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Provider and Billing Manual

2017



Ambetter.mhsindiana.com

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WELCOME

Welcome to Ambetter from MHS (“Ambetter”). Thank you for participating in our network of participating physicians, hospitals and other healthcare professionals.

Ambetter is a Qualified Health Plan (QHP) as defined in the Affordable Care Act. Ambetter will be offered to consumers through the Health Insurance Marketplace also known as the Exchange in Indiana. The Health Insurance Marketplace makes buying health insurance easier.

The Affordable Care Act is the law that has changed healthcare. The goals of the act are:

- to help more Americans get health insurance and stay healthy; and
- to offer consumers a choice of coverage leading to increased health care engagement and empowerment.

HOW TO USE THIS PROVIDER MANUAL

Ambetter is committed to assisting its provider community by supporting their efforts to deliver well-coordinated and appropriate health care to our members. Ambetter is also committed to disseminating comprehensive and timely information to its providers through this Provider Manual (“Manual”) regarding Ambetter’s operations, policies and procedures. Updates to this Manual will be posted on our website at Ambetter.mhsindiana.com. Additionally, providers may be notified via bulletins and notices posted on the website and potentially on Explanation of Payment notices. Providers may contact our Provider Services Department at 1-877-687-1182 to request that a copy of this Manual be mailed to you. In accordance with the Participating Provider Agreement, providers are required to comply with the provisions of this Manual. Ambetter routinely monitors compliance with the various requirements in this Manual and may initiate corrective action, including denial or reduction in payment, suspension or termination, if there is a failure to comply with any requirements of this Manual.

KEY CONTACTS AND IMPORTANT PHONE NUMBERS

The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available.

1. The provider’s NPI number
2. The practice Tax ID Number
3. The member’s ID number

Health Plan Information		
Website	Ambetter.mhsindiana.com	
Health Plan address	MHS Indiana 1099 N. Meridian Street Suite 400 Indianapolis, IN 46204	
Phone Number	Phone	TTY/TDD
MHS – Indiana	1-877-687-1182	1-800-743-3333

Department	Phone	Fax
Provider Services	1-877-687-1182	
Member Services		
Medical Management Inpatient and Outpatient Prior Authorization		1-855-702-7337
Concurrent Review/Clinical Information		1-855-685-6511
Admissions/Census Reports/Facesheets		1- 855-463-4251
Care Management		1-855-685-6510
Behavioral Health Prior Authorization		1- 855-283-9094
24/7 Nurse Advice Line		
Envolve Pharmacy		1- 855-702-7336
Envolve Vision		
Envolve Dental		pwp.dentalhw.com
Interpreter Services – Voiance		
To report suspected fraud, waste and abuse	1-866-685-8664	
EDI Claims assistance	1-800-225-2573 ext. 6075525	e-mail: EDIBA@centene.com

SECURE PROVIDER PORTAL

Ambetter offers a robust secure provider portal with functionality that is critical to serving members and to ease administration for the Ambetter product for providers. Each participating provider's dedicated Provider Relations Specialist will be able to assist and provide education regarding this functionality. The Portal can be accessed at Ambetter.mhsindiana.com.

Functionality

All users of the Secure Web Portal must complete a registration process. If you are already a registered user on the MHS Indiana Portal, a separate registration is not needed.

- Once registered, providers may:
 - check eligibility;
 - view the specific benefits for a member;
 - view benefit details including member cost share amounts for medical, pharmacy, dental, and vision services;
 - view the status of recent claims that have been submitted;

- view providers associated with the Tax Identification Number (“TIN”) that was utilized during the registration process;
- view demographic information for the providers associated with the registered TIN such as: office location, office hours and associated practitioners;
- update demographic information (address, office hours, etc.);
- for primary care providers, view and print patient lists. This patient list will indicate the member’s name, member ID number, date of birth and the product in which they are enrolled;
- submit authorizations and view the status of authorizations that have been submitted for members;
- view claims and the claim status;
- submit individual claims, batch claims or batch claims via an 837 file;
- view and download Explanations of Payment (EOP);
- view a member’s health record including visits (physician, outpatient hospital, therapy, etc.); medications, and immunizations;
- view gaps in care specific to a member including preventive care or services needed for chronic conditions; and
- send secure messages to Ambetter staff.

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Credentialing and Recredentialing

The credentialing and recredentialing process exists to verify that participating practitioners and providers meet the criteria established by Ambetter, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with MHS Indiana in the Medicaid product, the practitioner/provider will NOT be separately credentialed for the Ambetter product.

Notice: In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Ambetter of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.

Whether standardized credentialing form is utilized or a practitioner has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

- signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence; and ability to perform essential functions with or without accommodation;
- completed Ownership and Control Disclosure Form;
- current malpractice insurance policy face sheet which includes insured dates and the amounts of coverage;
- current Controlled Substance registration certificate, if applicable;
- current Drug Enforcement Administration (DEA) registration certificate for each state in which the practitioner will see Ambetter members;
- completed and signed W-9 form;

- current Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable;
- current unrestricted medical license to practice or other license in the State of Indiana;
- current specialty board certification certificate, if applicable;
- curriculum vitae listing, at minimum, a five year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants;
- signed and dated release of information form not older than 120 days; and
- current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.

Ambetter will primary source verify the following information submitted for credentialing and recredentialing:

- license through appropriate licensing agency;
- Board certification, or residency training, or professional education, where applicable;
- malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB);
- federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General).

For providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Recredentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the application is completed, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting.

Practitioners/Providers must be credentialed prior to accepting or treating members. Primary care practitioners cannot accept member assignments until they are fully credentialed.

Credentialing Committee

The Credentialing Committee, including the Medical Director or his/her physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including participation, denial, and termination. Committee meetings are typically held at least monthly and more often as deemed necessary. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Recredentialing

Ambetter conducts practitioner/provider recredentialing at least every 36 months from the date of the initial credentialing decision and most recent recredentialing decision. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, facilities and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, Ambetter conducts provider performance monitoring activities on all network practitioners/providers. Ambetter reviews monthly reports released by both Federal and State entities to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid. Ambetter also reviews member complaints/grievances against providers on an ongoing basis.

A provider's agreement may be terminated if at any time it is determined by the Ambetter Credentialing Committee that credentialing requirements or standards are no longer being met.

Practitioner Right to Review and Correct Information

All practitioners participating within the network have the right to review information obtained by Ambetter to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. Ambetter will inform providers in cases where information obtained from primary sources varies from information provided by the practitioner. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have 30 days of the initial notification to provide a written explanation detailing the error or difference in information to the Credentialing Committee.

The Credentialing Committee will then include this information as part of the credentialing or recredentialing process.

Practitioner Right to Be Informed of Application Status

All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Provider Services Department at 1-877-676-1182.

Practitioner Right to Appeal or Reconsideration of Adverse Credentialing Decisions

Applicants who are existing providers and who are declined continued participation due to adverse recredentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice.

New applicants who are declined participation may request a reconsideration within 30 days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than 60 days from the receipt of the additional documentation.

Provider Types That May Serve As PCPs

Providers who may serve as primary care providers (PCP) include Family Medicine, Family Medicine-Adolescent Medicine, Family Medicine-Geriatric Medicine, Family Medicine-Adult Medicine, General Practice, Pediatrics, Pediatrics-Adolescent Medicine, Internal Medicine, Internal Medicine-Adolescent Medicine, Internal Medicine-Geriatric Medicine, Obstetrics and Gynecology, Gynecology, Physician Assistants and Nurse Practitioners that practice under the supervision of the above specialties.

The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, or similar outpatient clinic. With prior written approval, Ambetter may allow a specialist provider to serve as a PCP for members with special health care needs, multiple disabilities or with acute or chronic conditions as long as the specialist is willing to perform the responsibilities of a PCP as outlined in this Manual.

Member Panel Capacity

All PCPs have the right to state the number of members they are willing to accept into their panel. Ambetter does not and is not permitted to guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following limits:

Practitioner Type	Ratio
General/Family Practitioners	One per 2,500 members
Pediatricians	One per 2,500 members
Internists	One per 2,500 members

If a PCP has reached the capacity limit for his/her practice and wants to make a change to their open panel status, the PCP must notify the Provider Services Department by calling 1-877-687-1182. A PCP must not refuse new members for addition to his/her panel unless the PCP has reached his/her specified capacity limit.

PCPs must notify Ambetter in writing, within 30 days in advance of their inability to accept additional members.

In no event will any established patient who becomes a member be considered a new patient. Providers must not intentionally segregate members from fair treatment and covered services provided to other non-members.

Member Selection or Assignment of PCP

Ambetter members will be directed to select a participating Primary Care Provider at the time of enrollment. In the event an Ambetter member does not make a PCP choice, Ambetter will usually select a PCP based on:

1. **A previous relationship with a PCP based on claims history.** If a member has not designated a PCP within the first 90 to 120 days of being enrolled in Ambetter, Ambetter will review claims history to determine if a PCP visit has occurred and assign the member to that PCP.
2. **Geographic proximity of PCP to member residence.** The auto-assignment logic is designed to select a PCP for whom the members will not travel more than the required access standards.
3. **Appropriate PCP type.** The algorithm will use age, and gender, and other criteria to identify an appropriate match, such as children assigned to pediatricians.

Pregnant women should be encouraged to select a pediatrician or other appropriate PCP for their newborn baby before the beginning of the last trimester of pregnancy. In the event the pregnant member does not select a PCP, Ambetter will auto-assign one for her newborn.

The member may change his or her PCP at any time with the change becoming effective no later than the beginning of the month following the member's request for change. Members are advised to contact the Member Services Department at 1-877-687-1182 for further information.

Withdrawing from Caring for a Member

Providers may withdraw from caring for a member. Upon reasonable notice and after stabilization of the member's condition, the provider must send a certified letter to Ambetter Member Services detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

PCP Coordination of Care to Specialists

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. **Paper referrals are not required.**

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member or a member of the provider's family or the member's family has a financial relationship.

Specialist Provider Responsibilities

Specialist providers must communicate with the PCP regarding a member's treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request.

To ensure continuity and coordination of care for the member, every specialist provider must:

- maintain contact and open communication with the member's referring PCP;
- obtain authorization from the Medical Management Department, if applicable, before providing services;
- coordinate the member's care with the referring PCP
- provide the referring PCP with consultation reports and other appropriate patient records within five business days of receipt of such reports or test results;
- be available for or provide on-call coverage through another source 24 hours a day for management of member care;
- maintain the confidentiality of patient medical information; and
- actively participate in and cooperate with all quality initiatives and programs.

Appointment Availability and Wait Times

Ambetter follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Ambetter monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability and wait time standards for members:

Appointment Type	Access Standards	
	PCPs	
Urgent or emergent care		24 hours
Non-urgent symptomatic		72 hours
Routine physical exam		3 months
Initial appointment (non-pregnant adult)		3 months
Routine gynecological exam		3 months
New obstetric patient	Within 1 month of date of attempt to schedule appointment	
Initial appointment well child	Within 1 month of date of attempt to schedule appointment	
Children with special health care needs		1 month
Specialist referral- emergency		24 hours
Specialist referral- urgent		48 hours

Appointment Type	Access Standards
Specialists	
Initial appointment	30 calendar days
Established patient follow-up	60 calendar days
Urgent new or established patient	48 hours
Behavioral Health	
Routine visits	10 business days
Urgent care	24 hours
Non-life threatening emergency	Directed to the Emergency Room

Wait Time Standards for All Provider Types

It is recommended that office wait times do not exceed 30 minutes before an Ambetter member is taken to the exam room.

Travel Distance and Access Standards

Ambetter offers a comprehensive network of PCPs, Specialist Physicians, Hospitals, Behavioral Health Care Providers, Diagnostic and Ancillary Services Providers to ensure every member has access to Covered Services.

The travel distance and access standards that Ambetter utilizes to monitor its network adequacy are in line with both state and federal regulations. For the standard specific to your specialty and county, please reach out to your Provider Relations Representative.

Providers must offer and provide Ambetter members appointments and wait times comparable to that offered and provided to other commercial members. Ambetter routinely monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply with this requirement.

Covering Providers

PCPs and specialist providers must arrange for coverage with another provider during scheduled or unscheduled time off. In the event of unscheduled time off, the provider must notify Provider Relations Department of coverage arrangements as soon as possible. For scheduled time off, the provider must notify the Provider Relations Department prior to the scheduled time off. The provider whom engaged the covering provider must ensure that the covering physician has agreed to be compensated in accordance with the Ambetter fee schedule in such provider’s agreement.

