



Welcome To Ambetter from Meridian

Your Partner In Better Healthcare
2024 Provider Orientation

ambetter
HEALTH

TM



PROVIDER ORIENTATION

2024

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 Engagement
- Public Website and Secure Portal
- Verification of Eligibility, Benefits and Cost Shares
- Referrals
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Specialty Companies and Vendors

QUESTIONS & ANSWERS





2024 Provider Orientation

OVERVIEW

WE ARE AMBETTER

We provide market-leading, affordable health insurance on the marketplace.

#1 carrier

on the health insurance marketplace

2014

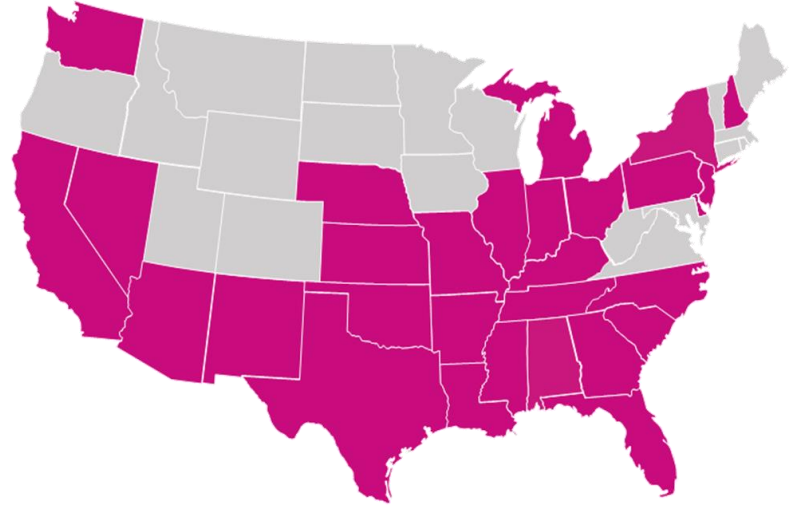
Year that Ambetter began

3.3M+

members insured

29

states



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

- Target a focused demographic
- Lower income, underinsured and uninsured



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**.



AFFORDABLE CARE ACT

AFFORDABLE CARE ACT (ACA):

Key Objectives

- Increase access to quality health insurance
- Improve affordability

ADDITIONAL PARAMETERS:

- Dependent coverage to age 26*
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80%* for individual coverage)

**May be greater based on state requirements*



AFFORDABLE CARE ACT

REFORM THE COMMERCIAL INSURANCE MARKET – MARKETPLACE OR EXCHANGES

- No more underwriting – guaranteed issue.
- There is no longer a Federal tax penalty associated with not having minimum essential coverage.*
- Minimum standards for coverage: benefits and cost sharing limits.
- The ACA created premium tax credits (also known as subsidies) and cost-sharing reductions (CSR) to help reduce costs for eligible consumers who buy a plan through the Marketplace.
- Subsidies may be available to eligible individuals/families who have a household income between 100 and 400 percent of the Federal Poverty Level (FPL), based on the taxpayer's family size.
 - Currently, the subsidy cap has been eliminated through Plan Year 2025, but that may be extended.
- CSRs are available to eligible individuals/families who have a household income between 100 and 250 percent of the FPL, based on the taxpayer's family size.

**States may enact tax penalties for not purchasing insurance*



HEALTH INSURANCE MARKETPLACE

The Health Insurance Marketplace is a service available in every state that helps people shop for and enroll in affordable health insurance. The Federal government operates the Marketplace (HealthCare.gov) for most states, but some states run their own Marketplaces.

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help.

Potential members can:

- Register for the exchange
- Determine eligibility for all health insurance programs (including Medicaid).
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, Federally facilitated, or a Federal-state hybrid — **Michigan is a Federally Facilitated Marketplace.**

The Health Insurance Marketplace is the ONLY WAY to purchase insurance and receive subsidies.



