Ambetter Ancillary Provider Quick Reference Guide

Home Health Providers

Important Contact Information

Service Name	Product	Phone Number	Hours of operation
Member Services	Ambetter	1-877-687-1169	Monday-Friday from 8 a.m. to 8 p.m. Eastern
Provider Services	Ambetter	1-877-687-1169	Monday-Friday from 8 a.m. to 8 p.m. Eastern
24/7 Toll-Free Interactive Voice Response (IVR) Line	All products	1-877-687-1169	24 hours a day
Home Health Auths	Ambetter	**Medical (Fax)** 1-855-678-6981 **Behavioral Health (Fax)** 1-844-208-9113	24 hours a day

Verifying Member Eligibility

These suggestions are not a guarantee of coverage.

Check member eligibility via:

- Secure Web Portal
    - Using the portal, any registered provider can quickly check member eligibility by indicating the date of service, member name and date of birth or the Ambetter ID number and date of birth.
    - Ensure you're selecting the correct plan type.
- 24/7 Toll-Free Interactive

Voice Response (IVR) Line:

- 1-877-687-1169

Provider Services:

- 1-877-687-1169

Authorizations

Prior authorization is required for certain services. To determine which services, require authorization, please refer to our Pre-Auth Tool

Prior authorization requests are processed by Sunshine Health's Utilization Management (UM) Department.

- **Standard requests:** Determination within **15** calendar days of receiving all necessary information.
- **Urgent requests:** Urgent and medically necessary to treat an injury, illness, or condition (not life threatening) to avoid complications and unnecessary suffering or severe pain; Determination within **72**-hour turnaround time.

Submit authorization requests via one of the following: Use the Pre-Auth Needed tool on our website to determine if prior authorization is required.

Submit prior authorizations via:

- Secure Provider Portal
- Medical Fax: 1-855-678-6981
- Behavioral Fax: 1-844-208-9113
- Phone: 1-877-687-1169

Note: Find a link to the the IP/OP Auth request form for fax submission on our Provider Resources page.

Utilization Management

Utilization Management Phone number: 1-877-687-1169 and follow prompts for services required.

- **Standard hours of operation**: Monday to Friday from 8 a.m. to 8 p.m. Eastern.
- **Weekend and After-Hours on Call-Numbers:** 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 by phone, fax, or web.

Home Health Claims

- Providers contracted with Medicare must bill according to CMS billing guidelines on CMS 1450 form.
- Providers contracted as Payor reimbursement can bill on a CMS 1450 or CMS 1500 form.
- CMS 1500 submissions must be billed in location 12.
- CMS 1450 submissions must be billed with Bill type 32X or 34X.
- Both Rev and CPT codes are required.
- Each visit must be billed individually on separate service line.
- Therapy services must be billed with the appropriate modifier(s).
- Nursing services must be billed with the appropriate modifier(s).
- Current Medicare requires episodic billing requirements.
- See the current Provider Billing Manual for full Home-Health billing disclosures and appropriate modifier use.

Important Links

- Provider Resources

Timely Claim Submission

Providers must submit claims in a timely manner as indicated in the following table.

Initial Claim		Reconsiderations or Claim Dispute		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Participating	Non-Participating	Participating	Non-Participating	Participating	Non-Participating
180 days	180 days	90 days	90 days	90 days from primary payers' EOP date to the date received.	90 days from primary payers' EOP date to the date received.

- **Initial Claims –** Days are calculated from the Date of Service (DOS) to the date received by Ambetter or from the EOP date. For observation and inpatient stays, the date is calculated from the date of discharge.

  Paper Claim Submission

  The mailing address for first time claims (Medical and Behavioral Health)

  Ambetter Attn: Claims
  P.O. Box 5010
  Farmington, MO 63640- 5010

- **Claims Dispute/Appeals –** Days are calculated from the date of the Explanation of Payment issued by Ambetter to the date received.
- **Coordination of Benefits –** Days are calculated from the date of Explanation of Payment from the primary payers to the date received

Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for corrected claims, reconsiderations, or claim disputes must be received within 90 days from the date of the original explanation of payment or denial. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 90-day timeframe unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1. A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays, or errors by Ambetter or the Federal and/or State regulatory body.
2. The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide their ID Card or information.
    - The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered.
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

Relevant Claim Definitions

- **Corrected claim –** A provider is changing the original claim.
- **Request for reconsideration –** A provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
- **Claim dispute/appeal –** A provider disagrees with the outcome of the request for reconsideration.

