AMBETTER FROM BUCKEYE HEALTH PLAN

10/30/2020

AGENDA

- **OVERVIEW**
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  - Affordable Care Act
- **WHAT YOU NEED TO KNOW**
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  - 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**

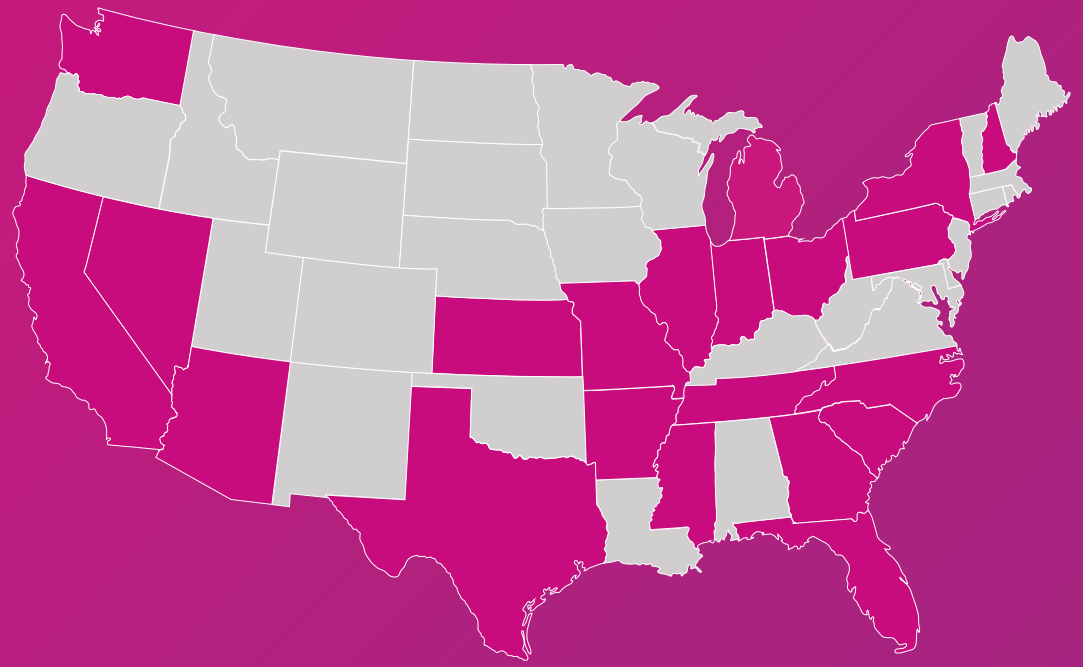
OVERVIEW

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

#1 carrier
on the health insurance marketplace

2M+
members insured across the country



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

KEY CONTACT INFORMATION

Ambetter from Buckeye Health Plan

PHONE

1-877-687-1189

TTY/TDD

1-877-941-9236

WEB

www.ambetter.buckeyehealthplan.com

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

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:

