice for Better Healthcare

Prior Authorization

Prior Authorization can be requested in 3 ways:

1. **The Ambetter secure portal found at Ambetter.mhsindiana.com**
   - If you are already a registered user of the MHS-Indiana portal, you do NOT need a separate registration!

2. **Fax Requests to: 1-855-702-7337**
   The Fax authorization forms are located on our website at Ambetter.mhsindiana.com

3. **Call for Prior Authorization at 1-877-687-1182**

Prior Authorization

Prior Authorization will be granted at the CPT code level.

1. If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
   - If during the procedure additional procedures are performed, in order to avoid a claim denial, the provider must contact the health plan to update the authorization. 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.

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 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.mhsindiana.com**

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

- **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

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 process before filing a Complaint/Grievance

Corrected Claims, Requests for Reconsideration or Claim Disputes

- All claim requests for corrected claims, reconsiderations or claim disputes must be received within 90 days from the date of the original notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 90 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance.

Complaints/Grievances/Appeals

Reconsiderations

A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.

The documentation must also include a description of the reason for the request.

Indicate “Reconsideration of (original claim number)”

Include a copy of the original Explanation of Payment

Unclear or non-descriptive requests could result in no change in the processing, a delay in the research, or delay in the reprocessing of the claim.

The “Request for Reconsideration” should be sent to:

Ambetter from MHS Indiana
Attn: Reconsideration
PO Box 5010
Farmington, MO 63640-5010

Complaints/Grievances/Appeals

Claim Dispute

A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

Providers wishing to dispute a claim must complete the Claim Dispute Form located at Ambetter.mhsindiana.com

To expedite processing of the dispute, please include the original request for reconsideration letter and the response.

The Claim Dispute form and supporting documentation should be sent to:

Ambetter from MHS Indiana
Attn: Claim Dispute
PO Box 5000
Farmington, MO 63640-5000

Complaints/Grievances/Appeals

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

- Claims are not appealable. Please follow the Claim Reconsideration, Claim Dispute and Complaint/Grievance process.

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.

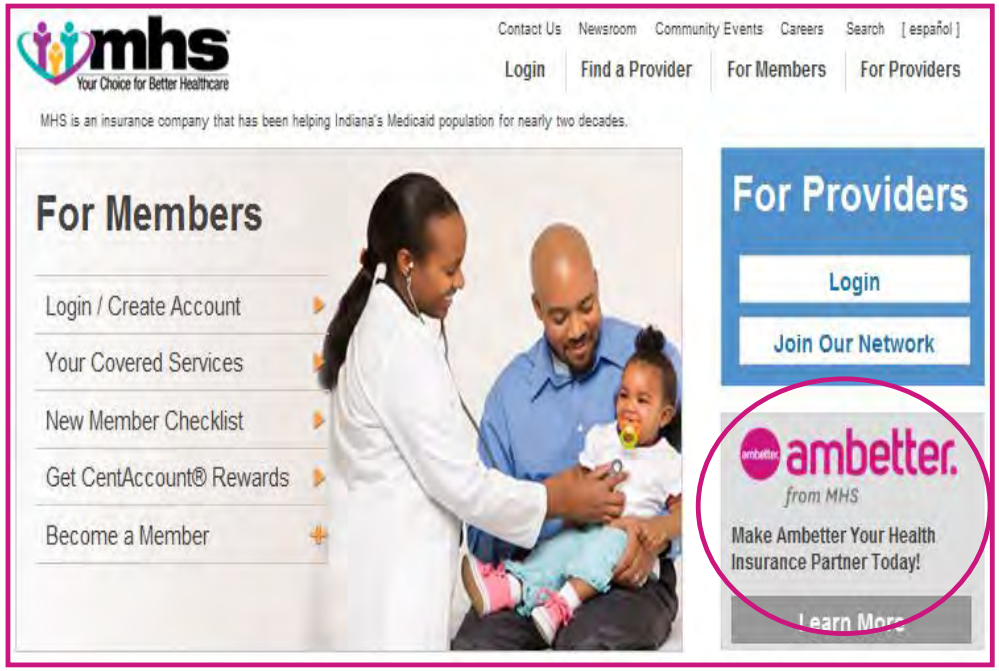
- Full Details of the Claim Reconsideration, Claim Dispute, Complaints/Grievances and Appeals processes can be found in our Provider Manual at: Ambetter.mhsindiana.com

Specialty Companies/Vendors

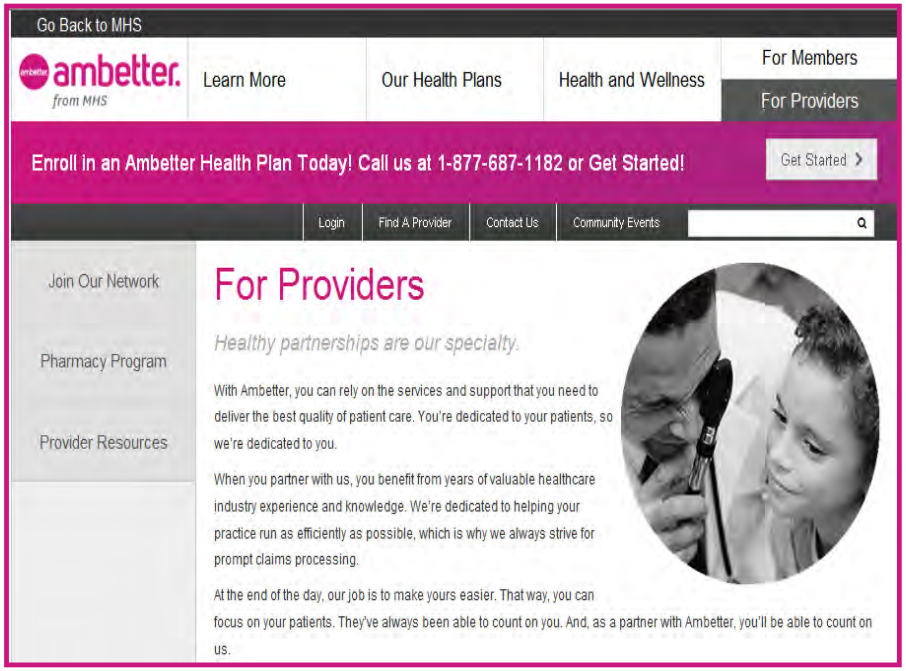
Service	Specialty Company/Vendor	Contact Information
Behavioral Health	Cenpatico Behavioral Health	1-877-687-1182 www.cenpatico.com
Vision Services	OptiCare	1-877-687-1182 www.opticare.com
Dental Services	DentaQuest	1-877-687-1182 www.dentaquest.com
Pharmacy Services	US Script	1-877-687-1182 www.usscript.com

Public Website

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



1. Go to Ambetter.mhsindiana.com and click on Ambetter



2. Go to Ambetter.mhsindiana.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…

Contact Information

Ambetter from MHS

Phone: 1-877-687-1182

TTY/TDD: 1-877-941-9232

Ambetter.mhsindiana.com

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Questions