Ambetter Health Behavioral Health Billing Clinic

Provider Training

Agenda

- Overview
- Overall: Ambetter Plans
- Verification of Eligibility, Benefits and Cost Shares
- Referrals and Prior Authorization
- Pharmacy
- Complaints and Appeals
- Claims
- Claim Tips
- Billing the Member
- Quality Improvement
- Provider Resources
- Helpful Websites
- Questions

Overview

Who We Are

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- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.
- The focus on **our products** is 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.
- 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**.

Ambetter Plans

Ambetter Health – Silver and Gold (Core)

- The Ambetter Health Silver and Gold network is our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own.
- Ambetter Health Silver Care plans provide the best value and most balance between monthly premiums and out-of-pocket costs.
- Ambetter Health Gold offers peace of mind for all healthcare needs. Members can expect higher monthly premiums to limit out-of-pocket expenses later.

Health Insurance Marketplace

PCP Selection and Panel Status:

- Ambetter emphasizes to members the importance of establishing a medical home (better care, greater appointment availability, consistent care, etc.). Part of that is the selection of a Primary Care Provider (PCP).
- While Silver and Gold members may see any provider they choose, Ambetter encourages providers to emphasize the importance of the medical home relationship to members.
- PCPs can still administer service if the member is not assigned to them and may wish to have member assigned to them for future care.
- PCPs should confirm that a member is assigned to their patient panel.
  - This can be done through the Secure Provider Portal.

Ambetter Value

Ambetter Value

- Value has a more restrictive, yet inclusive and adequate network being offered within a limited set of counties:
  - Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson.
- The Ambetter Health Value plan design differs in the following:
  - New for 2024, members will be assigned a PCP at the practitioner level.
  - Any specialty care rendered by a specialist outside of the PCP's group will require a referral prior to services being rendered to our members.
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, Behavioral Health/Substance Use Disorder, Urgent Care, Emergent Care, Labs, Radiology, Ambulance and Anesthesia.
  - The above provider or facility types will still be required to be in-network* and prior authorization requirements will continue to apply, as applicable.

Ambetter Virtual Access

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 Primary Care is relationship-based care with a consistent provider delivered virtually Available exclusively to Ambetter Virtual Access (AVA) members.
- Ambetter Virtual Access most closely mirrors the network offered within Silver and Gold.
  - There are a few exceptions most noticeably within our Hospital systems network.
- The Ambetter Virtual Access plan design differs in the following:
  - Teladoc is the preferred PCP group to which members will automatically be assigned.
    - Members under the age of 18 are the exception as they will be assigned to a local PCP.
  - Members utilize Teladoc's application that can be downloaded on a phone or table or by visiting Teladoc.com/AmbetterVirtualAccess/.
  - Teladoc (or local PCP) will be responsible to submit a referral to Ambetter in order for any specialty care provider to render services to our members.

Ambetter Virtual Access

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- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, Behavioral Health/Substance Use Disorder, Urgent Care, Emergent Care, Labs, Radiology, Ambulance and Anesthesia.
  - Urgent Care, Emergent Care, Labs, Ambulance, Radiology and Anesthesia.
  - The above provider or facility types will still be required to be in-network (except for emergent services) and prior authorization requirements will continue to apply as applicable.
- 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.
- In Texas, members will be enrolled in plans that require referrals. It is possible that providers may see 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.

Verification of Eligibility, Benefits and Cost Shares

Verification of Eligibility, Benefits and Cost Shares

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

1. The Ambetter Secure Provider Portal: Provider.SuperiorHealthPlan.com
   - If you are already a registered user of Superior's secure provider portal, you do NOT need a separate registration!
2. 24/7 Interactive Voice Response System: 1-800-964-2777
   - Enter the Member ID Number and the month of service to check eligibility.
3. Contact Provider Services: 1-877-687-1196

Verification of Eligibility, Benefits and Cost Shares

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 through the Ambetter Secure Provider Portal.
- Value members PCP will be listed as “Ambetter Value Medical Group” or “Ambetter Value CH Provider Partner.”

Verification of Eligibility

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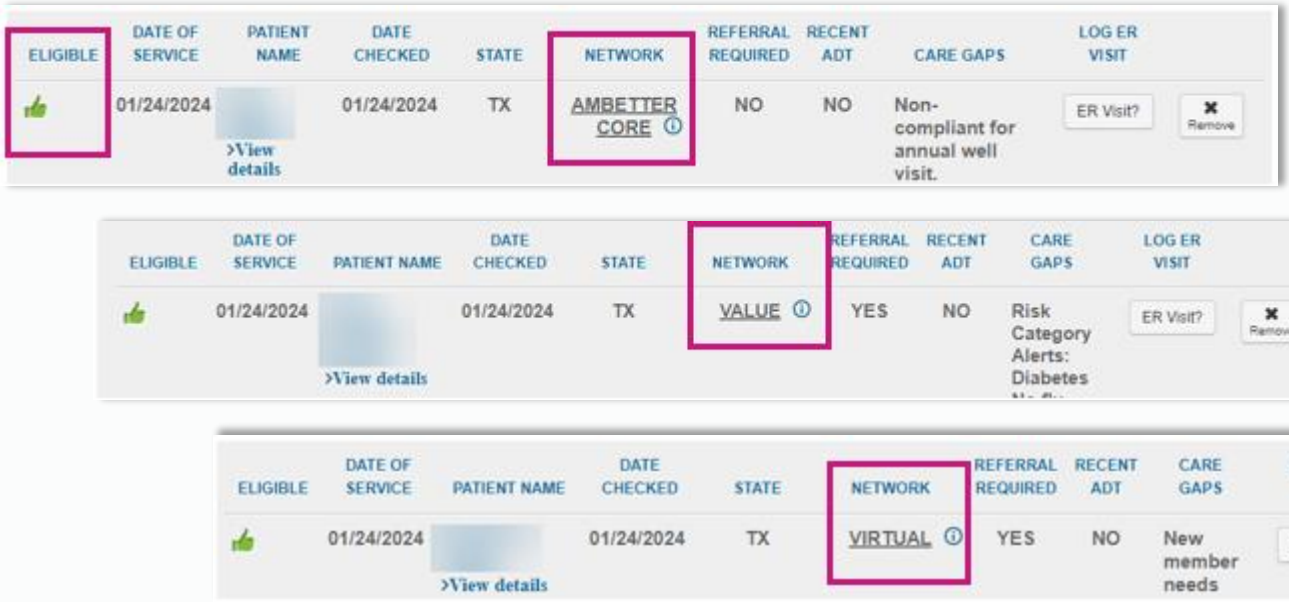
Ambetter Secure Provider Portal –
Confirming the Member's Network



ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	STATE	NETWORK	REFERRAL REQUIRED	RECENT ADT	CARE GAPS	LOG ER VISIT	
👍	01/24/2024	>View details	01/24/2024	TX	AMBETTER CORE ⓘ	NO	NO	Non-compliant for annual well visit.	ER Visit?	✖ Remove
👍	01/24/2024	>View details	01/24/2024	TX	VALUE ⓘ	YES	NO	Risk Category Alerts: Diabetes	ER Visit?	✖ Remove
👍	01/24/2024	>View details	01/24/2024	TX	VIRTUAL ⓘ	YES	NO	New member needs	ER Visit?	✖ Remove

Ambetter Silver and Gold ID Card (Core)

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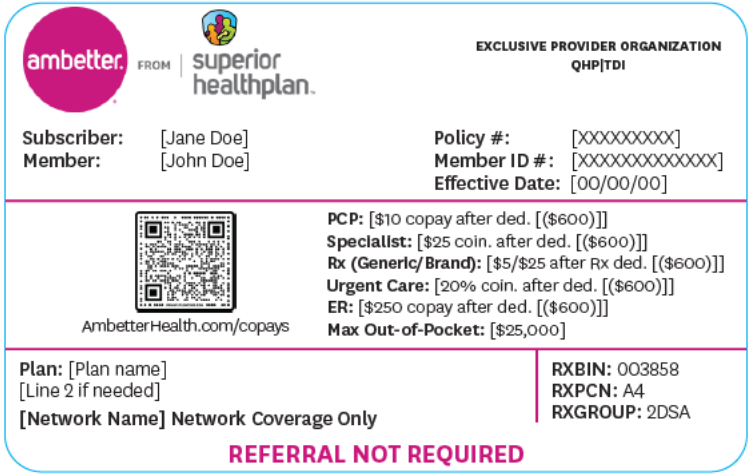
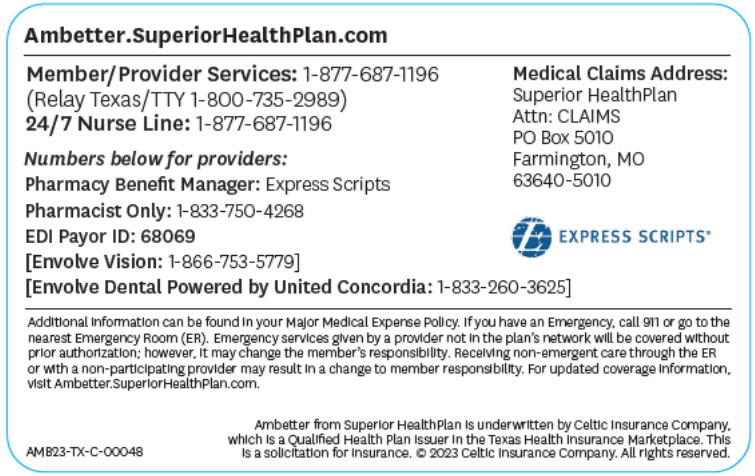
Member ID Card:





Note: Possession of an ID Card does not guarantee eligibility and benefits.

