Ambetter from Health Net

Provider Relations Specialist

11/16/2016

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 Took 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
- Tax penalties for not purchasing insurance
- 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 – ***Arizona 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)

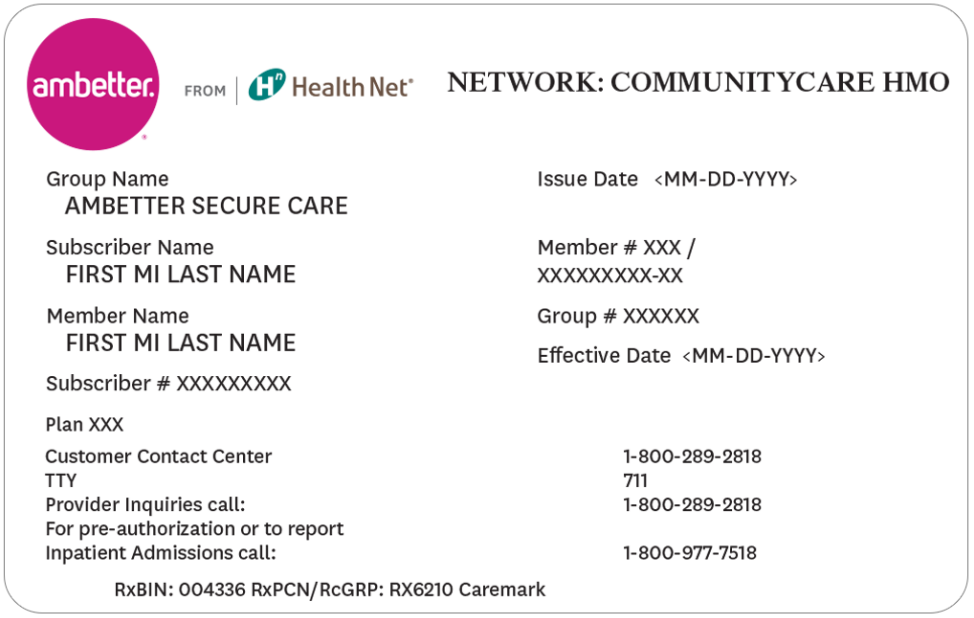
All Benefit Plans have cost shares in the form of copays, coinsurance and deductibles

- 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:



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

Health Insurance Marketplace

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, 1-888-926-1870

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

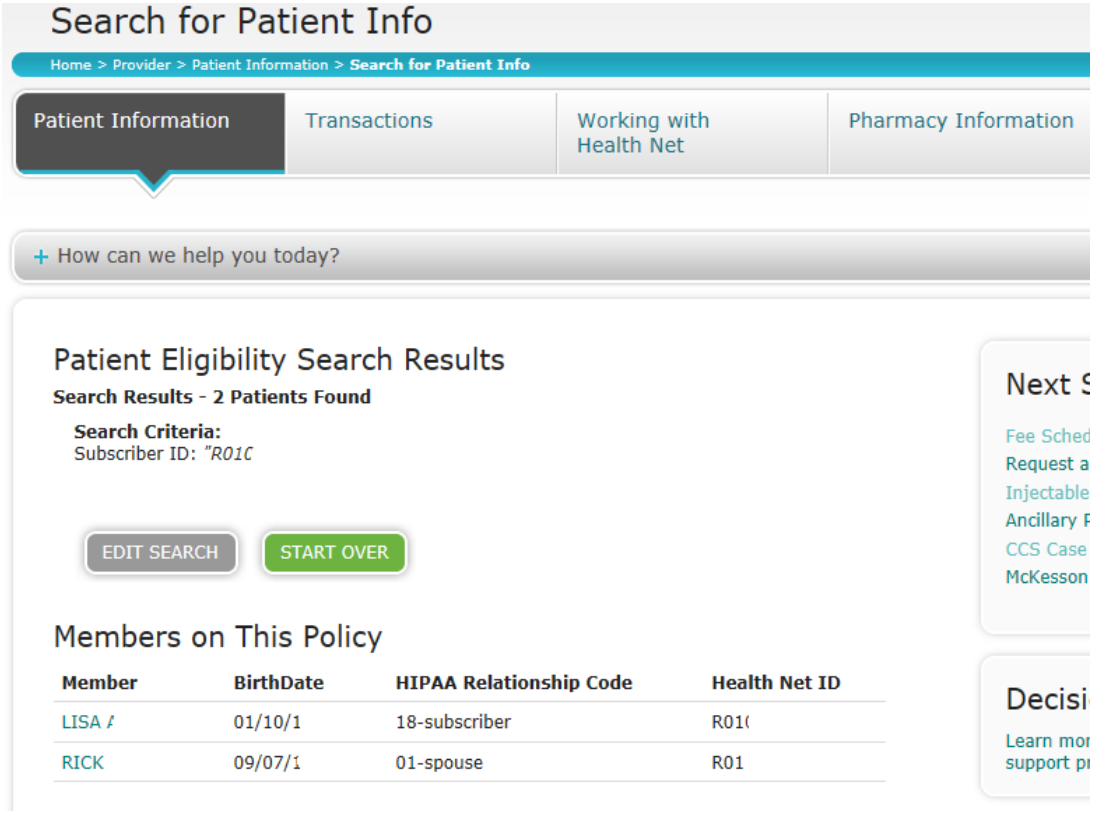
Eligibility, Benefits and Cost Shares can be verified in 3 ways:

1. **The Ambetter from Health Net secure portal found at: AmbetterHealthNet.com**
   - If you are already a registered user of the Health Net secure portal, you do NOT need a separate registration!

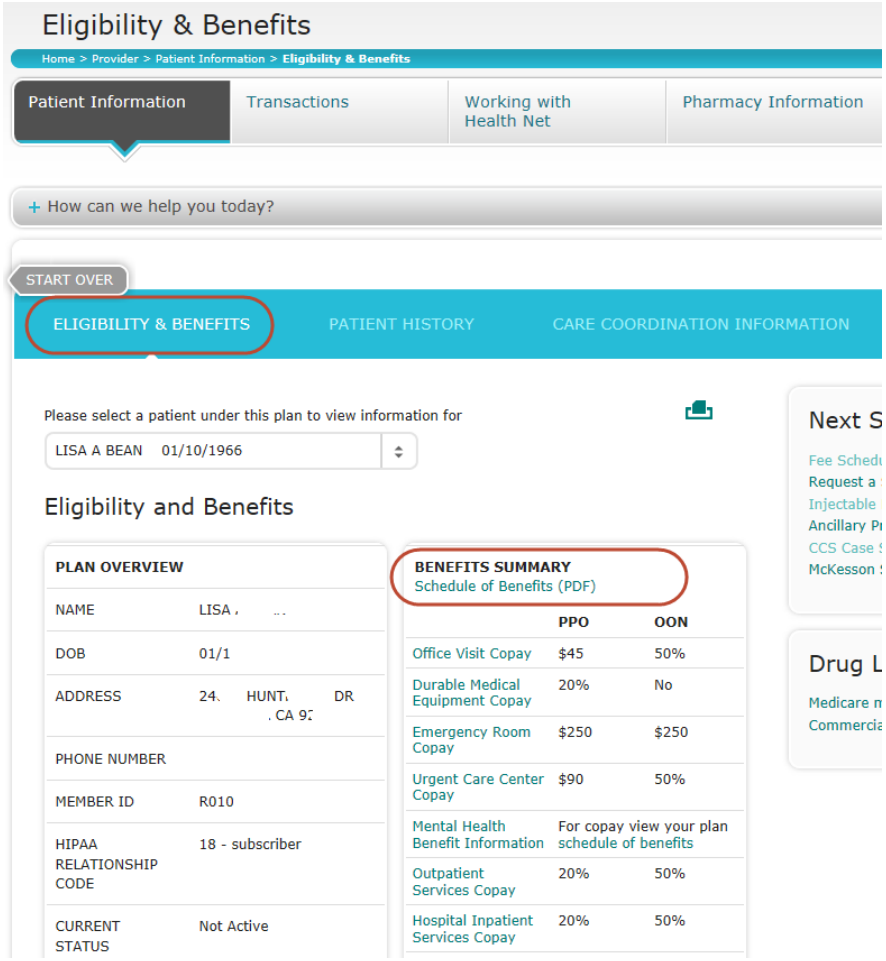
2. **24/7 Interactive Voice Response system**
   - Enter the Member ID Number and the month of service to check eligibility