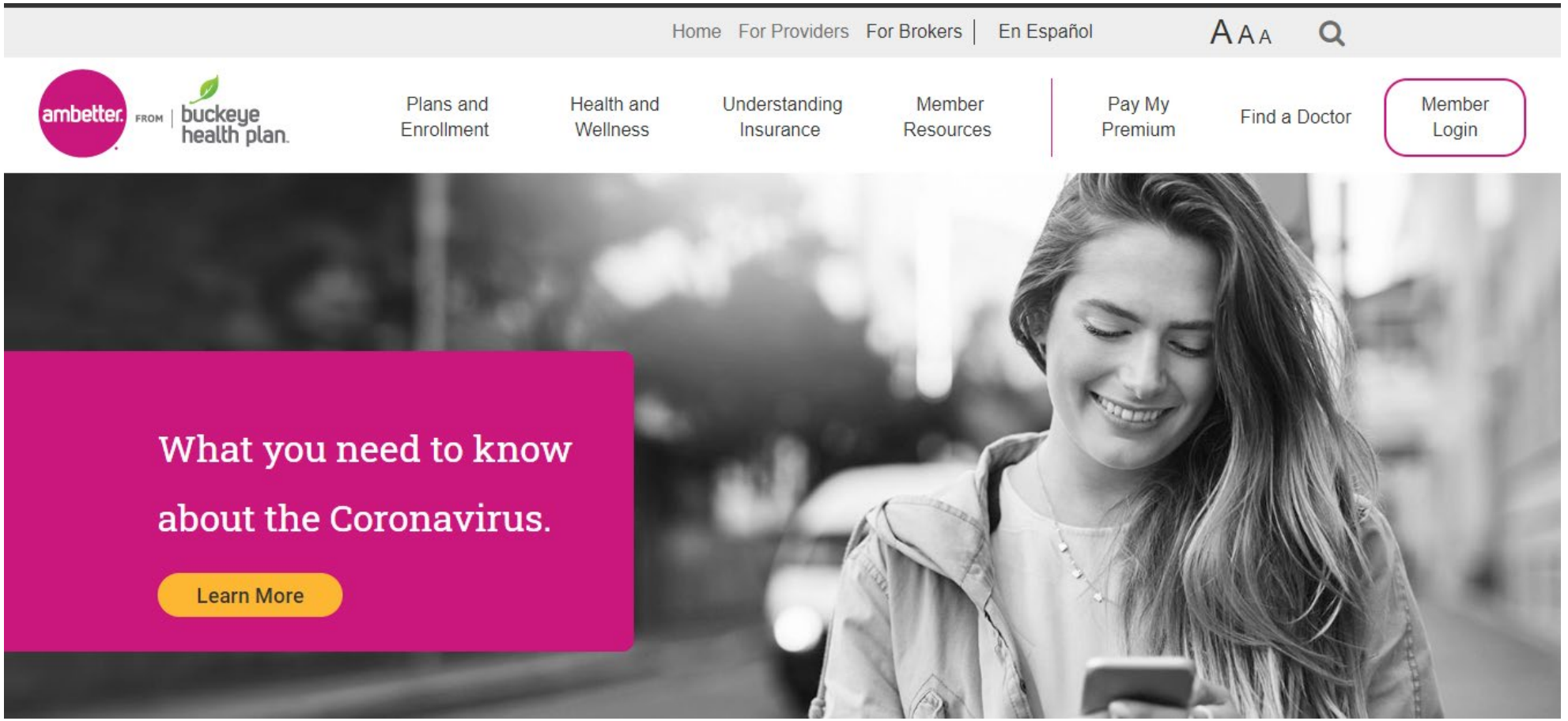
- Credentialing/Network Status
- Claims/Appeals Inquiries
- Prior-Authorization Inquiries
- Request for adding/deleting physicians to an existing group
- Contract clarification
- Facilitates operational concerns
- Assists in Provider Portal and PaySpan registration

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

THE AMBETTER PUBLIC WEBSITE

Ambetter.BuckeyeHealthPlan.com



THE AMBETTER PUBLIC WEBSITE

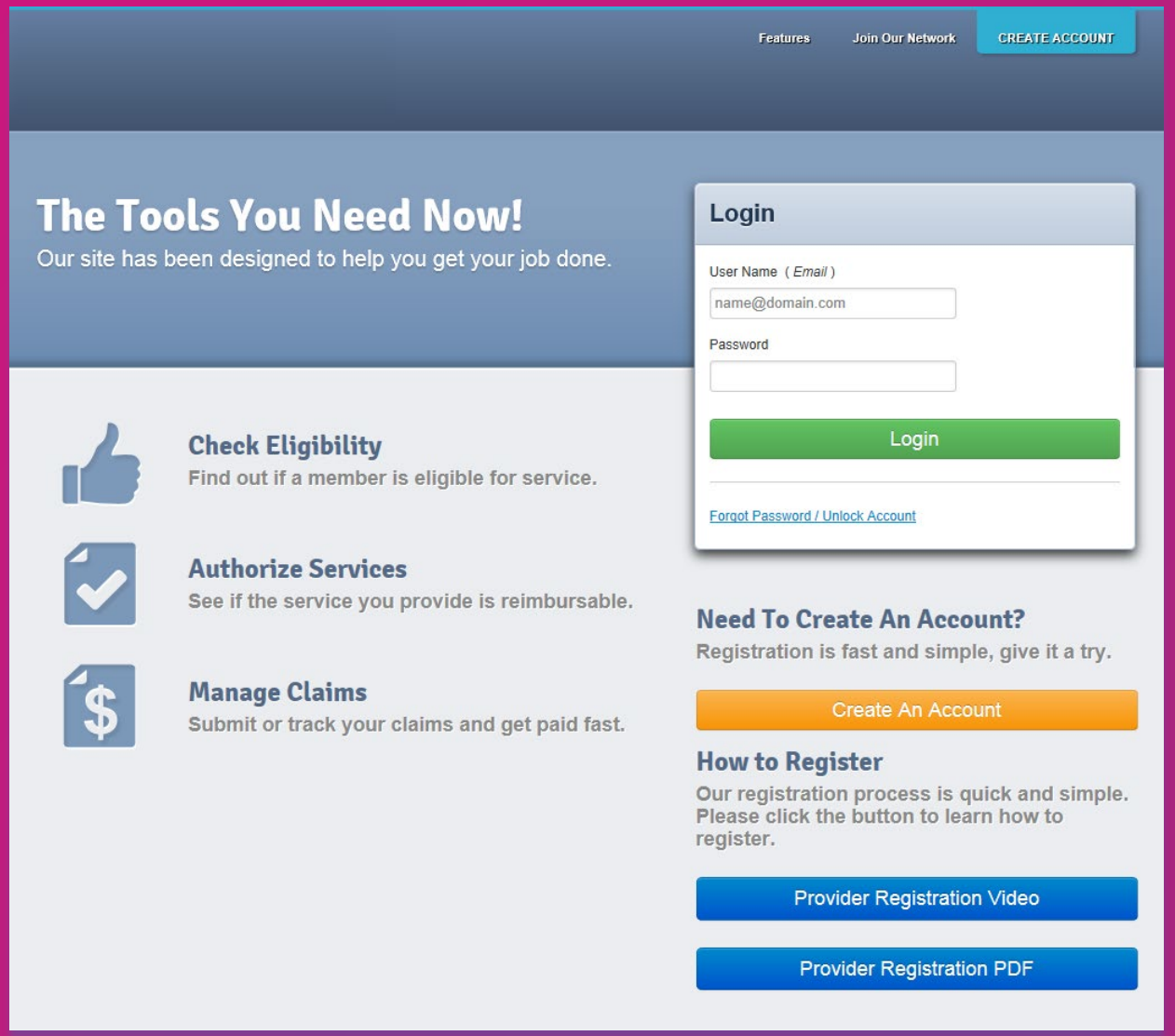
WHAT'S ON THE PUBLIC WEBSITE?

