



AMBETTER FROM BUCKEYE HEALTH PLAN

2/26/2021

AGENDA

- **OVERVIEW**

- Who We Are
- Affordable Care Act

- **WHAT YOU NEED TO KNOW**

- Key Contact Information
- Provider Manual
- Provider Services
- Provider Relations
- Public Website and Secure Portal
- Verification of Eligibility, Benefits and Cost Shares
- Specialty Referrals
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Specialty Companies and Vendors

- **Q & A**

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OVERVIEW

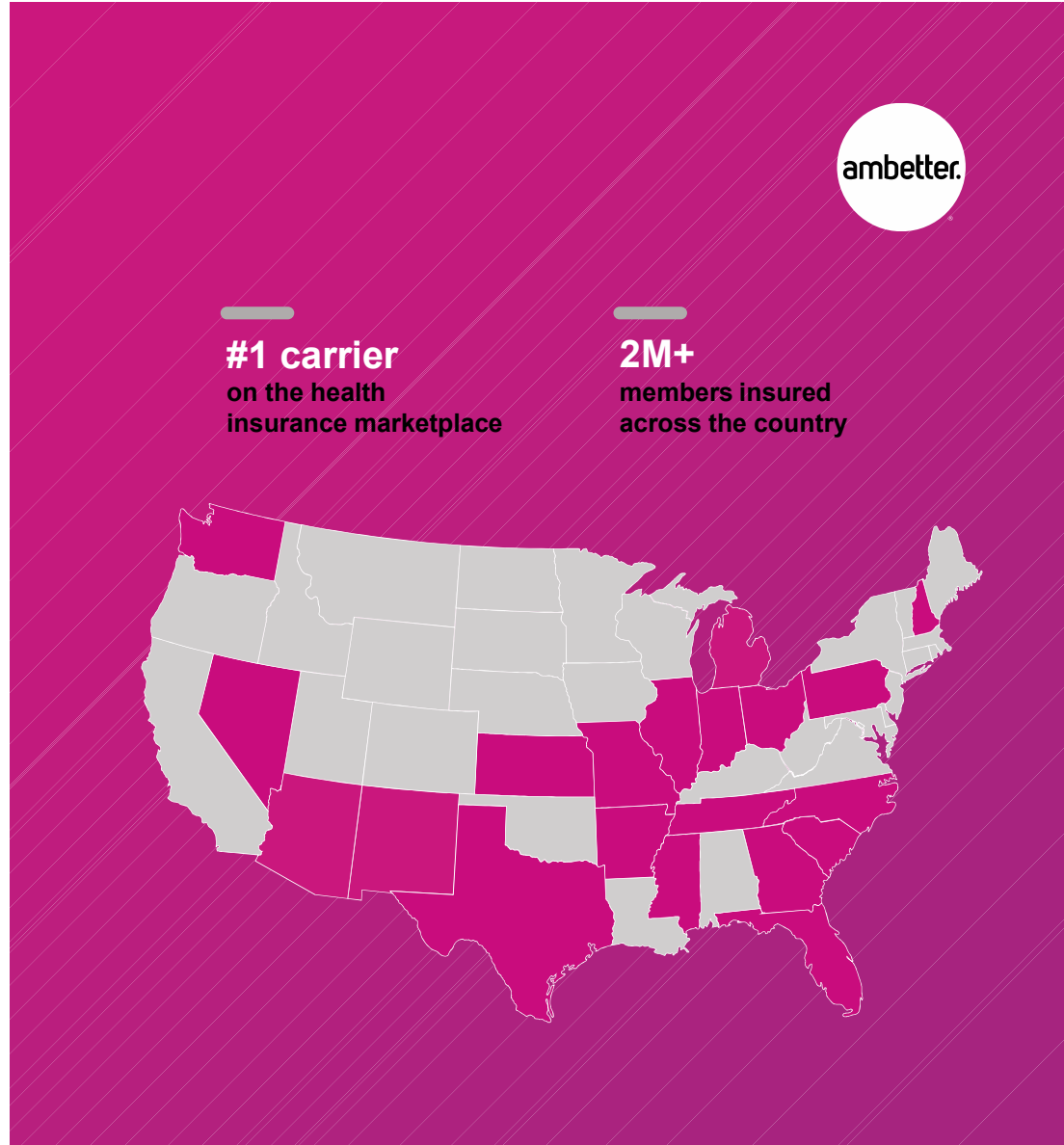


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WHO WE ARE

- Ambetter from Buckeye Health Plan provides market-leading, affordable health insurance on the Health Insurance Marketplace
- We are certified as a Qualified Health Plan issuer
- Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs

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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)

WHAT YOU NEED TO KNOW



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KEY CONTACT INFORMATION

Ambetter from Buckeye Health Plan

PHONE

1-877-687-1189

TTY/TDD

1-877-941-9236

WEB & SECURE PORTAL

www.ambetter.buckeyehealthplan.com

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THE PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER from Buckeye Health Plan.