Provider Phone Call Protocol

PCPs and specialist providers must:

- answer the member’s telephone inquiries on a timely basis;
- schedule appointments in accordance with appointment standards and guidelines set forth in this Manual;
- schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients;
- identify and, when possible, reschedule cancelled and no-show appointments;
- identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments);
- adhere to the following response times for telephone call-back wait times:

- after hours for non-emergent, symptomatic issues: within 30 minutes;
- same day for all other calls during normal office hours;
- schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours;
- have protocols in place to provide coverage in the event of a provider's absence; and
- document after-hours calls in a written format in either in the member's medical record or an after-hours call log and then transferred to the member's medical record.

Note: If after-hours urgent or emergent care is needed, the PCP, specialist provider or his/her designee should contact the urgent care center or emergency department in order to notify the facility of the patient's impending arrival. Ambetter does not require prior-authorization for emergent care.

Ambetter will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

Provider Data Updates and Validation

Ambetter believes that providing easy access to care for our members is extremely important. When information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) about your practice, your locations, or your practitioners changes, it is your responsibility to provide timely updates to Ambetter. Ambetter will ensure that our systems are updated quickly to provide the most current information to our members.

Additionally, Ambetter, and our contracted vendors, perform regular audits of our provider directories.

We need your support and participation in these efforts. CMS may also be auditing provider directories throughout the year, and you may be contacted by them as well. Please be sure to notify your office staff so that they may route these inquiries appropriately.

24-Hour Access to Providers

PCPs and specialist providers are required to maintain sufficient access to needed health care services on an ongoing basis and must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- a provider's office phone must be answered during normal business hours; and
- a member must be able to access their provider after normal business hours and on weekends. This may be accomplished through the following:
 - a covering physician;
 - an answering service;
 - a triage service or voicemail message that provides a second phone number that is answered; or
 - if the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish

Examples of unacceptable after-hours coverage include, but are not limited to:

- calls received after-hours are answered by a recording telling callers to leave a message;
- calls received after-hours are answered by a recording directing patients to go to an Emergency Room for any services needed; or

- not returning calls or responding to messages left by patients after-hours within 30 minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist provider for a clinical decision. Whenever possible, PCP, specialist providers, or covering professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Ambetter will monitor provider's compliance with this provision through scheduled and unscheduled visits and audits conducted by Ambetter staff.

Hospital Responsibilities

Ambetter has established a comprehensive network of hospitals to provide services to members. Hospital services and hospital-based providers must be qualified to provide services under the program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by accrediting agencies, if any, and Ambetter.

Hospitals must:

- notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit;
- obtain authorizations for all inpatient and selected outpatient services listed on the current prior authorization list, except for emergency stabilization services;
- notify the Medical Management Department by either calling or sending an electronic file of the ER admission within one business day. The information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service, and member's phone number;
- notify the Medical Management Department of all admissions via the ER within one business day; and
- notify the Medical Management Department of all newborn deliveries within one day of the delivery. Notification may occur by our secure provider portal, fax, or by phone
- adhere to the standards set Timeframes for Prior Authorization Requests and Notifications table in the Medical Management section of this manual

AMBETTER BENEFITS

Overview

There are many factors that determine which plan an Ambetter member will be enrolled. The plans vary based on the individual liability limits or cost share expenses to the member. The phrase "Metal Tiers" is used to categorize these limits.

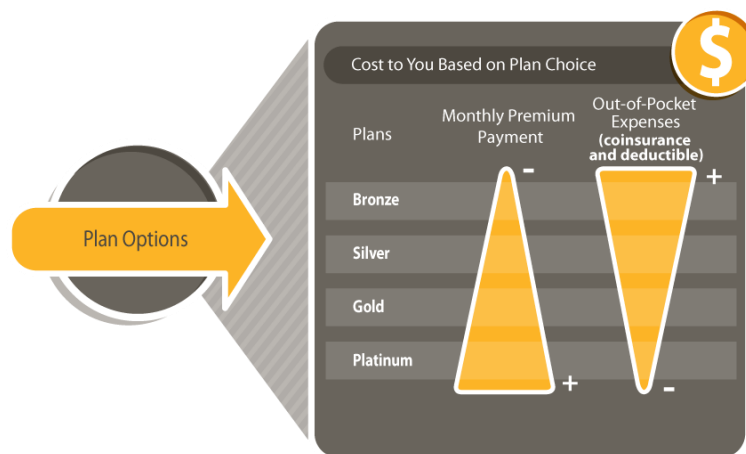
Under the Affordable Care Act (ACA) the Metal Tiers include Platinum, Gold, Silver, and Bronze. Essential Health Benefits (EHBs) are the same with every plan. This means that every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act.

The EHBs outlined in the Affordable Care Act are as follows:

- Preventive and wellness services and chronic disease management
- Maternity and newborn care
- Pediatric services including pediatric vision
- Outpatient or ambulatory services

- Laboratory services
- Various therapies (such as physical therapy and devices)
- Hospitalization
- Emergency services
- Mental health and substance use services, both inpatient and outpatient
- Prescription drugs

Each plan offered on the Health Insurance Marketplace (or Exchange) will be categorized within one of these “Metal Tiers”. The tiers are based on the amount of member liability. For instance, at a gold level, a member will pay higher premiums, but will have lower out-of-pocket costs, like copays. The following image is a basic depiction of how the cost levels are determined within each plan.



Our products are marketed under the following names:

Metal Tier	Marketing Names
Gold	Ambetter Secure Care
Silver	Ambetter Balanced Care
Bronze	Ambetter Essential Care

Additional Benefit Information

HMO Benefit Plans

Ambetter plans are HMO Benefit plans. Members who are enrolled with Ambetter must utilize in-network participating providers. Members and Providers can identify other participating providers by visiting our website at Ambetter.mhsindiana.com and clicking on Find-A-Provider. When an out-of-network provider is utilized, except in the case of emergency services, the Member will be 100% responsible for all charges. Depending on the benefit plan and any subsidies that the Member receives, most benefit plans contain copays, coinsurance and deductibles (cost shares). As stated elsewhere in this Provider Manual, cost shares may be collected at the time of service.

Preventive Services

In accordance with the Affordable Care Act, all preventive services which meet U.S Preventive Services Task Force (USPSTF) guidelines are covered at 100%. That is, there is no member cost share (copay, coinsurance, or deductible) applied to preventive health services which meet USPSTF A and B ratings. For a listing of services that are covered at 100% and associated benefits, please visit Ambetter.mhsindiana.com

Free Visits

There are certain benefit plans where three free visits are offered. That is, these visits will not be subject to member cost shares (copay, coinsurance or deductible).

- These three free visits only apply to the evaluation and management (E and M) codes provided by a Primary Care Provider.
- Preventive care visits are not included in the free visits. As mentioned above, in accordance with the ACA, preventive care is covered at 100% by Ambetter, separately from the free visits.
- The secure provider portal at Ambetter.mhsindiana.com has functionality to “accumulate or count” free visits. It is imperative that providers always verify eligibility and benefits.
- The following CPT codes will be associated with the free visit benefit when billed by a PCP: 99201-99205, 99211-99215, 99324-99328, 99334-99337, 99339-99345, 99347-99350, 99366, S0220-S0221, S0257

Integrated Deductible Products

Some Ambetter products contain an integrated deductible, meaning that the medical and prescription deductible are combined. In such plans:

- a member will reach the deductible first, then pay coinsurance until they reach the maximum out of pocket for their particular plan;
- copays will be collected before the deductible for services that are not subject to the deductible;
- other copays are subject to the deductible and the copay will be collected only after the deductible is met;
- services counting towards the integrated deductible include: Medical costs, physician services, and hospital services, essential health benefit covered services including pediatric vision and mental health services, and pharmacy benefits; and
- claims information including the accumulators will be displayed on the secure provider portal

Maximum Out-of-Pocket Expenses

All Ambetter benefit plans contain a maximum out-of-pocket expense. Maximum out-of-pocket is the highest or total amount that must be paid by the member toward the cost of their health care (excluding premium payments). The maximum out of pocket for in-network providers is \$6,500 for individuals and \$13,000 for families. Below are some rules regarding maximum out of pocket expenses.

- A member will reach the deductible first, then pay coinsurance until they reach the maximum out of pocket for their Ambetter benefit plan.
- Copays will be collected before and after the deductible.
- Only medical costs/claims are applied to the deductible. (For those benefit plans that contain adult vision and dental coverage, these expenses would not count towards the deductible).

- All out-of-pocket costs, including copays, apply to the maximum out of pocket. (As mentioned previously, this excludes premium payments).

Adding a Newborn or an Adopted Child

Coverage applicable for children will be provided for a newborn child or adopted child of an Ambetter member or for a member's covered family member from the moment of birth or moment of placement if the newborn is enrolled timely as specified in the member's Evidence of Coverage.



VERIFYING MEMBER BENEFITS, ELIGIBILITY, and COST SHARES

It is imperative that providers verify benefits, eligibility, and cost shares each time an Ambetter member is scheduled to receive services.

All members will receive an Ambetter member identification card.

Member Identification Card

Below is a sample member identification card. Please keep in mind that the ID card may vary due to the features of the plan selected by the member.

				IN NETWORK COVERAGE ONLY	
Subscriber: [Jane Doe]		Effective Date of Coverage:			
Member: [John Doe]		RXBIN: [004336]			
Policy #: [XXXXXXXXXX]		RXPCN: [ADV]			
Member ID #: [XXXXXXXXXX]		RXGROUP: [RX5453]			
Plan: [Ambetter Balanced Care 1]					
Copays		Coinsurance (Med/Rx): [50%/30%]			
PCP: [\$10]		Deductible (Med/Rx): [\$250/\$500]			
Specialist: [\$25]		Rx (Generic/Brand): [\$5/\$25]			
ER: [\$250]					
Ambetter.mhsindiana.com					
Member/Provider Services: [1-877-687-1182]			Medical Claims: Managed Health Services Attn: CLAIMS PO Box 5010 Farmington, MO 63640-5010		
TDD/TTY: [1-800-743-3333]					
24/7 Nurse Line: [1-877-687-1182]					
Numbers below for providers:					
Pharmacy Help Desk: [1-866-270-3922]					
EDI Payor ID: [68069]					
EDI Help Desk: [Ambetter.mhsindiana.com]					
<small>Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.mhsindiana.com.</small>					
<small>AMB16-IN-C-00064</small>		<small>©2016 Celtic Insurance Company. All rights reserved.</small>			

(The above is a reasonable facsimile of the Member Identification Card)

NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Preferred Method to Verify Benefits, Eligibility, and Cost Shares

To verify member benefits, eligibility, and cost share information, the preferred method is the Ambetter secure provider portal found at Ambetter.mhsindiana.com. Using the Portal, any registered provider can quickly check member eligibility, benefits and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, member name and date of birth or the member ID number and date of birth.

Other Methods to Verify Benefits, Eligibility and Cost Shares

<p>24/7 Toll Free Interactive Voice Response (IVR) Line at 1-877-687-1182</p>	<p>The automated system will prompt you to enter the member ID number and the month of service to check eligibility</p>
<p>Provider Services at 1-877-687-1182</p>	<p>If you cannot confirm a member's eligibility using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member name or member ID number and date of birth to verify eligibility.</p>

Importance of Verifying Benefits, Eligibility, and Cost Shares

Benefit Design

As mentioned previously in the Benefits section of this Manual, there are variations on the product benefits and design. In order to accurately collect member cost shares (coinsurance, copays and deductibles): you must know the benefit design. A member cost-sharing level and copayment is based on the member's health plan. You can collect the copayment amounts from the member at the time of service. The Secure Provider Portal found at Ambetter.mhsindiana.com will provide the information needed.

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)

A provision of the Affordable Care Act requires that Ambetter allow members receiving APTCs a three month grace period to pay premiums before coverage is terminated.

When providers are verifying eligibility through the secure provider portal during the first month of non-payment of premium, the provider will receive a message the nonpayment of premium due to the fact that claims may be submitted and paid during the first month. During months two and three of the non-payment of premium period, the provider will receive a message that the member is in a suspended status. If payment of all premiums due is not received from the Member at the end of the grace period, the Member policy will automatically terminate to the last date through which premium was paid. The Member shall be held liable for the cost of Covered Services received during the grace period, as well as any unpaid premium. In no event shall the grace period extend beyond the date the Member policy terminates. More discussion regarding the three month grace period for non-payment of premium may be found in the "Billing the Member" section of this manual.

MEDICAL MANAGEMENT

The components of the Ambetter Medical Management program are: Utilization Management, Care Management and Concurrent Review, Health Management and Behavioral Health. These components will be discussed in detail below.