Ambetter Value ID Card

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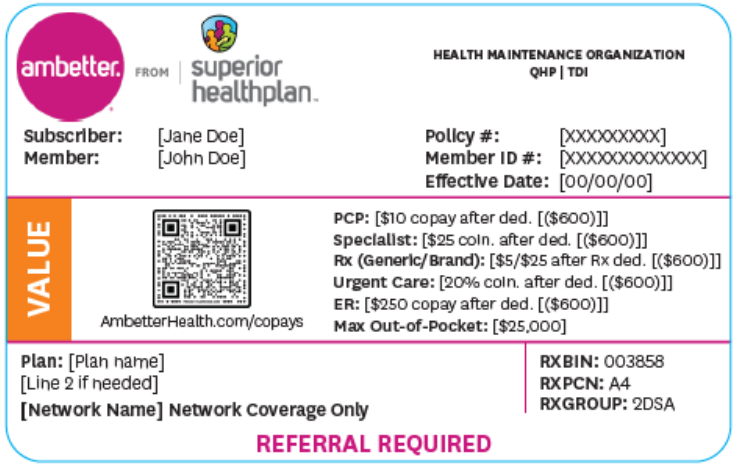
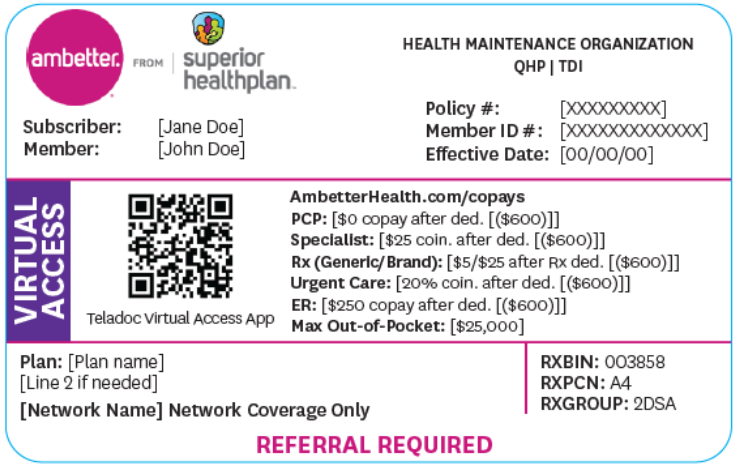
Member ID Card:

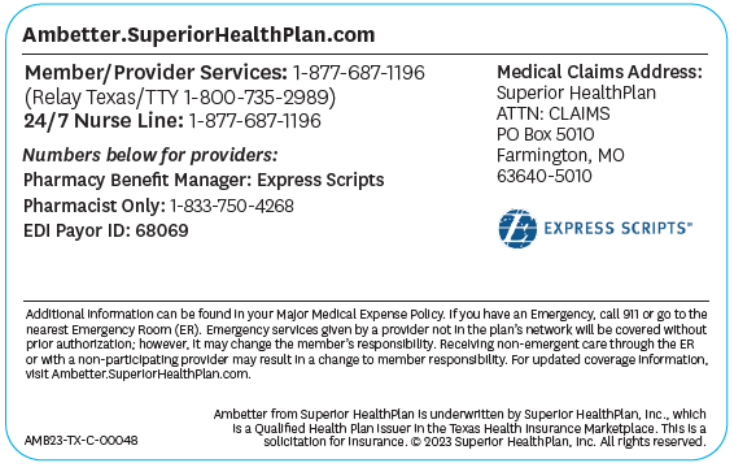


Note: Possession of an ID Card does not guarantee eligibility and benefits.

Ambetter Virtual Access ID Card

Member ID Card:





Note: Possession of an ID Card does not guarantee eligibility and benefits.

Essential Health Benefits

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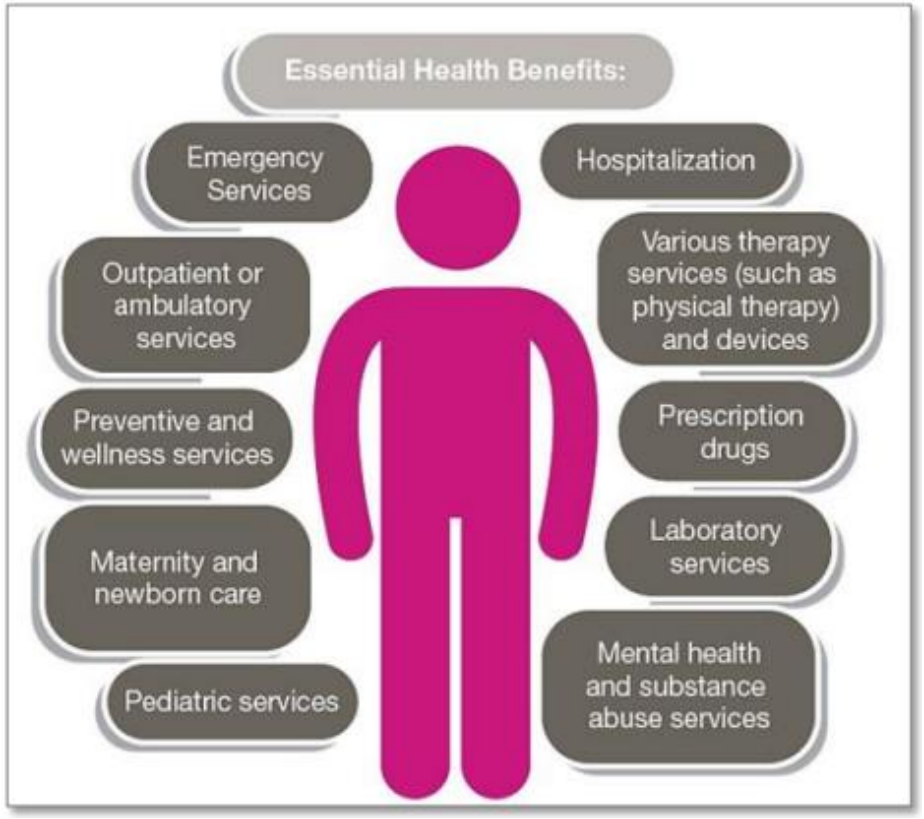


Note: Essential Health Benefits are offered within each Ambetter Health plan.

