AMERICAN HEALTH ADVANTAGE OF TEXAS

Quick Reference Guide

TX.AmHealthPlans.com

January 1, 2024 – December 31, 2024

Quick Reference Guide

American Health Advantage of Texas is a Health Maintenance Organization (HMO) contracted with Medicare and offers Institutional Special Needs Plans specifically designed for eligible Medicare beneficiaries living in one of our participating long-term care nursing homes or assisted living facilities or individuals living in the community that require an institutional level of care. In addition to providing all standard benefits offered by traditional Medicare, we include Part D pharmacy benefits, supplemental benefits not covered by traditional Medicare, and extensive clinical care management to ensure every member receives the services necessary to achieve their short- and long-term care goals. Our plan is contracted with TruHealth Advanced Practice Providers and RN case managers who, along with our clinical pharmacists, work with the member's primary care physician to address each member's full range of medical, functional, and behavioral health care needs in a coordinated and member-centric manner.

The plan offered through American Health Advantage of Texas is:

- **American Health Advantage of Texas (HMO-ISNP)** for Medicare Beneficiaries that reside in contracted nursing homes in the plan service area.

Table of contents

Please visit our website at **TX.AmHealthPlans.com** and click on the Providers and Partners page. Here you will find the full provider manual, provider forms, resources, provider training materials and other important information.

Important plan contact information

Provider help desk: General provider contract questions, claims status/payment questions, general plan information	**855-521-0628** (option 4)
Customer service: Verify member's benefits / coverage, general benefits questions	**855-521-0628** (option 4)
Utilization management: Authorizations for medical services, and continued stay reviews / updates	**855-521-0628** (option 4)
Website	**TX.AmHealthPlans.com**

Other important contact information

TruHealth Advanced Practice Provider / RN Case Manager: Share clinical information, request clinical assistance	**855-521-0628** (option 1) **Fax: 866-439-0073**
ELIXIR PHARMACY Technical Help Desk: General questions related to Part D drugs. Inquiries may pertain to operational areas related to Part D coverage such as benefit coverage, prior authorization, claims processing, claims submission, and claims payment.	**833-674-6201**

***TTY/TDD: 833-312-0046**

American Health Advantage of Texas provides for interpretation services to our providers who provide health services to our members with limited English proficiency and diverse cultural and ethnic backgrounds. If you require the services of a professional interpreter when dealing with one of our American Health Advantage of Texas members call the provider help desk at 855-521-0628.

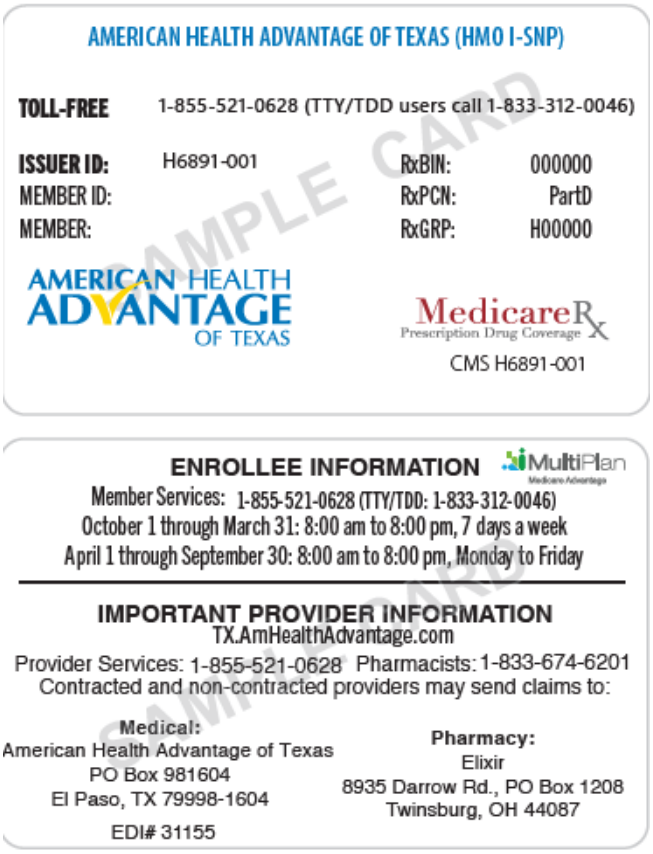
Hours of operation are 8:00 a.m. – 8:00 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31; and Monday to Friday (except holidays) from April 1 through September 30.

