AMBETTER OF NORTH CAROLINA INC.

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 Services
  - Public Website and Secure Portal
  - Verification of Eligibility, Benefits and Cost Shares
  - Prior Authorization
  - Claims, Billing and Payments
  - Complaints, Grievances and Appeals
  - Specialty Companies and Vendors
- **Q & A**

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OVERVIEW

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WE ARE

Ambetter.

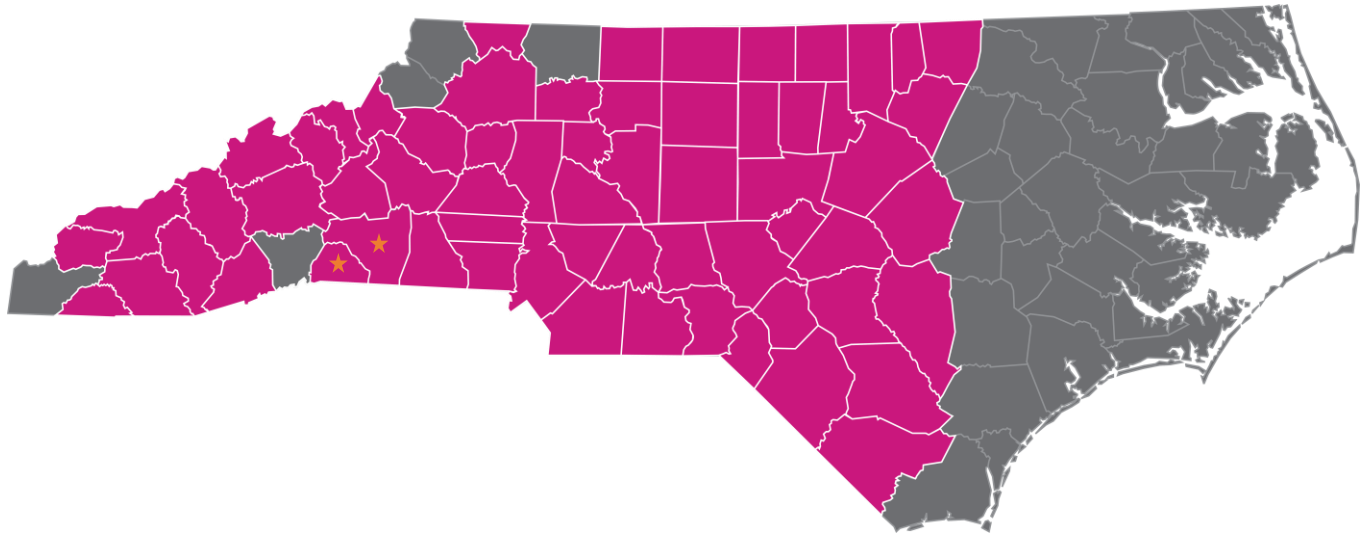
WE PROVIDE MARKET-LEADING, AFFORDABLE HEALTH INSURANCE ON THE MARKETPLACE.

#1 carrier
on the health insurance marketplace

2014
Year that Ambetter began

2.0M+
members insured

28
states

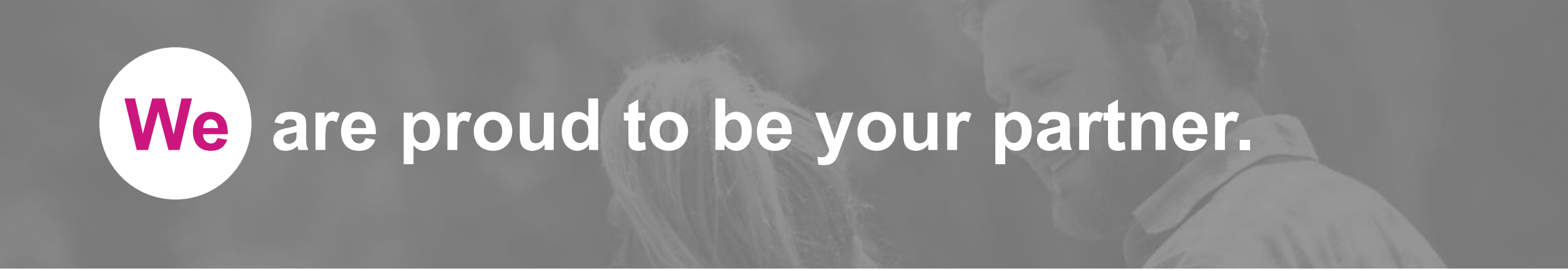


We target a focused demographic.

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)

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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)

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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 – – North Carolina ***is a Federally Facilitated Marketplace***

THE HEALTH INSURANCE MARKETPLACE IS THE ONLY WAY TO PURCHASE INSURANCE AND RECEIVE SUBSIDIES.

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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

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OUR NETWORKS

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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.

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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.

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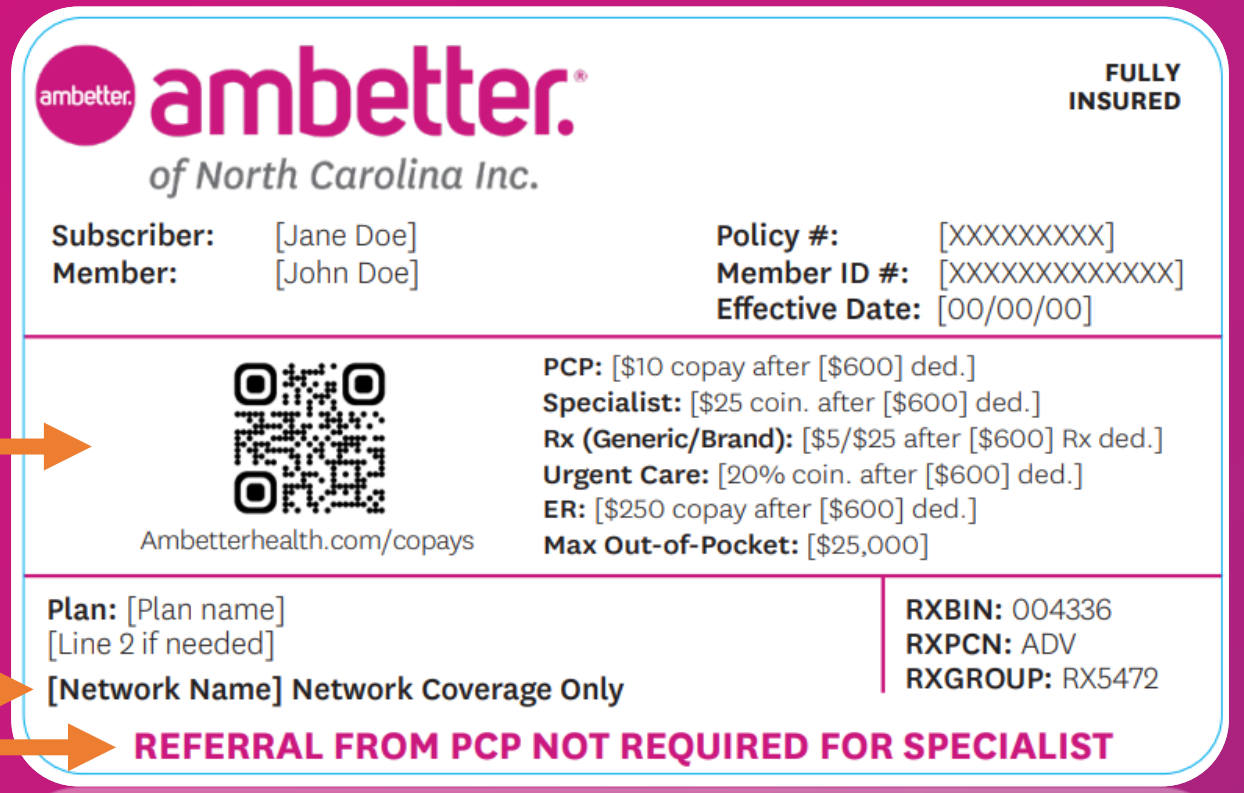
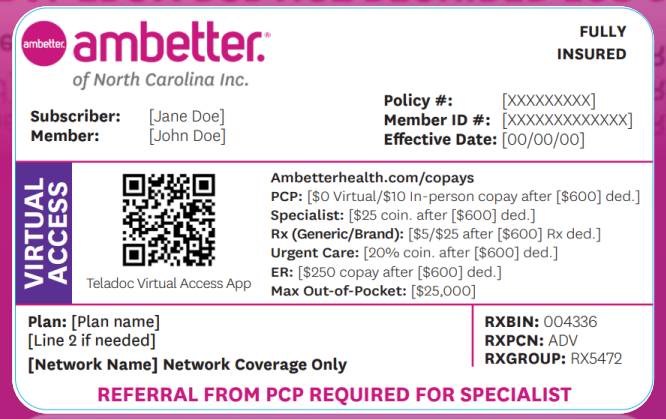
HOW TO IDENTIFY A MEMBER'S NETWORK