The Manual includes a wide array of important information relevant to providers including, but not limited to:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives
- And much more!

The Provider Manual can be found in the Provider section of the Ambetter from Buckeye Health Plan website at www.ambetter.buckeyehealthplan.com

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PROVIDER SERVICES

By calling **Ambetter** from **Buckeye Health Plan's** Provider Services number at **1-877-687-1189**, providers will be able to access real time assistance for all their service needs including:

- Credentialing/Network Status
- Claims/Appeals Inquiries
- Prior-Authorization Inquiries
- Request for adding/deleting physicians to an existing group
- Contract clarification
- Facilitates operational concerns
- Assists in Provider Portal and PaySpan registration



PROVIDER RELATIONS

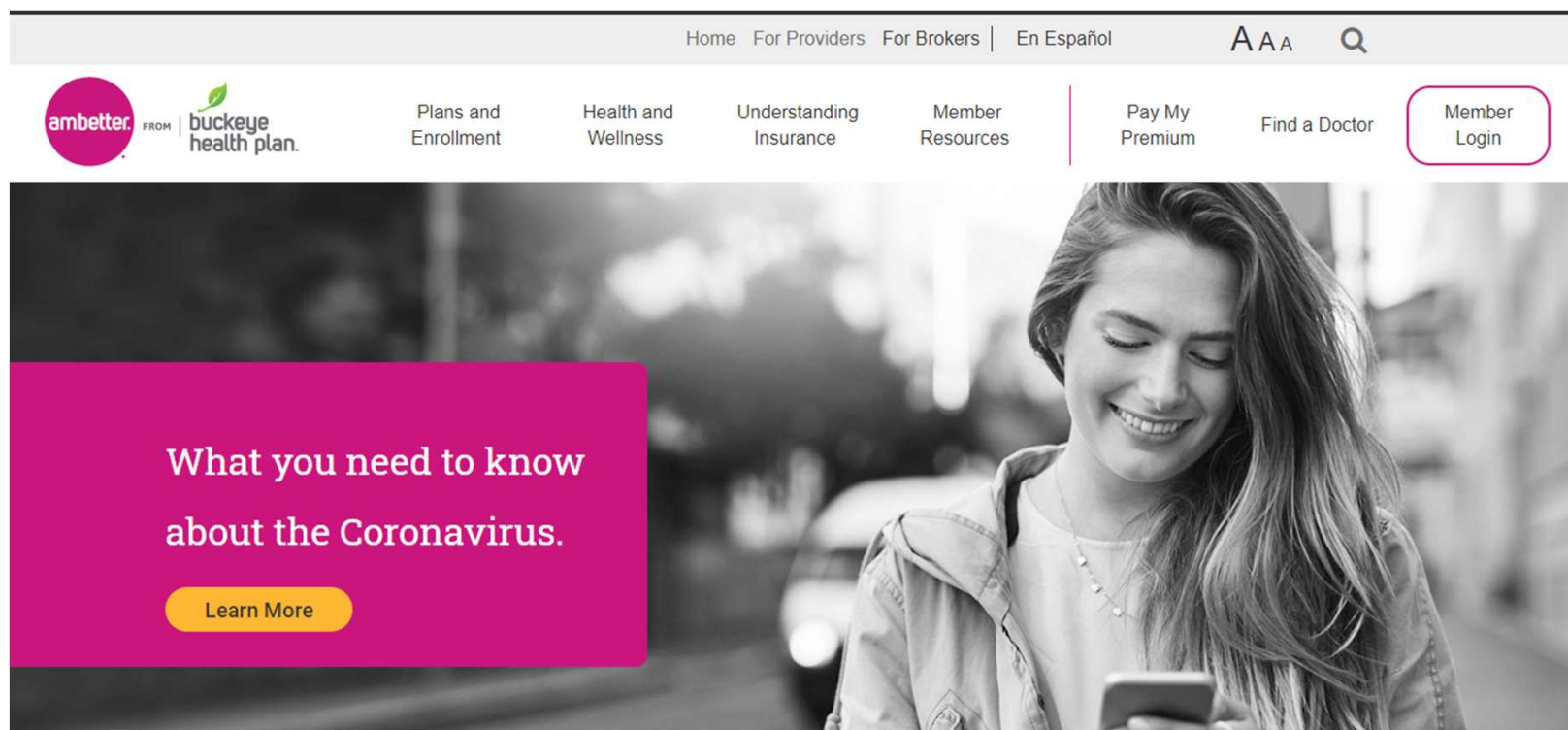
- Each provider has an **Ambetter** from **Buckeye Health Plan** Provider Network Specialist assigned to them. This team serves as the primary liaison between the Plan and our provider network and is responsible for:
 - Provider Education
 - HEDIS/Care Gap Reviews
 - Financial Analysis
 - Assisting Providers with EHR Utilization
 - Monitor performance patterns
 - Membership/Provider roster questions
 - Quality Incentive Program Education