Claims processing

Electronic claims (preferred)	Clearinghouse: Change Healthcare EDI billing number: 31155
Mailing address (paper claims)	P.O. Box 981604 El Paso, TX 79998-1604
For TIMELY FILING REQUIREMENTS for initial and corrected claims, please refer to your provider agreement. See additional claims filing information on the following pages.	

Identification of American Health Advantage of Texas Members

American Health Advantage of Texas members are issued a member identification card, a sample of which is below. Members have been asked to bring their ID card at each visit, but many may present for care with a copy of their Nursing Home Medical Record Face Sheet. This may be your primary means of identification rather than the ID card. Please see example copies of the Face Sheet on the next page; these will vary in information and format based on the facility, but all will have a section that identifies the primary payor as American Health Advantage of Texas. Most of our members have Medicaid as the secondary payor, so you may find the member's Medicaid number on the Face Sheet as well; if not, please contact the Skilled Nursing facility.



Identification of American Health Advantage of Texas Members

You can also identify an American Health Advantage of Texas member when they come into your office or facility by reviewing a copy of their Skilled Nursing Facility Face Sheet. Information and format of the Face Sheets will vary by facility; below please see example formats.

Sample face sheet (1)

Run Date/Time: 1/1/2021 3:04:44 PM		PATIENT ID: 123456		Admission ID: MNC 12345		Enterprise ID: None	
PATIENT NAME:		Preferred Name		U.S. Citizen		Martial Status	
Doe, Jane A.				Y		Widowed	
Phone #	SSN	Occupation (current or former)	Education Level	Military Service	Age	Birthdate	Email
731-555-1212	000-00-0000				81	3/6/1937	
Primary Residence							
Address		City, State, Zip		County			
123 ABC Road		Somewhere, TN 55512		Benton			

Admit From	Admit Date/Time	Discharge Date	Org Location
XYZ Hospital	2/2/2021		B/106/100 Hall/Sta
	8:00:00 PM		

Medicaid No.	Medicare A No.	Medicare B No.	Other Insurance
ZECM55555555	None	T03001234	RUGs Pending - RUG Pend/NA/NA; Private Pay- Pvt Pay/NA/NA; Private Pay - Pat Liab/NA/NA; Medicaid of TN - MCD?12345678912/NA; American Health Adv A - American Health Adv/T03001234/NA

Sample face sheet (2)

RESDIENT INFORMATION						
Resident Name	Preferred Name	Unit	Room/Bed	Admission Date	Init.Adm.Date	Orig. Adm.Date
DOE, JOHN B.				5/19/2021	4/23/2021	4/23/2021
Previous address		Previous phone		Legal Mailing Address		
555 Wind Breeze Street, Memphis TN 38116		901-555-5656		Same as Previous Address		
Sex	Birthdate	Age	Martial Status	Religion	Race	Occupation(s)
M	5/14/1940	80	Widowed	Non Denominational	Black or African American	mechanic
Admitted From		Admission Location			Birth Place	Citizenship
Acute care hospital		Baptist East				U.S.
TN MCO Number		Medicare (HIC) #			Medicare Beneficiary ID	
123456789					1Y23YJ4GR56	
Social Security #		Insurance 2			Insurance	
123-45-6789					American Health Advantage	
Policy #		Insurance Policy # 2				
T03009876						
PAYER INFORMATION						
Primary Payer	AMERICAN HEALTH ADVANTAGE OF TN	Member ID #	T03009876	Group #	null	Ins Company
Second Payer	Medicaid	Medicaid #	TD987543210			
Third Payer		Policy #		Group #		Ins. Company
Fourth Payer		Medicaid #		Group #		Ins. Company

Supplemental benefits offered in 2024

In addition to providing all standard benefits offered by traditional Medicare, the American Health Advantage of Texas plan includes Part D pharmacy benefits and the following supplemental benefits not covered by traditional Medicare.

