Frequently Asked Questions

AMERICAN HEALTH ADVANTAGE OF MISSISSIPPI

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

The Customer Services Department is available to assist with denial questions about claims. The number is. **1-844-917-0642**.

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

American Health Advantage of Mississippi, offered by American Health Plan of MS, Inc, is a Health Maintenance Organization (HMO) with a Medicare Contract to provide services to eligible Medicare beneficiaries residing in participating nursing facilities in our approved service area. American Health Advantage of Mississippi reimburses participating providers at the geographically adjusted Medicare fee schedule in effect at the date of service or date of discharge.

Can a medical provider dispense DME items?

If a medical provider is a licensed DME supplier and is contracted with American Health Advantage of Mississippi 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 greater than $250 in billed charges. Contact the Care Management Department at **1-844-917-0642** with authorization request for any DME questions. Please fax American Health Advantage of Mississippi Request for Authorization Form to us toll-free at: 1-844-917-0641.

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

American Health Advantage of Mississippi 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. Contact the Care Management Department at **1-844-917-0642** with authorization request questions.

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

Participating providers are required to get complete a re-credentialing application 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.

What fields on the claim forms are the NPI numbers supposed to 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.

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

American Health Advantage of Mississippi uses Medicare guidelines to determine if a non-emergency Ambulance transportation meets medical necessity. All non-emergent Ambulance transports require prior authorization from American Health Advantage of Mississippi. Please contact the Care Management Department at 1-844-917-0642 with authorization request questions.

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

The non-dual eligible 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 geographically adjusted Medicare fee schedule in effect at the date of service or date of discharge or the denial reason is incorrect, please submit a Provider Dispute Resolution Request form with the appropriate documentation to support your belief. You may also call your local Network Services Representative for further explanation.

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

If a claim has not been filed, please file the claim. Once the denial is received, submit a Claims Provider Dispute Resolution form along with supporting documentation as evidence that your initial verification showed that the member had Medicare. Also, submit a copy of the Explanation of Medicare Benefits (EOMB) for purposes of determining Timely Filing. The claim must be filed within 180 days of the Medicare denial date to meet the Timely Filing deadline.