- All members will receive an Ambetter member identification card. The ID card includes new information including:
  - The Ambetter Plan the member has selected;
  - The Provider Network the member belongs to; and
  - Any referral requirements based on the member's plan selection.
- *NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are rendered.*





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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 North Carolina, members will have a Teladoc 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 North Carolina, members will be enrolled in plans that DO **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.

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WHAT YOU NEED TO KNOW

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GETTING ACQUAINTED

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KEY CONTACT INFORMATION

Ambetter of North Carolina Inc.

PHONE

Phone: 1-833-863-1310
(Relay 711)

WEB

https://www.ambetterofnorthcarolina.com/

PORTAL

Provider.AmbetterofNorthCarolina.com

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THE PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER OF NORTH CAROLINA INC.

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 of North Carolina Inc. website at **https://www.ambetterofnorthcarolina.com/**

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PROVIDER SERVICES

- The **Ambetter of North Carolina Inc.** Provider Services department includes trained Provider Services 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 of North Carolina Inc.** Provider Services at **1-833-863-1310** providers will be able to access real time assistance for all their service needs

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PROVIDER ENGAGEMENT

- As an **Ambetter of North Carolina Inc.** provider, you will have Provider Engagement Coordinators available to assist you
- Our Provider Engagement Coordinators serve as the primary liaisons between our health plan and provider network
- Provider Engagement Coordinators are 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

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PROVIDER DATA

- Providers should submit updates to demographic data to AmbetterNCProviderDirectoryRequest@CENTENE.COM within thirty days of the data change becoming effective.
- Providers should also request and submit rosters by emailing: AmbetterNCProviderDirectoryRequest@CENTENE.COM
- Enrollments are effective thirty days from the date all clean documents are received.

- Please send the following items to AmbetterNCProviderDirectoryRequest@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

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PUBLIC WEBSITE AND SECURE PORTAL

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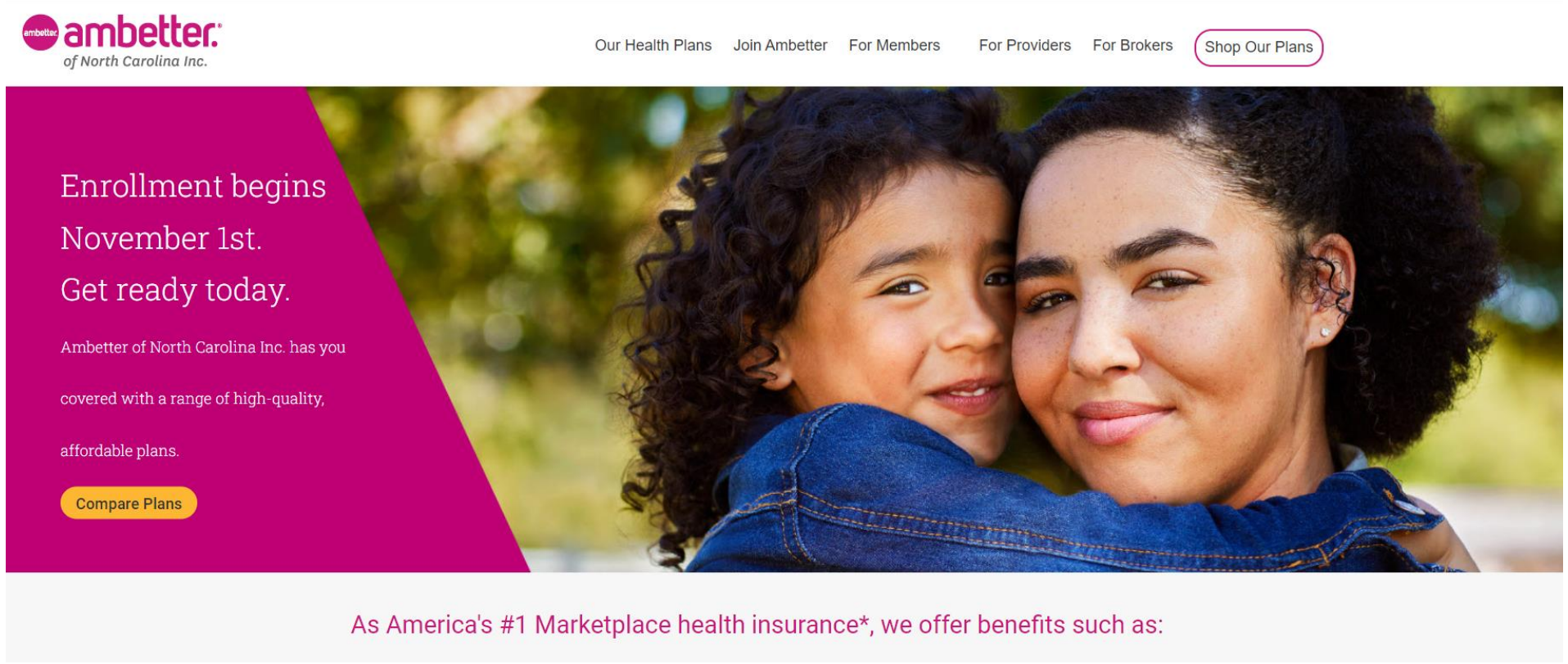
THE AMBETTER PUBLIC WEBSITE

AMBETTEROFNORTHCAROLINA.COM



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THE AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

- The 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
- Clinical and Payment Policies
- And much more!