Routine podiatry visits: Network Podiatrist provides services in office or nursing home setting; services include routine foot care, nail trimming and nail debridement. American Health Advantage of Texas covers up to eight (8) visits per benefit year.

Vision benefits: Through Network Vision Providers, one routine eye exam annually. American Health Advantage of Texas offers an allowance for eyewear (contact lenses, eyeglasses lenses and frames) up to $300 per benefit year.

In home / out of home support services: Ordered by PCP or Plan Care Team for companion to assist member with medical appointments outside of the facility or to assist with ADL's, comfort and/or supervision in the facility. American Health Advantage of Texas covers up to 57 hours per member per benefit year.

Hearing – testing and aids: Annual hearing evaluation; one screening per year for hearing aid fitting/evaluation administered through Nations Hearing at 877-212-0358. Includes up to two (2) hearing aids, up to $500 allowance per benefit year per ear.

Routine transportation: Routine, non-emergent transportation services by facility-owned van/medical transport to any health-related location. American Health Advantage of Texas covers up to thirty-six (36) one-way trips per benefit year per member.

2024 Prior Authorization List

Prior Authorization is required for the following covered services (by service level).
Services must be provided according to the Medicare Coverage Guidelines and limitations and are subject to review. All medical care, services, supplies and equipment must be medically necessary.

- **Ambulance Services** Medicare covered non-emergency ambulance transportation services (**NOTE**: No authorization is needed for non-emergency transport from hospital-to-nursing home or nursing home-to-hospital)
- **Cardiac Rehabilitation and Intensive Cardiac Rehabilitation**
- **Diabetic Supplies** with billed charges in excess of $250
- **Diagnostic Radiological Services** High tech radiology services including but not limited to MRI, MRA, PET, CTA, CT Scans, and SPECT.
  (**NOTE:** No authorization required for outpatient x-rays)
- **DME, Prosthetics, and Orthotics** with billed charges in excess of $250
- **Genetic Testing**
- **Home Health Care**
- **Inpatient Care** including but not limited to Inpatient Acute, Psychiatric, Behavioral Health, etc.
- **Medicare Part B Chemotherapy Drugs** with billed charges in excess of $250
- **Other Medicare Part B Drugs** covered drugs with billed charges in excess of $250
- **Out-of-Network Providers / Services** including but not limited to: physicians; cardiac rehab, intensive cardiac rehab; DME, prosthetics, orthotics suppliers; diagnostic tests/procedures; genetic testing; non-emergent ambulance transport; therapeutic radiological services; ambulatory surgery centers; inpatient and outpatient hospital and outpatient hospital observation; home healthcare; outpatient physical, speech / language, occupational therapy; skilled nursing facility care, etc.
- **Outpatient Hospital and Ambulatory Services**
- **Outpatient Hospital Observation**
- **Partial Hospitalization**
- **Skilled Nursing Facility** Medicare-required three midnight stay is waived
- **Therapy Services** (Physical, Speech, and Occupational Therapy) **Not** performed at LTC residence or other SNF Therapy Setting

NO AUTHORIZATION IS REQUIRED FOR:

- Medically necessary emergent services
- Urgently needed care
- Dialysis services

Request for Authorization of Services

(Form available at TX.AmHealthPlans.com on Providers and Partners page)

REQUEST FOR AUTHORIZATION OF SERVICES

PRIOR AUTHORIZATION IS REQUIRED FOR SERVICES BY ANY NON-PARTICIPATING PROVIDER AND FOR CERTAIN SERVICES BY PARTICIPATING PROVIDERS. Payment only for the medical services noted below, and is subject to the limitations and exclusions as outlined in the Evidence of Coverage.