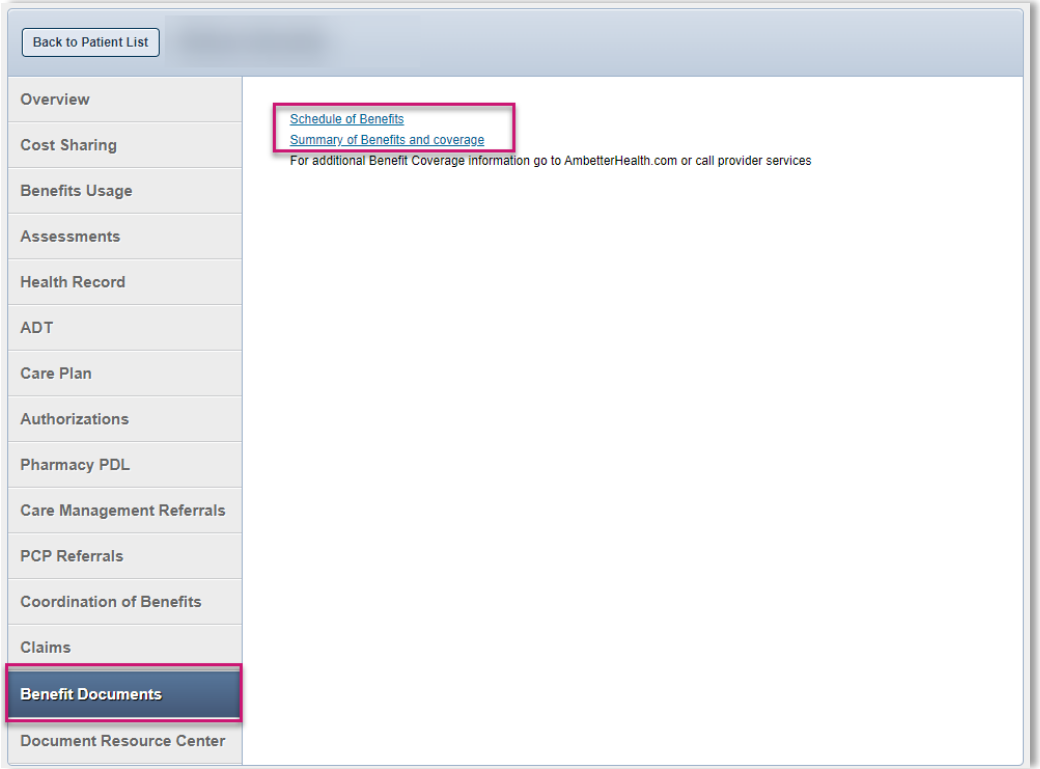
Other Benefits

FROM superior healthplan

- My Health Pays Rewards
- Health Management programs
- Optional Dental and Vision
- Start Smart for Your Baby
- Your Better Health Center
- Virtual 24/7 Care
  - This is one-time, episodic care, available 24/7, and delivered virtually

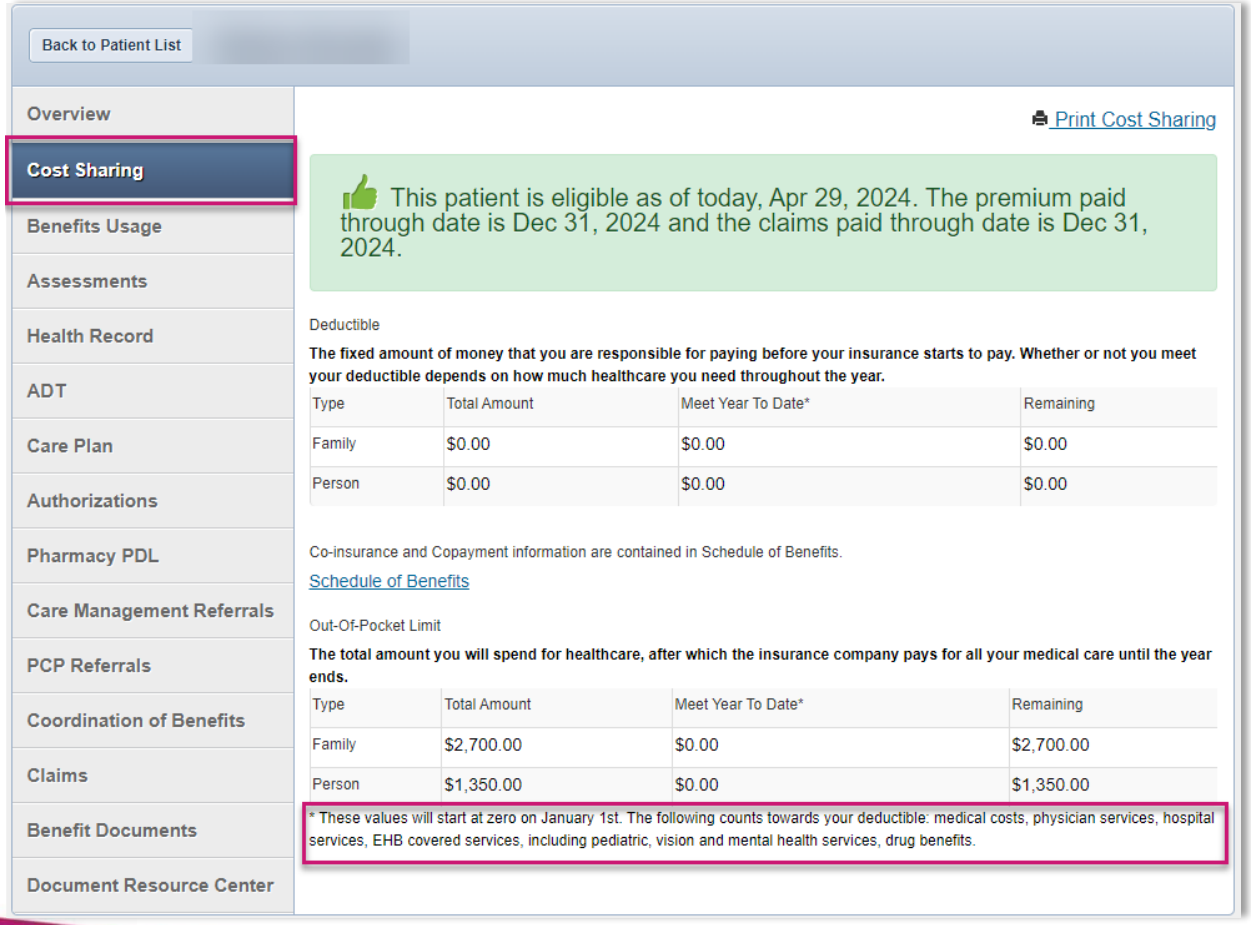
Verification of Benefits

- To verify a member's benefits in the Secure Provider Portal, please go to the **Benefit Documents** tab:



Verification of Cost Shares

- To verify how much remains of a member's deductible, visit the **Cost Sharing** tab in their profile.
- Note: There are separate tabs for Medical and Drug expenditure.



Referrals and Prior Authorization

Referrals

- Behavioral Health and Substance Use Disorder (SUD) services do not require a referral from the PCP.
- Any services outside of OB/GYN, Behavioral Health/SUD, Urgent Care, Emergent Care, Labs, DME, Ambulance, Radiology and Anesthesia will require a referral by the member's PCP for Ambetter Value and Ambetter Virtual Access.
  - The above provider or facility types will still be required to be in-network* with the member's Ambetter Health plan (Core, Value, Virtual) and prior authorization requirements will continue to apply, as applicable.
- Please note that referrals are different than a prior authorization. Services that don't require a referral may still require an authorization.

**ER and Ambulance providers may not be in network*

Specialty Referrals

Silver and Gold

- Members are educated to seek care or consultation with their PCP first.
- 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.
- Paper referrals are not required for members to seek care with in-network specialists.

Virtual

- Teladoc (or local PCP) will be responsible to submit a referral to Ambetter Health in order for any specialty care provider to render services to our members.

Value

- Any specialty care rendered by a specialist outside of the preferred physician group will require a referral prior to services being rendered to our members.

Prior Authorization

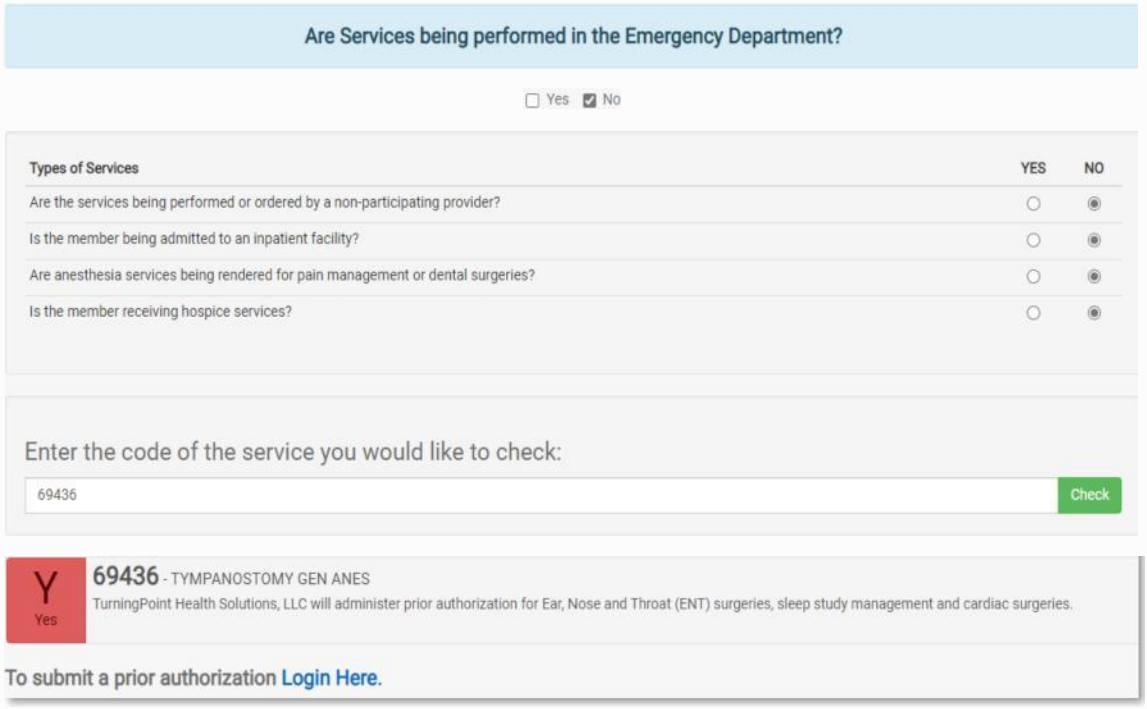
Procedures / Services*:

- Electroconvulsive Therapy (ECT)
  - Inpatient: Revenue Code 901
  - Outpatient: HCPCS 90870
- SUD
  - This service must be specified in your Ambetter contract by revenue code
- Residential Treatment Center (RTC)
  - This service must be specified in your Ambetter contract by revenue code
- Intensive Outpatient Programs
- Partial Hospitalization (PHP)
- Ambetter Psychological and NeuroPsycholgical Testing - Inpatient
- Transcranial Magnetic Stimulation Services
- Please ensure your billing code is specific to what you are requesting on your authorization
- For a complete checklist and forms, please visit Ambetter's Provider Resources webpage

*Please note: This is not meant to be an all-inclusive list and exclusions apply.

Pre-Auth Needed Tool

- 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 Health website at SuperiorHealthPlan.com/AmbetterPriorAuth



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 Ambetter 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.

Prior Authorization

Prior Authorization can be requested in 3 ways:

1. On the Secure Provider Portal at: Provider.SuperiorHealthPlan.com
   - If you are already a registered user of the Secure Provider Portal, you do not need a separate registration.
2. Fax requests to:
   - Outpatient: 1-855-537-3447 (Medical) or 1-844-307-4442 (Behavioral)
   - Inpatient: 1-866-838-7615 (Medical) or 1-866-900-6918 (Behavioral)
     - The fax authorization forms are found on Ambetter's Provider Resources webpage.
3. Call for Prior Authorization at 1-877-687-1196.

Prior Authorization

- Inpatient Authorization*:
  - All elective/scheduled admission notifications requested at least 5 Business Days prior to the scheduled date of admit including:
    - All services performed in out-of-network facilities
    - Behavioral health/substance use
    - Rehabilitation facilities
    - Observation stays exceeding 23 hours require Inpatient Authorization
    - Urgent/Emergent Admissions
      - Within one business day following the date of admission
    - Partial Inpatient, Psychiatric Residential Treatment Facility (PRTF) and/or Intensive Outpatient Programs

Please note: This is not meant to be an all-inclusive list and exclusions apply.

Prior Authorization

Service Type*	Timeframe
Scheduled Admissions	Prior Authorization required 5 Business Days prior to the scheduled admission date.
Emergent Inpatient Admissions	Notification within 1 Business Day
Observation – 48 hours or less	Notification within 1 Business Day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 Business Day
Emergency Room and Post-Stabilization, Urgent Care, and Crisis Intervention	No prior authorization required

* *This is not meant to be an all-inclusive list.*

Utilization Determination Timeframes

Type*	Timeframe
Prospective/Urgent	3 Calendar Days
Prospective/Non-Urgent	3 Calendar Days
Concurrent	24 hours
Retrospective	30 Calendar Days

Pre Authorization Exemption

- Providers will be exempt for six months from obtaining prior authorizations for specific services for which, during the review period, they received 90% medical necessity approval, with a minimum of 5 requests per service/procedure code/prescription.
  - Concurrent Inpatient review services are excluded from preauthorization exemption.
  - Prescription, outpatient and elective inpatient procedures are subject to review for prior authorization exemption.
- January and June of each year we are able to review between 5 and 20 medical records for claims received and may rescind prior authorization exclusion if:
  - 90% of medical necessity criteria are not met for the sample size.
  - Providers may request an independent review from an IRO if they disagree with Ambetter's decision.
- Out-of-network providers will still require prior authorization unless the provider is exempt for the service/procedure code/prescription.

Pharmacy

Pharmacy Benefit Manager

- Ambetter Health works with Express Scripts to process pharmacy claims for prescribed drugs. Some drugs on the Ambetter Health PDL may require prior authorization. For more information, please visit Ambetter's Pharmacy webpage. To submit an authorization:
  - RX BIN Number: 004336; Group ID: RX5458
  - Phone: 1-866-399-0928
  - Fax: 1-800-977-4170
- To submit Pharmacy Appeals:
  - Phone: 1-800-218-7453 ext. 22168
  - Fax:1-866-918-2266

Specialty Drugs

- Certain medications are only covered when supplied by Ambetter specialty pharmacy provider. Tier 4 drugs on the Preferred Drug List represent Specialty Drugs.
- AcariaHealth is the preferred specialty pharmacy provider of Ambetter Health. All specialty drugs, such as biopharmaceuticals and injectables, require prior authorization to be approved for payment by Ambetter Health.
- Contact AcariaHealth at:
  - Phone: 1-800-511-5144
  - Fax: 1-877-541-1503

Pharmacy Prior Authorization

- Some medications listed on the Ambetter Health Preferred Drug List (PDL) may require prior authorization.
- The information should be submitted by the practitioner or pharmacist to Pharmacy Services on the Medication Prior Authorization Request Form for Non-Specialty Drugs (PDF) found on Ambetter's Pharmacy webpage.
  - This form should be faxed to Ambetter Health Pharmacy Services at: 1-800-977-4170
- Ambetter Health will cover the medication if it is determined that:
  - There is a medical reason the member needs the specific medication.
  - Depending on the medication, other medications on the PDL have not worked.
- Authorization requests are reviewed by a licensed clinical pharmacist using the criteria established by the Ambetter Health Pharmacy & Therapeutics Committee.
- If the request is approved, Ambetter Health notifies the practitioner by fax.
- If the clinical information provided does not meet the coverage criteria for the requested medication, Ambetter Health will notify the member and their practitioner of alternatives and provide information regarding the appeal process.

Complaint Process

Provider Complaints

- A complaint is a verbal or written expression by a provider, which indicates dissatisfaction or dispute with Ambetter Health's policies, procedures, or any aspect of Ambetter Health's functions.
- A letter will be sent to the provider acknowledging receipt of the claim within 5 Business Days.
- Following the investigation of the complaint, a written complaint resolution will be sent to the provider within 30 Calendar Days from the received date of the complaint.
  - The letter includes the decision/resolution of the complaint, the facts utilized to resolve it and the provider's right to pursue arbitration or file a complaint with TDI if they are not satisfied with the outcome.
- For denials or reconsiderations of processed claims, a provider should follow the Claims Appeal/Reconsideration and Claims Dispute process.

Appeals of Adverse Determination

- Members may designate providers to act as their representative for filing appeals related to adverse determinations.
- Must be filed within 180 Calendar Days from the notice of adverse determination.
- Ambetter Health will acknowledge receipt within 5 Business Days of receiving the appeal.
- Ambetter Health will resolve each appeal and provide written notice as expeditiously as the member's health condition requires, but not to exceed 30 Calendar Days.
- An expedited appeal is available for denials of emergency care, continued stays for hospitalized members, or prescription drugs or intravenous infusions for which a member is receiving benefits.

Appeals of Adverse Determination

- Adverse determinations of a step-therapy protocol; or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient.
- An expedited appeal review is completed based on the immediacy of the condition, procedure, or treatment, but no later than one working day from the date all information necessary to complete the appeal is received.

