



ambetter.

# AMBETTER FROM BUCKEYE HEALTH PLAN

2023 Provider Orientation

*Confidential and Proprietary Information*

# AGENDA

- **OVERVIEW**
  - Who We Are
  - Affordable Care Act
  - The Health Insurance Marketplace
  - Our Networks
- **WHAT YOU NEED TO KNOW**
  - Key Contact Information
  - Provider Manual
  - Provider Relations
  - Provider Secure Portal
  - Verification of Eligibility, Benefits and Cost Shares
  - Referrals
  - Prior Authorization
  - Claims, Billing and Payments
  - Complaints, Grievances and Appeals
  - Specialty Companies and Vendors
- **Q & A**





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# OVERVIEW





WE ARE

# Ambetter.

WE PROVIDE MARKET-LEADING, AFFORDABLE HEALTH INSURANCE ON THE MARKETPLACE.



**#1 carrier**

on the health insurance marketplace



**2014**

Year that Ambetter began



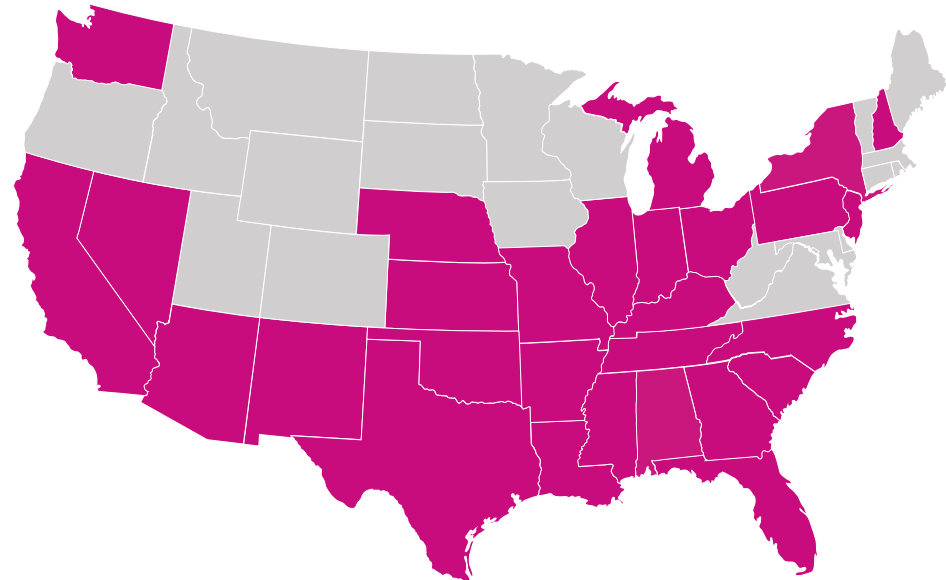
**2.0M+**

members insured



**28**

states



target a focused demographic.



**Lower income,**  
underinsured and uninsured

## LOCAL APPROACH TO CARE

Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs



**We**

are proud to be your partner.

- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.
- **Our products** focus on various cost shares — many with low or no copay amounts — to meet the budget and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.
- Additionally, the **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter's generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service.
- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

# 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 MARKETPLACE 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, federally facilitated or state partnership – – Ohio 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





# OUR NETWORKS



NETWORKS BUILT TO

# Offer More

- Ambetter now offers a robust suite of innovative networks that give members more coverage options to fit their needs and budget.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral requirements for certain types of care to be covered.
- As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.



OUR INNOVATIVE

# Networks

**Bronze | Silver | Gold\***: The Ambetter core network – our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own. Referrals aren't required.

**Ambetter Virtual Access\***: This network offers emphasizes licensed virtual primary care providers (PCPs) for members over the age of 18. Members have the ability to select an on-the-ground PCP upon request. In addition, All members can access our core network of on-the-ground providers and hospitals for additional healthcare needs when referred, as applicable, by their selected PCP. Ambetter Virtual Access networks can have referral requirements for certain types of care.