AUTHORIZATION REQUEST

Member Name _____ DOB _____ **Member ID** _____

Nursing Facility _____

Requesting Provider / Type _____ NPI/TIN: _____

Phone #: _____ Fax #: _____

Primary Diagnosis _____

Diagnoses (ICD-10 Codes) Related to Auth. Request _____

Servicing Provider/Facility: _____ NPI/TIN: _____

Servicing Provider Phone#: _____ Servicing Provider Fax#: _____

Include all Clinical Documentation with request. NOTE: A delay in submitting all relevant and necessary clinical required to make a medical necessity decision may result in a delay in receiving an authorization determination.

☐ **Inpatient Admit** ☐ **Observation** ☐ **Behavioral Health Admit** ☐ **SNF (post hospital discharge)** ☐ **SIP (Skill in Place)**

Start Date for service checked above _____ (this field must be completed)

☐ **DME** ☐ **New Patient - Non-participating Physician Office Visit** ☐ **Follow-up - Non-participating Physician Office Visit**

Procedure Code(s)/Quantities:_____Scheduled Date for Services_____

☐ **Diagnostic Testing or Procedure** (List Test or Procedure)_____

Procedure Code(s)_____Scheduled Date for Services_____

THERAPY / HHC

REQUEST FOR PART B THERAPY or HOME HEALTH SERVICES (attach care plan, initial evaluation, and most recent therapy notes)

Request is for ☐**Initial Visits** ☐**Additional visits**

	# Visits Requested	Frequency	Procedure Code(s)	SOC	Evaluation
PT	_____	_____W_____	_____	_____	_____
OT	_____	_____W_____	_____	_____	_____
ST	_____	_____W_____	_____	_____	_____
HHA	_____	_____W_____	_____	_____	_____ N/A _____

TO BE COMPLETED BY PERSON REQUESTING AUTHORIZATION

☐ **Standard Authorization:** Authorization Requests (properly completed and including supporting medical record documentation)are completed within 14 days per the CMS guidelines. Our goal is 5-7 days.

☐ **Expedited Authorization (Must Read and Sign):** By signing below I certify that waiting for a decision under the standard time frame could place the Member's life, or health in serious jeopardy.

SIGNATURE:_____ Date Completed:_____

Name of Person Completing this Form (please print name): _____

Notification will be faxed upon determination; please complete the following for notification of the decision.

Who is Receiving Authorization Notification Fax (please print name): _____

Contact phone number: Authorization Notification Fax number:

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

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Claims submission and claims processing

Electronic claims (preferred)	Clearinghouse: Change Healthcare EDI billing number: 31155
Mailing address (paper claims)	P.O. Box 981604 El Paso, TX 79998-1604
For TIMELY FILING REQUIREMENTS for initial and corrected claims, please refer to your provider agreement.	

If your clearinghouse says they do not show our Payor ID as able to transmit 837 (claims) or 835 (ERA) files please contact the Change Healthcare Helpdesk at 1-866-371-9066 or

https://support.changehealthcare.com/customer-support-portals

Important tips for claims submissions

- NPI numbers should be entered as follows:

  Individual Provider NPI goes in Box 24J on CMS1500

  Group NPI goes in Box 33A on CMS 1500

  Attending Physician NPI goes in box 76 on UB04

  Operating Physician NPI goes in box 77 on UB04

- Place all associated authorization numbers in Box 23 of the CMS1500 or Box 63 of the UB04

- For electronic submission, which is the preferred method, please use the following field locations for authorization numbers: CMS1500: 837p: Loop 2300, 2-180-REF02 (G1) UB04: 837i: Loop 2300, REF02

- Do not include multiple Place of Service codes on an individual claim; submit separate claims for each Place of Service. Claims submitted with multiple Place of Service Codes may be denied.

Please continue reading to view the Claims Reconsideration and Claims Dispute Resolution.

Participating Provider Reconsiderations and Claim Dispute Resolution

A participating provider may file a request for reconsideration of an American Health Advantage of Texas claim determination if the participating provider disagrees with the American Health Advantage of Texas claim determination. Such request must be submitted within 180 calendar days from the date of the initial Explanation of Payment (EOP).