HEALTH INSURANCE MARKETPLACE

FINANCIAL ASSISTANCE COMES IN THE FORM OF:

- Advanced Premium Tax Credits (APTC)
- Cost-Sharing Reductions (CSR)

ALL BENEFIT PLANS HAVE COST SHARES IN THE FORM OF COPAYS, COINSURANCE, AND DEDUCTIBLES

- Some members qualify for assistance with their cost shares based on income level.

The Health Insurance Marketplace is the ONLY WAY to purchase insurance and receive subsidies.





2024 Provider Orientation

OUR NETWORKS

NETWORKS BUILT TO OFFER MORE

- Ambetter 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 or prior authorization 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 are not required.

Ambetter Virtual Access*: This network offers licensed virtual Primary Care Providers (PCPs) for members over the age of 18. Members have the ability to select a brick-and mortar-PCP upon request. In addition, all members can access our core network of brick-and mortar-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, along with prior authorization requirements for non-Virtual Access providers.

**Network availability varies by state.*

HOW TO IDENTIFY A MEMBER'S NETWORK

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

- The member's **Provider Network**
- The **Ambetter Plan** the member has selected
- **Referral requirements** based on the member's plan selection

Note: Presentation of a member ID card is not a guarantee of eligibility. Providers must verify eligibility on the same day services are rendered.

Subscriber: [Jane Doe] Member: [John Doe]	Policy #: [XXXXXXXXXX] Member ID #: [XXXXXXXXXXXXXXXXXX] Effective Date: [00/00/00]
VIRTUAL ACCESS Teladoc Virtual Access App	Ambetterhealth.com/copays PCP: [\$0 Virtual/\$10 In-person copay after [\$600] ded.] Specialist: [\$25 coin. after [\$600] ded.] Rx (Generic/Brand): [\$5/\$25 after [\$600] Rx ded.] Urgent Care: [20% coin. after [\$600] ded.] ER: [\$250 copay after [\$600] ded.] Max Out-of-Pocket: [\$25,000]
	Plan: [Plan name] [Line 2 if needed] [Network Name] Network Coverage Only
REFERRAL FROM PCP REQUIRED FOR SPECIALIST	

Subscriber: [Jane Doe] Member: [John Doe]	Policy #: [XXXXXXXXXX] Member ID #: [XXXXXXXXXXXXXXXXXX] Effective Date: [00/00/00]
 Ambetterhealth.com/copays	PCP: [\$10 copay after [\$600] ded.] Specialist: [\$25 coin. after [\$600] ded.] Rx (Generic/Brand): [\$5/\$25 after [\$600] Rx ded.] Urgent Care: [20% coin. after [\$600] ded.] ER: [\$250 copay after [\$600] ded.] Max Out-of-Pocket: [\$25,000]
	Plan: [Plan name] [Line 2 if needed] [Network Name] Network Coverage Only
REFERRAL FROM PCP NOT REQUIRED FOR SPECIALIST	



OUR NETWORKS:

AMBETTER VIRTUAL ACCESS

- Ambetter Virtual Access supports the changing dynamics of how providers deliver care, and how members seek care, which increases access to primary and urgent care services in an agile way.
- Ambetter Virtual Access utilizes a robust national network of virtually-based PCPs through Teladoc Health.
- The network focuses on an online and easily accessible medical home offering for members. Key features include:
 - A patient-centered care plan within the app.

OUR NETWORKS:

AMBETTER VIRTUAL NETWORK

- Easy to access, member-friendly reminders for follow-up appointments, picking up prescriptions, etc.
- Full incorporation of virtual behavioral health providers.
- In Michigan, members will be enrolled in plans that 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. Prior authorizations are required for all non-Virtual Access providers.



2024 Provider Orientation

WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter from Meridian

WEB

www.AmbetterMeridian.com

PORTAL

[Ambetter Secure Provider Portal](#)

PHONE

1-833-993-2426 (TTY 711)



AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER FROM MERIDIAN.

The manual includes a wide-range of important information relevant to providers doing business with Ambetter.

Key information includes:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives

The Provider Manual can be found in the Provider section of the [Ambetter from Meridian website](#).