Utilization Management

The Ambetter Utilization Management initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. The Utilization Management Program's goals are to provide covered services that

are medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care. Ambetter does not reward providers, employees who perform utilization reviews or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve benefit coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Prior authorization is the request to the Utilization Management Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services.

Medically Necessary

Medically Necessary means any medical service, supply or treatment authorized by a physician to diagnose and treat a member's illness or injury which:

- is consistent with the symptoms or diagnosis;
- is provided according to generally accepted medical practice standards;
- is not custodial care;
- is not solely for the convenience of the physician or the member;
- is not experimental or investigational;
- is provided in the most cost effective care facility or setting;
- does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; and
- when specifically applied to a hospital confinement, it means that the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient.

Timeframes for Prior Authorization Requests and Notifications

The following timeframes are required for prior authorization and notification:

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within one business day
Observation – 23 hours or less	Notification within one business day for non-participating providers
Observation – greater than 23 hours	Requires inpatient prior authorization within one business day
Maternity admissions	Notification within one business day
Newborn admissions	Notification within one business day

Service Type	Timeframe
Neonatal Intensive Care Unit (NICU) admissions	Notification within one business day
Outpatient Dialysis	Notification within one business day
Organ transplant initial evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

Utilization Determination Timeframes

Utilization management decision making is based on appropriateness of care and service, and the covered benefits of the plan. Ambetter does not reward providers or other individuals for issuing denials of authorization.

Authorization decisions are made as expeditiously as possible. Below are the specific timeframes utilized by Ambetter. In some cases it may be necessary for an extension to extend the timeframe below. You will be notified if an extension is necessary. Please contact Ambetter if you would like a copy of the policy for UM timeframes.

Type	Timeframe
Prospective/Urgent	72 hours (three calendar days)
Prospective/Non-Urgent	15 calendar days
Concurrent/Urgent	24 hours (one calendar day)
Concurrent/Non-Urgent	15 calendar days
Retrospective	30 calendar days

Services Requiring Prior Authorization

The following list is not all-inclusive. Please visit the Ambetter website at Ambetter.mhsindiana.com and use the "Pre-Auth Needed?" tool or call the Utilization Management Department with questions. When the services in the Table below are Covered Services under the member's benefit plan, the service will require authorization. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment.

Note: All out of network services require prior authorization excluding emergency room services.

It is the responsibility of the facility, in coordination with the rendering practitioner to ensure that an authorization has been obtained for all inpatient and selected outpatient services, except for emergency stabilization services. All inpatient admissions require pre-authorization.

Any anesthesiology, pathology, radiology or hospitalist services related to a procedure or hospital stay requiring a pre-authorization will be considered downstream and will not require a separate pre-authorization.

Services related to an authorization denial will result in denial of all associated claims.

Procedures/Services	Inpatient Authorizations	Ancillary Services
<ul style="list-style-type: none"> • Potentially Cosmetic • Experimental or Investigational • High Tech Imaging (i.e., CT, MRI, PET) • Pain Management (unless performed on the same date as surgery) 	<ul style="list-style-type: none"> • All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including but not limited to: <ul style="list-style-type: none"> - Medical Admissions - Surgical Admissions - All services performed in out-of-network facilities - Hospice Care - Rehabilitation facilities - Transplants, not including evaluations • Observation <ul style="list-style-type: none"> - Observation stays exceeding 23 hours require Inpatient Authorization/Concurrent Review - Notification is required within 1 business day if admitted - Observation stays less than 23 hours require an authorization for non-participating providers only • Urgent/Emergent Admissions <ul style="list-style-type: none"> - Within 1 business day following the date of admission • Newborn Deliveries must include birth outcomes • Behavioral Health Admissions <ul style="list-style-type: none"> - All behavioral health admissions require authorization within 24 hours of admission via a phone call to the utilization management department • Partial Inpatient, and/or Intensive Outpatient Programs 	<ul style="list-style-type: none"> • Air Ambulance Transport (non-emergent fixed wing plane) • DME • Home health care services including home infusion, skilled nursing and therapy <ul style="list-style-type: none"> - Home Health Services - Private Duty Nursing - Hospice - Furnished Medical Supplies and DME • Orthotics/Prosthetics • Hearing Aid devices including cochlear implants (cochlear replacement batteries do not require prior authorization) • Genetic Testing • Quantitative Urine Drug Screen (except Urgent Care, ER, and Inpatient place of service)

Procedure for Requesting Prior Authorizations

Medical

The preferred method for submitting authorizations is through the secure provider portal at Ambetter.mhsindiana.com. The provider must be a registered user on the secure provider portal. (If a provider is already registered for the secure provider portal for one of our other products, that registration will grant the provider access to Ambetter). If the provider is not already a registered user on the secure provider portal and needs assistance or training on submitting prior authorizations, the provider should contact his or her dedicated Provider Relations Specialist.

Other methods of submitting the prior authorization requests are as follows:

- Phone the Medical Management Department at 1-877-687-1182. Our 24/7 Nurse Advice line can assist with urgent authorizations after normal business hours.
- Fax prior authorization request utilizing the Prior Authorization fax forms posted on the Ambetter website at Ambetter.mhsindiana.com. Please note: faxes will not be monitored after hours and will be responded to on the next business day. Please contact our 24/7 Nurse Advice Line at 1-877-687-1182 for after hour urgent admissions, inpatient notifications or requests.

Behavioral

The required method for prior authorization of inpatient admissions is to contact the health plan telephonically. Outpatient authorizations may be submitted via the secure provider portal or by fax.

Medical and Behavioral

The requesting or rendering provider must provide the following information to request authorization (regardless of the method utilized):

- member's name, date of birth and ID number;
- provider's NPI number, taxonomy code, name and telephone number;
- facility name, if the request is for an inpatient admission or outpatient facility services;
- provider location if the request is for an ambulatory or office procedure;
- the procedure code(s). Note: If the procedure codes submitted at the time of authorization differ from the services actually performed, it is **required** within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-877-687-1182 to update the authorization otherwise, this may result in claim denials;
- relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
- admission date or proposed surgery date, if the request is for a surgical procedure;
- discharge plans; and
- for obstetrical admissions, the date and method of delivery, estimated date of confinement and information related to the newborn or neonate.

Radiology and Diagnostic Imaging Services

As part of a continued commitment to further improve the quality of advanced imaging and radiology services, Ambetter is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA
- MRI/MRA

Key provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.
- It is the responsibility of the ordering physician to obtain authorization

NIA provides an interactive website (www.RadMD.com), which should be used to obtain online authorizations.

To obtain authorization, the provider should go to the NIA web-site www.RadMD.com, or through the NIA dedicated toll-free phone number 1-866-904-5096.

Behavioral Health Services

Ambetter has delegated the management of covered mental health and substance use disorder services to Envolve PeopleCare. Please refer to your contract with Cenpatico for specific information related to covered services and authorization requirements. Additional information regarding Behavioral Health services can be found in other sections of this Manual as applicable.

Pharmacy

The pharmacy benefits for Ambetter members vary based on the plan benefits. Information regarding the member's pharmacy coverage can be best found via our secure Provider Portal. Additional resources available on the website include the Ambetter Preferred Drug List, the US Script (Pharmacy Benefit Manager) Provider Manual and Medication Request/Exception Request forms.

The Ambetter formulary is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions and limitations;
- The Pharmacy Management Program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can make an exception request; and
- How Ambetter conducts generic substitution, therapeutic interchange and step-therapy.

The Ambetter formulary does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the professional judgment of the physician or pharmacist; and
- Relieve the physician or pharmacist of any obligation to the member.

The Ambetter formulary will be approved initially by the Ambetter Pharmacy and Therapeutics Committee (P & T), led by the Pharmacist and Medical Director, with support from community-based primary care providers and specialists. Once established, the Preferred Drug List will be maintained by the P & T Committee, through quarterly meetings, to ensure Ambetter members receive the most appropriate medications. The Ambetter formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the formulary Change Request policy can be used as a method to address the request. The

Ambetter P & T Committee reviews the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the formulary are available on our website, Ambetter.mhsindiana.com. Providers may also call Provider Services for hard copies of the formulary.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Ambetter network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out of network provider only upon receiving a prior authorization from the Ambetter Utilization Management Department.

Women's Health Care

Ambetter is committed to the promotion of the lifelong benefits of preventive care. Female members may see a network provider, who is contracted with Ambetter to provide women's health care services directly, without prior authorization for:

- medically necessary maternity care;
- preventive care (well care) and general examinations particular to women;
- gynecological care; and
- follow-up visits for the above services.

If the member's women's health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Ambetter's prior authorization requirements.

Abortion Services

When abortion services are Covered Services under the member's benefit plan, an abortion consent form must be submitted with the claim. The abortion consent form can be found on our website at Ambetter.mhsindiana.com.

Retrospective Review

Retrospective review is an initial review of services after services have been provided to a member. This may occur when authorization or timely notification to Ambetter was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Ambetter ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly.

Emergency

Emergency means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- place and individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Utilization Review Criteria

Utilization management decision making is based on appropriateness of care and service and the existence of coverage. Ambetter does not reward providers or other individuals for issuing denials of authorizations.

Ambetter has adopted the following utilization review criteria to determine whether services are medically necessary services for purposes of plan benefits:

Medical Services	Milliman Care Guidelines
Behavioral Health Services	InterQual® Adult and Pediatric Guidelines
Substance Use Disorder Services	Based upon the American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org

Ambetter's Medical Director, or other health care professionals who have appropriate clinical expertise in treating the member's condition or disease, review all potential adverse determinations and will make a decision in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from Milliman or other criteria as mentioned above. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-877-687-1182. Providers have the opportunity to discuss any adverse decisions with an Ambetter physician or other appropriate reviewer at the time of the notification to the requesting provider of an adverse determination. The Medical Director may be contacted by calling Ambetter at 1-877-687-1182 and asking for the Medical Director. An Ambetter Care Manager may also coordinate communication between the Medical Director and the requesting provider.

Care Management and Concurrent Review

Concurrent Review

The Ambetter from MHS Medical Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning Departments and when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status, proposed plan of care, discharge plans and subsequent diagnostic testing or procedures.

Care Management

Medical Care Management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Service/Care Coordination and Care Management are member-centered, goal-oriented, culturally relevant and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Ambetter's Care Management teams support physicians by tracking compliance with the Care Management plan, and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community Providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the member's ongoing care needs. The Ambetter Care Manager will contact the PCP, and/or, managing physician if the member is not following the plan of care or requires additional services.

Ambetter will provide individual Care Management services for members who have high risk, high-cost, complex or catastrophic conditions. The Ambetter Care Manager will work with all involved Providers to coordinate care, provide referral assistance and other care coordination, as required. The Ambetter Care Manager may also assist with a member's transition to other care, as indicated, when Ambetter benefits end.

Start Smart for Your Baby® (Start Smart) is a Care Management program available to women who are pregnant or have just had a baby. Start Smart is a comprehensive program that covers all phases of the pregnancy, postpartum and newborn periods. The program includes mailed educational materials for newly identified pregnant members and new mothers after delivery.

Telephonic Care Management by Registered Nurses and Social Services Specialists, as well as Marketplace Coordinators, is available. Ambetter's Care Managers work with the member to create a customizable plan of care in order to promote healthcare as well as adherence to Care Management plans. Care Managers will coordinate with physicians, as needed, in order to develop and maintain a plan of care to meet the needs of all involved.

All Ambetter members with identified needs are assessed for Care Management enrollment.

Members with needs may be identified via clinical rounds, referrals from other Ambetter staff members, via hospital census, via direct referral from Providers, via self-referral or referral from other Providers.

Care Management Process

Ambetter's Care Management for high risk, complex or catastrophic conditions contains the following key elements:

- Health Needs Screenings to identify members who potentially meet the criteria for Care Management.
- Assess the Member's risk factors to determine the need for Care Management.
- Notify the Member and their PCP of the Member's enrollment in Ambetter's Care Management program.
- Develop and implement a treatment plan that accommodates the specific cultural and linguistic needs of the member.
- Establish treatment objectives and monitor outcomes.
- Refer and assist the member in enduring timely access to Providers.
- Coordinate medical, residential, social and other support services.
- Monitor care/services.
- Revise the treatment plan as necessary.
- Assess the member's satisfaction with Complex Care Management services.
- Track plan outcomes.
- Follow-up post discharge from Care Management.
- Referring a member to Ambetter Care Management: Providers are asked to contact the Medical Management Department to refer a member identified in need of Care Management intervention.