To request a claims review / reconsideration, the participating provider must complete the Request for Reconsideration of a Claim Determination form and mail the completed form including required supporting documents to:

American Health Advantage of Texas
Attn: Claims Dispute
201 Jordan Road, Suite 200
Franklin, TN 37067
Fax: 844-280-5360

Request for reconsideration of a claim determination form

(Form available at TX.AmHealthPlans.com on Providers and Partners page).

PROVIDER DISPUTE RESOLUTION REQUEST

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Mail the completed form, along with any required supporting documentation to:

<Plan Name>
201 Jordan Road, Suite 200
Franklin, TN 37067
Toll-Free: 1-xxx-xxx-xxxx
Or Fax to 1-844-280-5360

*Provider NPI:	*Provider Tax ID:
*Provider Name:	Contracted: ☐ Yes ☐No
*Provider Address:	
Provider Type: ☐ SNF ☐ Hospital ☐ Ambulance ☐ DME ☐ Rehab ☐ Other(Please specify): _____	
CLAIM INFORMATION: ☐ Single ☐ Multiple (please provide listing) Number of Claims: _____	
*Patient Name:	
*Health Plan ID Number:	Claim Number:
*Date of Service:	Original Claim Amount Billed:
DISPUTE TYPE: ☐ Claim Denial ☐ Disputing Request for Reimbursement of Overpayment ☐ Disputing Underpayment of Claim Paid ☐ Other: _____	
*DESCRIPTION OF DISPUTE:	
EXPECTED OUTCOME:	
Contact Name:	Title:
Signature:	Date:
Phone#:	Fax #:

☐ Mark here if additional information is attached (please do not staple)

Note: **Non-Par Providers have 60 days from denial date to file appeal for post service claims.**
Par Providers have 180 days from date of Explanation of Payment (EOP) to file a dispute resolution request.

Hxxxx_NSPRCLMDSP_C

Frequently Asked Questions

Claims payment and submission

Who do I call if I have a question regarding a claim denial?

The Customer Services Department is available to assist with denial questions about claims. The number is 855-521-0628. You may also contact your local Provider Relations Representative for assistance.

What fee schedule does American Health Advantage of Texas use to pay providers?

American Health Advantage of Texas is a product of American Health Plans, Inc. (AHP), a Medicare Advantage organization that holds a Medicare contract to provide these services in several states. AHP uses the current Medicare fee schedule for the state where the services are rendered.

Does American Health Advantage of Texas automatically cross-over claims to State Medicaid for coordination of benefits?

At this time, there is no automatic cross-over. Providers will need to submit claims directly to State Medicaid along with the American Health Advantage of Texas Explanation of Payment for payment.

What should I do if I bill Medicare, the claim is denied, and I find out the member had American Health Advantage of Texas at the time of service, but timely filing has passed?

If you have not filed your claim to American Health Advantage of Texas, please do so. In order for the claim to be considered for payment, it must be filed to American Health Advantage of Texas within 180 days of the date of the Medicare EOP (Explanation of Payment). Upon receipt and processing by American Health Advantage of Texas, you will receive a timely filing denial for the claim. At that point, you may submit a Provider Dispute Resolution form along with supporting documentation as evidence that (1) your initial verification showed that the member had Medicare and (2) that the initial claim was sent to Medicare according to the timely filing requirements of your American Health Advantage of Texas provider agreement. Along with your Dispute Resolution Request, please submit a copy of the Medicare Explanation of Payment (EOP) for purposes of determining that the claim was initially filed to Medicare within this timely filing requirement. If that is the case, your claim will be adjudicated for payment according to the member's coverage and benefits. If not, the Resolution Request and claim will be denied due to this contractual provision.

In what fields on the claim form should the NPI numbers be entered?

- The individual provider's NPI number goes in Box 24J on the CMS 1500
- The group NPI number goes in Box 33A on the CMS 1500
- The attending physician's NPI number goes in Box 76 on the UB-04
- The operating physician's NPI number goes in Box 77 on the UB-04

Coverage and benefits

Can a medical provider dispense DME items?