Claims

Claims Definitions

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

Claims Definitions

- Corrected claim – A provider is changing the original claim
  - Corrected claims must be sent within 120 Days of the most recent adjudicated date of the claim, as reflected in the Explanation of Payment (EOP)
  - Original claim number must be inserted in field 64 of the UB-04 or field 22 of the HCFA 1500 of the paper claim, or the applicable 837 transaction loop for submitting corrected claims electronically
  - 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
- Request for reconsideration – A provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
  - Medical records are not required unless the request for reconsideration is related to a code audit, code edit, or authorization denial
- Claim dispute/appeal – A provider disagrees with the outcome of the request for reconsideration

Claim Submission

- The timely filing deadline for initial claims is 95 Calendar Days from the date of service or date of discharge.
- Claims may be submitted in 3 ways:
  1. On the Secure Provider Portal at Provider.SuperiorHealthPlan.com.
  2. Through an Electronic Clearinghouse:
     - Payor ID 68069 (Ambetter Behavioral and Medical claims)
     - For a list of our Clearinghouses, please visit our website at Ambetter.SuperiorHealthPlan.com.
  3. By mail, paper claims may be submitted to:

     Ambetter from Superior HealthPlan
     P.O. Box 5010
     Farmington, MO 63640-5010

Claim Submission

- Claim Reconsiderations:
  - Must be submitted within 120 Days of the EOP.
  - Claim Reconsiderations may be mailed to:
    Ambetter from Superior HealthPlan
    Attn: Level I Requires for Reconsideration
    P.O. Box 5010
    Farmington, MO 63640-5010
  - Providers can also use the Reconsider Claim button on the Claim Details screen within the Secure Provider Portal.
- Claim Disputes:
  - Must be submitted on a claim dispute form within 120 Days of the EOP.
  - A Claim Dispute form can be found on Ambetter's Provider Resources webpage.
  - The completed Claim Dispute form may be mailed to:
    Ambetter from Superior HealthPlan
    Attn: Level II – Claim Dispute
    P.O. Box 5010
    Farmington, MO 63640-5010

Claim Submission

- 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.
- 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.

Claims Tips and Caveats by Provider Type

Psychiatric Residential Treatment Facilities / Residential Treatment Centers

- Billing Reminders
  - Revenue Codes 1001 and 1002 – Authorization required
  - Behavioral Health Accommodations Location Codes: 21,51,55,56
  - Indicate on FL-6 off UB-04 the beginning and ending of service dates.
  - Utilize 1xx bill type codes instead of 8xx since the latter does not specify if the service was provided inpatient or outpatient

Substance Use Disorder Billing Reminders

- Substance Use Disorder (SUD) Inpatient billing requires a pairing of specific revenue codes with HCPCS codes for claims payment under the SUD benefit.
- Claims submitted for inpatient SUD services will require both code sets on the claim line. When the revenue code is billed without the corresponding HCPCS code, the claim will be denied.
- Inpatient billing is suggested to list a single claim line for the revenue code and HCPCS combination with the total units on one claim line.
- Billing each date of service on a separate claim line can cause the claims to pend for additional review. For faster claims processing bill a single claim line submission with all days/units on one line.

Billing Tips on Bill Type Codes for SUDs

- 0XX2 Interim—First Claim
  - This frequency code is used to indicate the first in a series of claims to the same third-party payer for the same confinement or course of treatment.
  - Interim claims are those in which the patient is expected to remain in a facility for an extended period of time. It is expected that further bills for the same confinement will be submitted.
  - Interim bills for a single stay must be submitted to the FI in the sequence in which it occurs to ensure proper utilization. Bills submitted out of sequence will be returned to the provider until all prior bills are received and processed.
  - This is a valid bill frequency code for home health and hospice claims. It reflects the first in a series of claims under the start of care date reported in **FL 12**.
  - Under Home Health Prospective Payment System (HH PPS), Requests for Anticipated Payments (RAPs) are billed under Type of Bill (TOB) code 0322 only. On the RAP, this code is used to reflect the first of an expected series of bills for which utilization is chargeable or that will update the inpatient deductible for the same confinement or course of treatment. Use this code for original or replacement RAPs.
  - All initial interim claims must indicate 30 (still patient) in **FL 17**, patient status.
  - Each hospital PPS interim bill (TOB 0112 [**FL 4**]) must include all diagnoses, procedures, and services from admission to the through date. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 1, sec. 50.2)

Billing Tips on Bill Type Codes for SUDs

- 0XX3 Interim—Continuing Claim (Not Valid for Medicare PPS Claims)
  - This bill frequency code is used to indicate that a bill is one of a series of claims for the same confinement or course of treatment. In other words, the bill has been submitted previously and further bills are expected.
  - This TOB code may be used only once per month (every 30 days).
  - TOB code 0XX3 should not be used for Medicare PPS claims. Instead, TOB 0XX7, replacement of prior claim and patient status code 30 **(FL 17)** must be used. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 1, sec. 50.2)
  - This is a valid bill frequency for hospice claims.
  - Subsequent interim bills must indicate 30 (still patient) in **FL 17,** patient status. No other patient status code other than 30 is appropriate for this bill frequency code.
  - Interim bills for a single stay must be submitted to the FI in the sequence in which it occurs to ensure proper utilization of hospital or SNF days. Bills submitted out of sequence will be returned to the provider until all prior bills are received and processed.
  - This bill frequency code cannot be used if the Admission Date field **(FL 12)** reflects the same
  - Date as the from date in the Statement Covers Period field **(FL 6)**.

Billing Tips on Bill Type Codes for SUDs

- 0XX4 Interim—Last Claim (Not Valid for Medicare Inpatient Hospital PPS Claims)
  - This is used to indicate that a bill is the last of a series of claims for the same confinement or course of treatment.
  - A discharge claim bill must indicate a patient status **(FL 17)** code of 01–06, 08 or 20. This bill frequency code cannot be used if the patient status is “still patient” (30).
  - TOB code 0XX4 should not be used for Medicare PPS claims. Instead, TOB 0XX7 Replacement of prior claim.
  - Interim bills for a single stay must be submitted to the FI in the sequence in which it occurs to ensure proper utilization of hospital or SNF days. Bills submitted out of sequence will be returned to the provider until all prior bills are received and processed.
  - This is a valid bill frequency code for hospice claims. It reflects the final bill under the start of care date reported in **FL 12**.
  - This code is not intended to be used in lieu of a code for late charges (TOB 0XX5), adjustments (TOB 0XX7 and 0XX8) or zero/nonpayment claims (TOB 0XX0).
  - The through date in the Statement Covers Period field **(FL 6)** must reflect the discharge date for this admission.
  - This bill frequency code cannot be used if the Admission Date field **(FL 12)** reflects the same date as the from date in the Statement Covers Period field **(FL 6)**.

SUD Billing Example

- The inpatient revenue code claim line best practice billing is to complete a single claim line with the first date of service of the stay and/or portion of the stay for interim bills in UB-04 box 45.

42 REV CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1002		H0018	07/31/19	15	15000.00	0.00	

Behavioral Health Partial Hospitalization Outpatient Billing Codes

Service Type	Revenue Code	CPT	Description
Psychiatric	0912 Partial Hospitalization - less intensive 0913 Partial Hospitalization – intensive	H0035 Mental health partial hospital, treatment, less than 24 hours	Designed to restore or maintain the functioning of individuals with serious mental and/or substance abuse disorders
Substance Use Disorders	0912 Partial Hospitalization - less intensive 0913 Partial Hospitalization - intensive	H0035 Mental health partial hospital, treatment, less than 24 hours	Individual, group, and family therapy, medical and nursing support, medication management, skill development, and expressive and activities therapy.
Eating Disorders	0912 Partial Hospitalization - less intensive 0913 Partial Hospitalization - intensive	H0035 Mental health partial hospital, treatment, less than 24 hours	Assists individuals who require structure for the majority of the day but who are able to contain their eating behavior at night.

Behavioral Health Inpatient Billing Codes

Service Type	Revenue Code	CPT	Description
Psychiatric	0114 Psychiatric R&B 0124 Private 0134 Semi-Private 0144 Deluxe 0154 Ward		Includes care delivered in psychiatric unit of general hospital, free-standing psychiatric hospital, and State hospital/Institutions.
Rehabilitation Treatment, Substance Use Disorders, Rehabilitation Treatment.	0118 Rehabilitation 0128 R&B Private 0138 Semi-Private 0148 Deluxe 0158 Ward		Service is offered to individuals who present with substance-related disorder whose biomedical and emotional/behavioral problems are sufficiently severe to require hospital level of care.
Substance Use Disorders, Detoxification	0116 Detoxification R&B 0126 Private 0136 Semi-Private 0146 Deluxe 0156 Ward	H0009 Acute detoxification (hospital inpatient)	Acute detoxification is an organized service that involves a planned regimen of 24-hour, medically directed/monitored, evaluation, care, and treatment of substance-related disorder in an acute-care inpatient setting.
Eating Disorder	0114 Psychiatric R&B 0124 Private 0134 Semi-Private 0144 Deluxe 0154 Ward		Services include medical management/monitoring, evaluation, psychopharmacology, structured meals, individual, group and nutritional therapies.

Claim Filing Tips
Behavioral Health PHP OP/IP

- All units on a single service line intake to discharge.
- Revenue Code is required on both the authorization request and the claim.
- Include authorization number on claim.
- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.

