FROM arkansas health & wellness

Welcome to Ambetter

from Arkansas Health & Wellness

Agenda

Overview

- Who We Are
- Affordable Care Act
- The Health Insurance Marketplace

What You Need To Know

- Key Contact Information
- Provider Toolkit and Manual
- 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

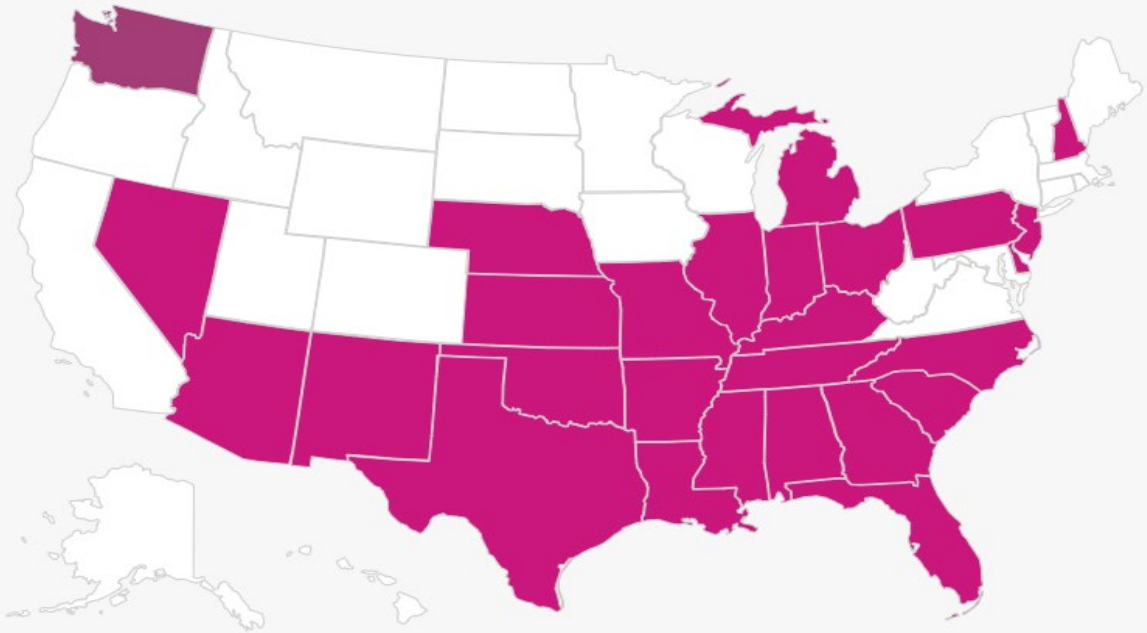
Q & A

Who We Are

- Ambetter from Arkansas Health & Wellness 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)

The Affordable Care Act

Reform the commercial insurance market – Marketplace or Exchanges

- No more underwriting – guaranteed issue
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL) – Effective only for the Arkansas market

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.

Health Insurance Marketplace

Online Marketplace for purchasing health insurance

Potential members can:

- Register
- Determine eligibility for all health insurance programs
- Shop for plans
- Enroll in a plan

Exchanges may be state-based, federally facilitated, or state partnership – Arkansas is a stated-based and federally facilitated Marketplace.

The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies.

What You Need to Know

Key Contact Information

Ambetter from Arkansas Health & Wellness

Phone: **1-877-617-0390 (TTY: 1-877-617-0392)**

Web: **Ambetter.ARHealthwellness.com**

Secure service portal: **provider.arhealthwellness.com**

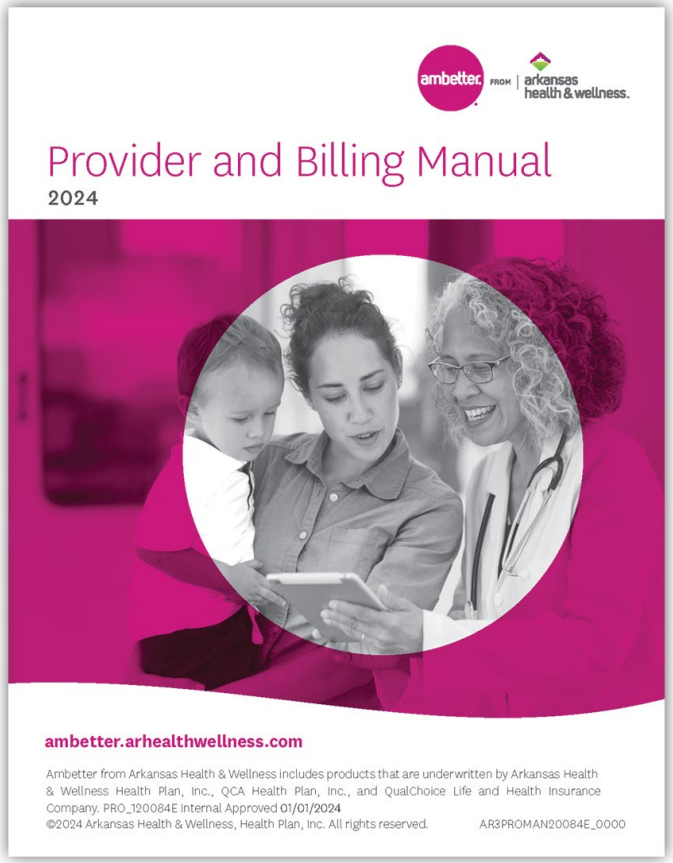
Getting Acquainted

Your toolkit will contain helpful information, such as:

- Welcome Letter
- Provider Introductory Brochure
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal

After you have completed the credentialing process, you will receive a provider toolkit. Our toolkit contains useful information for getting started as an Ambetter provider.