3. **Contact Provider Service at: 1-888-926-1870**

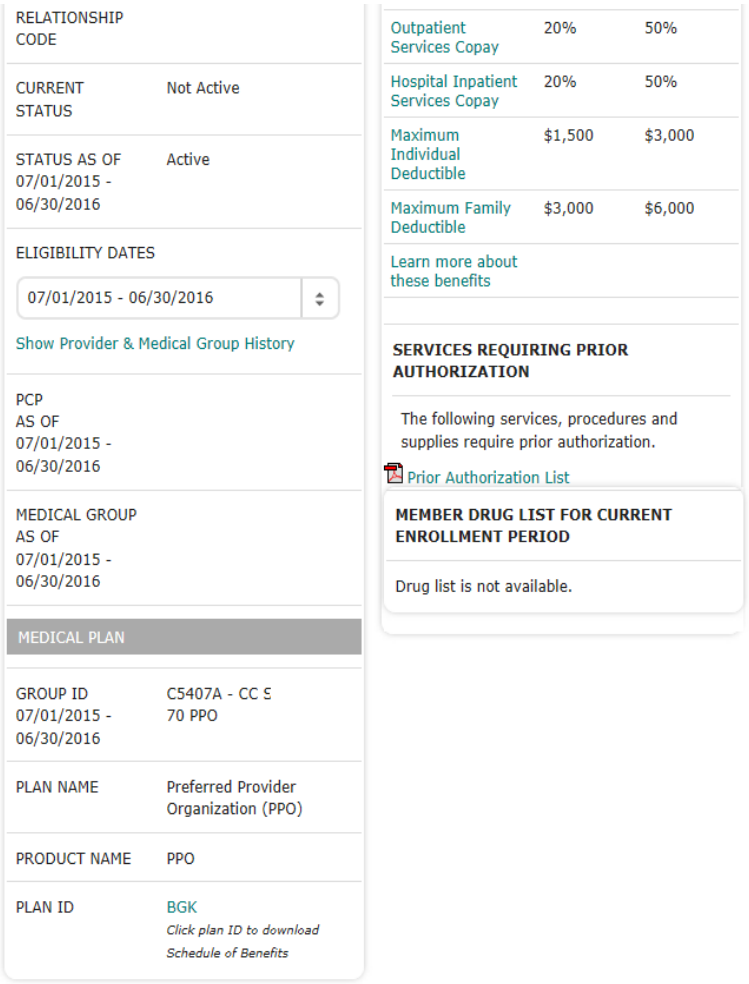
Verification of Eligibility



Verification of Benefits



Verification of Cost Shares



RELATIONSHIP CODE	
CURRENT STATUS	Not Active
STATUS AS OF 07/01/2015 - 06/30/2016	Active

ELIGIBILITY DATES

07/01/2015 - 06/30/2016

Show Provider & Medical Group History

PCP AS OF 07/01/2015 - 06/30/2016	
MEDICAL GROUP AS OF 07/01/2015 - 06/30/2016	

MEDICAL PLAN

GROUP ID 07/01/2015 - 06/30/2016	C5407A - CC S 70 PPO
PLAN NAME	Preferred Provider Organization (PPO)
PRODUCT NAME	PPO
PLAN ID	BGK *Click plan ID to download Schedule of Benefits*

Outpatient Services Copay	20%	50%
Hospital Inpatient Services Copay	20%	50%
Maximum Individual Deductible	$1,500	$3,000
Maximum Family Deductible	$3,000	$6,000

Learn more about these benefits

SERVICES REQUIRING PRIOR AUTHORIZATION

The following services, procedures and supplies require prior authorization.

Prior Authorization List

MEMBER DRUG LIST FOR CURRENT ENROLLMENT PERIOD

Drug list is not available.

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 Health Net** 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