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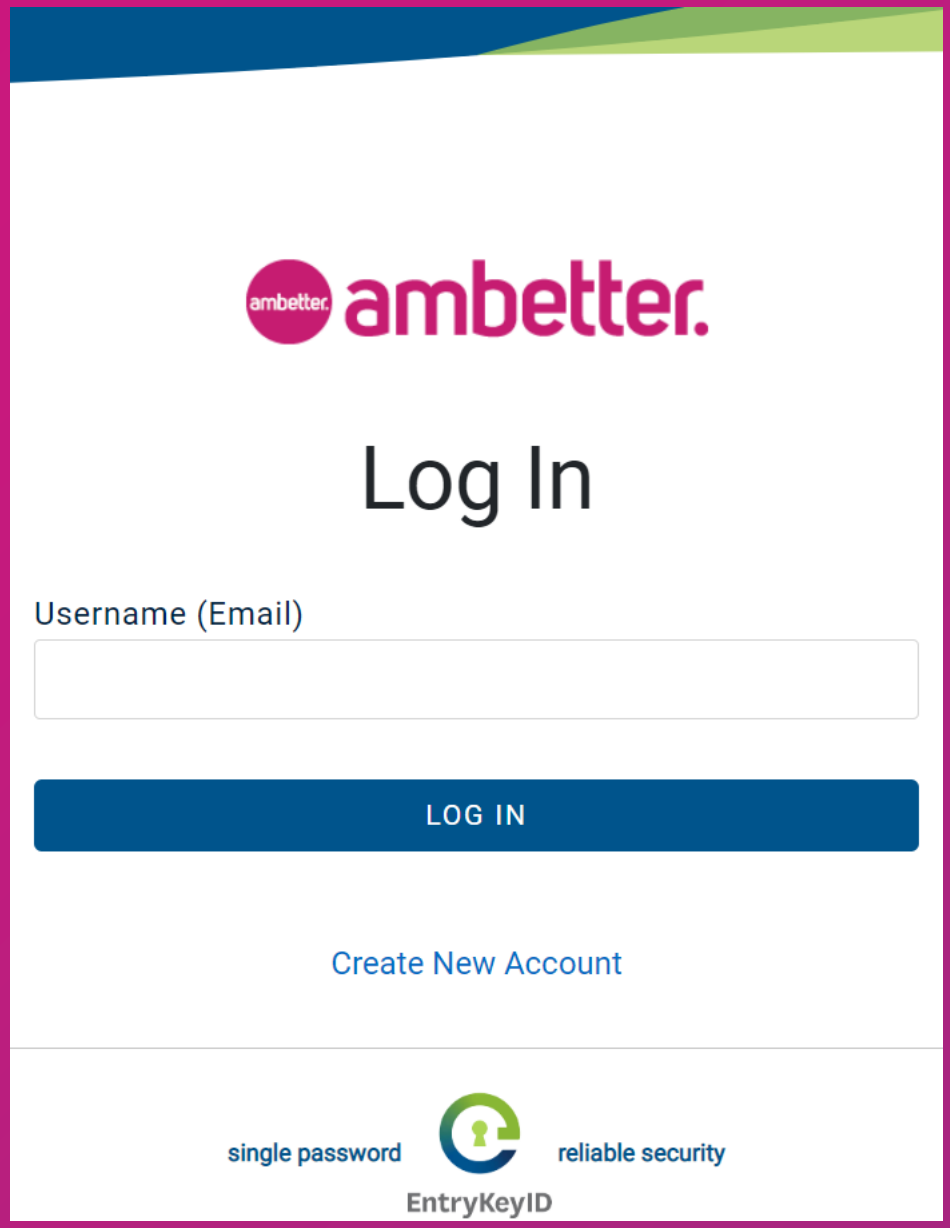
SECURE PROVIDER PORTAL

Registration is free and easy!

Contact Provider Services to get started!



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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

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SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

PCP reports available on **PROVIDER.AMBETTEROFNORTHCAROLINA.COM** 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

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VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