The Provider Manual



The Provider Manual is your comprehensive guide to doing business with Ambetter.

The Manual includes a wide array of important information relevant to providers:

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

The Provider Manual can be found on the Provider Resources section of the Ambetter website at **Ambetter.ARHealthWellness.com**.

Provider Services

The Ambetter Provider Services department is available to respond quickly and efficiently to all provider inquiries or requests including:

- Member Eligibility/Benefits
- Claim Status
- Prior Authorization Request
- Network Verification
- Appeal Status
- Check Stop Pay or Check Reissues
- Negative Balance Report Request
- Provider Demographic Change Request

By calling Provider Services at 1-877-617-0390, providers will be able to access real-time assistance for all their service needs.

Provider Relations

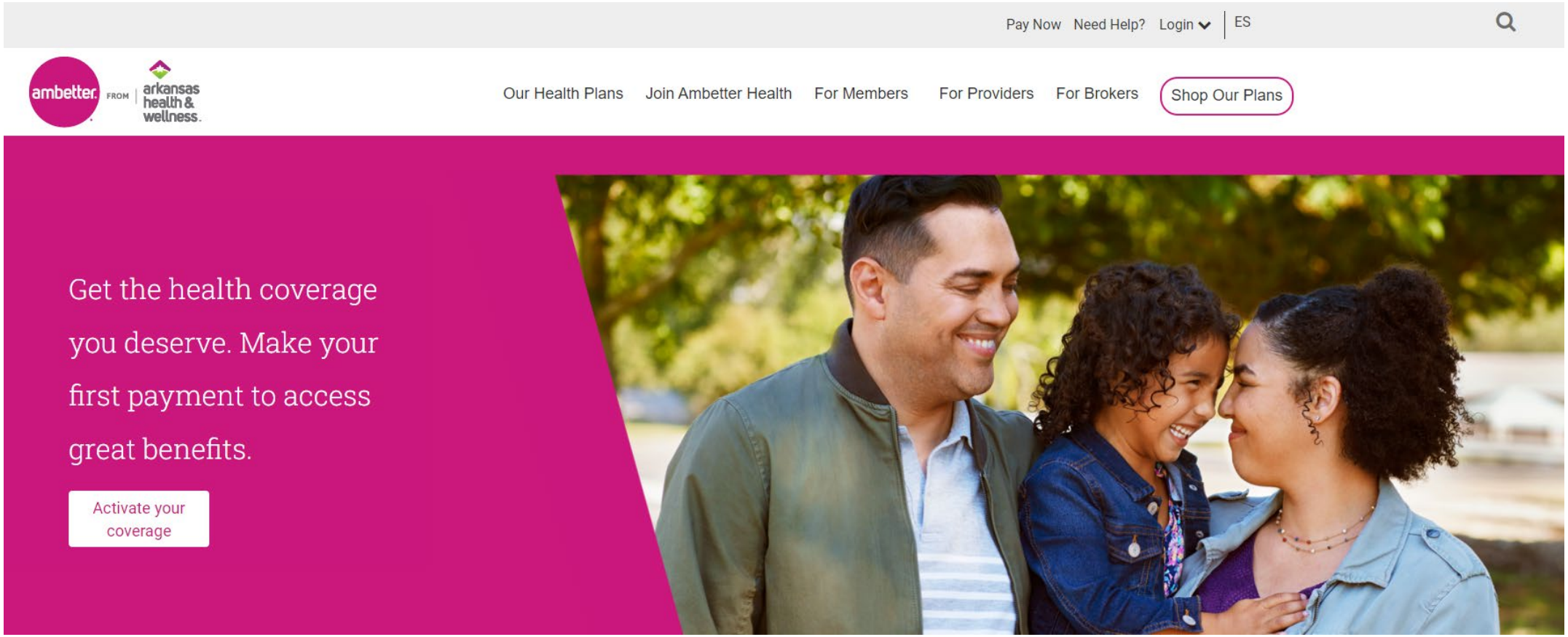
As an Ambetter provider, you will have a dedicated Provider Relations Specialist available to assist you.

Our Provider Relations Specialists serve as the primary liaisons between our health plan and provider network.