Common Claim Denials

EX Code	Description
EXBG	Type of bill missing or incorrect on claim
EXx3	Procedure code unbundled from Global Procedure Code
EXx9	Procedure Code Pairs Incidental, Mutually Exclusive or Unbundled
EXy1	Out-of-Network provider not covered per HMO/EPO policy
EXyq	Duplicate claims or multiple providers billing same/similar code(s)
EXA1	No record of prior authorization for service billed
EX29	Claim was not submitted within required timeframe
EXye	Denied for review of medical records and/or documentation

ERA/EFT through PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer.

- If you currently utilize PaySpan, you will need to register specifically for the Ambetter product.

- To register for PaySpan:
  - Call 1-877-331-7154, option 1, email providersupport@payspanhealth.com or, complete the Payspan Web Registration Code Request Form to receive your unique registration code.
  - Next, visit www.PaySpanHealth.com and click “Register Now”
    - Enter your registration code and click “Submit”
  - You will need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

Billing the Member

Billing the Member

- Copays, coinsurance and any unpaid portion of the deductible may be collected at the time of service.
- The Secure Provider Portal will indicate the amount of the deductible that has been met.
- 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.

Billing the Member in Suspended Status

- For members who are in a suspended status and seeking services from providers:
  - Providers may advise the member that services may not be delivered due to the fact that the member is in a suspended status. (Status must be verified through our Secure Provider Portal or by calling Provider Services. Providers should follow their internal policies and procedures regarding this situation.)
  - Should a provider make the decision to render services, the provider may collect from the member. Providers must submit a claim to Ambetter.
  - If the member subsequently pays their premium and is removed from a suspended status, Ambetter will adjudicate claims. The provider would then be responsible to reconcile the payment received from the member and the payment received from Ambetter. The provider may then bill the member for an underpayment or return to the member any overpayment.
  - If the member does not pay their premium and is terminated from their Ambetter plan, providers may bill the member for their full billed charges.
  - Non-participating providers may be limited by state or other regulations when balance billing members for amounts not considered to be copayments, coinsurance or deductible.

Claims Payment in Suspended Status

- Member 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 Affordable Care Act (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.

Suspended Status

- 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.

Note: When checking Eligibility, the Secure Provider Portal will indicate that the member is in a Suspended Status.

Quality Improvement

Quality Improvement

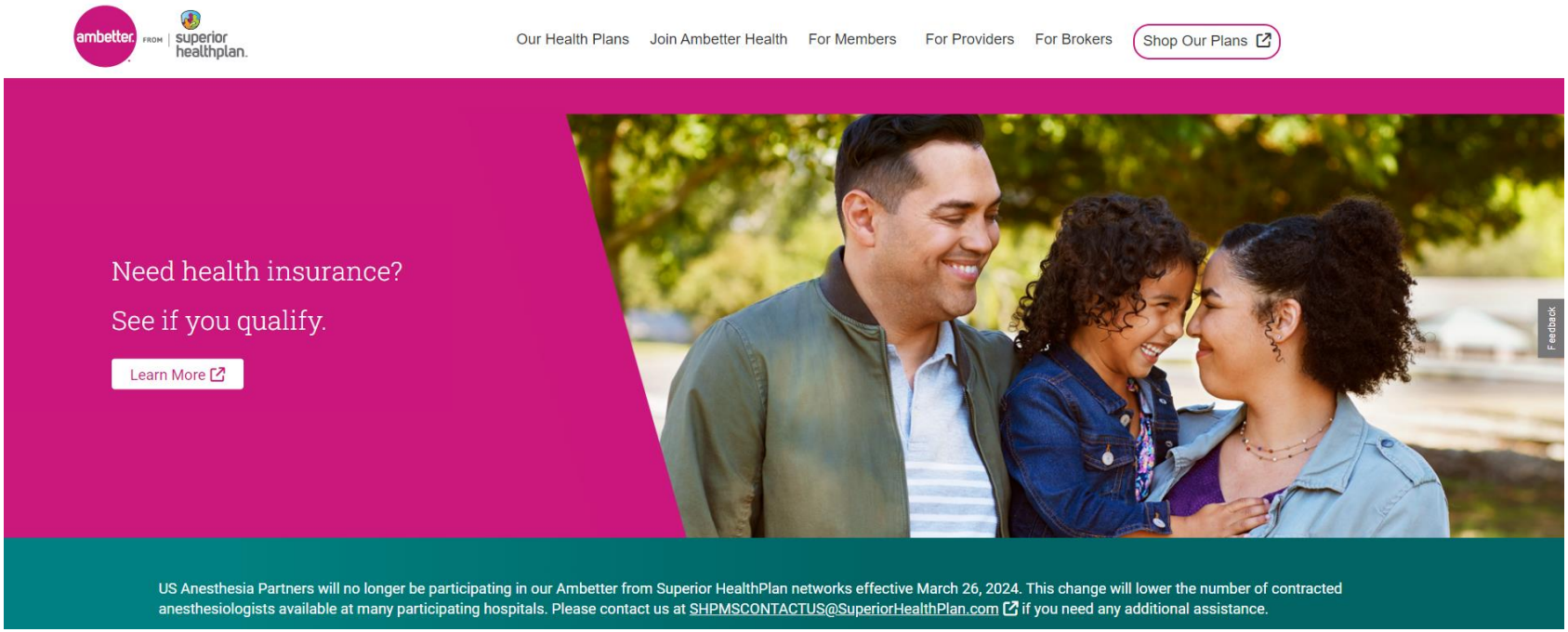
HEDIS and Risk Adjustment Programs

- Member Gap Forms
  - Provider initiative targeting Ambetter Health members who have a potential gap in their care.
    - Select providers will receive support from Optum or Vatica to close gaps for scheduled members or to reach out and schedule members in order to address care gaps.
  - Forms with care gaps unique to each of the targeted patients will be provided.
- Chart Retrievals
  - Our vendor partners will request charts for chart reviews, including the Risk Adjustment Data Validation Audit, for Ambetter members.
  - Charts are targeted based on reported and suspected chronic conditions for a member.
    - Coders then review medical charts to ensure claims data reflects the documented medical record accurately.
- Continuity of Care (CoC)
  - A provider engagement program that ensures that members receive care and treatment for all existing health conditions and not just acute health issues.
  - Providers will have access to Appointment Agendas that outline care gaps.

Helpful Websites

Ambetter Website

Ambetter.SuperiorHealthPlan.com



Website Resources

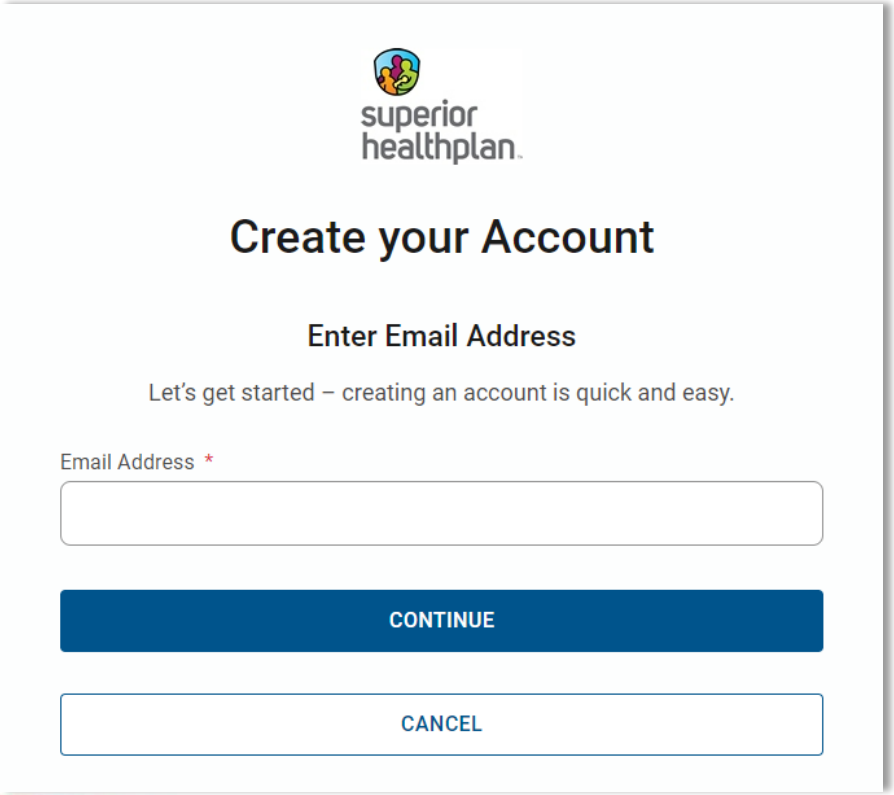
- Provider resources available on the Ambetter website include, but are not limited to:
  - The Provider and Billing Manual
  - Quick Reference Guides
  - Forms (Prior Authorization Fax forms, Behavioral Health forms, etc.)
  - The Pre-Auth Needed Tool
  - The Pharmacy Preferred Drug Listing
  - Trainings