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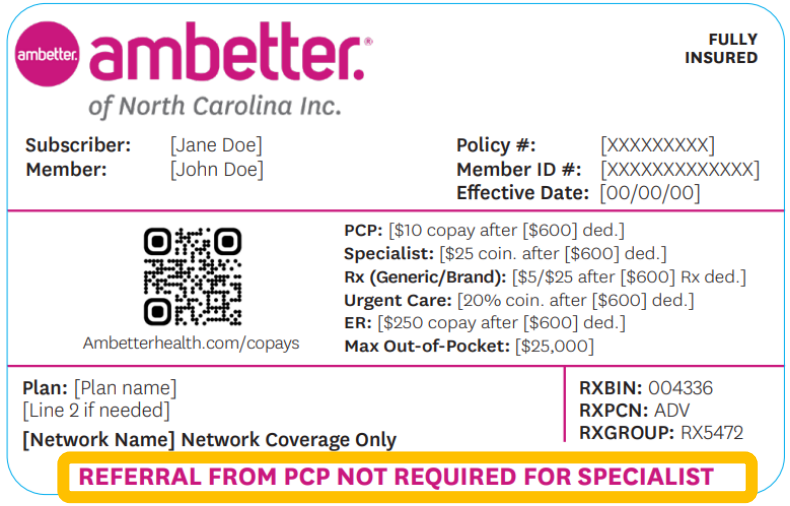
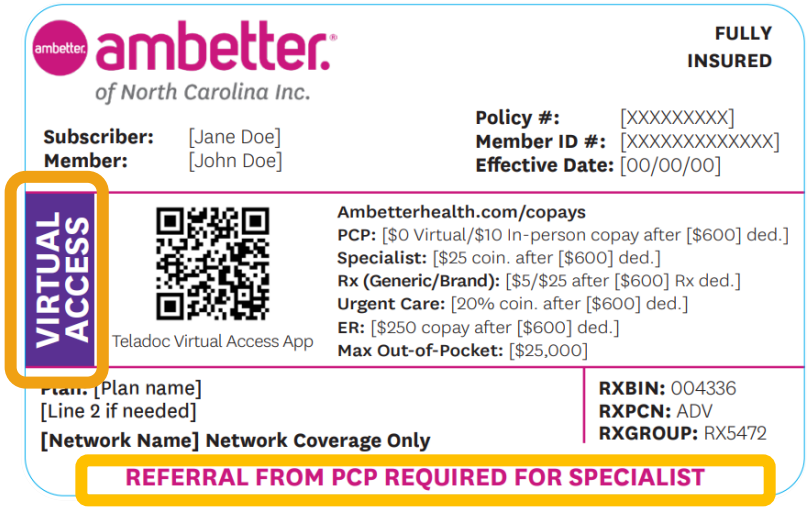
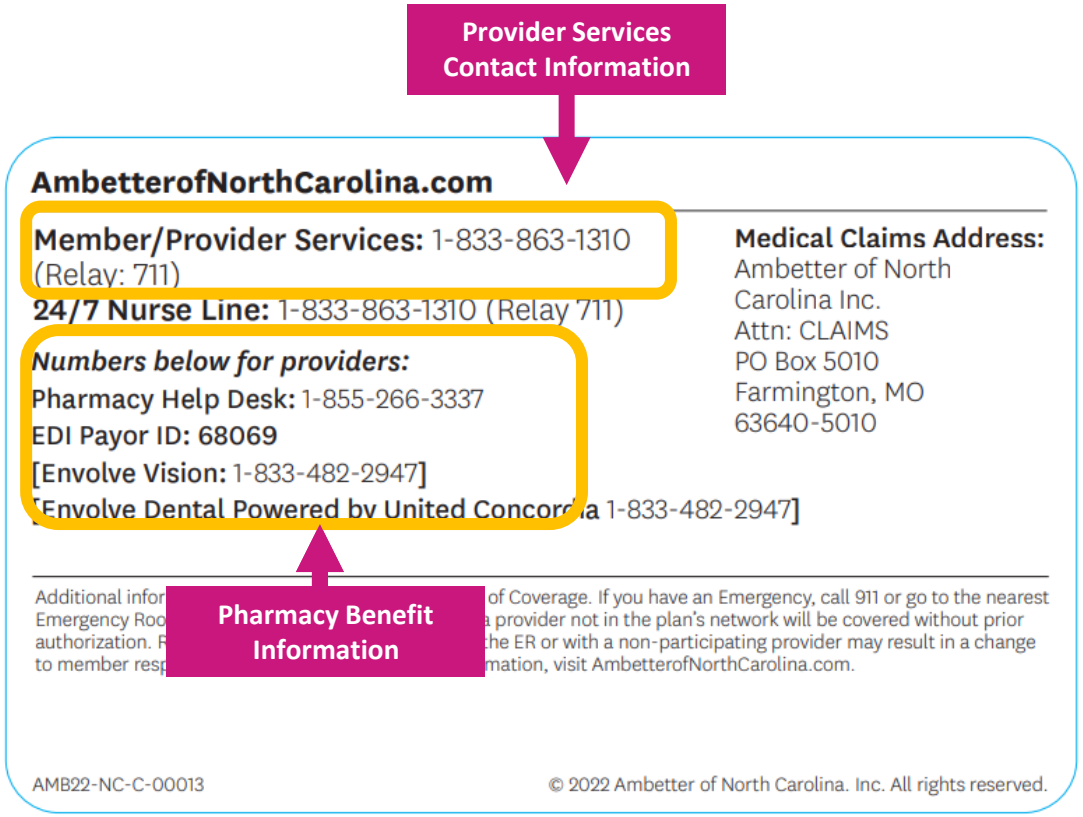
NAVIGATING THE MEMBER ID CARD







Plans can include:
- Ambetter Virtual Access

Certain plans may have a referral requirement. Please note:
1. Referral from PCP is required to see a specialist. Auth may be required.
2. Referral from PCP is **not** required to see a specialist. Auth may be required.

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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
- PCPs can still administer service if the member is not on their panel and they wish to have member assigned to them for future care

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VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARE

ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN 3 WAYS:

- ✓ **The Ambetter Secure Portal: https://provider.ambetterofnorthcarolina.com**
  - If you are already a registered user of the **Ambetter of North Carolina Inc.** 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: 1-833-863-1310

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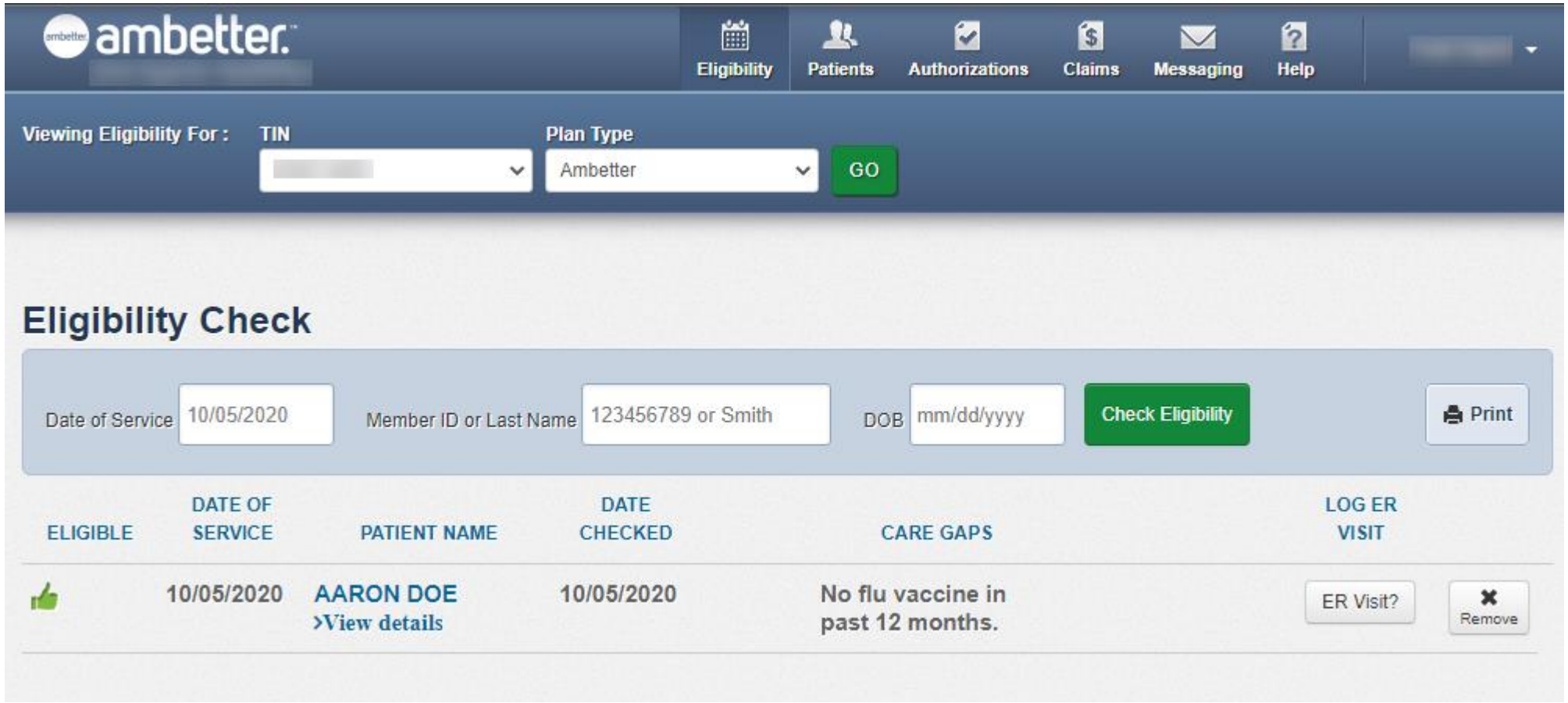
VERIFICATION OF ELIGIBILITY ON THE PORTAL