PROVIDER ENGAGEMENT

The **Ambetter from Meridian** Provider Engagement team includes trained staff available to respond quickly and efficiently to all provider inquiries, or requests, including:

- Credentialing/Network status
- Claims
- Request for adding/deleting physicians to an existing group

By calling **Ambetter from Meridian Provider Services** at **1-833-993-2426**, providers can access real time assistance for all their service needs.



PROVIDER ENGAGEMENT

- As an **Ambetter from Meridian** provider, you will have a dedicated Network Performance Advisor available to assist you.
- Our Network Performance Advisors serve as the primary liaisons between our health plan and the provider network.
- Your Network Performance Advisor is here to help you operate your practice and address needs, such as:



- ✓ **Inquiries related to administrative policies, procedures, and operational issues.**
- ✓ **Performance pattern monitoring**
- ✓ **Contract clarification**
- ✓ **Membership/provider roster questions**
- ✓ **Secure Portal registration and PaySpan**
- ✓ **Provider education**
- ✓ **HEDIS/care gap reviews**
- ✓ **Financial analysis**
- ✓ **EHR Utilization**
- ✓ **Demographic information updates**
- ✓ **Initiate credentialing of a new practitioner**



PROVIDER NETWORK OPERATIONS

- Providers can submit updates via the [Demographic Data Tool](#) within **30 days** of the data change becoming effective.
- Forms to add new practitioners can be found on our [website](#).
- Enrollments are effective **30 days** from the date all clean documents are received by Ambetter.



The following information can be found [here](#):

- **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.**



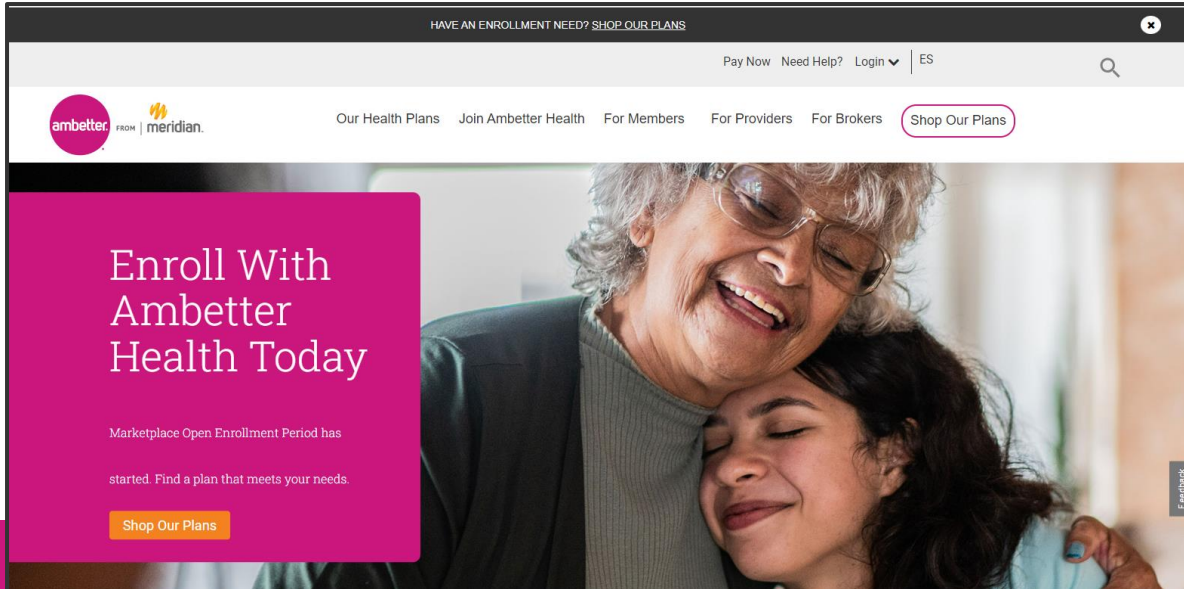


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PUBLIC WEBSITE & SECURE PORTAL

AMBETTER PUBLIC WEBSITE

www.AmbetterMeridian.com



AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!