Secure Provider Portal

- Information contained on Provider.SuperiorHealthPlan.com includes, but is not limited to:
  - Member Eligibility and Benefits and Patient Listings
  - Health Records and Care Gaps
  - Authorizations
  - Claims Submissions and Status
  - Corrected Claims and Adjustments
  - Payments History
  - Monthly PCP Cost Reports - Generated on a monthly basis and can be exported into a PDF or Excel format. Reports Include:
    - Patient List with HEDIS Care Gaps - Rx Claims Report
    - Emergency Room Utilization - High-Cost Claims

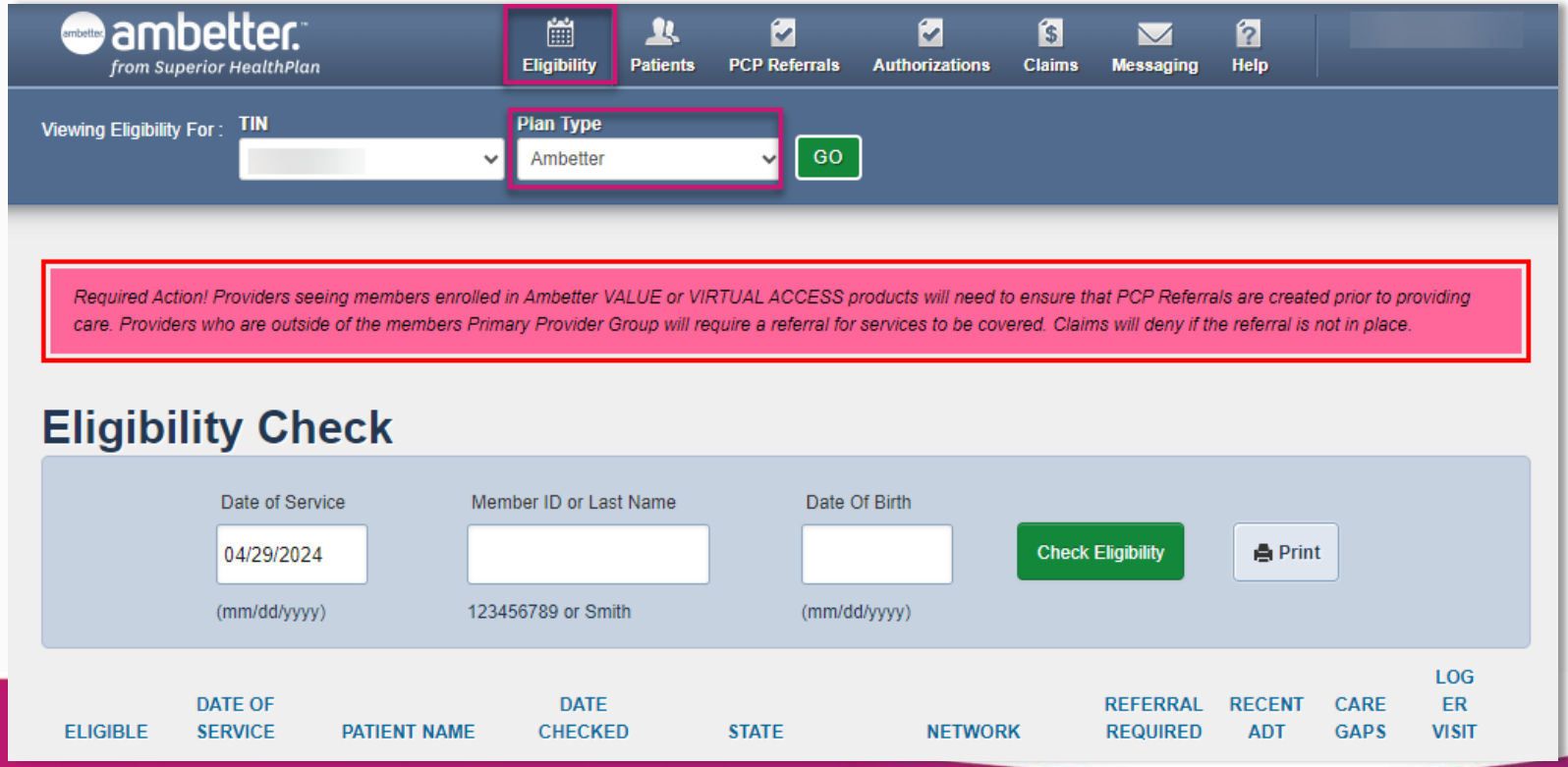
Secure Provider Portal

Registration is free and easy. Visit Provider.SuperiorHealthPlan.com to get started.



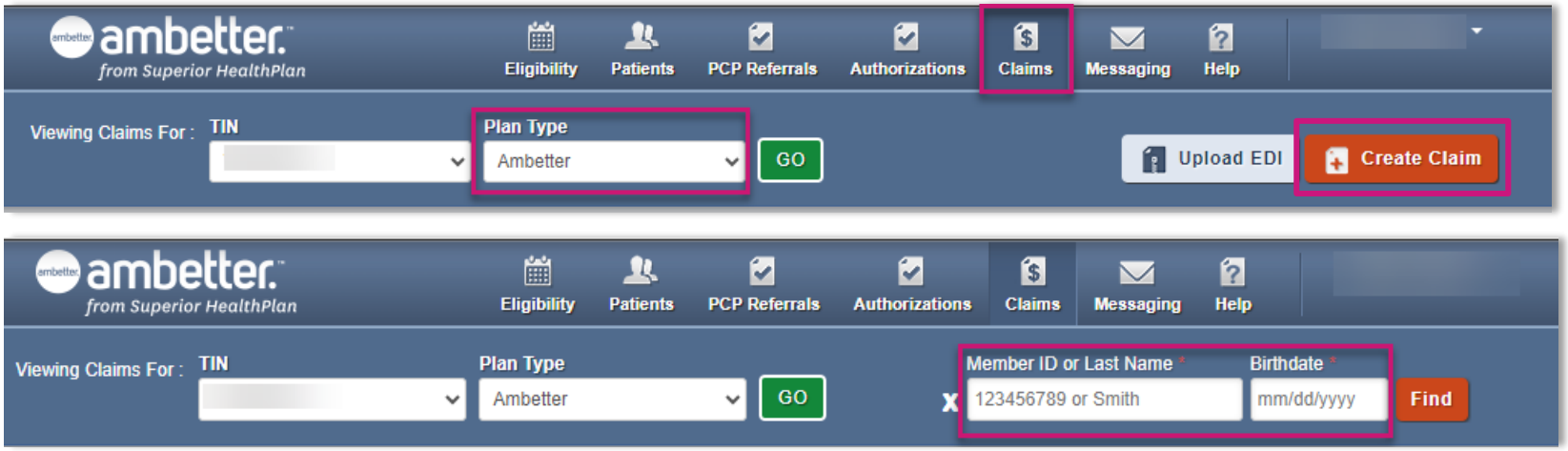
Verify Eligibility

For full instructions on how to verify eligibility, please reference the Secure Provider Portal – Quick reference Guide: How to Verify Eligibility (PDF) on Ambetter's Provider Resources webpage.