Health Management

Health Management is the concept of reducing health care costs and improving quality of life for individuals with a chronic condition through ongoing integrated care. Health management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations

and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health. Due to their proven success and expertise, Ambetter partners with Envolve PeopleCare and Cenpatico for health management programs for our members.

Envolve PeopleCare

Envolve PeopleCare programs promote a coordinated, proactive, disease-specific approach to health management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. Programs include but are not limited to:

- Adult and pediatric asthma
- Coronary artery disease (CAD)
- Adult and pediatric diabetes
- High blood pressure and high cholesterol management
- Low back pain
- Tobacco cessation

Cenpatico

Cenpatico offers a health management program to Ambetter members with depression in order to provide a coordinated approach in managing the disease and improve the health status of the member. This is accomplished by identifying and providing the most effective and efficient resources, enhancing collaboration between medical and behavioral health providers and ongoing monitoring of outcomes of treatment. Each of Cenpatico's health management programs are based on clinical practice guidelines and include researched evidence-based practices. Multiple communication strategies are used in the depression health management program to include written materials, telephonic outreach, web-based information, outreach through care managers, and participation in community events.

It is worth noting that diagnosis of a certain condition, such as diabetes, does not mean automatic enrollment in a health management program. Members with selected disease states will be stratified into risk groups that will determine need and the level of intervention most appropriate for each case. High-risk members with co-morbid or complex conditions will be referred for care management or health management program evaluation.

To refer a member for Care or Health Management call:

Care Management
1-877-687-1182

Ambetter's Member Welcome Survey

Members are requested to complete a Welcome Survey upon enrollment with Ambetter. Ambetter utilizes the information to better understand the member's health care needs in order to provide customized, educational information and services specific to the member's needs. The Member Welcome Survey form can be found at Ambetter.mhsindiana.com and completed online by the Member.

Ambetter's My Health Pays Member Incentive Program

Ambetter encourages our members to receive annual preventive services through our unique rewards program. Members can earn rewards for doing the following:

- Completing a Member Welcome Survey which verifies demographic information and health information at Ambetter.mhsindiana.com;

- receiving their annual wellness exam; and
- receiving their flu shot.

The rewards are sent out automatically to the member. The rewards are loaded on to a reloadable health restricted debit card. Members may utilize the debit card to pay for physician/hospital cost sharing (copays, coinsurance, or deductibles) or to help pay their premium payment. Additional information regarding this program can be found at Ambetter.mhsindiana.com.

Ambetter's Gym Membership Program

Ambetter promotes healthy lifestyle choices, like using a gym or health club on a regular basis. To help make it more affordable for our members who want to stay healthy and active, Ambetter offers discounted Gym memberships through our participating Gym network. Additionally, Ambetter will provide incentives to members that use their health club or gym regularly. The incentives will be added to the My Health Pays Incentive Card.

CLAIMS

The appropriate Center for Medicare and Medicaid Services (CMS) billing form is required for paper and electronic data interchange (EDI) claim submissions. The appropriate CMS billing form usage are CMS 1450 for facilities and CMS 1500 for professionals. In general, Ambetter follows the CMS billing requirements for paper, (EDI), and secure web-submitted claims. Ambetter is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials on the explanation of payment if not submitted correctly. **Claims will be rejected or denied if not submitted correctly.**

Verification Procedures

All claims filed with Ambetter are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted on our secure provider portal, individually or batch.
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.
- Claims must contain the CLIA number when CLIA waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- Taxonomy codes are required. Please see further details in this Manual for taxonomy requirements.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
 - Date of Service
 - Provider Type and/or provider specialty billing
 - Age and/or sex for the date of service billed

- Bill type
- All Diagnosis Codes are to their highest number of digits available.
- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
 - F2 – International Unit
 - GR – Gram
 - ME – Milligram
 - ML – Milliliter
 - UN - Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-9-CM and/or ICD-10-CM for the date of service billed.
 - For a CMS 1500 Claim Form, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
 - All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
 - N – No
 - U – Unknown
 - W – Not Applicable
 - Y - Yes
- Member is eligible for services under Ambetter during the time period in which services were provided.
- Services were provided by a participating provider, or if provided by an “out of network” provider, authorization has been received to provide services to the eligible member. (Excludes services by an “out of network” provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.)
- An authorization has been given for services that require prior authorization by Ambetter.
- Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member’s contract on the date of service and prior authorization processes were followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

Clean Claim Definition

A clean claim means a claim for payment of health care expenses that is submitted on a CMS 1500 or a UB04 claim form, in a format required by the Health Insurance Portability and Accountability Act of 1996

(HIPAA) with all required fields completed in accordance with Ambetter’s published claim filing requirements.

Non-Clean Claim Definition

A clean claim shall not include a claim:

- For payment of expenses incurred during a period for which premiums are delinquent; and
- For which Ambetter requires additional information in order to resolve the claim.

Upfront Rejections vs. Denials

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located in Appendix IX of this manual. A list of common upfront rejections can be located in Appendix I of this manual. Upfront rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial

If all edits pass and the claim is accepted, it will then be entered into the system for processing. A **denial** is defined as a claim that has passed edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below with explanations in Appendix II.

Timely Filing

Initial Claims		Reconsiderations or Claim Dispute/Appeals		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Par	Non-Par	Par	Non-Par	Par	Non-Par
180	90	180	90	180	90

- **Initial Claims and Claims Dispute/Appeals** - Days are calculated from the Date of Service to the date received by Ambetter or from the EOP date.
- **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.

Who Can File Claims?

All providers who have rendered services for Ambetter members can file claims. It is important that providers ensure Ambetter has accurate and complete information on file. Please confirm with the

Provider Services Department or your dedicated Provider Relations Specialist that the following information is current in our files:

1. Provider Name (as noted on current W-9 form)
2. National Provider Identifier (NPI)
3. Group National Provider Identifier (NPI) (if applicable)
4. Tax Identification Number (TIN)
5. Taxonomy code (This is a REQUIRED field when submitting a claim)
6. Physical location address (as noted on current W-9 form)
7. Billing name and address (as noted on current W-9 form)

We recommend that providers notify Ambetter 30-60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of the year 1099 IRS form will be mailed, a new W-9 form will be required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form or a 277 electronic file.

Claims for billable services provided to Ambetter members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Electronic Claims Submission

Providers are encouraged to participate in Ambetter's Electronic Claims/Encounter Filing Program through Centene. Ambetter (Centene) has the capability to receive an ANSI XS12N 837 professional, institutional, or encounter transaction. In addition, Ambetter (Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

Ambetter c/o Centene EDI Department
1-800-225-2573, extension 6075525
or by e-mail [at: EDIBA@centene.com](mailto:EDIBA@centene.com)

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Ambetter has the ability to receive coordination of benefits (COB or secondary) claims electronically. Ambetter follow the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

The Ambetter Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at Ambetter.mhsindiana.com.

Specific Data Record Requirements

Claims transmitted electronically must contain all of the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Ambetter, all EDI claims must first be forwarded to one of Ambetter's clearinghouses. This can be completed via a direct submission to a clearinghouse, or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan-specific requirements. Claims not meeting the requirements are immediately

rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Ambetter. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Ambetter and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Ambetter by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims; these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Ambetter.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor Customer Service Department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to clearly mark your claim as a corrected claim per the instruction provided in the corrected claim section.

Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to Ambetter must first pass the clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Ambetter. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in the Timely Filing section of this manual. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 6075525, or via e-mail at EDIBA@Centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

Specific Ambetter Electronic Edit Requirements – 5010 Information

- Institutional Claims – 837lv5010 Edits
- Professional Claims – 837Pv5010 Edits

Please refer to the EDI HIPAA Version 5010 Implementation section on our website for detailed information.

Corrected EDI Claims

- CLM05-3 Required 7 or 8.
- IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned.
 - Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

Exclusions

The following inpatient and outpatient claim times are excluded from EDI submission options and must be filed on paper:

- Claim records requiring supportive documentation or attachments, e.g. consent forms. (Note: COB claims can be filed electronically)
- Medical records to support billing miscellaneous codes
- Claims for services that are reimbursed based on purchase price e.g. custom DME, prosthetics. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review, e.g. complicated or unusual procedure. Provider is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity, e.g. oxygen, motorized wheelchairs.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Submitting Claims through clearinghouses Ambetter Payer ID number for all clearinghouses (Medical and Cenpatico) is 68069	<ul style="list-style-type: none"> • Allscripts/Payerpath • Availity • Capario • Claim Remedi • Claimsource • CPSI • DeKalb • Emdeon • First Health Care • Gateway EDI • GHNonline • IGI • MDonLine • Physicians CC • Practice Insight • Relay/McKesson • Smart Data • SSI • Trizetto Provider Solutions, LLC • Viatrack
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at EDIBA@Centene.com
Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com
Remittance Advice Questions:	Contact Ambetter Provider Services or the secure provider portal.

Action	Contact
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Service in writing include an updated W9.

Important Steps to a Successful Submission of EDI Claims:

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse regarding what data records are required.
3. Verify with Provider Services at Ambetter that the provider is set up in the Ambetter system prior to submitting EDI claims.
4. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Ambetter, and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Ambetter. ALWAYS review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit.
5. MOST importantly, all claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Ambetter has made it easy and convenient to submit claims directly to Ambetter on the secure provider portal at Ambetter.mhsindiana.com.

You must request access to our secure site by registering for a user name and password. If you have technical support questions, please contact Provider Services.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Detailed instructions for submitting via secure provider portal are also stored on our website; you must login to the secure site for access to this manual.

Paper Claim Submission

The mailing address for first time claims, corrected claims and requests for reconsideration:

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

The mailing address for claim disputes/appeals:

Ambetter from MHS
 P.O. Box 5000
 Farmington, MO 63640- 5000

Ambetter encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available on our websites. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. If a paper claim has been rejected, provider should submit the rejection letter with the corrected claim.

Acceptable Forms

Ambetter only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claims forms. Other claim form types will be upfront rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Ambetter does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms or handwritten forms will be upfront rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact Provider Services.

Important Steps to Successful Submission of Paper Claims:

1. Providers must file claims using standard claims forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red and handwritten claim forms will be rejected back to the provider.
3. Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (ex. 207Q00000X for Family Practice) in this section for correct processing of claims.
5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
7. Ensure all Diagnosis Codes are coded to their highest number of digits available
8. Ensure member is eligible for services during the time period in which services were provided.
9. Ensure that services were provided by a participating provider or that the "out-of-network" provider has received authorization to provide services to the eligible member.
10. Ensure an authorization has been given for services that require prior authorization by Ambetter.
11. Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form
12. Ensure all paper claim forms are typed or printed with either 10 or 12 Times New Roman font. Do not use highlights, italics, bold text, ink stamps or staples for multiple page submissions.

Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

Corrected Claims, Requests for Reconsideration or Claim Disputes/Appeals

All requests for corrected claims, reconsiderations or claim disputes/appeals must be received within 180 days from the date of the original explanation of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes/appeals received outside of the 180 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 of the following conditions are met:
3. The provider's records document that the member refused or was physically unable to provide his or her ID Card or information;
4. The provider can substantiate that he or she continually pursued reimbursement from the patient until eligibility was discovered; and
5. 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 from MHS
PO 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 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the UB-04 form.

- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.

Request for Reconsideration

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. Phone call to Provider Services
 - This method may be utilized for requests for reconsideration that do not require submission of supporting or additional information. An example of this would be when a provider may believe a particular service should be reimbursed at a particular rate but the payment amount did not reflect that particular rate.
2. Providers may utilize 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 UB-04 form.

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

Ambetter from MHS
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. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps to submit a claim dispute/appeal.

Claim Dispute/Appeal

A claim dispute/appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

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

Ambetter from MHS
PO Box 5000
Farmington, MO 63640-5000

A claim dispute/appeal will be resolved within 30 calendar days. A provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

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 transmitted via EFT to the designated bank account
- **Convenient payments & retrieval of remittance information**
- **Electronic remittance advices presented online**
- **HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System**
- **Reduce accounting expenses** – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- **Improve 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, assign to different payers to different bank accounts, as desired

For more information, please visit our provider home page on our website at Ambetter.mhsindiana.com. If further assistance is needed, please contact our Provider Services Department at 1-877-687-1182.