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

1. Submit a corrected claim via the Secure Provider Portal. Follow the instructions on the portal for submitting a correction.
2. Submit a corrected claim electronically via a clearinghouse.
    - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = **Original Claim Number**
    - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = **Original Claim Number**
3. Submit a corrected paper claim to:

Ambetter
Attn: Corrected Claims
P.O. Box 5010
Farmington, MO 63640- 5010

- Upon submission of a corrected paper claim, the original claim number must be **typed** in field 22 (CMS 1500) and in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.
- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected

Request for Reconsiderations

All requests for corrected claims or reconsiderations/claim disputes must be received within 90 days from the date of the original explanation of payment or denial.

A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit, or authorization denial, medical records **must accompany** the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. Providers may elect to call to Provider Services. This method is for requests for reconsideration that do not require submission of supporting or additional information. An example of this is when a provider believes a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that particular rate.
2. Providers may use the Request for Reconsideration form found on our website (preferred method).
3. Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a CMS 1450 (UB-04 form). The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.
4. It is not necessary to attach a copy of the submitted claim.

   Written requests for reconsideration and any applicable attachments must be mailed to:

   Ambetter
   Attn: Request for Reconsideration
   P.O. Box 5010 Farmington, MO 63640- 5010

   When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP.

Claim Dispute

A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.

A claim dispute/appeal must be submitted on a claim dispute/appeal form found on our website. The claim dispute form must be completed in its entirety. Mail completed claim dispute/appeal forms to:

Ambetter

Attn: Claim Dispute

P.O. Box 5010

Farmington, MO 63640- 5010

A claim dispute/appeal will be resolved within 60 calendar days. If the request for reconsideration or the claim dispute results in an adjustment to the claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

Provider Changes

Network Participation Request Form

A Home Health provider that is not currently in the Ambetter network but wants to join should complete a Network Participation Request form.

Provider Terminations

Providers should refer to their contracts for specific information about terminating their contracts with Ambetter Sunshine Health.
In general, providers are required to notify the health plan within 90 days of terminating

Provide the termination information on office letterhead and include the provider name, tax identification number, NPI, and termination date

Email the request to SunshineProviderRelations@SunshineHealth.com and notify your Provider Relations Representative.

Find My Provider Rep Tool

Locate your Provider Representative.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Ambetter partners with specific vendors to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment. Providers are able to enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact Provider Services.

Benefits include:

- Elimination of paper checks – All deposits transmit via EFT to the designated bank account
- Convenient payments & remittance information retrieval
- Electronic remittance advices presented online
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System
- Reduced accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improved cash flow – Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts – You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily.
- Manage multiple Payers – Reuse enrollment information to connect with multiple payers and assign to different payers to different bank accounts as desired.

For more information, please visit our provider home page on our website at ambetter.sunshinehealth.com. If further assistance is needed, please contact our Provider Services Department at 1-877-687-1169 (Relay Florida 1-800-955-8770).

Case Management

We understand the special needs of our members. For members that have complex medical or behavioral health needs, we offer Care Management services that are member-centered, family-focused and culturally competent. Our Care Managers are registered nurses or social workers. They can help members:

- Better understand and manage their health condition.
- Coordinate services.
- Locate community resources.

A Care Manager will work with members and their doctor to help ensure members get the care they need. Members with a severe medical condition, our Care Managers will work with them, and their PCP to develop a plan of care that meets the member needs and those of their caregiver's. Care Management can be reached at 1-877-687-1169 (Relay Florida 1-800-955-8770).

24-Hour Nurse Advice Line

The Nurse Advice Line can assist providers with checking member eligibility. It can also connect members to telemedicine for urgent care visits. Hours of operation are 24 hours a day, 7 days a week.

- 1-877-687-1169 (Relay Florida 1-800-955-8770).

Telemedicine

- Ambetter Telehealth powered by Teladoc is your convenient, 24-hour access to in-network Ambetter healthcare providers for non-emergency health issues.
- Get medical advice, a diagnosis or a prescription by phone or video.
- As part of our Health Management Program, Ambetter offers $0 copay for in-network Telehealth providers*.
  * $0 cost share applies for in-network telehealth services through Ambetter Telehealth. $0 Ambetter Telehealth cost share does not apply to HSA plans until the deductible is met.

Additional Resources:

Find A Provider (FAP) Tool – If you need assistance locating a specialist or facility for a member, please visit our Ambetter Guide to find nearby in-network care. Here you will be able to search by provider name, NPI and specialty type.

For Providers Page – Stay up to date on provider communication by visiting our Provider Resources page.