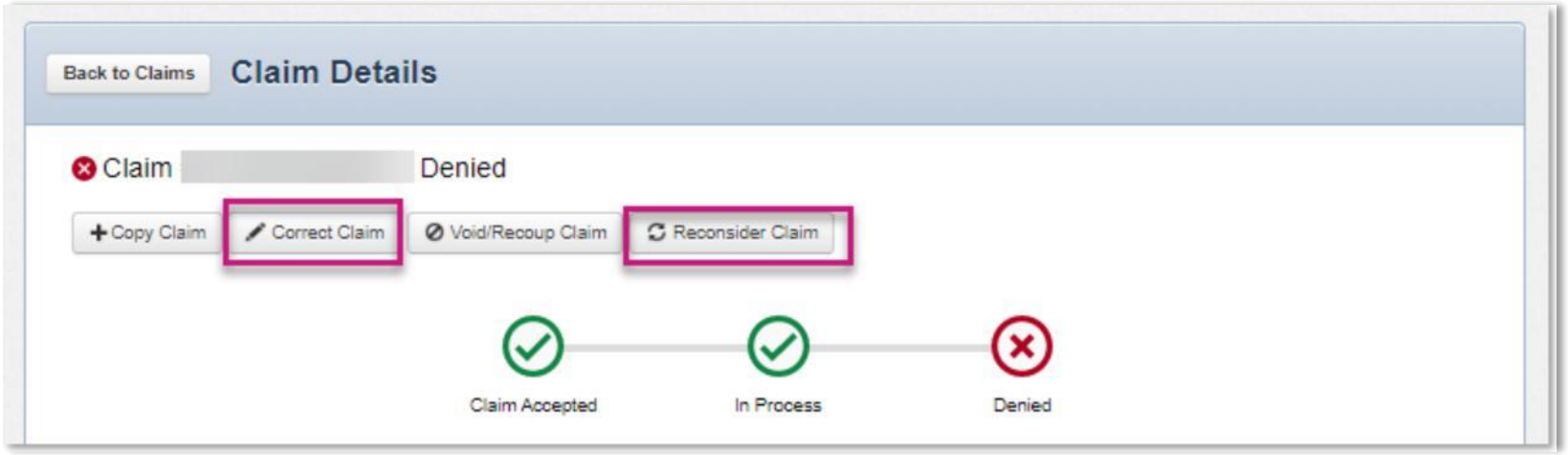
Submitting Claims

To submit claims via the Secure Provider Portal, click on **Claims** in the tool bar, then select **Create Claim**. Input **the Member ID or Last Name** and their **Birthdate** then click **Find**.



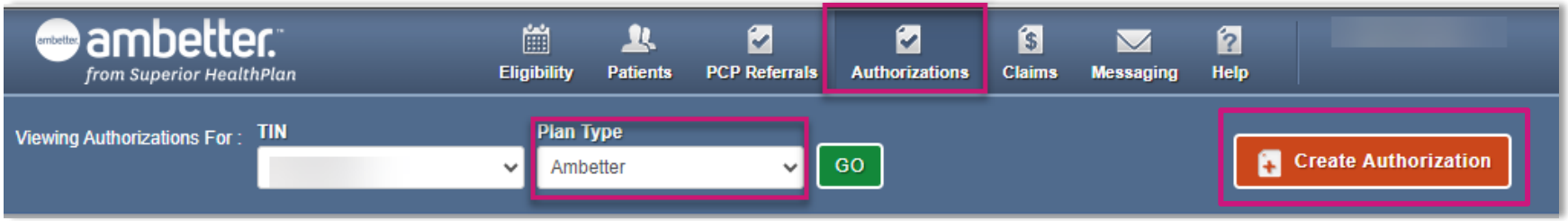
Claims Corrections and Reconsiderations

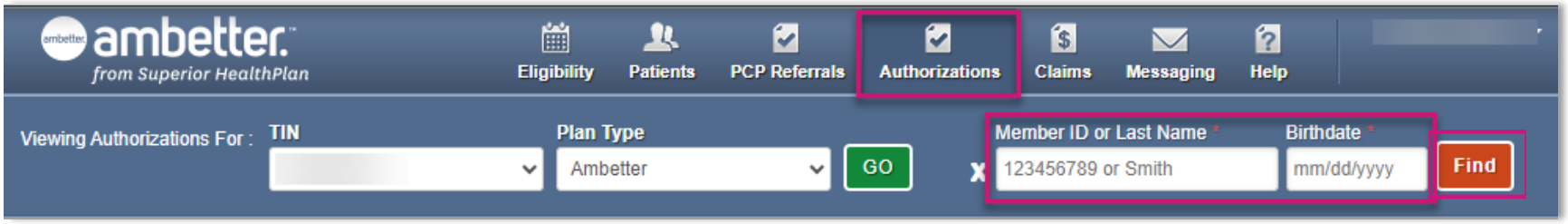
Once a claim adjudicates, it can be corrected or submitted for reconsideration. To do this, click on the claim number and then select **Correct Claim** or **Reconsider Claim**.



Submitting Authorizations

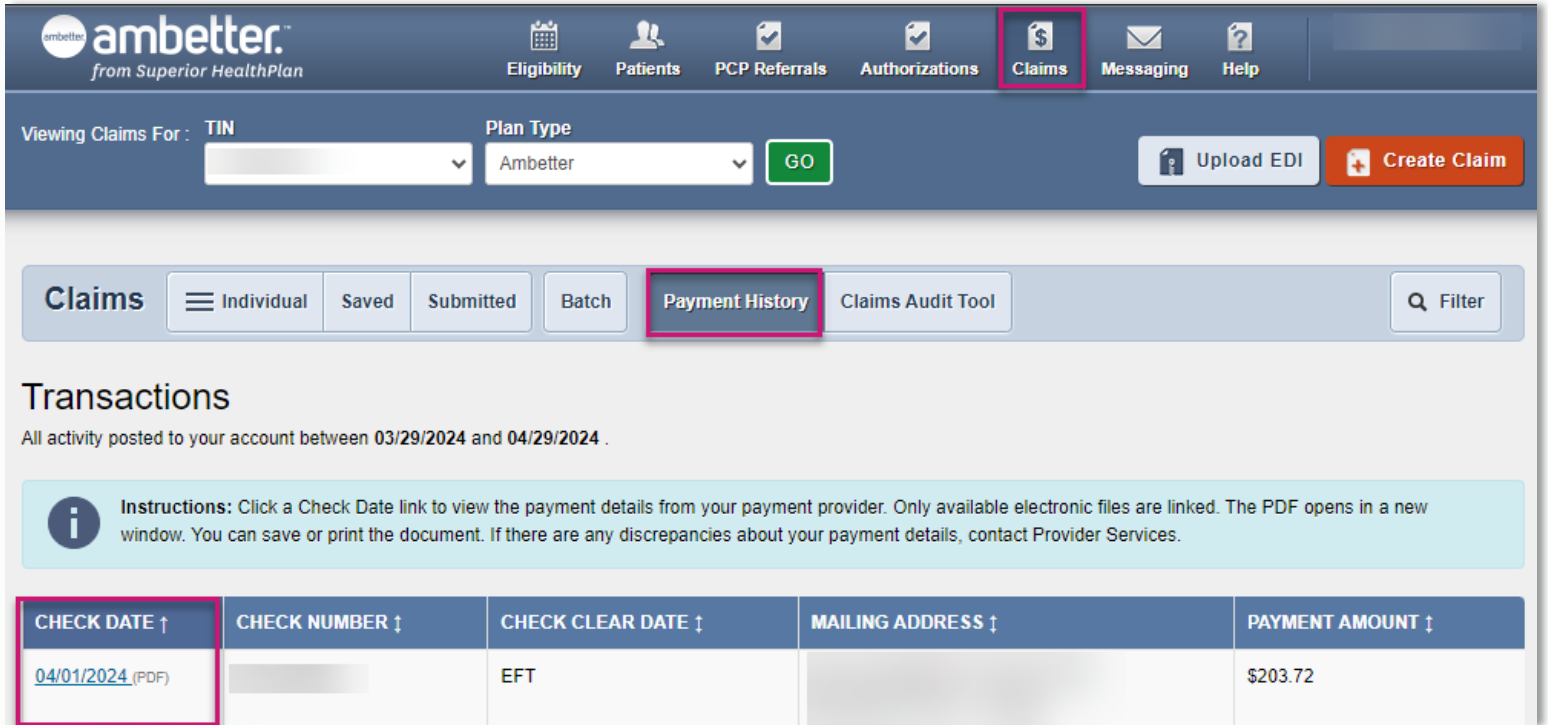
To submit authorizations, click on **Authorizations** in the tool bar, then click on **Create Authorization**. Input the **Member ID or Last Name** and their **Birthdate** then click **Find**.





Locating an Explanation of Payment

To locate an Explanation of Payment (EOP), click on **Claims** from the main tool bar then select **Payment History** from the **Claims** tool bar. Click on the **Check Date** to download the Explanation of Payment.



Provider Resources

Provider Services

- The Provider Services department is 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
- Providers can access real time assistance for their service needs, Monday – Friday, 8:00 a.m. – 6:00 p.m. local time, by calling Provider Services at: 1-877-687-1196.

Account Management

Each provider has an Account Manager assigned to them. This Account Manager serves as the primary liaison between Ambetter and our provider network. The Account Management team is responsible for:

- Provider education
- Claims assistance
- Demographic information update
- Provider enrollment status
- Administrative policies, procedures and operational issues
- Contract clarification
- Membership/provider roster questions
- Provider Portal registration and PaySpan

For any questions, or to schedule a training, you may contact our Behavioral Health Account Management team at AM.BH@SuperiorHealthPlan.com.

Questions