Your Provider Relation Specialist is here to help with things like:

- Inquiries related to administrative policies, procedures, and operational issues
- Performance pattern monitoring
- Secure Portal registration and training
- Provider education
- Financial analysis
- Electronic Health Records (EHR) utilization
- Demographic information updates
- Escalation assistance

The Ambetter Public Website

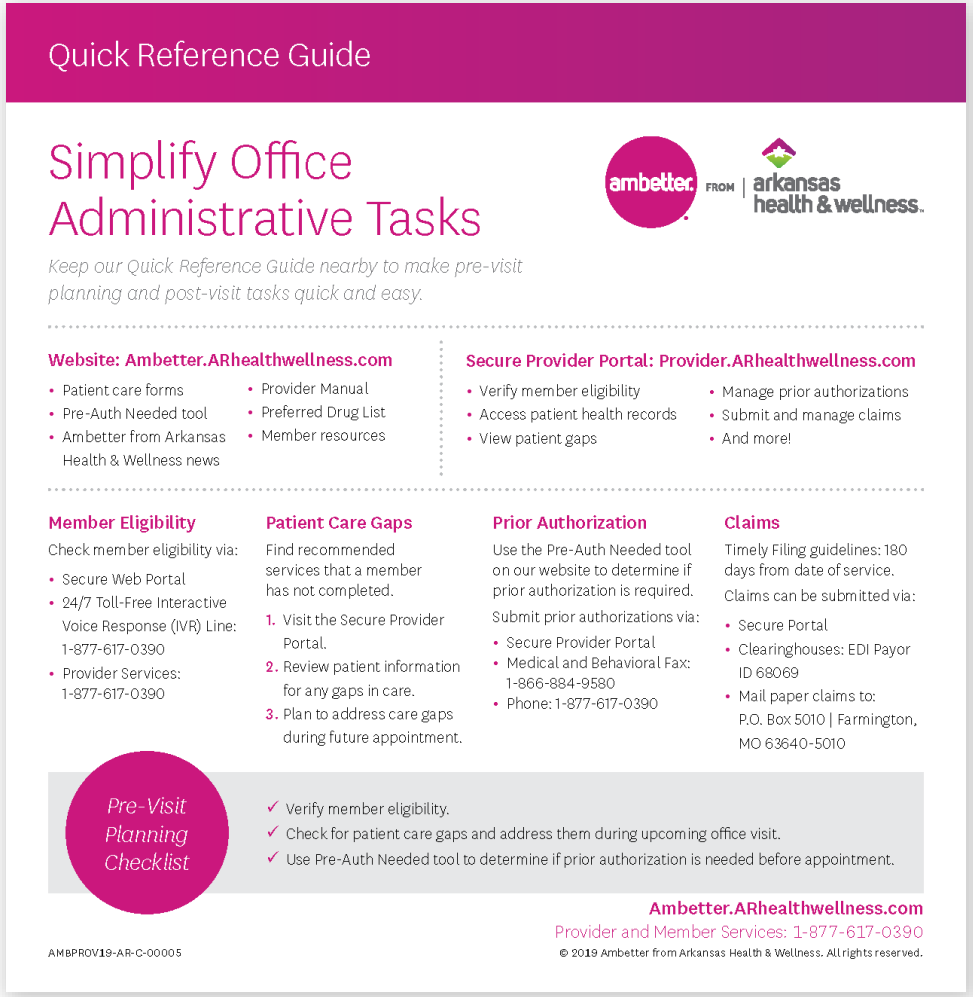


Ambetter.ARHealthWellness.com

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 Check Tool
- Clinical and Payment Policies
- The Pharmacy Preferred Drug Listing
- And much more!



Quick Reference Guide

Simplify Office Administrative Tasks

Keep our Quick Reference Guide nearby to make pre-visit planning and post-visit tasks quick and easy.

Website: Ambetter.ARhealthwellness.com

- Patient care forms
- Pre-Auth Needed tool
- Ambetter from Arkansas Health & Wellness news
- Provider Manual
- Preferred Drug List
- Member resources

Secure Provider Portal: Provider.ARhealthwellness.com

- Verify member eligibility
- Access patient health records
- View patient gaps
- Manage prior authorizations
- Submit and manage claims
- And more!

Member Eligibility

Check member eligibility via:

- Secure Web Portal
- 24/7 Toll-Free Interactive Voice Response (IVR) Line: 1-877-617-0390
- Provider Services: 1-877-617-0390

Patient Care Gaps

Find recommended services that a member has not completed.

1. Visit the Secure Provider Portal.
2. Review patient information for any gaps in care.
3. Plan to address care gaps during future appointment.

Prior Authorization

Use the Pre-Auth Needed tool on our website to determine if prior authorization is required.

Submit prior authorizations via:

- Secure Provider Portal
- Medical and Behavioral Fax: 1-866-884-9580
- Phone: 1-877-617-0390

Claims

Timely Filing guidelines: 180 days from date of service.

Claims can be submitted via:

- Secure Portal
- Clearinghouses: EDI Payor ID 68069
- Mail paper claims to: P.O. Box 5010 | Farmington, MO 63640-5010

Pre-Visit Planning Checklist

- ✓ Verify member eligibility.
- ✓ Check for patient care gaps and address them during upcoming office visit.
- ✓ Use Pre-Auth Needed tool to determine if prior authorization is needed before appointment.