Contact your Provider Engagement Administrator to get started!

The screenshot shows the login interface for the Ambetter Secure Provider Portal. At the top right, there is a language selector set to "English". The Ambetter logo is centered at the top. Below it, the text "Log In" is displayed. A text input field labeled "Username (Email)" is present, with a cursor inside. Below the input field is a dark blue button labeled "LOG IN". Underneath the button is a link for "Create New Account". At the bottom, there is a section for "EntryKeyID" with the tagline "single password reliable security". At the very bottom, there are links for "Help", "Privacy Policy", and "Terms of Use", along with the copyright notice "© 2022 Centene".

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility and patient listings
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- PCP Referrals for Value and Virtual plans



SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

PCP reports available on [Ambetter Secure Provider Portal](#) are generated monthly 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






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VERIFICATION OF ELIGIBILITY, BENEFITS & COST SHARES

NAVIGATING THE MEMBER ID CARD



Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXXX]
Member ID #: [XXXXXXXXXXXXXXXXXX]
Effective Date: [00/00/00]

VIRTUAL ACCESS


 Teladoc Virtual Access App

Ambetterhealth.com/copays
 PCP: [\$0 Virtual/\$10 In-person copay after [\$600] ded.]
 Specialist: [\$25 coin. after [\$600] ded.]
 Rx (Generic/Brand): [\$5/\$25 after [\$600] Rx ded.]
 Urgent Care: [20% coin. after [\$600] ded.]
 ER: [\$250 copay after [\$600] ded.]
 Max Out-of-Pocket: [\$25,000]

Plan: [Plan name]
 [Line 2 if needed]

[Network Name] Network Coverage Only

RXBIN: 004336
RXPCN: ADV
RXGROUP: RX5478

REFERRAL FROM PCP REQUIRED FOR SPECIALIST

Plans can include:

- Ambetter Gold / Silver / Bronze
- Ambetter Virtual Access

Referral from PCP is required to see a specialist. Auth may be required.

Pharmacy Benefit Information

Provider Services Contact Information

AmbetterMeridian.com

Member/Provider Services: 1-833-993-2426 (TTY Relay 711)
24/7 Nurse Line: 1-833-993-2426 (TTY Relay 711)

Numbers below for providers:
Pharmacy Help Desk: 1-888-964-0141
 EDI Payor ID: 68069

Medical Claims Address:
 Meridian
 Attn: CLAIMS
 PO Box 5010
 Farmington, MO
 63640-5010

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 AmbetterMeridian.com.

Ambetter from Meridian is underwritten by Meridian Health Plan of Michigan, Inc.
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ELIGIBILITY, BENEFITS & COST SHARE

PROVIDER 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, and they wish to have the member assigned to them for future care.



ELIGIBILITY, BENEFITS & COST SHARE

ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN THREE WAYS:

- ✓ **The Ambetter Secure Portal**
If you are already a registered user of the Ambetter from Meridian 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**
1-833-993-2426 (TTY 711)

VERIFICATION OF ELIGIBILITY ON THE PORTAL

Viewing Eligibility For : TIN Plan Type

We are currently experiencing issues displaying the 'PCP Referrals Made' list. Please search for the Member in order to see their referrals or call provider services for more information.

Required Action! Providers seeing members enrolled in Ambetter VALUE or VIRTUAL ACCESS products will need to ensure that PCP Referrals are created prior to providing care. Providers who are outside of the members Primary Provider Group will require a referral for services to be covered. Claims will deny if the referral is not in place.

Eligibility Check

Date of Service (mm/dd/yyyy) Member ID or Last Name DOB

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	STATE	NETWORK	REFERRAL REQUIRED	RECENT ADT	CARE GAPS	LOG ER VISIT
	08/18/2023	Smith View details	08/18/2023	FL	CMS Exp Bronze Std Core ⓘ	NO	NO	Non-compliant for annual well visit.	ER Visit? <input type="button" value="Remove"/>



VERIFICATION OF COST SHARES ON THE PORTAL

The screenshot displays the Ambetter Health portal interface. At the top, there is a navigation bar with icons for Manage Practice, Eligibility, Patients, PCP Referrals, Authorizations, Claims, and Messaging. Below this, search filters for 'Viewing Patients For' (TIN) and 'Plan Type' (Ambetter) are visible, along with a 'Find Patient' button.