*\*Network availability varies by state.*

*Confidential and Proprietary Information*

## HOW TO IDENTIFY A MEMBER'S NETWORK

All members will receive an Ambetter member identification card. The ID card includes new information including:

- The Provider Network the member belongs to; and
- Any referral requirements based on the member's plan selection.
- You can find an example of the member ID card on our website:  
<https://ambetter.buckeyehealthplan.com/provider-resources/manuals-and-forms/provider-id-card-samples.html>



# AMBETTER VIRTUAL ACCESS

- Ambetter Virtual Access leans into the changing dynamics of how providers are delivering care, and how members are seeking care, increasing access to primary and urgent care services in a nimble way.
- Ambetter Virtual Access utilizes a robust national network of virtually-based PCPs.
  - In some states members will have Teladoc PCPs and in other states members will have Babylon PCPs. **In Ohio, members will have a Babylon PCP.**
- The network centers on an online, easily accessible medical home offering, with key features such as:
  - Creates a patient-centered care plan within the app
  - Easy to access, member-friendly reminders for follow-ups, picking up prescriptions, etc.
  - Full incorporation of virtual behavioral health providers
- Note that in some states, Ambetter Virtual Access members will be enrolled in plans where a referral from a PCP is required in order to see a specialists.
  - In Ohio, members will be enrolled in plans that **DO NOT require referrals**. However, it is possible that you may see Ambetter Virtual Access members from other states with a different referral requirement. Always check the member's ID card to determine if a referral is or is not required.



# WHAT YOU NEED TO KNOW





# GETTING ACQUAINTED



# KEY CONTACT INFORMATION

## PHONE

**1-855-766-1189**

## TTY/TDD

**1-877-941-9236**

## WEB

<https://www.buckeyehealthplan.com/providers.html>





# 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 [ambetter.buckeyehealthplan.com](https://ambetter.buckeyehealthplan.com)



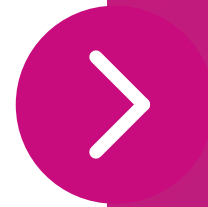
# PROVIDER RELATIONS

- The **Ambetter from Buckeye Health Plan** 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 Buckeye Health Plan** Provider Services at **1-877-687-1189** providers will be able to access real time assistance for all their service needs



# PROVIDER RELATIONS

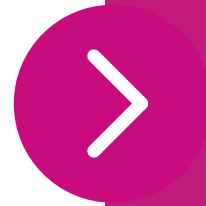
- As an **Ambetter from Buckeye Health Plan** provider, you will have a dedicated Provider Engagement Administrators (PEA) available to assist you
- Our PEAs, serve as the primary liaisons between our health plan and provider network. You can find your assigned PEA at:  
<https://www.buckeyehealthplan.com/providers/our-provider-engagement-administrators.html>
- Your PEA is here to help with things like:



- ✓ Inquiries related to administrative policies, procedures, and operational issues
- ✓ Performance pattern monitoring
- ✓ Contract clarification
- ✓ Membership/provider roster questions
- ✓ Secure Portal registration and Pay Span
- ✓ Provider education
- ✓ HEDIS/Care gap reviews
- ✓ Financial analysis
- ✓ EHR Utilization

# PROVIDER NETWORK OPERATIONS

- Providers should submit updates to demographic data to [OHIOCONTRACTING@CENTENE.COM](mailto:OHIOCONTRACTING@CENTENE.COM) within thirty days of the data change becoming effective.
- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation to [OHIOCONTRACTING@CENTENE.COM](mailto:OHIOCONTRACTING@CENTENE.COM)
- Enrollments will be effective the date all clean documents are received.