Ambetter.ARhealthwellness.com

Provider and Member Services: 1-877-617-0390

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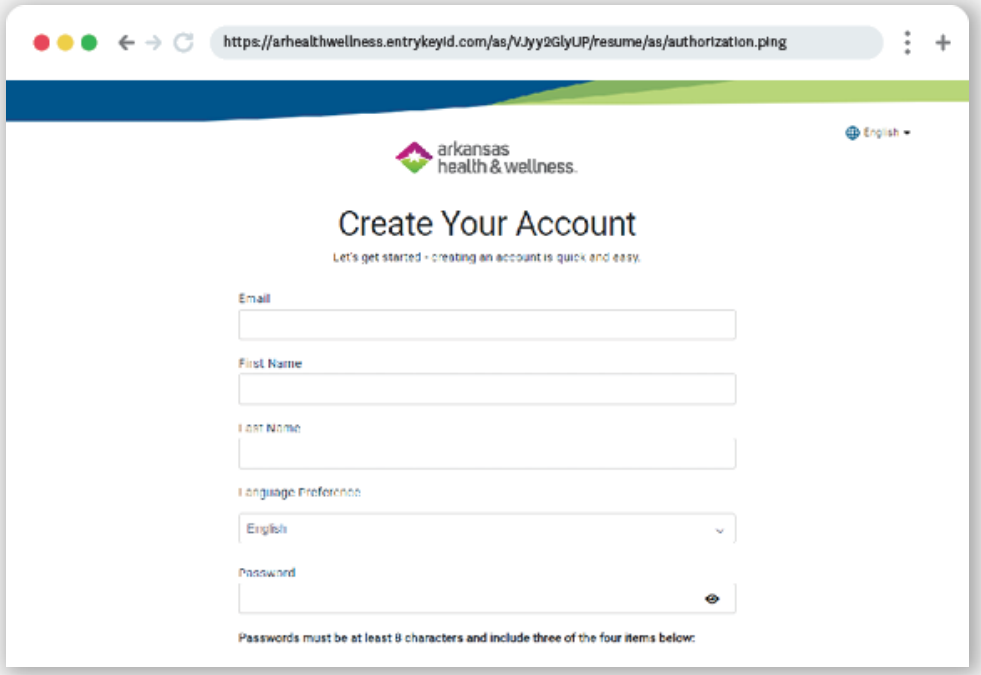
Secure Provider Portal



- Registration is free and easy!
- A registration video and PDF are available to assist you.
- Contact your Provider Relations Specialist if you have questions.

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
- Electronic remittance
- Payment history
- Monthly PCP cost reports
- Provider analytics reports

Secure Provider Portal

Insightful reports

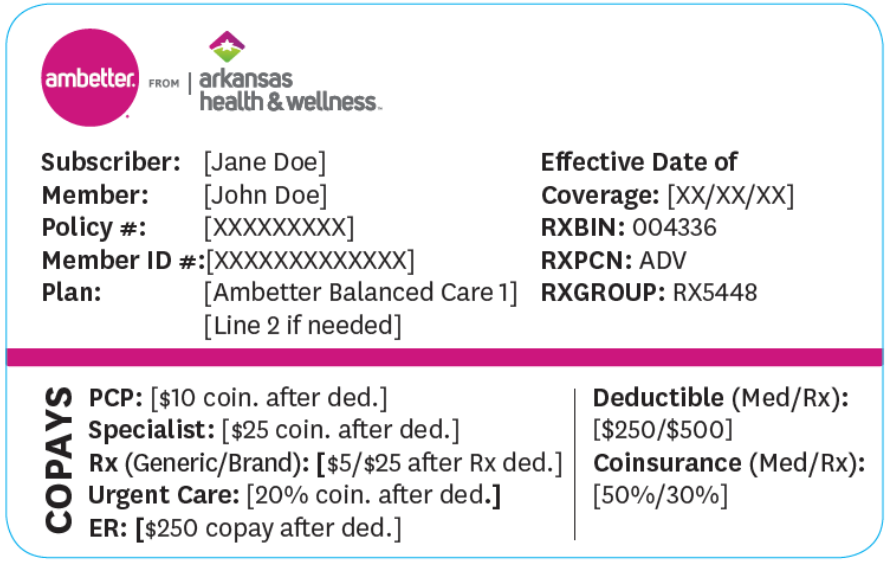
- PCP reports available on the Ambetter from Arkansas Health & Wellness Secure Portal at Provider.ARHealthWellness.com, are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP reports include:

Patient List with HEDIS® Care Gaps	Emergency Room Utilization	Rx Claims Report	High-Cost Claims

Verification of Eligibility, Benefits, and Cost Share

Member ID card


ambetter. FROM | arkansas health & wellness.

Subscriber: [Jane Doe]
Member: [John Doe]
Policy #: [XXXXXXXXX]
Member ID #:[XXXXXXXXXXXX]
Plan: [Ambetter Balanced Care 1]
[Line 2 if needed]

Effective Date of Coverage: [XX/XX/XX]
RXBIN: 004336
RXPCN: ADV
RXGROUP: RX5448

COPAYS
PCP: [$10 coin. after ded.]
Specialist: [$25 coin. after ded.]
Rx (Generic/Brand)**: [**$5/$25 after Rx ded.]
Urgent Care: [20% coin. after ded.**]**
ER: [$250 copay after ded.]

Deductible (Med/Rx): [$250/$500]
Coinsurance (Med/Rx): [50%/30%]


Ambetter.ARhealthwellness.com

Member/Provider Services:
1-877-617-0390
TTY/TDD: 1-877-617-0392
24/7 Nurse Line: 1-877-617-0390

Numbers below for providers:
Pharmacy Help Desk: 1-844-432-0698
EDI Payor ID: 68069
EDI Help Desk: Ambetter.ARhealthwellness.com

Medical Claims:
Arkansas Health & Wellness
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

NovaSys HEALTH Marketplace Network

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 given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.ARhealthwellness.com.

