1. Overview of the Affordable Care Act
2. The Health Insurance Marketplace
3. Need To Know
4. Verification of Eligibility, Benefits and Cost Shares
5. Specialty Referrals
6. Ambetter Website and Secure Portal
7. Utilization Management
8. Claims
9. Complaints/Grievances and Appeals
10. Ambetter Partnership
11. Questions
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 – Indiana is a Federally Facilitated Marketplace

The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies.
2017 Dates and Deadlines

• **November 1, 2016:** Open Enrollment started — first day to enroll, re-enroll, or change a 2017 insurance plan through the Health Insurance Marketplace. Coverage can start as soon as January 1, 2017.

• **December 15, 2016:** Last day to enroll in or change plans for coverage to start January 1, 2017.

• **January 1, 2017:** 2017 coverage starts for those who enroll or change plans by December 15.

• **January 31, 2017:** Last day to enroll in or change a 2017 health plan. After this date, plan changes or enrollment occur if qualified for special enrollment period.
WHAT YOU NEED TO KNOW…
Coverage available in:

Adams, Allen, Dekalb, Elkhart, Huntington, Kosciusko, Marshall, St. Joseph, Wells, Whitley, Boone, Clark, Daviess, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Johnson, Knox, Lake, Madison, Marion, Miami, Porter, Pulaski, Steuben, Vanderburgh
Verification of Eligibility, Benefits and Cost Share

Member ID Card:

* 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, ambetter.mhsindiana.com
  • Calling Provider Services, 1-877-687-1182

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.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 Cost Shares
Ambetter Website
Ambetter Website

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

1. Go to mhsindiana.com and click on Ambetter
2. Go to Ambetter.mhsindiana.com
Utilizing Our Website
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.
Secure Provider Portal

PCP Reports

- PCP reports available on Ambetter of Indiana 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
Verification of Eligibility
# Verification of Benefits

![Image of a patient verification interface](image)

## Overview

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Program</th>
<th>Product Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 1, 2011</td>
<td>Ongoing</td>
<td>Ambetter</td>
<td>CORE 1</td>
</tr>
<tr>
<td>Nov 15, 2010</td>
<td>Feb 25, 2011</td>
<td>Hoosier Healthwise</td>
<td>TANF</td>
</tr>
</tbody>
</table>
Ambetter from Indiana is an HMO Benefit Plan.

Members enrolled in Ambetter must utilize in-network participating providers except in the case of emergency services.

Participating providers can be identified by visiting our website and clicking on Find a Provider.

If an out of network provider is utilized, (except in the case of emergency services), the member will be 100% responsible for all charges.
Utilization Management
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 see care with in-network specialists.

• If an out of network provider is utilized, (except in the case of emergency services), the member will be 100% responsible for all charges.
Prior Authorization

Procedures / Services*

• Potentially Cosmetic
• Experimental or Investigational
• High Tech Imaging (i.e., CT, MRI, PET)
• Infertility
• Obstetrical Ultrasound
  – One 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 to be 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 23 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 to be 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 to be an all-inclusive list
Prior Authorization

Ancillary Services, cont.

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

* This is not meant to be an all-inclusive list
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

• 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.
## Prior Authorization

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled admissions</td>
<td>Prior Authorization required five business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Elective outpatient services</td>
<td>Prior Authorization required five business days prior to the elective outpatient admission date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Observation – 23 hours or less</td>
<td>Notification within one business day for non-participating providers</td>
</tr>
<tr>
<td>Observation – greater than 23 hours</td>
<td>Requires inpatient prior authorization within one business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization, urgent care and crisis intervention</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Newborn admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit (NICU) admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Outpatient Dialysis</td>
<td>Notification within one business day</td>
</tr>
</tbody>
</table>

*This is not meant to be an all-inclusive list*
# Utilization Determination Timeframes

<table>
<thead>
<tr>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective/Urgent</td>
<td>One (1) Business day</td>
</tr>
<tr>
<td>Prospective/Non-Urgent</td>
<td>Two (2) Business days</td>
</tr>
<tr>
<td>Emergency services</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Concurrent/Urgent</td>
<td>Twenty-four (24) hours (1 calendar day)</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Thirty (30) calendar days</td>
</tr>
</tbody>
</table>

*This is not meant to be an all-inclusive list*
Claims
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.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 180 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 180 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

• 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

January 1st: Member pays their premium
February 1st: Premium is due
Member does not pay their premium
Provider may continue to submit claims and will be reimbursed for services
March 1st:
Premium is due
Member does not pay their premium
Member is placed in a SUSPENDED status
Claims may be submitted but will be pended
The EOP will state: “LZ Pend-Non-Payment of Premium
April 1st:
Premium is due
Member does not pay their premium
Member remains in a SUSPENDED status
Claims may be submitted but will be pended
The EOP will state: “LZ Pend-Non-Payment of Premium
May 1st:
Premium is due
Member does not pay their premium
Member is terminated
Provider may bill Member directly for services provided in March and April (months 2 and 3)

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.
Taxonomy Code

Example of Taxonomy Code – CMS 1500

- ZZ Qualifier
- Rendering Taxonomy
- Rendering NPI
- Group NPI
- Group Taxonomy with ZZ Qualifier
CLIA Number

CLIA Number is required on CMS 1500 Submissions in Box 23

CLIA Number is not required on UB04 Submissions
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 auto-enrolled in PaySpan for the Ambetter product

- If you do not currently utilize PaySpan: To register call 1-877-331-7154 or visit www.payspanhealth.com
Complaints/Grievances/Appeals
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 180 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 180 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
Ambetter from MHS Partnership
# Specialty Companies/Vendors

<table>
<thead>
<tr>
<th>Service</th>
<th>Specialty Company/Vendor</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>Cenpatico Behavioral Health</td>
<td>1-877-617-0390 cenpatico.com</td>
</tr>
<tr>
<td>High Tech Imaging Services</td>
<td>National Imaging Associates</td>
<td>1-877-617-0390 radmd.com</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Envolve Vision</td>
<td>1-877-617-0390 visionbenefits.envolvehealth.com</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Envolve Dental</td>
<td>1-855-609-5157 dentalhw.com</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Envolve Pharmacy Solutions</td>
<td>1-877-617-0390 pharmacy.envolvehealth.com</td>
</tr>
</tbody>
</table>
Provider Services

- **Ambetter from MHS Indiana** Member/Provider Services department includes trained Provider Relations 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 MHS Indiana’s** Member/Provider Services number at 1-877-687-1182 providers will be able to access real time assistance for all their service needs.
Provider Relations

- Each provider will have an Ambetter from MHS Indiana 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
  - HEDIS/Care Gap Reviews
  - Financial Analysis
  - Assisting Providers with EHR Utilization
  - Demographic Information Update
  - Initiate credentialing of a new practitioner
  - Facilitate 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
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
Key Things to Remember

- Members enrolled in Ambetter must utilize in-network participating providers except in the case of emergency services.
- Provider may bill Member directly for services provided while member is in suspended status.
Contact Information

Ambetter from MHS

Phone: 1-877-687-1182

TTY/TDD: 1-877-941-9232

Ambetter.mhsindiana.com
Questions