The main content area is titled 'Smith' and includes a 'Print Cost Sharing' link. A green notification box states: "This patient is eligible as of today, Aug 18, 2023. The premium paid through date is Aug 31, 2023 and the claims paid through date is Aug 31, 2023."

The 'Deductible' section explains that the fixed amount of money is responsible for paying before insurance starts. It includes a table with the following data:

Type	Total Amount	Meet Year To Date*	Remaining
Family	\$15,000.00	\$0.00	\$15,000.00
Person	\$7,500.00	\$0.00	\$7,500.00

The 'Out-Of-Pocket Limit' section explains that the total amount spent on healthcare is covered until the year ends. It includes a table with the following data:

Type	Total Amount	Meet Year To Date*	Remaining
Family	\$18,000.00	\$163.81	\$17,836.19
Person	\$9,000.00	\$163.81	\$8,836.19

A footnote states: "* 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

The screenshot displays the Ambetter Health portal interface. At the top, there is a navigation bar with icons for Manage Practice, Eligibility, Patients, PCP Referrals, Authorizations, Claims, and Messaging. Below this, a search bar allows users to filter patients by TIN and Plan Type (currently set to Ambetter), with a 'GO' button and a 'Find Patient' button. The main content area shows a patient profile for 'Smith'. A sidebar on the left lists various patient management options, with 'Benefit Documents' highlighted. The main content area for 'Benefit Documents' includes links for 'Schedule of Benefits' and 'Summary of Benefits and coverage', along with a note directing users to the AmbetterHealth.com website or provider services for more information.

ambetter

Manage Practice Eligibility Patients PCP Referrals Authorizations Claims Messaging

Viewing Patients For: TIN [] Plan Type: Ambetter [] GO Find Patient

Back to Patient List Smith

Overview
Cost Sharing
Benefits Usage
Assessments
Health Record
ADT
Care Plan
Authorizations
Pharmacy PDL
Care Management Referrals
PCP Referrals
Coordination of Benefits
Claims
Benefit Documents
Document Resource Center
Notes

[Schedule of Benefits](#)
[Summary of Benefits and coverage](#)
For additional Benefit Coverage information go to AmbetterHealth.com or call provider services





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REFERRALS

AMBETTER PCP 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 plan materials 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.



EXCEPTIONS 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.

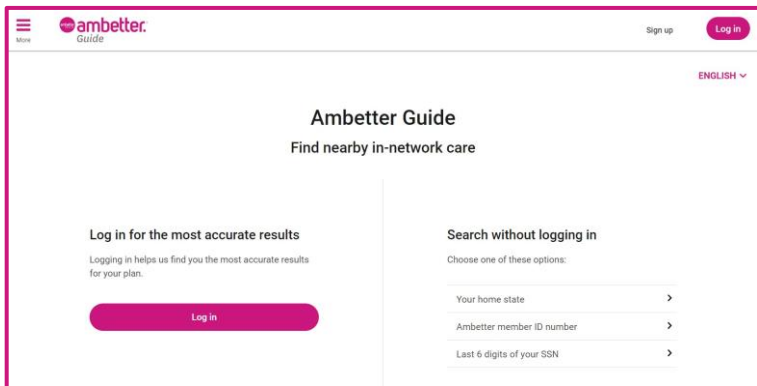


AMBETTER REFERRAL REQUIREMENTS

Ambetter Plan	Referral Requirement?
Gold / Silver / Bronze	No
Ambetter Virtual Access	Yes, for care outside of PCP



MAKING A VIRTUAL ACCESS REFERRAL



1. Go to [Ambetter Guide](#)
2. Select 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), select 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

ONCE YOU IDENTIFY THE SPECIALIST'S NAME AND NPI, SUBMIT THE INFORMATION ON THIS SCREEN.