- 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

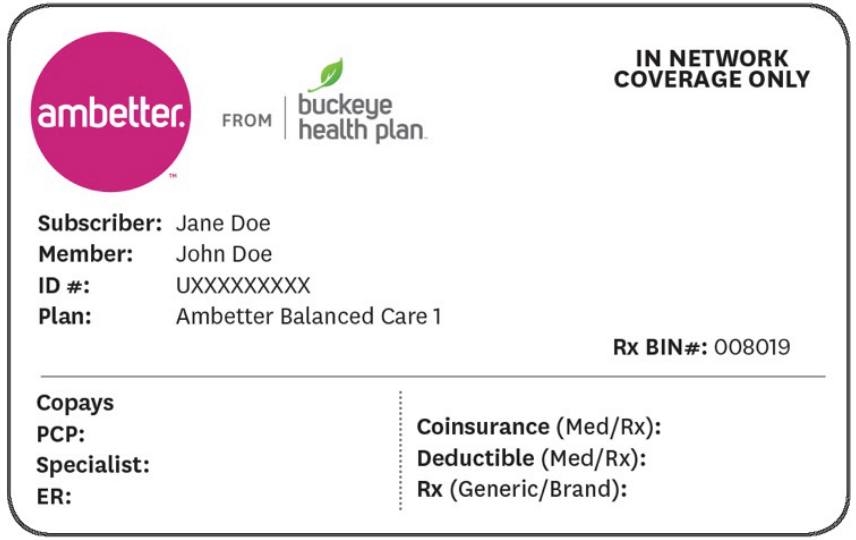
Registration is free and easy!

- **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.



VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

MEMBER ID CARD



**** 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

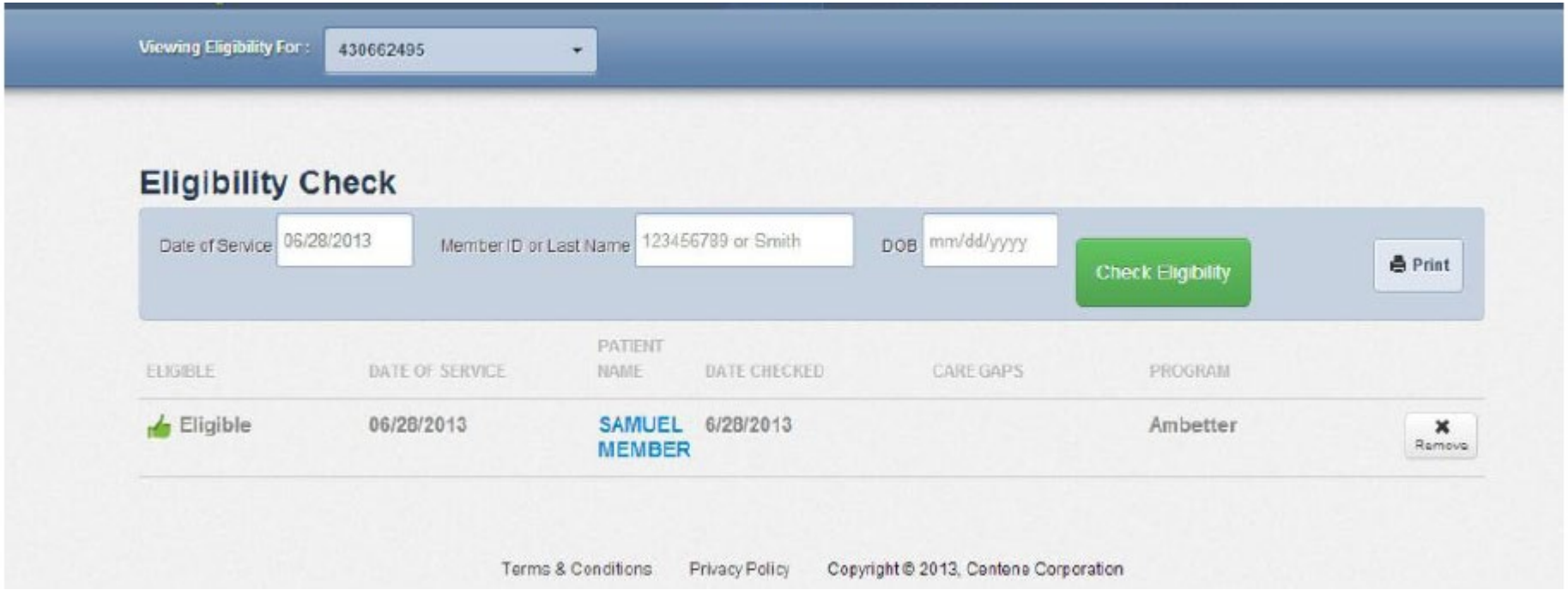
ELIGIBILITY VERIFICATION CAN BE DONE VIA:

- 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



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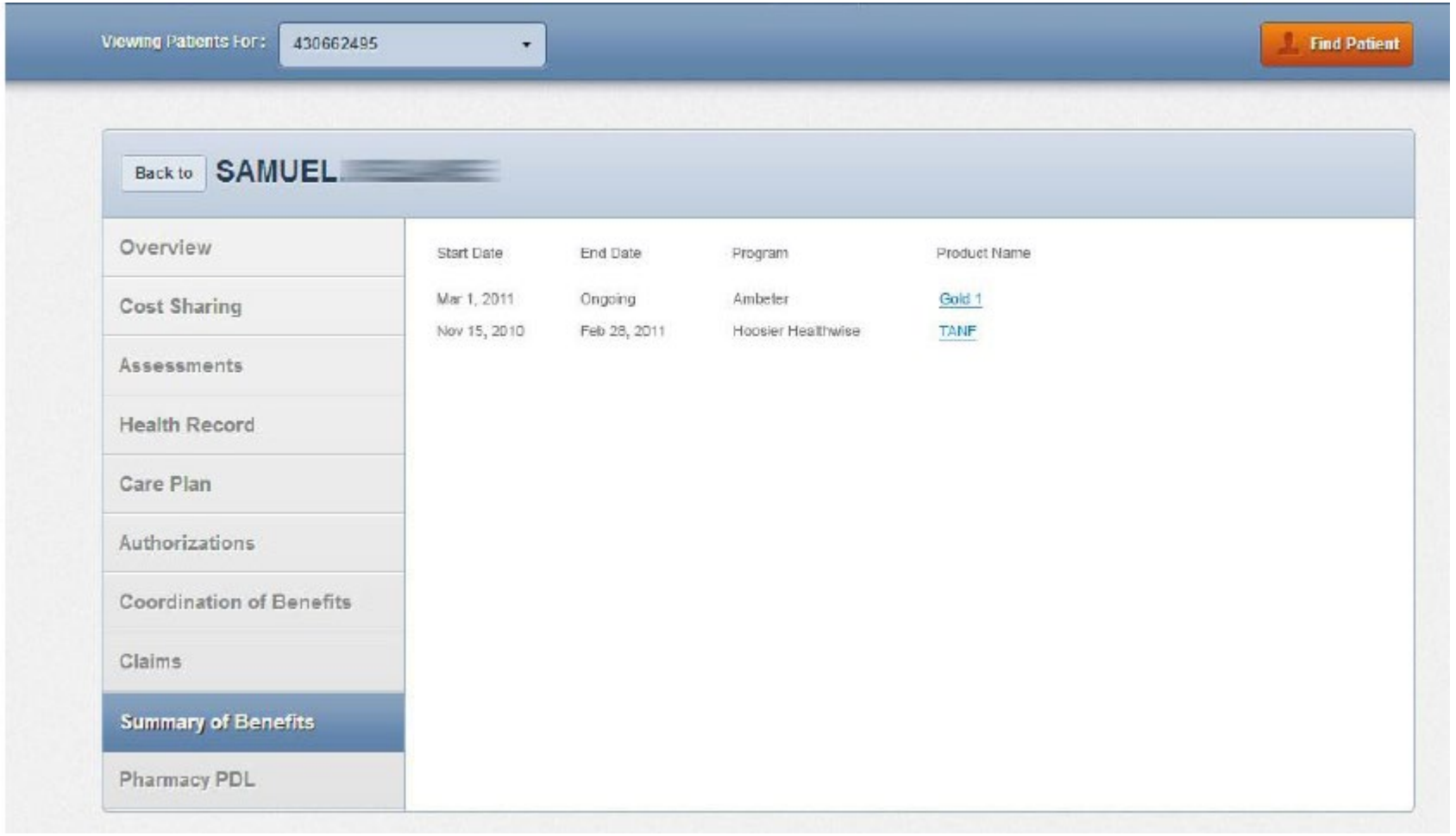
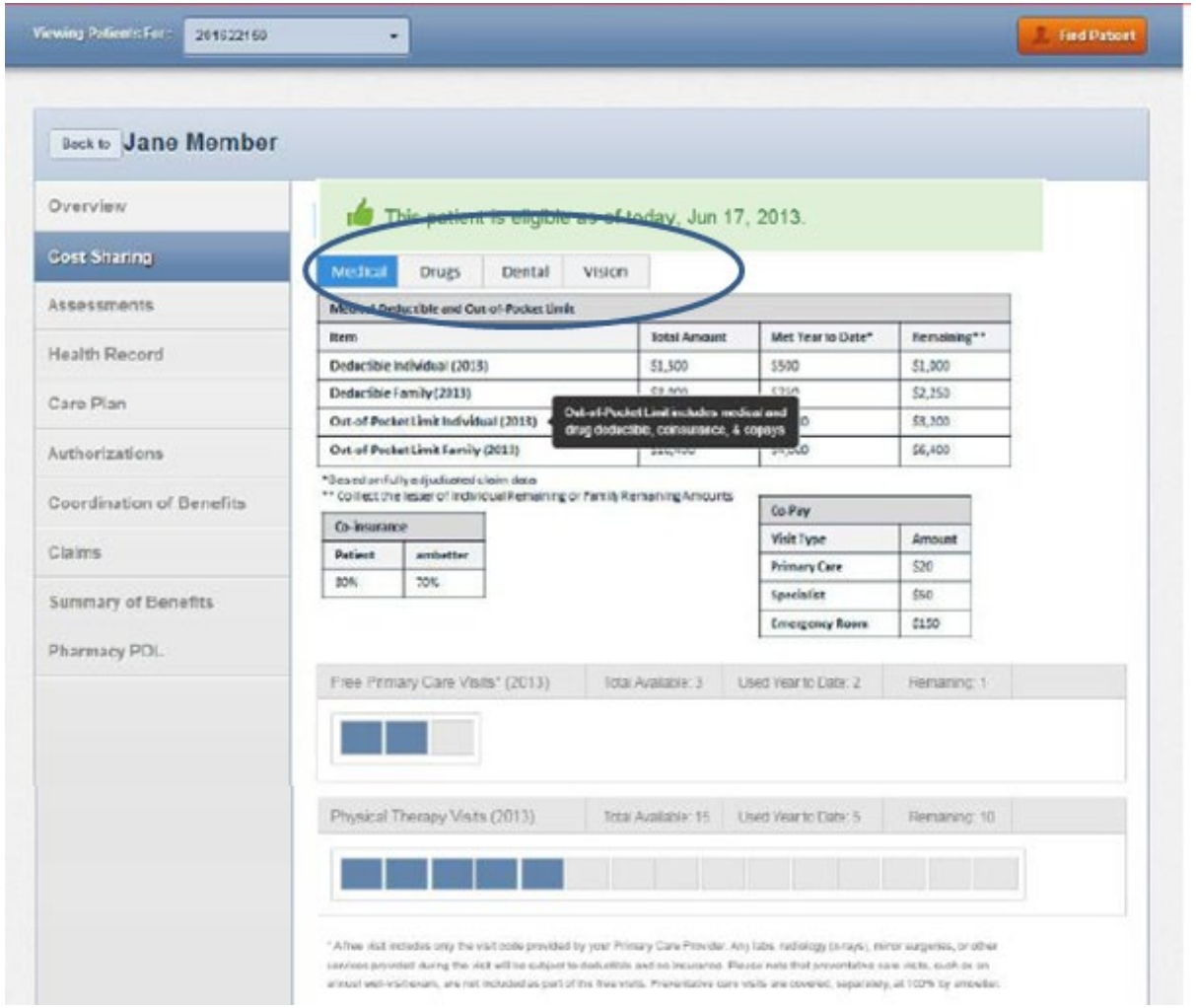
VERIFICATION OF BENEFITS ON THE PORTAL