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THE AMBETTER PUBLIC WEBSITE

Ambetter.BuckeyeHealthPlan.com



THE AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

- The Provider and Billing Manual
- Quick Reference Guides
- Important 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

Registration is free and easy!

- **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 Data Analytics Reports
 - Patient List with HEDIS Care Gaps report is generated on a monthly basis and can be exported into a PDF or Excel format.


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The screenshot displays the Secure Provider Portal website. At the top, a dark blue navigation bar contains links for 'Features', 'Join Our Network', and a 'CREATE ACCOUNT' button. The main content area has a light blue header with the text 'The Tools You Need Now!' and a sub-header 'Our site has been designed to help you get your job done.' Below this, three service tiles are shown: 'Check Eligibility' (thumbs up icon), 'Authorize Services' (checkmark icon), and 'Manage Claims' (dollar sign icon). To the right, a 'Login' form is visible, featuring fields for 'User Name (Email)' and 'Password', a 'Login' button, and a link for 'Forgot Password / Unlock Account'. Below the login form, a section titled 'Need To Create An Account?' includes a 'Create An Account' button and a 'How to Register' section with links for 'Provider Registration Video' and 'Provider Registration PDF'.


Features Join Our Network CREATE ACCOUNT

The Tools You Need Now!

Our site has been designed to help you get your job done.

**Check Eligibility**
Find out if a member is eligible for service.

**Authorize Services**
See if the service you provide is reimbursable.

**Manage Claims**
Submit or track your claims and get paid fast.

Login

User Name (Email)

Password

Login

[Forgot Password / Unlock Account](#)

Need To Create An Account?

Registration is fast and simple, give it a try.

Create An Account

How to Register



Our registration process is quick and simple. Please click the button to learn how to register.

Provider Registration Video

Provider Registration PDF

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

MEMBER ID CARD

| | | |
|---|---|-------------------------------------|
|  |  | IN NETWORK COVERAGE ONLY |
| Subscriber: Jane Doe | | |
| Member: John Doe | | |
| ID #: UXXXXXXXX | | |
| Plan: Ambetter Balanced Care 1 | | |
| | | Rx BIN#: 008019 |
| <hr/> | | |
| Copays | | |
| PCP: | | Coinsurance (Med/Rx): |
| Specialist: | | Deductible (Med/Rx): |
| ER: | | Rx (Generic/Brand): |

| | |
|---|--|
| Ambetter.BuckeyeHealthPlan.com | |
| Member/Provider Services: 1-877-687-1189 TDD/TTY: 1-877-941-9236 24/7 Nurse Line: 1-877-687-1189 | Medical Claims: Buckeye Health Plan Attn: CLAIMS PO Box 5010 Farmington, MO 63640-5010 |
| Numbers below for providers: Pharmacy Help Desk: 1-855-339-4806 EDI Payor ID: 68069 EDI Help Desk: 1-800-225-2573 ext. 25525 | |
| <small>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 by a provider not in the plan's network will be covered without prior authorization. For updated coverage information, visit Ambetter.BuckeyeHealthPlan.com.</small> | |
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** Possession of an ID Card is not a guarantee of eligibility and benefits*

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDERS MUST 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, 1-877-687-1189

PANEL STATUS

- Primary Care Physicians (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 on their panel and they wish to have member assigned to them for future care

VERIFICATION OF ELIGIBILITY ON THE PORTAL

Viewing Eligibility For: 438662495

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 ON THE PORTAL

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 25, 2011 | Hoosier Healthwise | TANF |
| Health Record | | | | |
| Care Plan | | | | |
| Authorizations | | | | |
| Coordination of Benefits | | | | |
| Claims | | | | |
| Summary of Benefits | | | | |
| Pharmacy PDL | | | | |