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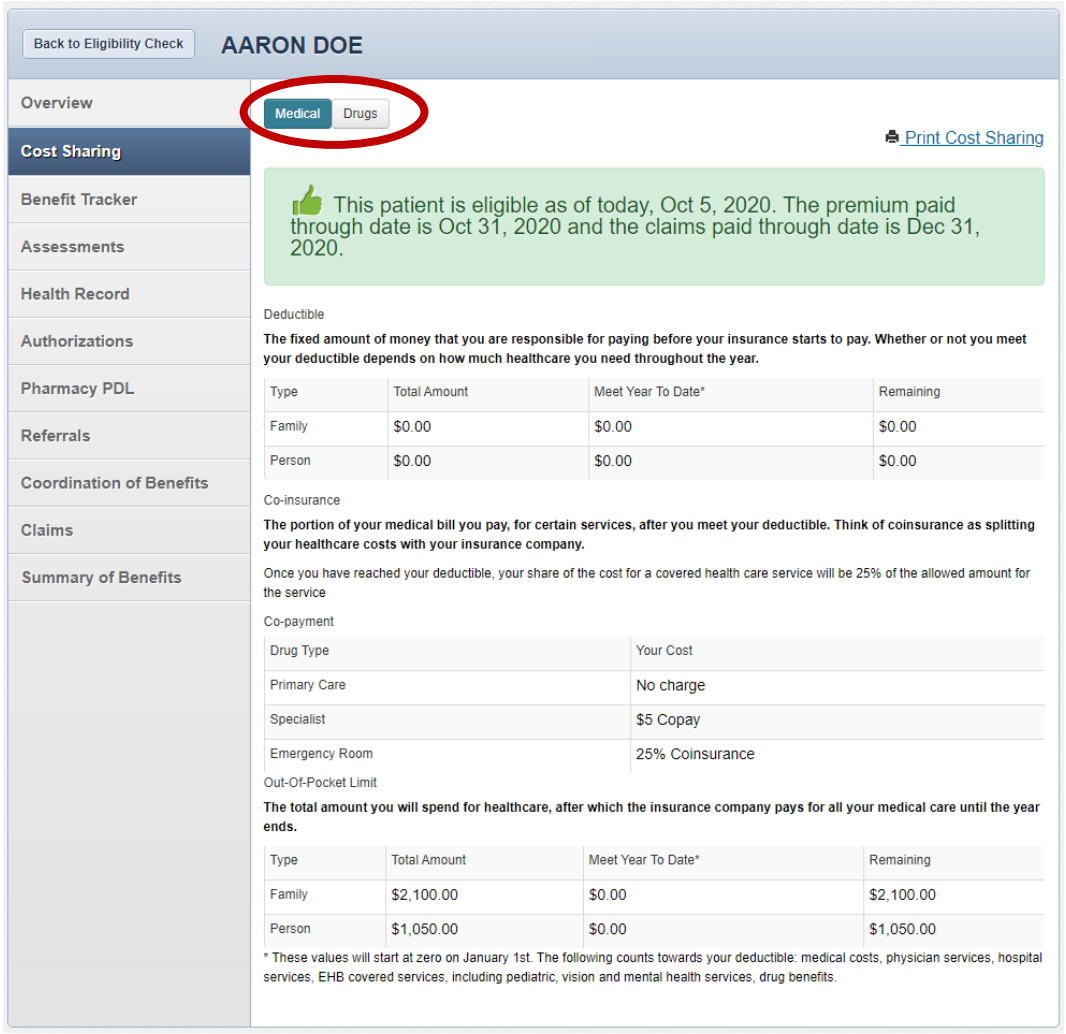
VERIFICATION OF COST SHARES ON THE PORTAL



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VERIFICATION OF BENEFITS ON THE PORTAL

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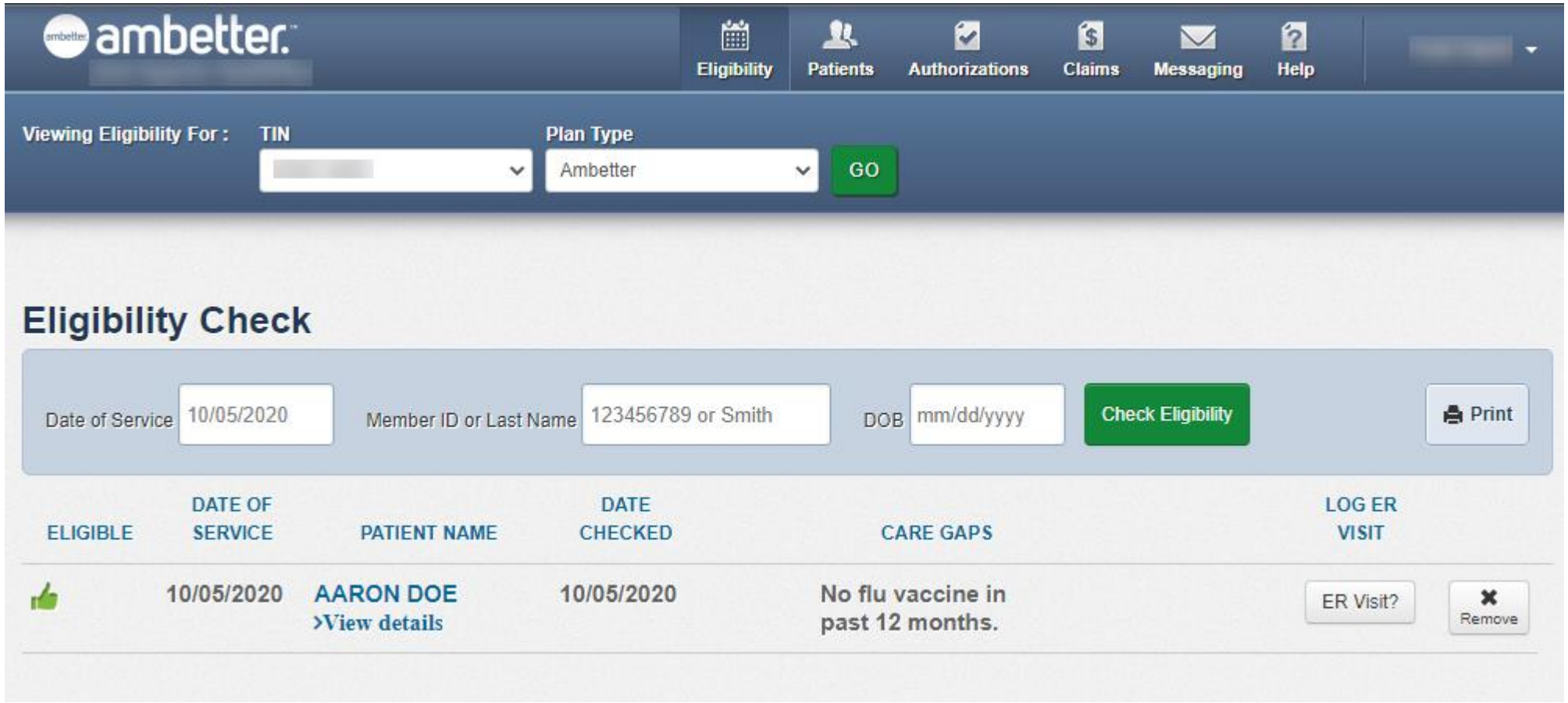