VERIFICATION OF COST SHARES ON THE PORTAL



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

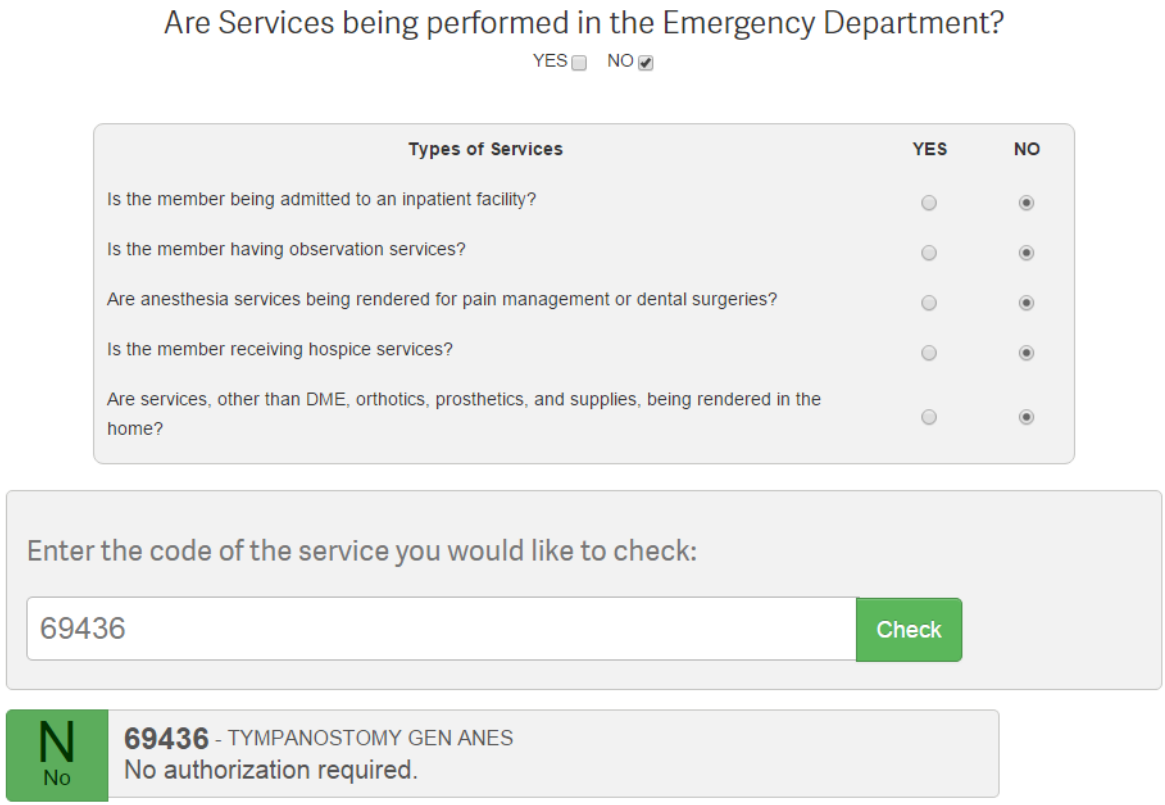
- **1-888-241-0664**

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.

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**



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

- 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

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at AmbetterofArkansas.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

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)

QUESTIONS?