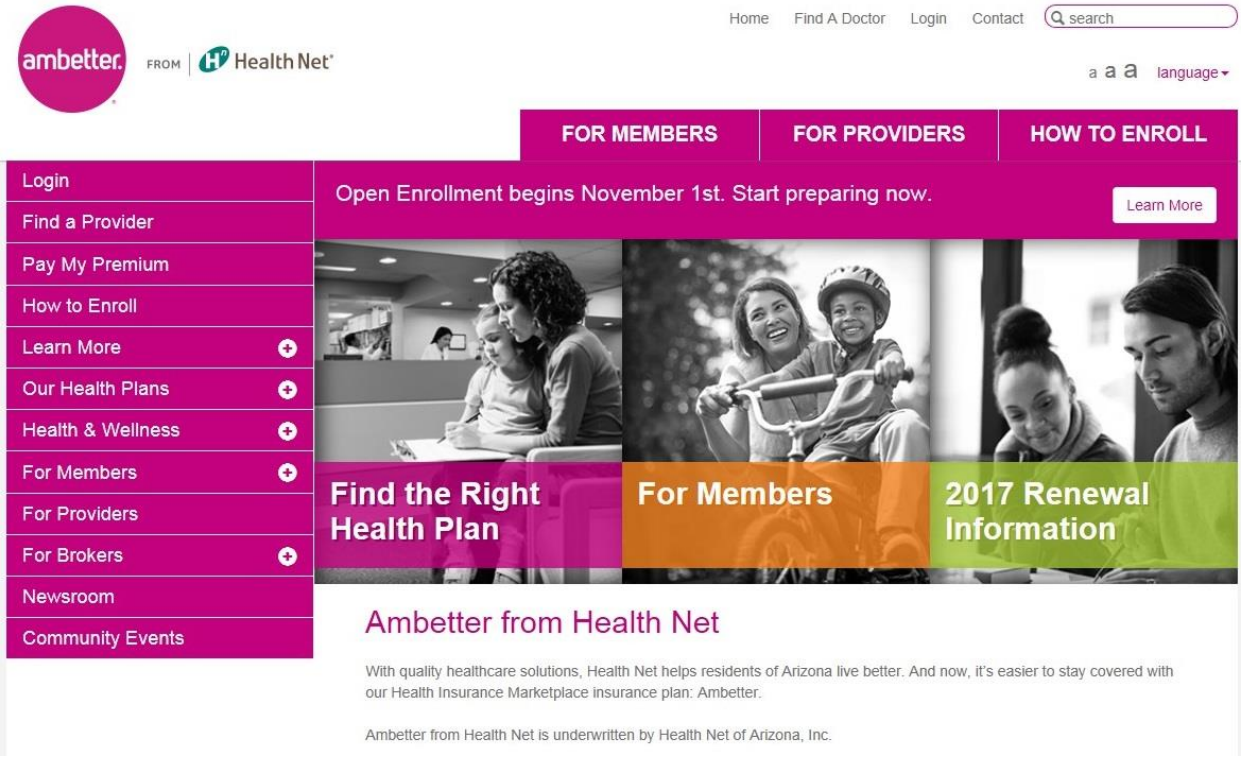
- By calling **Ambetter from Health Net** Member/Provider Services at 1-888-926-1870**,** providers will be able to access real time assistance for all their service needs.

Provider Relations

- Each provider will have a **Ambetter from Health Net** 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
  - Demographic Information Update
  - Initiate credentialing of a new practitioner
  - Contract clarification
  - Facilitate to inquiries related to administrative policies, procedures, and operational issues
  - Monitor performance patterns
  - Membership/Provider roster questions
  - Assist in Provider Portal and EDI registration

Public Website

AmbetterHealthNet.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 Pharmacy Preferred Drug Listing
- And much more…