VERIFICATION OF COST SHARES ON THE PORTAL

Viewing Patient's Fee: 261922150 Find Patient

Back to Jane Member

Overview

Cost-Sharing

Assessments

Health Record

Care Plan


Authorizations

Coordination of Benefits

Claims

Summary of Benefits

Pharmacy PDL



Medical Drugs Dental Vision

Medical Deductible and Out-of-Pocket Limits

| Item | Total Amount | Met Year to Date* | Remaining** |
|---------------------------------------|--------------|-------------------|-------------|
| Deductible Individual (2013) | \$1,100 | \$550 | \$1,800 |
| Deductible Family (2013) | \$2,150 | \$1,100 | \$2,150 |
| Out-of-Pocket Limit Individual (2013) | \$6,100 | \$0 | \$6,100 |
| Out-of-Pocket Limit Family (2013) | \$6,400 | \$0 | \$6,400 |

*Based on fully adjudicated claim data
**Collect the total of individual remaining or family remaining amounts

| Co-Insurance | |
|--------------|----------|
| Deductible | ambetter |
| 80% | 20% |

| Co Pay | |
|----------------|--------|
| Visit Type | Amount |
| Primary Care | \$20 |
| Specialist | \$40 |
| 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

*After 1st includes only the visit code provided by your Primary Care Provider. Any lab, radiology (x-rays), minor surgery, or other services provided during the visit will be subject to evaluation and co-insurance. Please note that preventative care visits, such as an annual well-visit/physical, are not included as part of the free visits. Preventative care visits are covered, separately, at 100% by ambetter.

SPECIALTY REFERRALS

WHEN OUR MEMBERS NEED TO VISIT A SPECIALIST, KNOW THAT:

- We educate them to seek care or consultation with their Primary Care Provider (PCP) 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*

HOW TO SECURE PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION? IT can be requested in THE FOLLOWING ways:

✓ Secure Web Portal

- <https://ambetter.buckeyehealthplan.com/>

This is the preferred and fastest method.

✓ Phone

- **1-877-617-0390**

✓ Fax

- **1-888-241-0664**

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned via phone, fax or web.

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IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the Ambetter from Buckeye Health Plan website at www.ambetter.buckeyehealthplan.com

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 REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Pain management
- Urgent/Emergent Inpatient Admissions
- Observation stays exceeding 48 hours
- Partial Inpatient, PRTF, and/or Intensive Outpatient Programs
- Home Health, DME, SNF, Therapy, and Hospice
- Orthotics/Prosthetics
- Hearing Aid devices including cochlear implants
- Genetic Testing
- Quantitative Urine Drug Screen

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

CORRECT CODING FOR 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 will 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.

HOW TO SUBMIT A CLAIM

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 Provider Portal

www.ambetter.buckeyehealthplan.com

2. Electronic Clearinghouse

- Payor ID 68069
- Clearinghouses currently utilized by Ambetter will continue to be utilized
- For a listing our clearinghouses, please visit our website at www.ambetter.buckeyehealthplan.com

3. Mail

P.O. Box 5010
Farmington, MO64640-5010

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, Providers can use the **Reconsider Claim** button on the Claim Details screen within the portal
- 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.
- Mail claim reconsiderations to:
P.O. Box 5010
Farmington, MO 63640-5010

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The logo for Ambetter, featuring the word "ambetter." in a lowercase, sans-serif font inside a white circle.

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at www.ambetter.buckeyehealthplan.com
- Mail completed Claim Dispute form to:

P.O Box 5000
Farmington, MO 63640-5000

CLAIM SUBMISSION – SUSPENDED STATUS

WHAT IF A MEMBER IS 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 – SUSPENDED STATUS

EXAMPLE TIMELINE OF MEMBER IN SUSPENDED STATUS

- **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”.

OTHER HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE 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

AND DON'T FORGET THE 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

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service
- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the Secure Provider Portal at www.ambetter.buckeyehealthplan.com
- 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

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CLAIMS PAYMENTS: ELECTRONIC FUNDS TRANSFER

PAYSPAN: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan, you will need to register specifically for Ambetter
- **Set up your PaySpan account:**
 - Visit www.payspanhealth.com and click Register
 - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

COMPLAINTS, GRIEVANCES AND 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 AND 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 AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider 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

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our website at www.ambetter.buckeyehealthplan.com

OUR SPECIALTY COMPANIES AND VENDORS

| Service | Specialty Company/Vendor | Contact Information |
|----------------------------|-----------------------------|--|
| High Tech Imaging Services | National Imaging Associates | 866-214-2569 www.radmd.com |
| Vision Services | Envolve Vision Benefits | 1-800-334-3937 www.envolvevision.com |
| Dental Services | Dental Health and Wellness | www.dentalhw.com |
| Pharmacy Services | Envolve Pharmacy Solutions | 1-866-399-0928 (Phone) 1-866-399-0929 (Fax) |



ambetter.

QUESTIONS?



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