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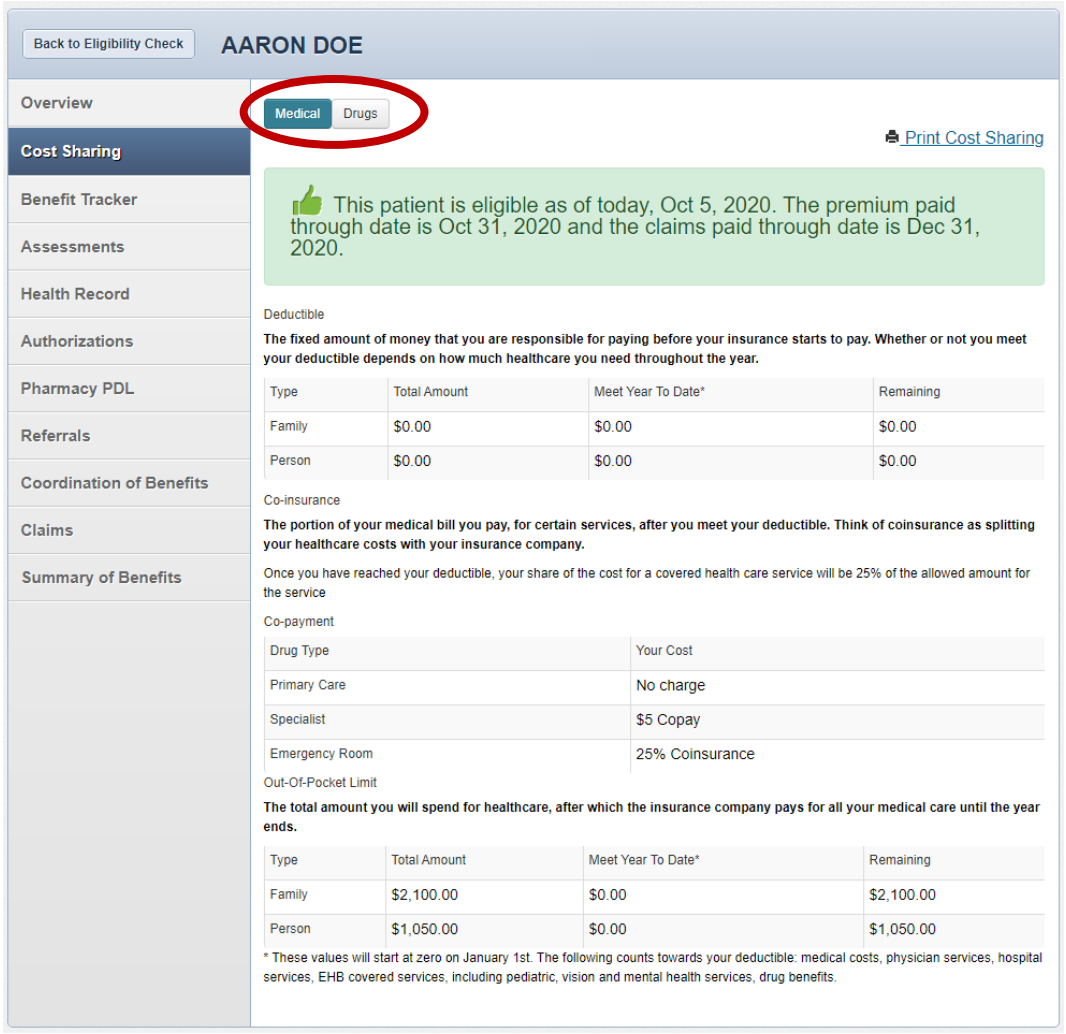
VERIFICATION OF COST SHARES ON THE PORTAL



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VERIFICATION OF BENEFITS ON THE PORTAL

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REFERRALS

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AMBETTER VIRTUAL ACCESS REFERRAL REQUIREMENTS

- Ambetter Virtual Access has 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.

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EXEMPTIONS TO AVA REFERRAL REQUIREMENTS

The following Ambetter Virtual Access 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.

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AMBETTER REFERRAL REQUIREMENTS

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

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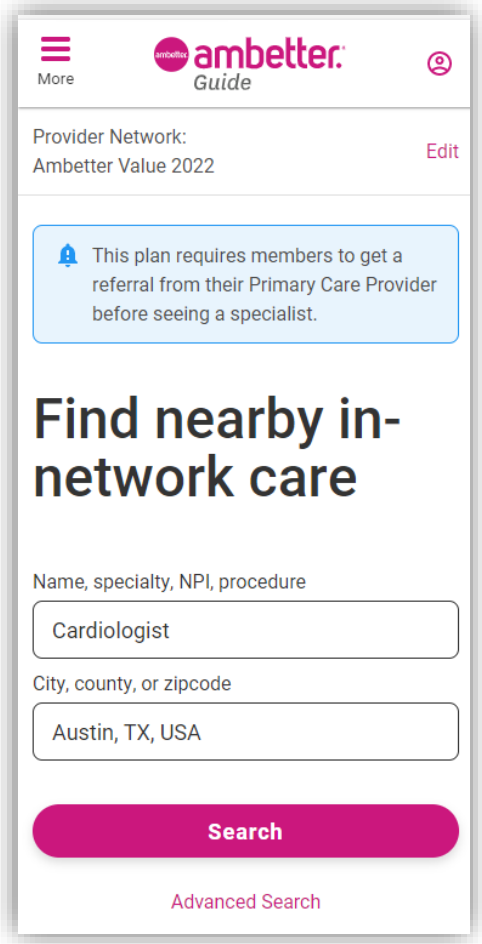
FINDING AN AMBETTER VIRTUAL ACCESS PROVIDER



1. Go to Ambetter Guide: https://guide.ambetterhealth.com/
2. Click the option for Ambetter Virtual Access
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.