AMB18-AR-C-00056

Possession of a member 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

Panel Status:

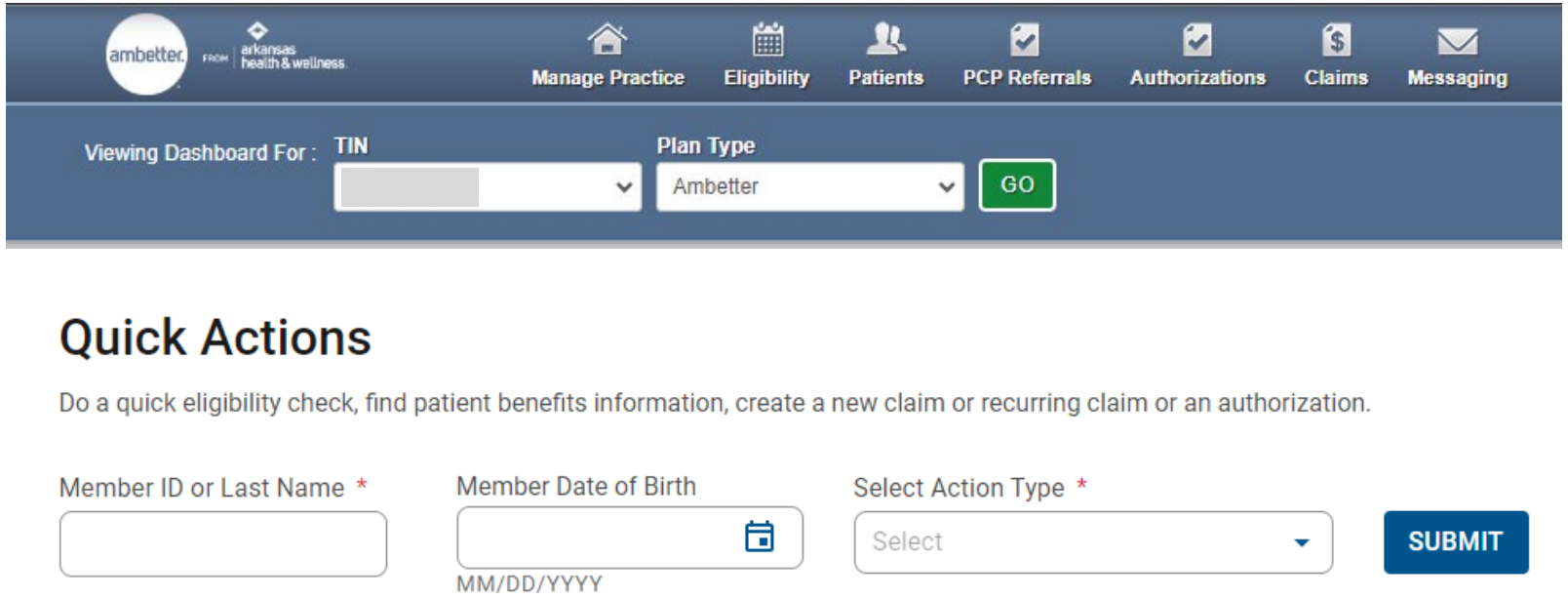
- PCPs should confirm that a member is assigned to their patient panel.
- This can be done via our Secure Provider Portal.
- PCPs can still administer service if the member is not on their panel.
- The member can also request to be reassigned for future PCP visits.

Verification of Eligibility, Benefits, and Cost Share

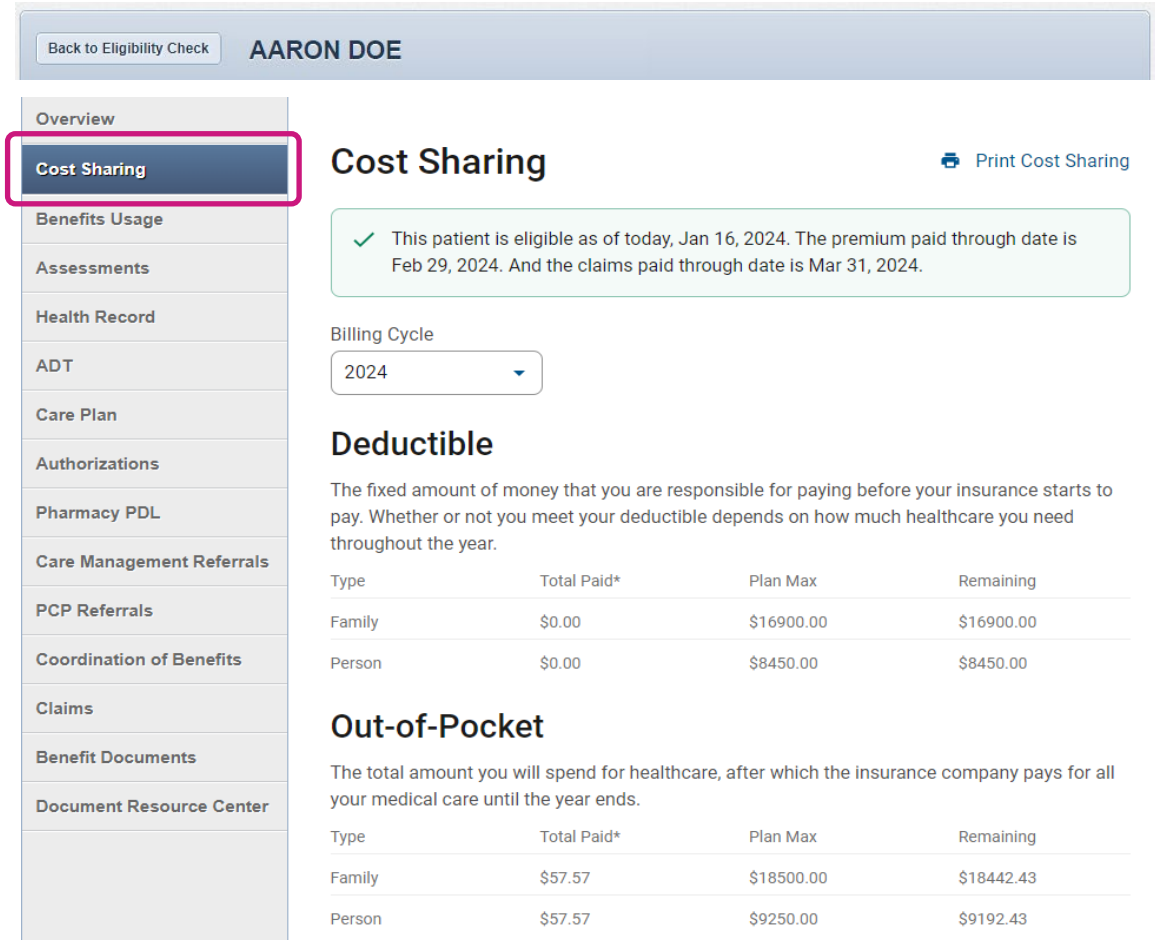
Eligibility, Benefits, and Cost Shares can be verified in 3 ways:

- The Secure Portal: Provider.ARHealthWellness.com
- 24/7 Interactive Voice Response System
  - Enter the Member ID number and the month of service to check eligibility
- Contact Provider Services: 1-877-617-0390

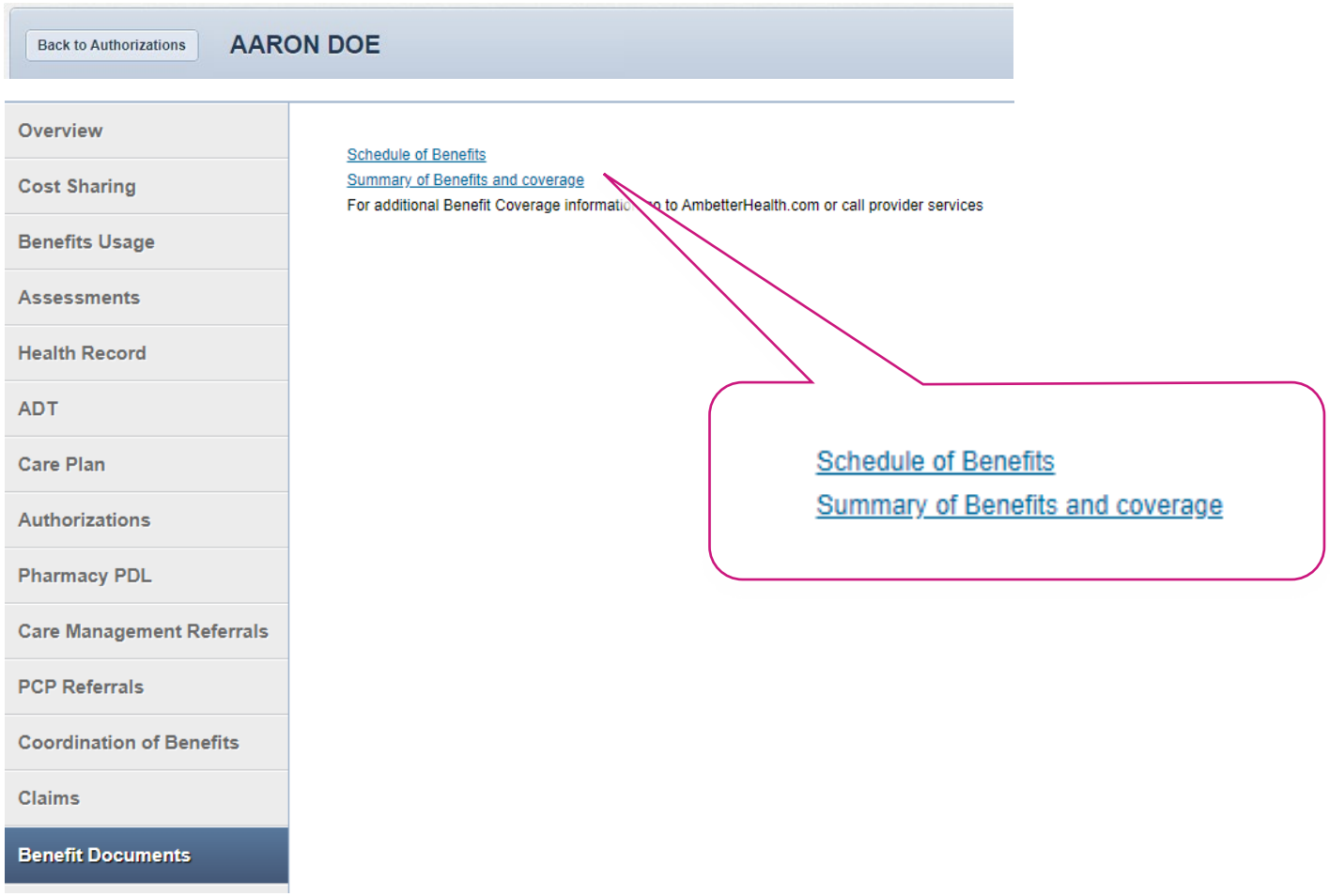
Verification of Eligibility on The Portal



Verification of Cost Shares on The Portal



Verification of Benefits 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 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.