1. Select the “PCP Referrals” tab at the top of the screen.
2. Click the “Create Referral” button.
3. Complete the fields on the PCP Referral form.

Tip: Please utilize the Helpful Information section for assistance/guidance.

The screenshot shows the 'Create Referral' form in the Ambetter Health secure provider portal. The form is titled 'Create Referral' and includes the following sections:

- Patient Information:** Patient Name (Smith), Birth Date, Member ID, Plan (Ambetter Value), and Primary Provider Group.
- Referral Date:** Start Date (08/18/2023) and End Date (11/18/2023). Includes helpful information and a link to the Ambetter Guide.
- Referring Provider:** Search field for provider name, with fields for Name, Title, and Phone.
- Referred To Provider:** Search field for provider name, with fields for Name, Title, and Phone.
- Referral Type & Visits:** Select Referral Type (Consult & Treatment) and Visits (1).
- Referred To Provider's Specialty:** Select Specialty.
- Notes (optional):** Text area for notes.
- ATTACHMENTS:** Drag & Drop Files or Select Files From Your Computer. Includes a note: 'Upload PDF or Word Doc. 5 MB maximum and 25 MB maximum per file.'

At the bottom right, there are 'CANCEL' and 'NEXT' buttons. A small note at the bottom states: 'Note: Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual.'



RECEIVING A REFERRAL

1. Once you receive a referral for care from the member's PCP, the member will schedule an appointment with you.
2. Log in to the Secure Provider Portal.
3. Navigate to "Referrals" tab at the top.
4. Click on "Referrals Received" to see the referral tracking table.
5. When you are 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 the 'PCP Referrals' section of a web application. At the top, there are navigation tabs for 'Manage Practice', 'Eligibility', 'Patients', 'PCP Referrals', 'Authorizations', 'Claims', and 'Managing'. Below the navigation, there is a search bar for 'Viewing Referrals For' with a dropdown menu set to 'Provider' and a 'GO' button. A 'Create Referral' button is also visible. A tooltip titled 'What's New: Filter Referrals' provides instructions on how to use the filter tool. The main content area is divided into two tabs: 'PCP Referrals Received' (selected) and 'PCP Referrals Made'. A 'Filter' button is present, along with a 'Filter By Keywords' search box. The table below lists various referrals with columns for Submitted date, Referral ID, Member Name, Plan, Specialty, Visits Left, Start-End Dates, and Status. The table contains 10 rows of data. At the bottom of the table, there is a 'DOWNLOAD' button and a 'Rows per page' selector set to 10, showing 1-8 of 9 rows. A note at the bottom states: '*Visits Left* is based on claims processing starting on 1/1/2023. If Ambetter has not received a claim for a date of service, it will not be included in the counts above.' A 'Status Type Explanation' section at the bottom defines the status codes: ACTIVE, EXPIRED, CANCELLED, and CLOSED.

Submitted	Referral ID	Member Name	Plan	Specialty	Visits Left	Start - End Dates	Status
07/20/2023	REF1C		Ambetter Value	Obstetrics & Gynecology & Allowed Visits	6	07/20/2023 - 10/18/2023	Active
06/30/2023	REF15		Ambetter Value	Obstetrics & Gynecology 12 Allowed Visits	12	06/30/2023 - 09/28/2023	Active
05/02/2023	REF06		Ambetter Value	Obstetrics & Gynecology: Gynecology & Allowed Visits	6	05/02/2023 - 07/31/2023	Expired
03/30/2023	REF14		Ambetter Value	Obstetrics & Gynecology & Allowed Visits	6	03/30/2023 - 05/28/2023	Expired
03/27/2023	REF20		Ambetter Value	General Acute Care Hospital & Allowed Visits	6	03/27/2023 - 05/25/2023	Expired
03/24/2023	REF18		Ambetter Value	Obstetrics & Gynecology & Allowed Visits	6	03/24/2023 - 04/20/2023	Expired
01/22/2023	REF11		Ambetter Value	Obstetrics & Gynecology & Allowed Visits	6	03/22/2023 - 05/20/2023	Expired
03/07/2023	REF9D0E9966		Ambetter Value	Obstetrics & Gynecology: Gynecology & Allowed Visits	6	03/07/2023 - 05/05/2023	Expired
02/23/2023	REF8EAC4788		Ambetter Value	Obstetrics & Gynecology & Allowed Visits	6	02/23/2023 - 05/24/2023	Expired





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PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?