If a medical provider is a licensed DME supplier and is contracted with American Health Advantage of Texas to supply DME, the provider may dispense DME items. Please see Prior Authorization DME requirements in the Quick Reference Guide. In addition, Prior Authorization is required for All DME items with billed charges greater than $250. Submit your authorization request to the fax number indicated on the prior authorization form.

Is there an annual limit for Physical Therapy, Occupational Therapy or Speech Therapy like Medicare?

American Health Advantage of Texas does not have an annual limit for Physical Therapy, Occupational Therapy or Speech Therapy. Benefits are based on medical necessity and Prior Authorization is required. Submit your authorization request to the fax number indicated on the prior authorization form.

How does American Health Advantage of Texas determine if non-emergency ambulance transportation is covered?

American Health Advantage of Texas uses Medicare guidelines to determine if a non-emergency ambulance transport meets medical necessity. All non-emergent ambulance transports require prior authorization. Submit your authorization request to the fax number indicated on the prior authorization form.

Credentialing

How often are participating providers required to be re-credentialed?

Participating providers are required to be re-credentialed every three years.

How will I know when my new provider has been credentialed?

The credentialing process includes final approval from the Medical Advisory Committee (MAC). Upon completion of the process, a letter is sent advising the provider of his/her acceptance into the network.

Member billing

Can I bill the patient if my payment from American Health Advantage of Texas was not what I anticipated?

The member should not be billed any more than the copay, coinsurance or deductible. Please note that copays, coinsurance and deductible amounts for dual eligible members should be billed to the appropriate state Medicaid program. If you believe the payment is inconsistent with the current Medicare fee schedule or the denial reason is incorrect, please submit a Claims Reconsideration Request with the appropriate documentation to support your belief. You may also contact your local Provider Relations Representative for further assistance.

Fraud, waste or abuse

American Health Advantage of Texas encourages participating providers to implement processes to detect and prevent fraudulent activities from our members and Medicare beneficiaries. Your diligence protects your reputation and revenue, as well as taxpayer's money. Contact American Health Advantage of Texas Compliance and Ethics Hotline, the U.S Office of the Inspector General or Medicare's customer service center if you know of something that may need investigating. You can even provide your report anonymously.

Contact information for fraud, waste or abuse:

American Health Advantage of Texas
Hotline: 1-866-205-2866
Email: Compliance@AmHealthPlans.com

U.S. Office of Inspector General
Hotline: 1-800-447-8477
TTY: 1-800-377-4950
Website: oig.hhs.gov/report-fraud/index.asp

Medicare Customer Service Center
Hotline: 1-800-633-4227
TTY: 1-877-486-2048
Website: medicare.gov/forms-help-resources/help-fight-medicare-fraud/how-report-medicare-fraud
Hours: 24 hours a day / 7 days per week

Examples of beneficiary fraud, waste, or abuse

- **Misrepresentation of status** - identity, eligibility, or medical condition – to illegally receive a medical service, item, or prescription drug benefit.
- **Identity theft** – uses another person's American Health Advantage of Texas member identification card and/or Medicare card to obtain medical services, items, or prescription drugs.
- **Doctor shopping** – Member or Medicare beneficiary consult several doctors to obtain multiple prescriptions for narcotic painkillers or other drugs.
- **Improper coordination of benefits** – Member or Medicare beneficiary fails to disclose all insurance policies or leverages multiple policies to game the system and receive more benefits than allowed.
- **Prescription forging, altering or diversion** – Member or Medicare beneficiary changes a prescription without the prescriber's approval to increase quantities or get additional refills.

- **Resale of drugs on black market** – Member or Medicare beneficiary falsely obtain drugs for resale.

AMERICAN HEALTH ADVANTAGE OF TEXAS

Toll-free: 1-855-521-0628 (TTY/TDD users call 833-312-0046) TX.AmHealthPlans.com