Referrals are not required for members to seek care with in-network specialists.

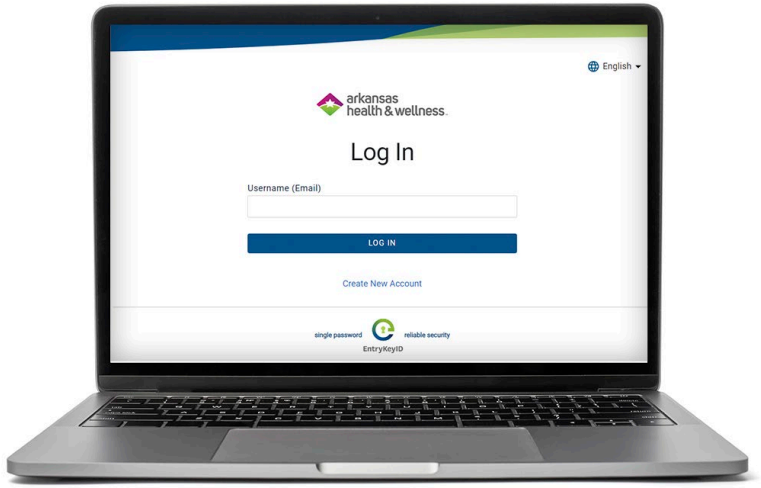
How to Secure Prior Authorization

Need a prior authorization? Request one in the following ways:

Secure Web Portal: **Provider.ARHealthWellness.com**
This is the preferred and fastest method.

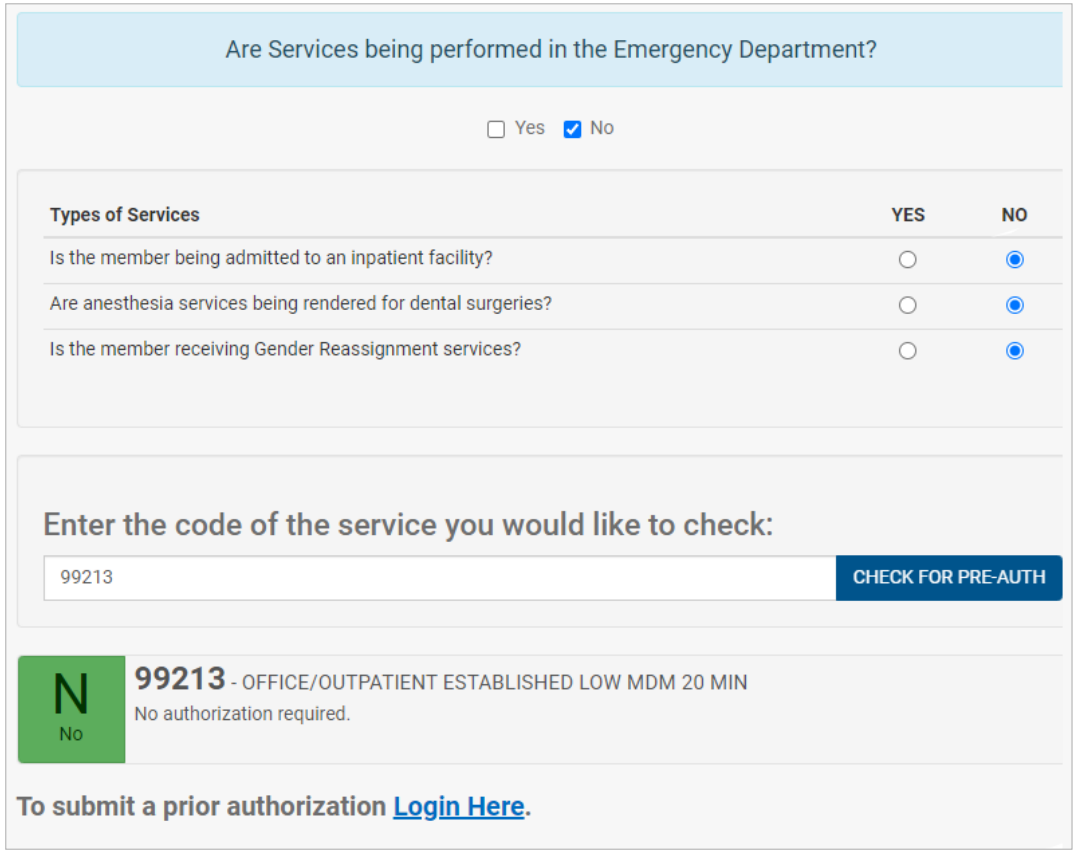
Phone: **1-877-617-0390 (TTY: 1-877-617-0392)**