It can be requested in the following ways:

- ✓ [Ambetter Secure Provider Portal](#) (This is the preferred and fastest method.)
- ✓ Phone **1-833-993-2426 (TTY 711)**
- ✓ Fax **1-833-913-2996**

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 at www.AmbetterMeridian.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

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

**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 more than 48 hours require Inpatient Authorization
- Urgent/Emergent Admissions
- Within one business 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
 - Therapy
 - Private duty nursing
 - Adult medical day care
 - Hospice
 - Furnished medical supplies and 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 5 days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required 5 days prior to the elective outpatient service date
Emergent inpatient admissions	Notification 1 business day
Observation – 48 hours or less	Notification within 1 day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 business day
Maternity admissions	Notification within 1 business day
Newborn admissions	Notification within 1 business day
Neonatal Intensive Care Unit (NICU) admissions	Notification within 1 business day
Outpatient Dialysis	Notification within 1 business day

UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Within 72 hours of receipt of all information needed to complete the review.
Prospective/Non-Urgent	Within 9 calendar days of receipt of all information needed to complete the review.
Concurrent/Urgent	1 calendar day from receipt of request.
Concurrent/Non-Urgent	15 days
Retrospective	30 Days

PRIOR AUTHORIZATION: CORRECT CODING

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.





2024 Provider Orientation

CLAIMS, BILLING & PAYMENTS

CLAIMS

WHAT IS A CLEAN CLAIM?

- A clean claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation, or particular circumstances 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 365 days from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. The Secure Ambetter Provider Portal

2. **Electronic Clearinghouse**

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

3. **Mail**

Ambetter from Meridian
P.O. Box 5010
Farmington, MO 64640-5010



CLAIM RECONSIDERATIONS & DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Reconsider Claim** button on the Claim Details screen within the Secure Provider 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 **120 days** of the Explanation of Payment.
- Mail claim reconsiderations to:
Ambetter from Meridian
Attn: Claims
P.O. Box 5010
Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within **120 days** of the Explanation of Payment.
- A Claim Dispute form can be found on our website [Provider Resources page](#).
- Mail completed Claim Dispute form to:
Ambetter from Meridian
Attn: Claims
P.O. Box 5010
Farmington, MO 63640-5010



CLAIM SUBMISSION: SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- 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.
- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a three-month grace period for paying claims.
- 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 A 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.”



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.

REMINDER: DO NOT 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 [Ambetter Secure Provider Portal](#).
- 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).



2024 Provider Orientation

COMPLAINTS, GRIEVANCES & APPEALS

COMPLAINTS, GRIEVANCES & APPEALS

CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal.

COMPLAINT/GRIEVANCE

- A member's appeal must be filed within **180 calendar days** of the Notice of Action.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within **30 calendar days**.



COMPLAINTS, GRIEVANCES & APPEALS

APPEALS

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal.

MEDICAL NECESSITY

- Must be filed within **30 calendar days** from the Notice of Action.
- Ambetter shall acknowledge receipt within **30 calendar days** of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed **30 calendar days**.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed **72 hours**.



COMPLAINTS, GRIEVANCES & APPEALS

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 [AmbetterMeridian.com](https://www.AmbetterMeridian.com).





2024 Provider Orientation

SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES & VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-866-842-1767 www.radmd.com
Vision Services	Envolve Vision©	1-833-993-2426 www.envolvevision.com
Dental Services	Envolve Dental©	1-833-993-2426 www.envolvedental.com
Pharmacy Services	Pharmacy Services	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)



2024 Provider Orientation

Questions & Answers

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