Please send the following items to [OHIOCONTRACTING@Centene.com](mailto:OHIOCONTRACTING@Centene.com):

- ✓ Contract Clarification
- ✓ Demographic information updates
- ✓ Initiate credentialing of a new practitioner
- ✓ Inquiries related to the status of a new practitioner or Join Our Network request



# PROVIDER SECURE PORTAL



# SECURE PROVIDER PORTAL

<https://www.buckeyehealthplan.com/providers.html>

**Registration is easy!**

**Contact Provider  
services to get  
started!**



## Log In

Username (Email)

LOG IN

[Create New Account](#)

single password



reliable security

EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#) © 2022 Centene

# SECURE PROVIDER PORTAL

## WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility & patient listings
- Health records & care gaps
- Authorizations
- Claims submissions & status
- Corrected claims & adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports



# SECURE PROVIDER PORTAL

## INSIGHTFUL REPORTS

PCP reports available on the [secure provider 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





The logo for Ambetter, featuring the word "ambetter." in a lowercase, sans-serif font, centered within a white circle. A small registered trademark symbol (®) is located at the bottom right of the circle.

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# VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES



# 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

## 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  
<https://www.buckeyehealthplan.com/providers.html>
- PCPs can still administer service if the member is not on their roster and they 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:

- ✓ **The Ambetter Secure Portal:** <https://www.buckeyehealthplan.com/providers.html>
  - If you are already a registered user of the **Ambetter from Buckeye Health Plan** secure portal, you do NOT need a separate registration!
- ✓ **24/7 Interactive Voice Response System**
  - Enter the Member ID Number and the month of service to check eligibility

**Contact Provider Services: 1-877-687-1189**



# VERIFICATION OF ELIGIBILITY ON THE PORTAL

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Eligibility Patients Authorizations Claims Messaging Help

Viewing Eligibility For : TIN Plan Type Ambetter GO

### Eligibility Check

Date of Service 10/05/2020 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	LOG ER VISIT
	10/05/2020	AARON DOE <a href="#">View details</a>	10/05/2020	No flu vaccine in past 12 months.	ER Visit? Remove



# VERIFICATION OF COST SHARES ON THE PORTAL

Back to Eligibility Check **AARON DOE**

Overview **Medical** Drugs

[Print Cost Sharing](#)

This patient is eligible as of today, Oct 5, 2020. The premium paid through date is Oct 31, 2020 and the claims paid through date is Dec 31, 2020.

**Deductible**  
The fixed amount of money that you are responsible for paying before your insurance starts to pay. Whether or not you meet your deductible depends on how much healthcare you need throughout the year.

Type	Total Amount	Meet Year To Date*	Remaining
Family	\$0.00	\$0.00	\$0.00
Person	\$0.00	\$0.00	\$0.00

**Co-insurance**  
The portion of your medical bill you pay, for certain services, after you meet your deductible. Think of coinsurance as splitting your healthcare costs with your insurance company.  
Once you have reached your deductible, your share of the cost for a covered health care service will be 25% of the allowed amount for the service

**Co-payment**

Drug Type	Your Cost
Primary Care	No charge
Specialist	\$5 Copay
Emergency Room	25% Coinsurance

**Out-Of-Pocket Limit**  
The total amount you will spend for healthcare, after which the insurance company pays for all your medical care until the year ends.

Type	Total Amount	Meet Year To Date*	Remaining
Family	\$2,100.00	\$0.00	\$2,100.00
Person	\$1,050.00	\$0.00	\$1,050.00

\* These values will start at zero on January 1st. The following counts towards your deductible: medical costs, physician services, hospital services, EHB covered services, including pediatric, vision and mental health services, drug benefits.



# VERIFICATION OF BENEFITS ON THE PORTAL

Back to Authorizations    **AARON DOE**

Overview	<a href="#">Summary of Benefits</a>
Cost Sharing	
Benefit Tracker	
Assessments	
Health Record	
Care Plan	
Authorizations	
Pharmacy PDL	
Referrals	
Coordination of Benefits	
Claims	
<b>Summary of Benefits</b>	
Document Resource Center	
Notes	





# REFERRALS



# AMBETTER REFERRAL REQUIREMENTS

- Some Ambetter plans have referral requirements.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned provider or primary care group will be denied.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member access experiences to ensure members understand the rules associated with their plan.
- Referring providers can use our Secure Provider Portal to initiate referrals on behalf of members.