Risk Adjustment and Correct Coding

Risk adjustment is a critical element of the Affordable Care Act (ACA) that will help ensure the long-term success of the Health Insurance Marketplace. Accurate calculation of risk adjustment requires accuracy and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-9 CM and after October 1, 2015, ICD-10-CM, CPT, and HCPCS code sets. Providers should note the following guidelines:

1. Code all diagnoses to the highest level of specificity, which means assigning the most precise ICD code that most fully explains the narrative description in the medical chart of the symptom or diagnosis;
2. Ensure medical record documentation is clear, concise, consistent, complete, legible, and meets CMS signature guidelines (each encounter must stand alone);
3. Submit claims and encounter information in a timely manner;
4. Alert Ambetter of any erroneous data submitted and follow Ambetter's policies to correct errors in a timely manner;
5. Provide medical records as requested in a timely manner; and
6. Provide ongoing training to their staff regarding appropriate use of ICD coding for reporting diagnoses.

Accurate and thorough diagnosis coding is imperative to Ambetter's ability to manage members, comply with Risk Adjustment Data Validation audit requirements and effectively offer a Marketplace product. Claims submitted with inaccurate or incomplete data will often require retrospective chart review.

Coding Of Claims/ Billing Codes

Ambetter requires claims to be submitted using codes from the current version of ICD-9-CM/ ICD-10-CM (effective 10-01-15), ASA, DRG, CPT, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of services
- Code inappropriate for the age or sex of the member
- Diagnosis code missing digits
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Ambetter.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. A separate claim needs to be submitted for the mother, and her newborn.

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code / modifier combinations.

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

For more information regarding billing codes, coding, and code auditing/editing, please contact Ambetter Provider Services.

Clinical Lab Improvement Act (CLIA) Billing Instructions

CLIA numbers are required for CMS 1500 claims where CLIA Certified or CLIA waived services are billed. If the CLIA number is not present, the claim will be upfront rejected. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim type submissions:

Paper Claims

If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

*Note - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA

certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

*Note - The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

Please refer to the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.

Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

*Note - An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Taxonomy Code Billing Requirement

Taxonomy numbers are required for all Ambetter claims. Claims submitted without taxonomy numbers will be upfront rejected with an EDI Reject Code of 91. If the claim was submitted on paper, a rejection letter will be returned indicating that the taxonomy code was missing.

The verbiage associated with Reject 06 is as follows: Invalid or Missing Taxonomy Code. . Please contact Provider Services to resolve this issue.

Below are three scenarios involving the Taxonomy Code Billing Requirement.

Scenario One: Rendering NPI is different than the Billing NPI

CMS 1500 Form

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
Rendering NPI	<u>Unshaded</u> portion of box 24J	2310B	NM109
		2420A	NM109

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
Taxonomy Qualifier ZZ	Shaded portion of box 24 I	2310B	PRV02 REF01
		2420A	PRV02 REF01
Rendering Provider Taxonomy Number	Shaded portion of box 24J	2310B	PRV03 REF02
		2420A	PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Billing Provider Group Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") e.g. box 33b ZZ208D00000X EDI PRV*PE*PXC*208D00000X Billing Provider Group FTIN(EI)/SSN(SY)	Box 33b	2000A	PRV03
		2010AA	REF01 REF02

Scenario Two: Rendering NPI and Billing NPI are the same

CMS 1500 Form

It is NOT necessary to submit the Rendering NPI and Rendering Taxonomy in this Scenario; however, if box 24 I and 24 J are populated, then all data MUST be populated.

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC")	Box 33b	2000A	PRV03
		2010AA	REF01 REF02
Billing Provider Group FTIN(EI)/SSN(SY) e.g.			

REF*EI*999999999

Below is an example of the fields relevant to Scenario One and Scenario Two above.

The image shows a UB 04 form with several callouts pointing to specific fields:

- ZZ Qualifier**: Points to the 'QUAL' field in the 'PHYSICIAN OR SUPPLIER INFORMATION' section.
- Rendering Taxonomy**: Points to the 'NPI' field in the 'PHYSICIAN OR SUPPLIER INFORMATION' section.
- Rendering NPI**: Points to the 'NPI' field in the 'PHYSICIAN OR SUPPLIER INFORMATION' section.
- Group NPI**: Points to the 'NPI' field in the 'PHYSICIAN OR SUPPLIER INFORMATION' section.
- Group Taxonomy with ZZ Qualifier**: Points to the 'QUAL' field in the 'PHYSICIAN OR SUPPLIER INFORMATION' section.

Scenario Three: Taxonomy Requirement for UB 04 Forms

Required Data	Paper UB 04	Electronic Submission
Taxonomy Code with B3 Qualifier	Box 81 CC	Billing Level 2000A Loop and PRVR segment

Below is an example of the UB 04 form:

Below is an example of the UB 04 form

The image shows a UB 04 form with two callouts:

- B3 Qualifier**: Points to the 'B3CC' field in the 'REMARKS' section.
- Taxonomy**: Points to the 'QUAL' field in the 'PHYSICIAN OR SUPPLIER INFORMATION' section.

CODE EDITING

Ambetter uses HIPAA compliant clinical claims editing software for physician and outpatient facility coding verification. The software will detect, correct, and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of

correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding “rule.” When the software edits a claim that does not adhere to a coding rule, a recommendation known as an “edit” is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code editing software is a useful tool to ensure provider compliance with correct coding, a fully automated code editing software application will not wholly evaluate all clinical patient scenarios. Consequently, Ambetter uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Moreover, Ambetter may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the HealthCare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. **Level I HCPCS Codes (CPT):** This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.
2. **Level II HCPCS:** The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics and etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.
3. **Miscellaneous/Unlisted Codes:** The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to

the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. **Temporary National Codes:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.
5. **HCPCS Code Modifiers:** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion; certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

These codes represent where a patient had services performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims editing software application contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research and etc.

The software applies edits that are based on the following sources

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits includes column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments. Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- CMS Claims Processing Manual
- CMS Medicaid NCCI Policy Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources such as, HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals

- AMA resources
 - CPT Manual
 - AMA Website
 - Principles of CPT Coding
 - Coding with Modifiers
 - CPT Assistant
 - CPT Insider's View
 - CPT Assistant Archives
 - CPT Procedural Code Definitions
 - HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations
 - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
 - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations

Code Editing and the Claims Adjudication Cycle

Code editing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

Deny: Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions

Replace and Pay: Code editing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Editing Principles

The below principles do not represent an all-inclusive list of the available code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling

CMS National Correct Coding Initiative-

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claims payment. CMS has designated certain combinations of codes that should never be billed together. These are also known as Column 1/Column II edits. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column I code is considered an integral component of the column II code.

The CMS NCCI edits consist of Procedure to Procedure (PTP) edits for physicians and hospitals and the Medically Unlikely Edits for professionals and facilities. While these codes should not be billed together, there are circumstances when an NCCI modifier may be appended to the column 2 code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

PTP Practitioner and Hospital Edits

Some procedures should not be reimbursed when billed together. CMS developed the Procedure to Procedure (PTP) Edits for practitioners and hospitals to detect incorrect claims submitted by medical providers. PTP for practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). The PTP-hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

MUE's reflect the maximum number of units that a provider would bill for a single member, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information and clinical judgment

Code Bundling Rules Not Sourced To CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public-domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0 or 10 day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with “MMM”

Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility; they are considered bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime. Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code editing will evaluate prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example a nurse practitioner and physician bill for office visits for the same member on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

Rules look for claims where the add-on CPT code was billed without the primary service CPT code or if the primary service code was denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where the modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the same provider bills more than one outpatient consultation code for the same member in the member's history. This rule will deny the office consultation code and replace it with a more appropriate evaluation and management service, established patient or subsequent hospital care code. Another example, the rule will evaluate if a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. This rule will replace the second submission with the appropriate established patient visit. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes

Deleted Codes: Evaluates claims for procedure codes which have been deleted

Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.

Age Rules: Identifies procedures inconsistent with member's age

Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Ambetter's clinical validation services is modifier -25 and -59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1," Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). Ambetter's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier - 59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier 59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier -59 as follows: “Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 related to the portion of the definition that allows its use to describe “different procedure or surgery”. NCCI guidelines state that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

Ambetter uses the following guidelines to determine if modifier -59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated;
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier - 25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a “significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service”. Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value

of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Ambetter uses the following guidelines to determine whether or not modifier 25 was used appropriately. If any one of the following conditions is met then, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient’s condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member’s need for additional services.
- To avoid incorrect denials providers should assign all applicable diagnosis codes that support additional E/M services.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Payment and Clinical Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective edits. These policies are posted on each health plan’s provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Reconsiderations Related To Code Editing And Editing

Claims appeals resulting from claim-editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code edit or edit and request claim reconsideration, you must submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code edit or edit will be upheld.

Viewing Claims Coding Edits

Code Editing Assistant

A web-based code editing reference tool designed to “mirror” how the code editing product(s) evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking “Claim Editing Tool” in our secure provider portal.

This tool offers many benefits:

- PROSPECTIVELY access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- PROACTIVELY determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered, and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a “what if” or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate

The code editing assistant can be accessed from the provider web portal.

Disclaimer

This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker’s compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If third party liability coverage is determined after services are rendered, Ambetter will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

BILLING THE MEMBER

Covered Services

Ambetter providers are prohibited from billing the member for any covered services except for copayments, coinsurance and deductibles.

- Copayments, coinsurance and any unpaid portion of a deductible may be collected from the member at the time of service.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member the overpaid amount within 45 days.

For members who are in a suspended status and seeking services from providers:

1. 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.)
2. 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, claims will be adjudicated by Ambetter. 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-Covered Services

Contracted providers may only bill Ambetter members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- the specific service(s) to be provided;
- a statement that the service is not covered by Ambetter;
- a statement that the member chooses to receive and pay for the specific service; and
- the member is not obligated to pay for the service if it is later found that service was covered by Ambetter at the time it was provided, even if Ambetter did not pay the provider for the service because the provider did not comply with Ambetter requirements.

Billing for “No-Shows”

Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call in advance to cancel the appointment. The “no show” appointment must be documented in the medical record.

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)

For purposes of this discussion, please note the following:

1. Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.

2. All members associated with the subscriber will inherit the enrollment status of the subscriber.
3. After the initial premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium.
4. Coverage will remain in force during the grace period.
5. If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period. The member shall be held liable for the cost of Covered Services received during the grace period, as well as any unpaid premium.
6. During the months two and three of the grace period, claims will be pended. The EX Code on the Explanation of Payment will state: "LZ – Pend: Non-Payment of Premium." During month one, claims may be submitted and paid.

Premium Grace Period for Members NOT Receiving Advanced Premium Tax Credits (APTCs)

1. Premium payments are due in advance on a calendar month basis.
2. Monthly payments are due on or before the first day of each month for coverage effective during such month.
3. There is a one-month grace period. If any required premium is not paid before the date it is due, it may be paid during the grace period.
4. During the grace period, coverage will remain in force.

Failure to Obtain Authorization

Providers may NOT bill members for services when the provider fails to obtain an authorization and the claim is denied by Ambetter.

No Balance Billing

Payments made by Ambetter to providers less any copays, coinsurance or deductibles which are the financial responsibility of the member, will be considered payment in full. That is, providers may not seek payment from Ambetter members for the difference between the billed charges and the contracted rate paid by Ambetter.