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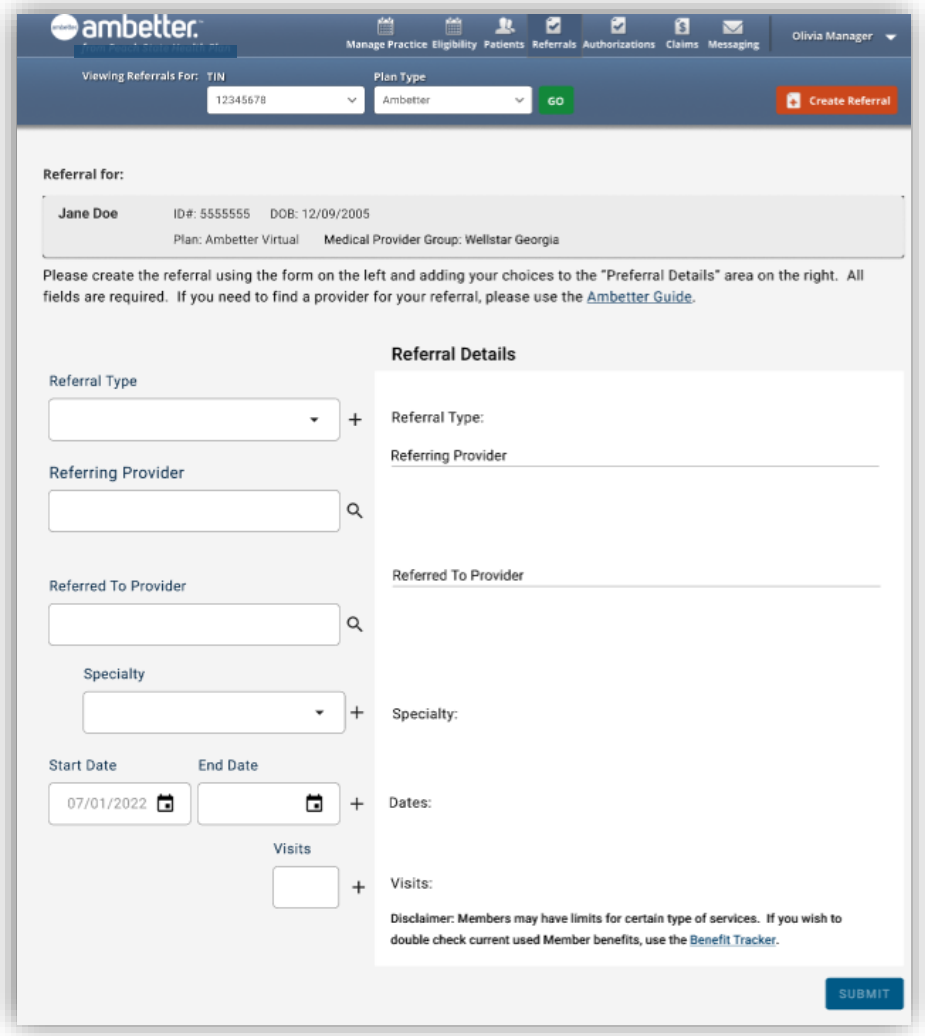
MAKING A REFERRAL: SECURE PROVIDER PORTAL

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.



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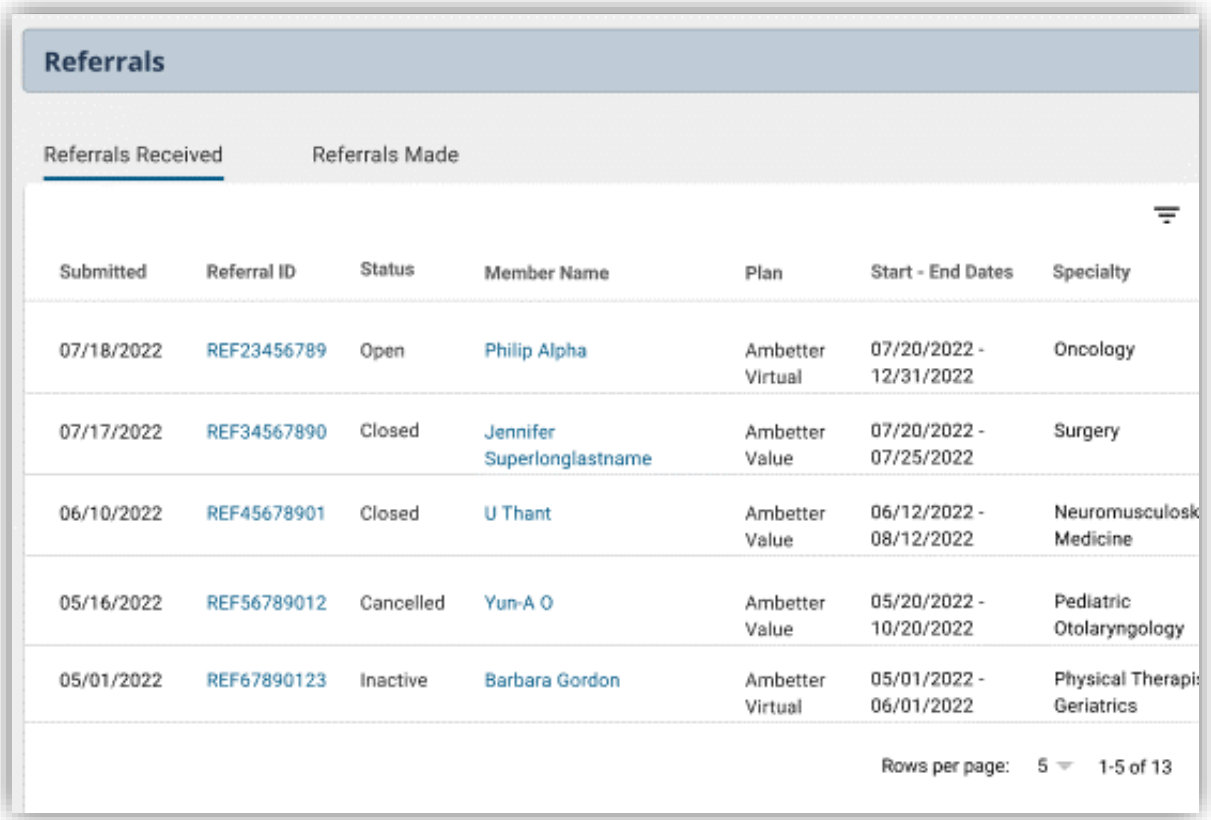
RECEIVING A REFERRAL

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.



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PRIOR AUTHORIZATION

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HOW TO SECURE PRIOR AUTHORIZATION

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

✓ Secure Web Portal

https://provider.ambetterofnorthcarolina.com

This is the preferred and fastest method.