# EXEMPTIONS TO REFERRAL REQUIREMENTS

The following services are **exempt** from referral requirements:

- Emergency or urgent care services
- In-network mental, behavioral health and substance abuse disorder services
- Obstetrical or gynecological services
- Labs, X-Ray/Imaging, Anesthesiology

*Prior authorization requirements will also apply, as necessary.*



# AMBETTER REFERRAL REQUIREMENTS

Ambetter Plan	Referral Requirement?
Gold / Silver / Bronze	No
Ambetter Virtual Access	No



# MAKING AN AMBETTER VIRTUAL ACCESS REFERRAL

The screenshot shows the Ambetter Guide mobile app interface. At the top, there is a navigation bar with a hamburger menu icon, the Ambetter logo, and a user profile icon. Below the navigation bar, the text "Provider Network: Ambetter Value 2022" is displayed with an "Edit" link. A blue notification box contains the text: "This plan requires members to get a referral from their Primary Care Provider before seeing a specialist." The main heading is "Find nearby in-network care". Below this, there are two input fields: "Name, specialty, NPI, procedure" with the text "Cardiologist" entered, and "City, county, or zipcode" with the text "Austin, TX, USA" entered. A large pink "Search" button is positioned below the input fields, and a smaller "Advanced Search" link is located at the bottom of the screen.

1. Go to Ambetter Guide: <https://guide.ambetterhealth.com/>
2. Click the option for “Your Home State”
3. On the next screen, set the state field to the member’s home state. If a year field is present (e.g., during Open Enrollment), set it to the current year. Click the button to advance.
4. On the next screen, select the Ambetter Virtual Access option. Click the button to advance.
  1. If you do not see an Ambetter Virtual Access option, go back to the prior screen and make sure you have the state (and year, if present) set correctly.
5. The next screen includes fields for (1) a search term and (2) the search location.
  1. The search term field has no default. Enter the specialty you wish to search.
  2. The search location field defaults to the location set by your internet service provider. Set the search location to a ZIP or city appropriate for the member.
6. Submit the search. Results will load on the next screen.
7. Click through on any result to see full details about the provider, including their NPI.



# MAKING A REFERRAL: SECURE PROVIDER PORTAL

1. Click on the “Referrals” tab at the top of the screen.
2. Click the “Create Referral” button.
3. Enter the NPI into the Provider Portal Referral Intake field to find the provider you chose.
4. Complete the remaining fields in the PCP Referral form.

The screenshot displays the Ambetter Secure Provider Portal interface. At the top, there is a navigation bar with the Ambetter logo and several menu items: Manage Practice Eligibility, Patients, Referrals, Authorizations, Claims, Messaging, and Olivia Manager. Below the navigation bar, there are two dropdown menus: "Viewing Referrals For: TIN" (set to 12345678) and "Plan Type" (set to Ambetter), followed by a "GO" button and a "Create Referral" button.

The main content area is titled "Referral for:" and shows patient information for Jane Doe (ID#: 5555555, DOB: 12/09/2005). Below this, it states "Plan: Ambetter Virtual" and "Medical Provider Group: Wellstar Georgia". A message instructs the user to create the referral using the form on the left and adding choices to the "Referral Details" area on the right. It notes that all fields are required and provides a link to the Ambetter Guide.

The form is divided into two columns. The left column contains the following fields:

- Referral Type: A dropdown menu with a plus sign to its right.
- Referring Provider: A search field with a magnifying glass icon.
- Referred To Provider: A search field with a magnifying glass icon.
- Specialty: A dropdown menu with a plus sign to its right.
- Start Date: A date picker set to 07/01/2022.
- End Date: A date picker.
- Visits: A numeric input field with a plus sign to its right.