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Providers must comply with the rights of members as set forth below.:

1. To participate with providers in making decisions about his/her health care. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options
2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly
3. To receive the benefits for which the member has coverage
4. To be treated with respect and dignity
5. To privacy of their personal health information, consistent with state and federal laws, and Ambetter policies

6. To receive information or make recommendations, including changes, about Ambetter's organization and services, the Ambetter network of providers, and member rights and responsibilities
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care provider about what might be wrong (to the level known), treatment and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life and health are in serious danger
8. To make recommendations regarding the Ambetter member's rights, responsibilities and policies
9. To voice complaints or appeals about: Ambetter, any benefit or coverage decisions Ambetter makes, Ambetter coverage, or the care provided
10. To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by the provider(s) of the medical consequences
11. To see their medical records
12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Ambetter rules and guidelines. Ambetter will notify members at least 60 days before the effective date of the modifications. Such notices shall include the following:
 - Any changes in clinical review criteria
 - A statement of the effect of such changes on the personal liability of the member for the cost of any such changes
13. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice
14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment
15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion
16. To access medically necessary urgent and emergency services 24 hours a day and seven days a week
17. To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability
18. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care provider or other provider. The primary care provider or other provider must discuss different treatment plans with the member. The member must make the final decision
19. To select a primary care provider within the network. The member has the right to change their primary care provider or request information on network providers close to their home or work.
20. To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care provider

21. To have access to an interpreter when the member does not speak or understand the language of the area
22. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment
23. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:
 - Living Will
 - Health Care Power of Attorney
 - "Do Not Resuscitate" Orders

Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive

Member Responsibilities

1. To read their Ambetter contract in its entirety
2. To treat all health care professionals and staff with courtesy and respect
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider so they understand the care they are receiving
4. To review and understand the information they receive about Ambetter. The member needs to know the proper use of covered services
5. To show their I.D. card and keep scheduled appointments with their provider, and call the provider's office during office hours whenever possible if the member has a delay or cancellation
6. To know the name of their assigned primary care provider. The member should establish a relationship with their primary care provider. The member may change their primary care provider verbally or in writing by contacting the Ambetter Member Services Department
7. To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it
8. To understand their health problems and participate, along with their health care providers in developing mutually agreed upon treatment goals to the degree possible
9. To supply, to the extent possible, information that Ambetter and/or their providers need in order to provide care
10. To follow the treatment plans and instructions for care that they have agreed on with their health care providers
11. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care provider to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision
12. To follow all health benefit plan guidelines, provisions, policies and procedures
13. To use any emergency room only when they think they have a medical emergency. For all other care, the member should call their primary care provider

14. To, give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Ambetter coverage, the member must provide this information to Ambetter
15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients, who are Ambetter members, and other healthcare workers with dignity and respect
2. To receive accurate and complete information and medical histories for members' care
3. To have their patients, who are Ambetter members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
4. To expect other network providers to act as partners in members' treatment plans
5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times
6. To make a complaint or file an appeal against Ambetter and/or a member
7. To file a grievance on behalf of a member, with the member's consent
8. To have access to information about Ambetter quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
9. To contact Provider Services with any questions, comments, or problems
10. To collaborate with other health care professionals who are involved in the care of members
11. To not be excluded, penalized, or terminated from participating with Ambetter for having developed or accumulated a substantial number of patients in Ambetter with high cost medical conditions
12. To collect member copays, coinsurance, and deductibles at the time of the service

Provider Responsibilities

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
 - Recommend new or experimental treatments
 - Provide information regarding the nature of treatment options
 - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered
 - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
2. To treat members with fairness, dignity, and respect
3. To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical

disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care

4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service
6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
7. To allow members to request restriction on the use and disclosure of their personal health information
8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
9. To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process
10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
12. To respect members' advance directives and include these documents in the their medical record
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions
14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately
15. To follow all state and federal laws and regulations related to patient care and rights
16. To participate in Ambetter data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data
17. To review clinical practice guidelines distributed by Ambetter
18. To comply with the Ambetter Medical Management program as outlined herein
19. To disclose overpayments or improper payments to Ambetter
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
21. To obtain and report to Ambetter information regarding other insurance coverage the member has or may have
22. To give Ambetter timely, written notice if provider is leaving/closing a practice
23. To contact Ambetter to verify member eligibility and benefits, if appropriate
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services
26. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds

27. To provide hours of operation to Ambetter members which are no less than those offered to other commercial members

CULTURAL COMPETENCY

Ambetter views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender and/or ethnic groups and accommodating the patient's culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Ambetter is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of Ambetter's Cultural Competency Program, providers must ensure that:

- members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them;
- medical care is provided with consideration of the members' primary language, race and/or ethnicity as it relates to the members' health or illness;
- office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training;
- office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order assist the member in accurately identifying their race or ethnicity;
- treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on health care;
- office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area; and
- an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Ambetter considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- denying a member a covered service or availability of a facility; and
- providing an Ambetter member a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay members (examples: separate waiting rooms, delayed appointment times).

COMPLAINT PROCESS

Provider Complaint/Grievance and Appeal Process

Claim Complaints must follow the claim dispute process and then the complaint process below. Medical necessity and authorization denials are handled in the Appeal process below. Please note that claim payments are not appealable. Claim complaints must be handled via the claim dispute and complaint process. Claim disputes may be mailed to:

Ambetter from MHS
Attn: Claim Disputes
 PO Box 5000
 Farmington, MO 63640-5000

Complaint/Grievance

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Ambetter’s policies, procedure, or any aspect of Ambetter’s functions. Ambetter logs and tracks all complaints/grievances whether received verbally or in writing. A provider has 30 calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint / grievance. After a complete review of the complaint/grievance, Ambetter shall provide a written notice to the provider within 20 calendar days from the received date of Ambetter’s decision. If the complaint/grievance is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint.

Authorization and Coverage Complaints

Authorization and Coverage Complaints must follow the Appeal process below.

An Appeal is the mechanism which allows providers the right to appeal actions of Ambetter such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Ambetter. A provider has 33 calendar days from Ambetter’s notice of action to file the appeal. Ambetter shall acknowledge receipt of each appeal within three business days after receiving an appeal. Ambetter shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member’s health condition requires, but shall not exceed 30 calendar days from the date Ambetter receives the appeal. Ambetter may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Ambetter demonstrates that there is need for additional information and how the delay is in the member’s best interest. For any extension not requested by the member, Ambetter shall provide written notice to the member for the delay.

Expedited appeals may be filed with Ambetter if the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member’s appeal. In instances where the member’s request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member’s health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Ambetter may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Ambetter provides evidence satisfactory evidence that a delay in rendering the decision is in the member’s best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

Member Complaint/Grievance and Appeal Process

To ensure Ambetter member's rights are protected, all Ambetter members are entitled to a Complaint/Grievance and Appeals process. The procedures for filing a Complaint/Grievance or Appeal are outlined in the Ambetter member's Evidence of Coverage. Additionally, information regarding the Complaint/Grievance and Appeal process can be found on our website at Ambetter.mhsindiana.com or by calling Ambetter at 1-877-687-1182.

If a member is displeased with any aspect of services rendered:

1. The member should contact our Member Services department at 1-877-687-1182. The member Services representative will assist the member.
2. If the member continues to be dissatisfied, they may file a formal complaint/grievance. Again, our Member Services department is available to assist with this process. Information regarding this process can be found at: Ambetter.mhsindiana.com.
3. Depending on the nature of the complaint/grievance, the member will be offered the right to appeal our decision. At the conclusion of this formalized process, the member will receive written confirmation of the determination. Ambetter will complete the appeal process in the timeframes as specified in rules and regulation.
4. The member has the right to appeal to an external independent review organization.
5. A member may designate in writing to Ambetter that a provider is acting on behalf of the member regarding the complaint/grievance and appeal process.

Site reviews are performed at provider offices and facilities when the member complaint threshold is met. A site review evaluates:

- physical accessibility;
- physical appearance;
- adequacy of waiting and examining room space; and
- adequacy of medical/treatment record keeping.

Mailing Address

The mailing address for non-claim related Member and Provider Complaints/Grievances and Appeals is:

Ambetter from MHS
1099 N. Meridian Street
Suite 400
Indianapolis, IN 46204

Ombudsman Service

Ombudsman service is an additional program available to Ambetter members who need help resolving concerns, issues or complaints. Ambetter's Ombudsman representatives are part of a non-profit, independent organization, who work with Ambetter to solve problems on behalf of Ambetter members. Participation in the service is voluntary and does not replace the member's ability to utilize the complaint or grievance process.

Ambetter members can easily access an Ombudsman representative by calling 1-844-321-9619. Representatives will provide member education and/or provide assistance with contacting the right people for assistance with the Health Insurance Marketplace and Ambetter plans.

QUALITY IMPROVEMENT PLAN

Overview

Ambetter's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives applying reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the level of care and service among plan initiatives, including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Ambetter requires all practitioners and providers to cooperate with all QI activities and allow Ambetter to use practitioner and/or provider performance data to ensure success of the QAPI program.

Ambetter is accredited by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to improving health care quality. The NCQA seal is a widely recognized symbol of quality. NCQA health plan accreditation surveys include rigorous on-site and off-site evaluations of over sixty (60) standards and selected Healthcare Effectiveness Data and Information Set (HEDIS) measures. A national oversight committee of physician analyzes the team's findings and assigns an accreditation level based on the performance level of each plan evaluated to NCQA's standards. This recognition is the result of our long-standing dedication to provide quality health care service and programs to our members.

Ambetter will promote the delivery of appropriate care with the primary goal being to improve the health status of its members. Where the member's condition is not amenable to improvement, Ambetter will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, the Ambetter QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QAPI Program Structure

The Ambetter Board of Directors (BOD) has the ultimate oversight for the care and service provided to members. The Board of Directors oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is:

- enhance and improve quality of care;
- provide oversight and direction regarding policies, procedures, and protocols for member care and services; and
- offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the QI, UM, and Credentialing and recredentialing programs.

The following standard sub-committees report directly to the Quality Assessment and Performance Improvement Committee (QIC):

- Credentialing Committee

- Grievance and Appeals Committee
- Utilization Management Committee
- Performance Improvement Team
- HEDIS Steering Committee
- Pharmacy and Therapeutics Committee
- Delegate Vendor Operations Committee
- Subcommittees may also include the Member Advisory Committee, Physician Advisory Committee, Hospital Advisory Committee, and the Community Advisory Committee, based on plan needs and state requirements.

Practitioner Involvement

Ambetter recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Ambetter encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the level of clinical care and the level of service provided to Ambetter members. The Ambetter QAPI Program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.

To that end, the Ambetter QAPI Program scope encompasses the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member experience
- Patient safety
- Primary care provider changes
- Pharmacy

- Provider and plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including under and over utilization

Ambetter's primary quality improvement goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

Quality Improvement goals include but are not limited to the following:

- A high level of health status and quality of life will be experienced by Ambetter members;
 - Network quality of care and service will meet industry-accepted standards of performance;
 - Ambetter services will meet industry-accepted standards of performance;
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across plan functional areas;
- Member satisfaction will meet the plan's established performance targets;
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease and well child visits.
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Ambetter's QAPI Program **objectives** include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement;
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice;
- To select areas of study based on demonstration of need and relevance to the population served;
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time;
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standardized measures of health outcomes;
- To allocate personnel and resources necessary to:
 - support the quality improvement program, including data analysis and reporting;
 - meet the educational needs of members, providers and staff relevant to quality improvement efforts;
- To seek input and work with members, providers and community resources to improve quality of care;
- To oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services;

- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care;
- To recommend and institute “focused” quality studies in clinical and non-clinical areas, where appropriate.
- Conduct and report annual CAHPS surveys and certified HEDIS results for Ambetter members
- Achieve and maintain NCQA accreditation
- Monitor for compliance with regulatory and NCQA requirements

Practice Guidelines

Evidence based preventive health Preventive Health and clinical practice guidelines Clinical Practice Guidelines are provided to assist providers, members, medical consenters, and caregivers in making decisions regarding health care in specific clinical situations. Guidelines are adopted from recognized sources, in consultation with network providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the QAPI Program, valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and needs of the members.

Preventive health and clinical practice guidelines are reviewed annually and updated upon significant new scientific evidence or change in national standards or at least every two years. Ambetter from MHS will distribute updated guidelines to all affected providers and make all current preventive health and clinical practice guidelines available through provider orientations and other group sessions, provider e-newsletters, online via the HEDIS Resource Page, online via the secure provider portal, and targeted mailings.

A complete listing of approved preventive health and clinical practice guidelines is available at Ambetter.mhsindiana.com. The full guidelines are available to print, or hard copies may be requested by contacting the Ambetter from MHS Quality Improvement department.

Patient Safety and Quality of Care

Patient safety is a key focus of the Ambetter QAPI Program. Monitoring and promoting patient safety is integrated throughout activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Ambetter employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the QI Department of potential quality of care issues. Adverse events may also be identified through claims based reporting and analyses. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The Ambetter QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Ambetter to monitor improvement over time.

Annually, Ambetter develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Ambetter communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Ambetter website at Ambetter.mhsindiana.com.

At any time, Ambetter providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Ambetter's progress in meeting the QAPI Program goals by contacting the Quality Improvement Department.

Quality Rating System

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. Purchasers of health care may use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate the clinical management of its members. Physician-specific scores are being used as evidence of preventive care from primary care office practices.

HEDIS Rate Calculations

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-9/ICD-10, and HCPCS codes can reduce the necessity of medical record reviews (see the Ambetter.mhsindiana.com and HEDIS brochure (posted on Ambetter.mhsindiana.com) for more information on reducing HEDIS medical record reviews). HEDIS measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c values, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who conducts Medical Record Reviews (MRR) for HEDIS

Ambetter may contract with an independent national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are conducted on an ongoing basis with a particular focus from January through May each year. At that time, a sample of your patient's medical records may be

selected for review, you will receive a call and/or a letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Ambetter which allows them to collect PHI on our behalf.

How can providers improve their HEDIS scores?