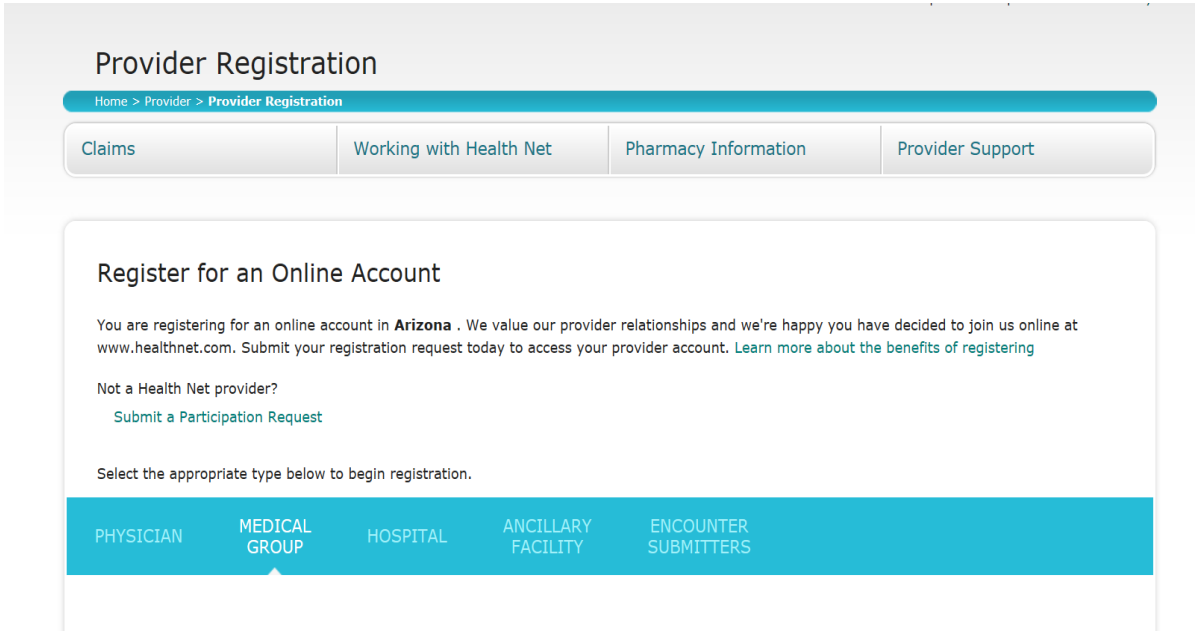
Secure Provider Portal

Information contained on our Secure Provider Portal

- Member Eligibility
- Authorizations
- Claims Submissions & Status

Secure Provider Portal

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



Prior Authorization

Procedures / Services*

- Transplant related services including evaluation
- Experimental or Investigational
- Outpatient diagnostic procedures are authorized by eviCore healthcare.
- Maternity – notification required only at time of first prenatal visit
- Behavioral health or substance abuse services are approved by MHN

** 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
  - Hospice care
  - Rehabilitation facilities
  - Skilled Nursing Facility
- *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
  - Notification required only, as soon as possible, but no later than 24 hours or by next business day
  - Contact the Ambetter from Health Net Hospital Notification Unit

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

Prior Authorization

Ancillary Services*

- Non emergent Air or ground Ambulance Transport (non-emergent fixed-wing airplane)
- DME
  - Contact health net for bone growth stimulators
  - Contact Preferred Home Care for CPAP, hospital beds
- Outpatient Occupational, Speech, Physical Therapy
  - Includes home setting
  - Initial evaluation does not require prior authorization

- *Orthotics/Prosthetics – Items exceeding $2,500 in billed charges*
- *Genetic Testing*

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

Prior Authorization

Service Type	Timeframe
Scheduled admissions	Prior Authorization required
Emergent inpatient admissions	Notification asap, but not later than 24 hours or by next business day
Maternity admissions	Notification
Newborn admissions	Notification asap, but not later than 24 hours or by next business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day

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

Utilization Determination Timeframes

Type	Timeframe
Prospective/Urgent	72 hours
Prospective/Non-Urgent	10 business days
Emergency services	Do not require prior authorization
Concurrent/Urgent	72 hours
Retrospective	Thirty (30) calendar days

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

Prior Authorization

Prior Authorization can be requested in 2 ways:

2. **Fax Requests to: 1-800-840-1097**
   The fax authorization forms are located on our website at **AmbetterHealthNet.com**

3. **Call for Prior Authorization at 1-800-977-7518**

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 may 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. **Electronic Clearinghouse**
   - Payor ID 38309
   - Clearinghouses Capario, Emdeon/WebMD, MD-OnLine

2. **Paper claims may be submitted to:**
   PO Box 14225, Lexington, KY 40512

Note: **Claims can be verified on AmbetterHealthNet.com**

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 14225, Lexington, KY 40512

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at AmbetterHealthNet.com
- The completed Claim Dispute form may be mailed to:

Health Net of Arizona, Inc.
Attention: Provider Appeals
P.O. Box 279378
Sacramento, CA 95827-9378
Fax: (800) 977-6762

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.

- 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

EDI Enrollment

- Ambetter partners with Caparío, Emdeon (WebMd), and MD On-Line
- Ambetter from Health Net Payer ID 38309
- Providers can contact HN EDI team at (866) EDI-HNET or (866) 334-4638

Complaints/Grievances/Appeals

Claims

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

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

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted 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: AmbetterHealthNet.com

Specialty Companies/Vendors

Service	Specialty Company/Vendor	Contact Information
Behavioral Health	Mental Health Network (MHN)	1-800-977-0281 www.mhn.com
High Tech Imaging Services	Evicore Healthcare	1-888-693-3211 www.evicore.com
Vision Services	EyeMed Vision Care	1-888-581-3648 www.eyemedvisioncare.com
Dental Services	N/A	N/A
Pharmacy Services	Envolve Pharmacy Solutions	1-800-410-6565

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 Health Net

Phone: 1-888-926-1870

TTY: 1-888-926-1870 (TTY:711)

AmbetterHealthNet.com

Questions