The right column, titled "Referral Details", contains the following fields:

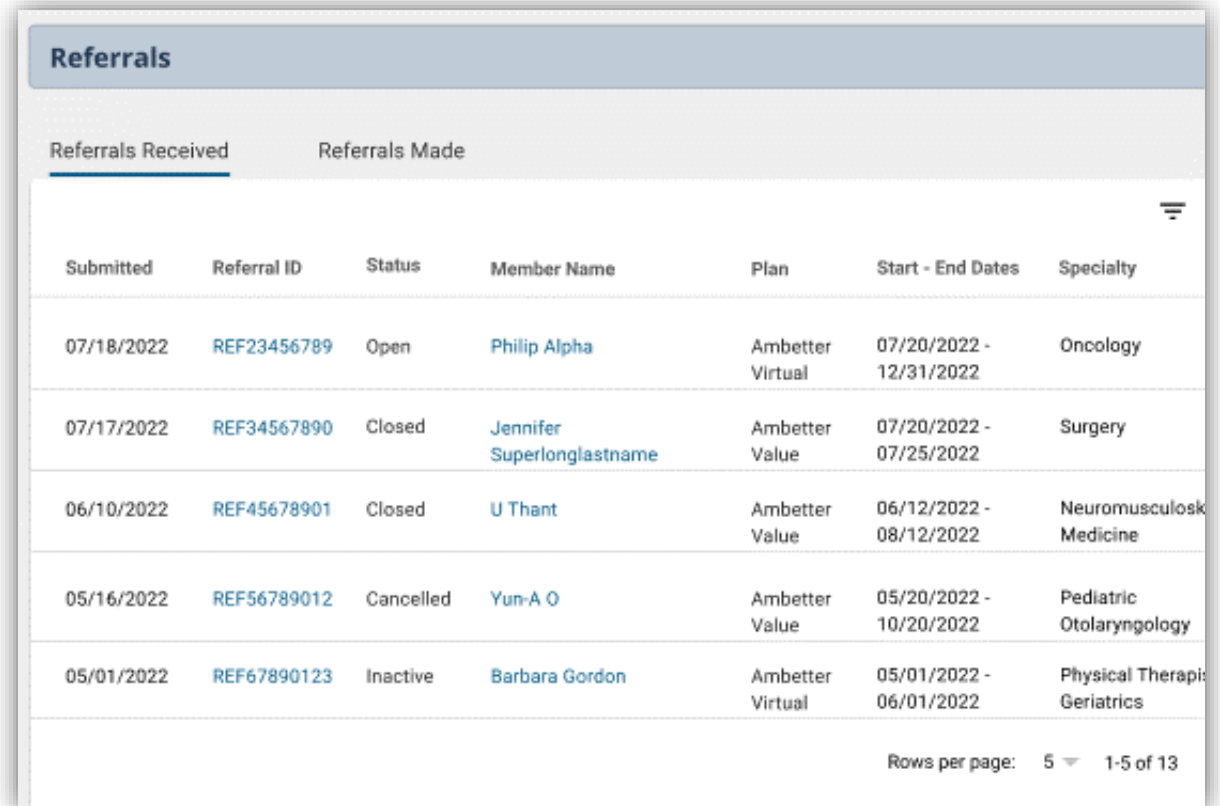
- Referral Type: A text input field.
- Referring Provider: A text input field.
- Referred To Provider: A text input field.
- Specialty: A text input field.
- Dates: A text input field.
- Visits: A text input field.

At the bottom right of the form, there is a "SUBMIT" button and a disclaimer: "Disclaimer: Members may have limits for certain type of services. If you wish to double check current used Member benefits, use the Benefit Tracker."



# RECEIVING A REFERRAL

1. Once referred to you for care outside of their PCP, a member will set up an appointment.
2. Log in to the provider portal.
3. Navigate to 'Referrals' tab at the top.
4. Click on 'Referrals Received' to see the referral tracking table.
5. When you're ready to submit a claim for the referred service, reference this table for the referral ID/REF#.
6. Submit claims form with the REF#.
7. **Claim form MUST include a REF# if a referral is required for the service.** If no REF# is submitted, the claim will be denied.



The screenshot shows a web interface for 'Referrals'. It has two tabs: 'Referrals Received' (which is selected) and 'Referrals Made'. Below the tabs is a table with the following columns: Submitted, Referral ID, Status, Member Name, Plan, Start - End Dates, and Specialty. The table contains six rows of data. At the bottom right of the table, there is a 'Rows per page' dropdown set to 5 and a page indicator '1-5 of 13'.