- **Understand the specifications** established for each HEDIS measure.
- **Submit claims and encounter data for each and every service rendered.** All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Ambetter. Claims and encounter data is the most clean and efficient way to report HEDIS.
- **Submit claims and encounter data correctly, accurately, and on time.** If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- **Ensure chart documentation reflects all services provided.** Keep accurate chart/medical record documentation of each member service and document conversation/services.
- **Submit claims and encounter data using CPT codes related to HEDIS** measures such as diabetes, eye exam, and blood pressure, where appropriate.

If you have any questions, comments, or concerns related to the annual HEDIS project or medical record reviews, please contact the Quality Improvement Department at 1-877-684-1182.

Provider Satisfaction Survey

Ambetter conducts an annual provider satisfaction survey which includes questions to evaluate the provider experience with Ambetter and our services such as claims, communications, utilization management, and provider services. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the Ambetter network. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Ambetter, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

Qualified Health Plan (QHP) Enrollee Survey

The QHP Enrollee survey is a tool that measures the member experience and is integral to support CMS's ongoing administration of the Health Insurance Marketplace as well as a requirement for NCQA accreditation. It is a standardized survey administered annually to members by an NCQA-certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services. It gives a general indication of how well the plan is meeting the members' expectations. Member responses to the QHP survey are used in various aspects of the quality program including, but not limited to monitoring member perception of practitioner access and availability and care coordination. This survey is similar to the NCQA survey tool CAHPS (Consumer Assessment of Healthcare Provider Systems) used for other lines of business. Members receiving behavioral health services have the opportunity to respond to the Experience of Care Health Outcomes (ECHO) survey to provide feedback and input into the quality oversight of the behavioral health program.

Provider Performance Monitoring and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the level and cost-

effectiveness of care. Ambetter will manage a provider performance monitoring program to capture data relating to healthcare access, costs, and level of care that Ambetter members receive.

The Ambetter Provider Profiling Program is designed to analyze utilization data to identify provider utilization and care issues. Ambetter will use provider profiling data to identify opportunities to improve communications to providers regarding preventive health and clinical practice guidelines. Provider profiling is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and level of care in alignment with evidence-based clinical practice guidelines. The Ambetter Program and Provider Overview Reports will increase provider awareness of performance, identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. Ambetter's Profiling Program incorporates the latest advances in this evolving area.

REGULATORY MATTERS

Medical Records

Ambetter providers must keep accurate and complete patient medical records which are consistent with 45 CFR 156, and financial and other records pertinent to Ambetter members. Such records enable providers to render the most appropriate level of health care service to members. They will also enable Ambetter to review the level and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Ambetter requires providers to maintain all records for members for at least 10 years after the final date of service, unless a longer period is required by applicable state law.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the standards set forth below:

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.

- Evidence that preventive screening and services are offered in accordance with Ambetter practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR Part 2 and any applicable State Laws.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Ambetter members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Federal And State Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance abuse treatment and communicable disease records.

For example, HIPAA requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov and then select "Regulations and Guidance" and "HIPAA – General Information";
- 42 CFR Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.samhsa.gov
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Ambetter network are independently obligated to know, understand and comply with these laws.

Ambetter takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws. Please contact the Ambetter Compliance Officer by phone at 1-877-687-1182 or in writing (refer to address below) with any questions about our privacy practices.

Ambetter from MHS
1099 N. Meridian Street
Suite 400
Indianapolis, IN 46204

National Network

Ambetter is a national network where contracted providers may provide Covered Services to Covered Persons in accordance with the Ambetter Provider Manual. In addition, the following requirements sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Commercial-Exchange/Qualified Health Plan Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a

Covered Person, is subject to the law cited in the parenthetical at the end of a provision on the Schedules, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable:

Commercial-Exchange Regulatory Requirements:

(Arkansas)	NovaSys Health, Inc.
(Florida)	Sunshine State Health Plan, Inc.
(Georgia)	Peach State Health Plan, Inc.
(Illinois)	IlliniCare Health Plan, Inc.
(Indiana)	Coordinated Care Corporation, d/b/a Managed Health Services - IN
(Kansas)	Sunflower State Health Plan, Inc.
(Massachusetts)	CeltiCare Health Plan of Massachusetts, Inc.
(Mississippi)	Magnolia Health Plan, Inc.
(Missouri)	Home State Health Plan, Inc.
(New Hampshire)	Granite State Health Plan, Inc.
(Ohio)	Buckeye Community Health Plan, Inc.
(Oregon)	Trillium Community Health Plan, Inc.
(South Carolina)	Absolute Total Care, Inc.
(Texas)	Superior Healthplan, Inc.
(Washington)	Coordinated Care of Washington, Inc.
(Wisconsin)	Managed Health Services Insurance Corporation

WASTE, ABUSE, AND FRAUD

Ambetter takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with the federal and state laws. Ambetter, in conjunction with its parent company, Centene, operates a waste, abuse and fraud unit. Ambetter routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this Manual. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. These actions include but are not limited to:

- remedial education and training to prevent the billing irregularity;
- more stringent utilization review;
- recoupment of previously paid monies;
- termination of provider agreement or other contractual arrangement;
- civil and/or criminal prosecution; and
- any other remedies available to rectify

Some of the most common WAF practices include:

- unbundling of codes;
- up-coding services;
- add-on codes billed without primary CPT;
- diagnosis and/or procedure code not consistent with the member's age/gender;
- use of exclusion codes;
- excessive use of units;
- misuse of benefits; and

- claims for services not rendered.

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664. Ambetter takes all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

WAF Program Compliance Authority and Responsibility

The Ambetter Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Ambetter is committed to identifying, investigating, sanctioning and prosecuting suspected waste, abuse and fraud.

The Ambetter provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

1. knowingly presenting, or causing to be presented a false claim for payment or approval;
2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. conspiring to commit any violation of the False Claims Act;
4. falsely certifying the type or amount of property to be used by the Government;
5. certifying receipt of property on a document without completely knowing that the information is true;
6. knowingly buying Government property from an unauthorized officer of the Government; and
7. knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government

For more information regarding the False Claims act, please visit www.cms.hhs.gov.

Physician Incentive Programs

On an annual basis and in accordance with Federal Regulations, Ambetter must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- effective date of the Physician Incentive Program;
- type of Incentive Arrangement;
- amount and type of stop-loss protection;
- patient panel size;
- description of the pooling method, if applicable;
- for capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services;
- the calculation of substantial financial risk (SFR);
- whether Ambetter does or does not have a Physician Incentive Program; and

- the name, address and other contact information of the person at Ambetter who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stop-loss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Relations Specialist.

APPENDIX

- I. Common Causes for Upfront Rejections
- II. Common Causes of Claim Processing Delays and Denials
- III. Common EOP Denial Codes
- IV. Instructions for Supplemental Information CMS-1500 (02/12) Form, Shaded Field 24a-G
- V. Common HIPAA Compliant EDI Rejection Codes
- VI. Claim Form Instructions
- VII. Billing Tips and Reminders
- VIII. Reimbursement Policies

Appendix I: Common Causes for Upfront Rejections

Common causes for upfront rejections include but are not limited to:

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small.
- Member Date of Birth is missing.
- Member Name or Identification Number is missing.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from required fields. Example: "Statement From" or "Service From" dates.
- Type of Bill is invalid.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail is missing.
- Date of Service is prior to member's effective date.
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14).
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17).
- Occurrence Code/Date is missing or invalid.
- Revenue Code is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- A missing CLIA Number in Box 23 or a CMS 1500 for CLIA or CLIA waived service
- Incorrect Form Type used.
- A missing taxonomy code and qualifier in box 24 I, 24 J or Box 33b on the CMS 1500 form or Box 81 CC on the UB04 form (see further requirements in this Manual).

Appendix II: Common Cause of Claims Processing Delays and Denials

- Procedure or Modifier Codes entered are invalid or missing.
- This includes GN, GO, or GP modifier for therapy services.
- Diagnosis Code is missing the 4th or 5th digit.
- DRG code is missing or invalid.
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete.
- Third Party Liability (TPL) information is missing or incomplete.
- Member ID is invalid.
- Place of Service Code is invalid.
- Provider TIN and NPI do not match.
- Revenue Code is invalid.
- Dates of Service span do not match the listed days/units.
- Tax Identification Number (TIN) is invalid.

Appendix III: Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

EX Code	Description
0B	ADJUST: CLAIM TO BE RE-PROCESSED CORRECTED UNDER NEW CLAIM NUMBER
18	DENY: DUPLICATE CLAIM SERVICE
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
46	DENY: THIS SERVICE IS NOT COVERED
A1	DENY: NO AUTHORIZATION ON FILE THAT MATCHES SERVICES(S) BILLED.
AB	ACE LINE ITEM REJECTION
AQ	ACE CLAIM LEVEL RETURN TO PROV. MUST CALL PROV SERVICES FOR MORE DETAIL.
AT	ACE CLAIM LEVEL REJECTION
fq	DENY: RESUBMIT CLAIM UNDER FQHC RHC CLINIC NPI NUMBER
IM	DENY: MODIFIER MISSING OR INVALID
M3	DENY: NO ASSOCIATED FACILITY CLAIM RECEIVED
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
xf	MAXIMUM ALLOWANCE EXCEEDED
y1	DENY: SERVICE RENDERED BY NON AUTHORIZED NON PLAN PROVIDER

EX Code	Description
ya	DENIED AFTER REVIEW OF PATIENT'S CLAIM HISTORY
Za	DENY - PROVIDER BILLING ERROR
ZW	After rvw, prev decision upheld, see prov handbook for appeal process

Appendix IV: Instructions for Supplemental Information

CMS- 1500 (02/12) FORM, SHADED FIELD 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) Claim Form field 24-A-G:

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Code (NDC)
- CTR Contract Rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollar signs (ex. 1000.00; 123.45).

Additional Information for Reporting NDC:

When adding supplemental information for NDC, enter the information in the following order:

- Qualifier
- NDC Code
- One space
- Unit/basis of measurement qualifier
 - F2- International Unit
 - ME – Milligram

- UN – Unit
 - GR – Gram
 - ML - Milliliter
- Quantity
 - The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999).
 - When entering a whole number, do not use a decimal (ex. 2).
 - Do not use commas.

Unspecified/Miscellaneous/Unlisted Codes

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.	I.	J.
From To						SERVICE	EMG	(Explain Unusual Circumstances)				DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPCS Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
ZZ						Laparoscopic Ventral Hernia Repair Op Note Attached											NPI

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.	I.	J.	
From To						SERVICE	EMG	(Explain Unusual Circumstances)				DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPCS Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER									
10	01	05	10	01	05	11		E1399				12	165	00	1	N	G2	12345678901
																	NPI	0123456789

NDC Codes

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.	I.	J.	
From To						SERVICE	EMG	(Explain Unusual Circumstances)				DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPCS Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER									
N459148001665 UN1								J0400				1	250	00	40	N	G2	12345678901
																	NPI	0123456789

Appendix V: Common Business EDI Rejection Codes

These codes on the follow page are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

ERROR_ID	ERROR_DESC
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag

ERROR_ID	ERROR_DESC
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc

ERROR_ID	ERROR_DESC
74	Reject. DOS prior to 6/1/2006; OR Invalid DOS
75	Invalid Unit
76	Original claim number required
77	INVALID CLAIM TYPE
81	Invalid Unit;Invalid Prv
83	Invalid Unit;Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

Appendix VI: Claim Form Instructions

Billing Guide for a CMS 1500 and CMS 1450 (UB-04) Claim Form.

