



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:

	FROM  Health Net*	NETWORK: COMMUNITYCARE HMO
Group Name AMBETTER SECURE CARE	Issue Date <MM-DD-YYYY>	
Subscriber Name FIRST MI LAST NAME	Member # XXX / XXXXXXXXXX-XX	
Member Name FIRST MI LAST NAME	Group # XXXXXX	
Subscriber # XXXXXXXXX	Effective Date <MM-DD-YYYY>	
Plan XXX		
Customer Contact Center	1-800-289-2818	
TTY	711	
Provider Inquiries call:	1-800-289-2818	
For pre-authorization or to report Inpatient Admissions call:	1-800-977-7518	
RxBIN: 004336 RxPCN/RcGRP: RX6210 Caremark		

*** 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

Search for Patient Info

Home > Provider > Patient Information > Search for Patient Info

Patient Information Transactions Working with Health Net Pharmacy Information

+ How can we help you today?

Patient Eligibility Search Results

Search Results - 2 Patients Found

Search Criteria:
Subscriber ID: *R01C

EDIT SEARCH START OVER

Members on This Policy

Member	BirthDate	HIPAA Relationship Code	Health Net ID
LISA /	01/10/1	18-subscriber	R01C
RICK	09/07/1	01-spouse	R01C

Next Steps

- Fee Sched
- Request a
- Injectable
- Ancillary F
- CCS Case
- McKesson

Decisions

Learn more support page



Verification of Benefits

Eligibility & Benefits

Home > Provider > Patient Information > Eligibility & Benefits

Patient Information Transactions Working with Health Net Pharmacy Information

+ How can we help you today?

START OVER

ELIGIBILITY & BENEFITS PATIENT HISTORY CARE COORDINATION INFORMATION

Please select a patient under this plan to view information for

LISA A BEAN 01/10/1966

Eligibility and Benefits

PLAN OVERVIEW	
NAME	LISA A BEAN
DOB	01/10/1966
ADDRESS	24 HUNTINGTON DR SANTA ANA, CA 92705
PHONE NUMBER	
MEMBER ID	R010
HIPAA RELATIONSHIP CODE	18 - subscriber
CURRENT STATUS	Not Active

BENEFITS SUMMARY		
Schedule of Benefits (PDF)		
	PPO	OON
Office Visit Copay	\$45	50%
Durable Medical Equipment Copay	20%	No
Emergency Room Copay	\$250	\$250
Urgent Care Center Copay	\$90	50%
Mental Health Benefit Information	For copay view your plan schedule of benefits	
Outpatient Services Copay	20%	50%
Hospital Inpatient Services Copay	20%	50%

Next Steps

- Fee Schedule
- Request a Prescription
- Injectable Medications
- Ancillary Programs
- CCS Case Management
- McKesson Services

Drug List

- Medicare Prescription Drug
- Commercial Insurance



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 <i>Click plan ID to download Schedule of Benefits</i>

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

The screenshot shows the website's navigation and main content area. At the top right, there are links for Home, Find A Doctor, Login, and Contact, along with a search bar and a language selector. The main navigation bar includes 'FOR MEMBERS', 'FOR PROVIDERS', and 'HOW TO ENROLL'. A left sidebar lists various user actions like Login, Find a Provider, and Pay My Premium. The main content area features a banner for Open Enrollment, a grid of three featured articles, and a section for 'Ambetter from Health Net' with a descriptive paragraph and a note about underwriting.

ambetter. FROM Health Net

Home Find A Doctor Login Contact

a a language ▾

FOR MEMBERS **FOR PROVIDERS** **HOW TO ENROLL**

Login
Find a Provider
Pay My Premium
How to Enroll
Learn More +
Our Health Plans +
Health & Wellness +
For Members +
For Providers
For Brokers +
Newsroom
Community Events

Open Enrollment begins November 1st. Start preparing now. [Learn More](#)

Find the Right Health Plan **For Members** **2017 Renewal Information**

Ambetter from Health Net

With quality healthcare solutions, Health Net helps residents of Arizona live better. And now, it's easier to stay covered with our Health Insurance Marketplace insurance plan: Ambetter.

Ambetter from Health Net is underwritten by Health Net of Arizona, Inc.



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

Provider Registration

Home > Provider > **Provider Registration**

Claims Working with Health Net Pharmacy Information Provider Support

Register for an Online Account

You are registering for an online account in **Arizona**. We value our provider relationships and we're happy you have decided to join us online at www.healthnet.com. Submit your registration request today to access your provider account. [Learn more about the benefits of registering](#)

Not a Health Net provider?
[Submit a Participation Request](#)

Select the appropriate type below to begin registration.

PHYSICIAN MEDICAL GROUP HOSPITAL ANCILLARY FACILITY ENCOUNTER SUBMITTERS



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](https://www.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](https://www.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 Capario, 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	Involve 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](https://www.AmbetterHealthNet.com)



Questions