✓ Phone

1-833-863-1310

✓ Fax

1-844-536-2412

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

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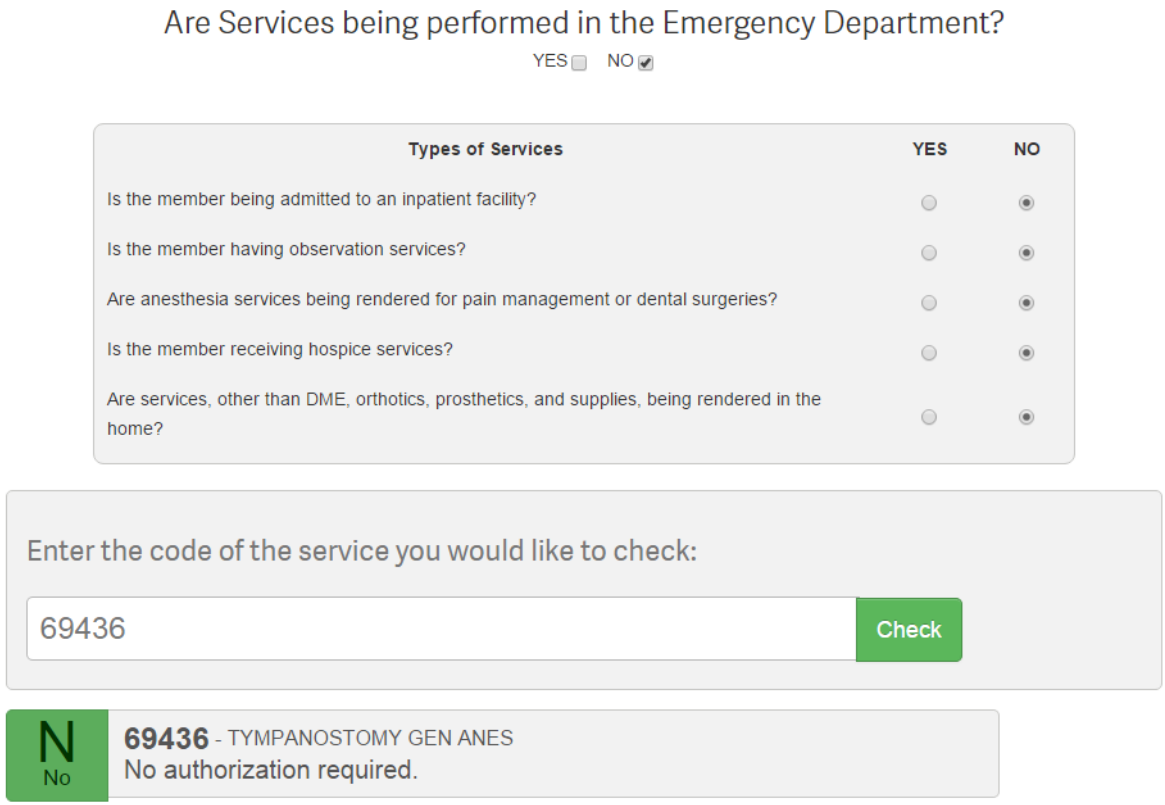
IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the **Ambetter of North Carolina Inc.** website at **ambetterofnorthcarolina.com**



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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 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.*

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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*

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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.*

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PRE-AUTHORIZATION PROGRAMS

RADIOLOGY AND SPECIALTY THERAPIES

- Effective January 2019, Ambetter of North Carolina Inc. has selected **National Imaging Associates, Inc. (NIA)** to implement a radiology benefit management program for outpatient advanced imaging services
- Effective January 2021, Ambetter of North Carolina Inc. will also work with **National Imaging Associates (NIA)** for the Utilization Management of outpatient rehabilitative and habilitative Physical Medicine services (Physical, Occupational, and Speech Therapy).
- For helpful resources such as Quick Reference Guides, FAQs, trainings, tip sheets, and more visit NIA's provider website for Ambetter of North Carolina Inc.
- National Imaging Associates Provider Portal: WWW.RADMD.COM

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PRE-AUTHORIZATION PROGRAMS

ONCOLOGY/SUPPORTIVE DRUGS:

- Beginning November 1, 2021, all oncology-related infused, oral chemotherapeutic drugs/supportive agents, and radiation treatments will require a prior authorization from **New Century Health (NCH)** before being administered in either the provider's office, outpatient hospital, ambulatory setting, or infusion center.
- This requirement applies to Ambetter of North Carolina Inc. members of all ages
- Program includes pre-authorization management for Oral and Infused chemotherapy agents, supportive and symptom management drugs and Radiation Oncology services
- In scope specialties include:
  - Gynecologic Oncology
  - Hematology
  - Medical Oncology
  - Neurological Oncology
  - Pediatric Oncology
  - Surgical Oncology
  - Radiation Oncology
  - Urology
- Portal users may log in to the NCH provider portal by going to my.newcenturyhealth.com
- For more information and a list of medication this impacts, please view the August 10th news bulletin

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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 24 hours
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 24 hours
Maternity admissions	Notification within 24 hours
Newborn admissions	Notification within 24 hours
Neonatal Intensive Care Unit (NICU) admissions	Notification within 24 hours
Outpatient Dialysis	Notification within 24 hours

For additional details, please see the Provider and Billing Manual

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UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Within 72 hours of receipt of all information needed to complete the review.
Prospective/Non-Urgent	Within 3 business days of receipt of all information needed to complete the review.
Emergency services	60 minutes (1 hour)
Concurrent/Urgent	Within twenty-four (24) hours of receipt of request when all necessary information is available.
Retrospective	Thirty (30) calendar days

For additional details, please see the Provider and Billing Manual

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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 of North Carolina Inc. 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

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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 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

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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**
   provider.ambetterofnorthcarolina.com

2. **Electronic Clearinghouse**
   - Payer ID 68069
   - Clearinghouses currently utilized by Ambetter will continue to be utilized
   - For a listing of clearinghouses, please visit our website at **ambetterofnorthcarolina.com**

3. **Mail**
   P.O. Box 5010
   Farmington, MO 64640-5010

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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 ambetterofnorthcarolina.com
- Mail completed Claim Dispute form to:

P.O Box 5010
Farmington, MO 63640-5010

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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

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CLAIM SUBMISSION – SUSPENDED STATUS

EXAMPLE TIMELINE OF MEMBER IN SUSPENDED STATUS

- **January 1st**
  Member pays premium
- **February 1st**
  Premium due – member does not pay
- **March 1st**
  Member placed in suspended status
- **April 1st**
  Member remains in suspended status
- **May 1st**
  If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

Claims for members in a suspended status are not considered "clean claims".

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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

FOR ADDITIONAL INFORMATION ON CLAIMS SUBMISSION, SEE BILLING MANUAL

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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://provider.ambetterofnorthcarolina.com/**

- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days

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CLAIMS PAYMENTS: ELECTRONIC FUNDS TRANSFER

PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

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

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COMPLAINTS, GRIEVANCES AND APPEALS

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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

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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

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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 **https://ambetterofnorthcarolina.com/**

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SPECIALTY SERVICES & VENDORS

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OUR SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services and Specialty Therapies	National Imaging Associates	866-214-2569 www.radmd.com
Oncology/Supportive Drugs	New Century Health (NCH)	1-888-999-7713 https://my.newcenturyhealth.com
Vision Services	Envolve Vision Benefits	www.envolvevision.com
Dental Services	Envolve Dental	www.envolvedental.com
Pharmacy Services		1-866-399-0929 (Fax)

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QUESTIONS?

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