Submitted	Referral ID	Status	Member Name	Plan	Start - End Dates	Specialty
07/18/2022	REF23456789	Open	Philip Alpha	Ambetter Virtual	07/20/2022 - 12/31/2022	Oncology
07/17/2022	REF34567890	Closed	Jennifer Superlonglastname	Ambetter Value	07/20/2022 - 07/25/2022	Surgery
06/10/2022	REF45678901	Closed	U Thant	Ambetter Value	06/12/2022 - 08/12/2022	Neuromusculosk Medicine
05/16/2022	REF56789012	Cancelled	Yun-A O	Ambetter Value	05/20/2022 - 10/20/2022	Pediatric Otolaryngology
05/01/2022	REF67890123	Inactive	Barbara Gordon	Ambetter Virtual	05/01/2022 - 06/01/2022	Physical Therapi Geriatrics





# PRIOR AUTHORIZATION



# HOW TO SECURE PRIOR AUTHORIZATION

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

✓ Secure Web Portal

<https://www.buckeyehealthplan.com/providers.html>

This is the preferred and fastest method.

✓ Phone

**1-877-687-1189**

✓ 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 at [Pre Auth Check](#)

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



# PRIOR AUTHORIZATION REQUIREMENTS

## INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING\*:

- All elective/scheduled admission notifications requested at least 5 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 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions
- Within 1 day following the date of admission
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

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



# PRIOR AUTHORIZATION REQUIREMENTS

## ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE\*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (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

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



# PRIOR AUTHORIZATION TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one (1) business day
Observation – 48 hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification within one (1) business day
Maternity admissions	Notification within one (1) business day
Newborn admissions	Notification within one (1) business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within one (1) business day
Outpatient Dialysis	Notification within one (1) business day



# UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Three (3) calendar days
Prospective/Non-Urgent	Fourteen (14) calendar days
Emergency services	60 minutes (1 hour)
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days



# 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.





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®

# CLAIMS, BILLING AND PAYMENTS



# CLAIMS

## WHAT IS A 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 a particular circumstance requiring special treatment that prevents timely payment

## ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected
- A claim for which a third-party resource should be responsible





# 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**

<https://www.buckeyehealthplan.com/providers.html>

### **2. Electronic Clearinghouse**

- Payor ID 68069
- Clearinghouses currently utilized by Ambetter will continue to be utilized
- For a listing of clearinghouses, please visit our secure provider portal at the link above.

### **3. Mail**

P.O. Box 5010  
Farmington, MO 64640-5010



# 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**



## 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.BuckeyeHealthPlan.com](https://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 1<sup>st</sup>**  
Member pays premium
- **February 1<sup>st</sup>**  
Premium due – member does not pay
- **March 1<sup>st</sup>**  
Member placed in suspended status
- **April 1<sup>st</sup>**  
Member remains in suspended status
- **May 1<sup>st</sup>**  
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 <https://www.buckeyehealthplan.com/providers.html>
- 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](http://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)



The logo for Ambetter, featuring the word "ambetter." in a lowercase, sans-serif font, centered within a white circle. A small registered trademark symbol (®) is located at the bottom right of the circle.

ambetter.

# COMPLAINTS, GRIEVANCES AND APPEALS





# 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 days of the Notice of Action
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 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 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 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 [ambetter.buckeyehealthplan.com](https://ambetter.buckeyehealthplan.com)





# SPECIALTY SERVICES & VENDORS



# OUR SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	844-265-1278 <a href="http://www.radmd.com">www.radmd.com</a>
Vision Services	Envolve Vision®	1-800-334-3937 <a href="http://www.envolvevision.com">www.envolvevision.com</a>
Dental Services	Envolve Dental®	<a href="http://www.envolvedental.com">www.envolvedental.com</a>
Pharmacy Services	Pharmacy Services	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)





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# QUESTIONS?



*Confidential and Proprietary Information*