Fax: **1-866-884-9580**



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 Check Tool to quickly determine if a service or procedure requires prior authorization by CPT ® code.
- Available on the For Providers menu of our website: Ambetter.ARHealthWellness.com

Prior Authorization Requirements

Procedures/Services That Need Prior Authorization Include*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g., CT, MRI, PET) authorized through National Imaging Associates (NIA)
- Outpatient therapy (PT, ST, OT) authorized through NIA
- Infertility
- Obstetrical ultrasound
- Two allowed in a nine-month period — any additional will require prior authorization, except those rendered by perinatologists. (Reference: Payment Policy number CP.MP.38)
- For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- All musculoskeletal (orthopedic, spine, neuro, & pain management) authorized through TurningPoint

*This list is not all-inclusive. Use the Pre-Auth Check 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 five business 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 exceeding 23 hours require Inpatient Authorization.
- Urgent/Emergent Admissions — within one business day following the date of admission
- Newborn deliveries must include birth outcomes.
- Partial Inpatient, Psychiatric Residential Treatment Facility (PRTF), and/or Intensive Outpatient Programs (IOP)

*This list is not all-inclusive. Use the Pre-Auth Check 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 healthcare 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 Check 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	One (1) business day
Prospective/Non-Urgent	Two (2) business 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 services 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.

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 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

Claims may be submitted in three ways:

1. The Secure Provider Portal

Provider.ARHealthWellness.com

2. Electronic Clearinghouse

- Payor ID 68069
- Clearinghouses currently utilized by Ambetter will continue to be utilized.
- For a listing our clearinghouses, please visit Ambetter.ARHealthWellness.com.

3. Mail

Ambetter from Arkansas Health & Wellness

Attn: Claims
P.O. Box 5010

Farmington, MO 64640-5010

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Claim Submission – Suspended Status

What if a member is in suspended status?

- A provision of the Affordable Care Act (ACA) allows members who are receiving Advanced Premium Tax Credits (APTCs) a three-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**	Member pays premium
February	**1**	Premium due – member does not pay
March	**1**	Member placed in suspended status
April	**1**	Member remains in suspended status
May	**1**	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 in box 24J shaded area.
- This is necessary in order to accurately adjudicate the claim.

Don't forget the CLIA number!

- If the claim contains Clinical Laboratory Improvement Amendments (CLIA)-certified or -waived services, CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for Electronic Data Interchange (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 Provider.ARHealthWellness.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 PayspanHealth.com and click Register.
- You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

Claim Reconsiderations and Claim Disputes

Claim reconsiderations:

- For reconsideration requests, providers can use the Reconsider Claim button on the Claim Details screen within the Secure Provider Portal.
- For written requests from a provider about a disagreement in the manner in which a claim was processed, the Claim Dispute Form should be used. Forms are available on the Provider Resources page of our website at Ambetter.ARHealthWellness.com.
- Claim reconsiderations must be submitted within 180 days of the Explanation of Payment.
- Mail claim reconsiderations to:
  Ambetter from Arkansas Health & Wellness
  Attn: Level 1 – Request for Reconsideration
  P.O. Box 5010
  Farmington, MO 63640-5010

Claim disputes:

- Must be submitted within 180 days of the Explanation of Payment
- Claim Dispute Forms are available on the Provider Resources page of our website.
- Mail completed forms to:
  Ambetter from Arkansas Health & Wellness
  Attn: Level II – Claim Dispute
  P.O. Box 5000
  Farmington, MO 63640-5000

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

- A complaint/grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Ambetter's policies, procedures, or any aspect of Ambetter's functions. Ambetter logs and tracks all complaints/grievances whether received verbally or in writing.
- A provider has 30 calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint/grievance.
- After a complete review of the complaint/grievance, Ambetter shall provide a written notice to the provider within 30 calendar days from the received date of Ambetter's decision.

Complaints, Grievances, and Appeals

Appeals

- For claims, the claims reconsideration, claims dispute, and complaint/grievances process must be exhausted prior to filing an appeal.

Pre-Service/Medical Necessity

- A member has 180 calendar days from the notice of action to file the appeal.
- Ambetter shall acknowledge receipt within five business days of receiving the appeal.
- Ambetter shall resolve each pre-service appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Ambetter receives the appeal (60 calendar days for post-service appeals).
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. Decisions for expedited disputes are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the dispute.

Complaints, Grievances, and Appeals

Member representatives

- Members may designate a provider to act as their representative for filing appeals related to medical necessity.
  - A member may designate in writing to Ambetter that a provider or other individual is acting on behalf of the member regarding the complaint/grievance and appeal process.
- 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.ARHealthWellness.com.

Our Specialty Companies and Vendors

Service	Specialty Company/Vendor	Contact Information
High-Tech Imaging Services Outpatient therapy (PT, ST, OT)	Evolent (previously NIA)	877-617-0390 www.radMD.com
Vision Services	Envolve Vision Benefits	1-877-617-0390 EnvolveVision.com
Dental Services	Envolve Dental	1-877-617-0390 EnvolveDental.com
Pharmacy Services	Envolve Pharmacy Solutions	1-877-617-0390 (Phone) 1-866-399-0929 (Fax)
Orthopedic and Spinal Surgical Services	TurningPoint	1-866-619-7054 (Phone) 501-263-8850 (Phone) 501-588-0994 (Fax) TurningPoint-healthcare.com

Questions?