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided

Note: Claims with missing or invalid Required (R) field information will be rejected or denied

Completing a CMC 1500 Claim Form

Please see the following example of a CMS 1500 form.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <small>(Medicare#) (Medicaid#) (ID#/Doc#) (Member ID#) (ID#) (ID#) (ID#)</small>										<input type="checkbox"/> HICA <input type="checkbox"/> HICA	
1. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)				4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)				8. RESERVED FOR NUCC USE	
CITY STATE ZIP CODE TELEPHONE (Include Area Code)				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL _____				15. OTHER DATE MM DD YY QUAL _____	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____		17b. NPI _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMG _____		C. _____		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS _____ MODIFIER _____		E. DIAGNOSIS POINTER _____	
25. FEDERAL TAX I.D. NUMBER SSN EIN _____				26. PATIENT'S ACCOUNT NO. _____		27. ACCEPT ASSIGNMENT? (on back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				32. SERVICE FACILITY LOCATION INFORMATION NPI _____		33. BILLING PROVIDER INFO & PH # () NPI _____		30. Ref'd for NUCC Use			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Field #	Field Description	Instruction or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being filed. Enter "X" in the box noted "Other"	R
1a	INSURED'S I.D. NUMBER	The 9-digit identification number on the member's Ambetter I.D. Card	R
2	PATIENTS NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Ambetter I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8 digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Ambetter I.D. Card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM DD YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	C

Field #	Field Description	Instruction or Comments	Required or Conditional
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If auth = C If CLIA = R (If both, always submit the CLIA number)

Field #	Field Description	Instruction or Comments	Required or Conditional
24a-j General Information		<p>Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.</p> <p>The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number.</p> <p>Shaded boxes 24 a-g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete.</p> <p>The un-shaded area of a claim line is for the entry of claim line item detail.</p>	
24 A-G Shaded	SUPPLEMENTAL INFORMATION	<p>The shaded top portion of each service claim line is used to report supplemental information for:</p> <p>NDC Narrative description of unspecified codes</p> <p>Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.</p>	C
24 A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM□DD□YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.	R
24 B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24 C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24 D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	<p>Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.</p> <p>Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.</p>	R

Field #	Field Description	Instruction or Comments	Required or Conditional
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service or the claim will be rejected/denied.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for ID, if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	<u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. <u>Atypical Providers:</u> Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider’s 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g.,	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Ambetter recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Ambetter. Ambetter programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed. Note: Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	c
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		<p>Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).</p> <p>Third line -In the designated block, enter the city and state.</p> <p>Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555).</p> <p>NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission</p>	
33a	GROUP BILLING NPI	<p>Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the 10-character NPI ID.</p>	R
33b	GROUP BILLING OTHERS ID	<p>Enter as designated below the Billing Group taxonomy code. Typical Providers:</p> <p>Enter the Provider Taxonomy Code. Use ZZ qualifier.</p> <p>Atypical Providers:</p> <p>Enter the Provider ID number.</p>	R

Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Ambetter. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.
- Please refer to your provider contract with Ambetter or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

UB-04 Claim Form Example

1 PATIENT NAME	2 PATIENT ADDRESS	3a PAT CONT #	3b MED REC #	4 TYPE OF BILL																
		5 FED TAX NO.	6 STATEMENT COVER PERIOD FROM	7 THROUGH																
8 PATIENT NAME	9 PATIENT ADDRESS																			
10 BIRTH DATE	11 SEX	12 DATE	13 ADMISSION 13-181	14 TYPE	15 DRG	16 DRG	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30
31 OCCURRENCE DATE	32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE DATE	37 OCCURRENCE DATE	38 OCCURRENCE DATE	39 OCCURRENCE DATE	40 OCCURRENCE DATE	41 OCCURRENCE DATE	42 OCCURRENCE DATE	43 OCCURRENCE DATE	44 OCCURRENCE DATE	45 OCCURRENCE DATE	46 OCCURRENCE DATE	47 OCCURRENCE DATE	48 OCCURRENCE DATE	49 OCCURRENCE DATE	50 OCCURRENCE DATE	
51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	
69 REV CD	70 DESCRIPTION	71 HCPCS/RATE / ICD9 CODE	72 SE-IV DATE	73 SE-IV UNITS	74 TOTAL CHARGES	75 NON-COMD CHARGES	76	77	78	79	80	81	82	83	84	85	86	87	88	
PAGE	OF	CREATION DATE	TOTALS																	
89 PRIOR NAME	90 HEALTH PLAN ID	91 REL ENG	92 REAR	93 PRIOR PAYMENTS	94 EST AMOUNT DUE	95 NPI	96 OTHER PRIV ID	97	98	99	100	101	102	103	104	105	106	107	108	
109 INSURED'S NAME	110 REL	111 INSURED'S UNIQUE ID	112 GROUP NAME	113 INSURANCE GROUP NO.	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	
129 TREATMENT AUTHORIZATION CODES	130 DOCUMENT CONTROL NUMBER	131 EMPLOYER NAME	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	
149 ADMIT DATE	150 TREATMENT REASON ICD	151 OTHER PROCEDURE DATE	152 OTHER PROCEDURE DATE	153 OTHER PROCEDURE DATE	154 OTHER PROCEDURE DATE	155 OTHER PROCEDURE DATE	156 OTHER PROCEDURE DATE	157 OTHER PROCEDURE DATE	158 OTHER PROCEDURE DATE	159 OTHER PROCEDURE DATE	160 OTHER PROCEDURE DATE	161 OTHER PROCEDURE DATE	162 OTHER PROCEDURE DATE	163 OTHER PROCEDURE DATE	164 OTHER PROCEDURE DATE	165 OTHER PROCEDURE DATE	166 OTHER PROCEDURE DATE	167 OTHER PROCEDURE DATE	168 OTHER PROCEDURE DATE	169 OTHER PROCEDURE DATE
170 REMARKS	171 ICD	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190

Field #	Field Description	Instruction or Comments	Required or Conditional
1	UNLABELED FIELD	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9 digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1 st Digit – Indicating the type of facility. 2 nd Digit – Indicating the type of care. 3 rd Digit- Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM / THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not used	Not Required
8a-8b	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the member's Ambetter I.D. card	Not Required
		8b – enter the patient's last name, first name, and middle initial as it appears on the Ambetter ID card. Use a comma or space to separate the last and first names. <u>Titles:</u> (Mr., Mrs., etc.) should not be reported in this field. <u>Prefix:</u> No space should be left after the prefix of a name (e.g. McKendrick. H) <u>Hyphenated names:</u> Both names should be capitalized and separated by a hyphen (no space) <u>Suffix:</u> a space should separate a last name and suffix.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		Enter the patient's complete mailing address of the patient.	
9	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R
13	ADMISSION HOUR	00-12:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions. Enter the 1-digit code indicating the of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		<p>For Type of admission 1,2,3, or 5:</p> <ol style="list-style-type: none"> 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referral (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law Enforcement 9 Information not available <p>For Type of admission 4 (newborn):</p> <ol style="list-style-type: none"> 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available 	
16	DISCHARGE HOUR	<p>Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge.</p> <p>00-12:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59</p>	C
17	PATIENT STATUS	<p>REQUIRED for inpatient and outpatient claims. Enter the 2 digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes:</p> <ol style="list-style-type: none"> 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran’s Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	<p>Occurrence Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.</p>	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	<p>Occurrence Span Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.</p>	C
37	(UNLABELED FIELD)	REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	<p>Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields.</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be</p>	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e. PAGE "1" OF "1"). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required
50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	HEALTH PLAN IDENTIFICATION NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y".	R
53	ASG. BEN.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Ambetter is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Ambetter Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
67 A-Q	OTHER DIAGNOSIS CODE	<p>Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. “E” and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>Note: Claims with incomplete or invalid diagnosis codes will be denied.</p>	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	<p>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. “E” codes and most “V” are NOT acceptable as a primary diagnosis.</p> <p>Note: Claims with missing or invalid diagnosis codes will be denied.</p>	R
70	PATIENT REASON CODE	<p>Enter the ICD-9/10-CM Code that reflects the patient’s reason for visit at the time of outpatient registration. Field 70a requires entry, fields 70b-70c are conditional.</p> <p>Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or “5”. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims with missing or invalid diagnosis codes will be denied.</p>	R
71	PPS/DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	UNLABELED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	<p>CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied.</p>	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		DATE: Enter the date the principal procedure was performed (MMDDYY).	
74 a-e	OTHER PROCEDURE CODE DATE	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-9/ICD-10 Procedure</p> <p>Codes may be entered. Do not enter the decimal, it is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>	C
75	UNLABELED		Not Required
76	ATTENDING PHYSICIAN	<p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>0B – State License #.</p> <p>1G – Provider UPIN.</p> <p>G2 – Provider Commercial #.</p> <p>B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician's last name.</p> <p>FIRST: Enter the attending physician's first name.</p>	R
77	OPERATING PHYSICIAN	<p>REQUIRED when a surgical procedure is performed.</p> <p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>0B – State License #.</p> <p>1G – Provider UPIN.</p> <p>G2 – Provider Commercial #.</p> <p>B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician's last name.</p>	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		FIRST: Enter the attending physician's first name.	
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7 digit Provider number of ordering physician	R

Appendix VII: Billing Tips and Reminders

Adult Day Health Care

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 99

Ambulance

- Must be billed on a CMS 1500 Claim Form.
- Appropriate modifiers must be billed with the Transportation Codes

Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers must submit charges using the CMS 1500 Claim Form
- Must be billed in place of service 24
- Invoice must be billed with Corneal Transplants
- Most surgical extractions are billable only under the ASC

Anesthesia

- Bill total number of minutes in field 24G of the CMS 1500 Claim Form and must be submitted with the appropriate modifier.
- Failure to bill total number of minutes may result in incorrect reimbursement or claim denial
- Appropriate modifiers must be utilized

APC Billing Rules

- Critical Access Hospitals (CAHs) are required to bill with 13x-14x codes.
- Bill type for APC claims are limited to 13xs-14x range
- Late charge claims are not allowed. Only replacement claims. Claims with late charges will be denied to be resubmitted.
- Claims spanning two calendar years will be required to be submitted by the provider as one claim.
- CMS Maximum Unit Edits (MUEs) will be applied per line, per claim.
 - Claim lines exceeding the MUE value will be denied.
- Observation: Providers are required to bill HCPCS G0378 along with the revenue code. The Observation G code will allow the case rate. CMS is proposing significant changes to observation rules and payment level for 2014, and this will be updated accordingly.
- Ambulance Claims: Need to be submitted on a CMS 1500 form. Any Ambulance claim submitted on a UB will be denied.
- Revenue codes and HCPCS codes are required for APC claims.

Comprehensive Day Rehab

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 99
- Acceptable modifiers

Deliveries

- Use appropriate value codes as well as birth weight when billing for delivery services.

DME/Supplies/Prosthetics and Orthotics

- Must be billed with an appropriate modifier
- Purchase only services must be billed with modifier NU
- Rental services must be billed with modifier RR

Hearing Aids

- Must be billed with the appropriate modifier LT or RT

Home Health

- Must be billed on a UB 04
- Bill type must be 3XX
- Must be billed in location 12
- Both Rev and CPT codes are required

- Each visit must be billed individually on separate service line

Long Term Acute Care Facilities (LTACs)

- Long Term Acute Care Facilities (LTACs) must submit Functional Status Indicators on claim submissions.

Maternity Services

- Providers must utilize correct coding for Maternity Services.
- Services provided to members prior to their Ambetter effective date, should be correctly coded and submitted to the payer responsible.
- Services provided to the member on or after their Ambetter effective date, should be correctly coded and submitted to Ambetter.

Modifiers

Appropriate uses of 25, 26, TC, 50, GN, GO, GP, TD, TE:

- **25 Modifier** - should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of another procedure (e.g., 99381 and 99211-25. Modifier 25 is subject to the code edit and audit process. Appending a modifier 25 is not a guarantee of automatic payment and may require the submission of medical records.

Well-Child and sick visit performed on the same day by the same physician).

*NOTE: 25 modifiers are not appended to non E&M procedure codes, e.g. lab.

- **26 Modifier** – should never be appended to an office visit CPT code.
 - Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes
 - Inappropriate use may result in a claim denial/rejection
- **TC Modifier** – used to indicate the technical component of a test or study is performed
 - Inappropriate use may result in a claim denial/rejection
- **50 Modifier** – indicates a procedure performed on a bilateral anatomical site
 - Procedure must be billed on a single claim line with the 50 modifier and quantity of one.
 - RT and LT modifiers or quantities greater than one should not be billed when using modifier 50
- **GN, GO, GP Modifiers** – therapy modifiers required for speech, occupational, and physical therapy
- **TD and TE Modifiers** - nursing modifiers required for nursing services

Supplies

- Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.
- Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may not be billed separately. Providers may not bill for any reusable supplies.

Present on Admission (POA)

- Present on Admission (POA) Indicator is required on all inpatient facility claims
- Failure to include the POA may result in a claim denial/rejection

Rehabilitation Services – Inpatient Services

- Functional status indicators must be submitted for inpatient Rehabilitation Services.

Telemedicine

- Physicians at the distant site may bill for telemedicine services and MUST utilize the appropriate modifier to identify the service was provided via telemedicine.
 - E&M CPT plus the appropriate modifier
 - Via interactive audio and video tele-communication systems.

Appendix VIII: Reimbursement Policies

As a general rule, Ambetter follows Medicare reimbursement policies. Instances that vary from Medicare include:

Admissions for Same or Related Diagnoses

Inpatient admissions for the same or a related diagnoses occurring within 30 days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

Calculating Anesthesia

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Certified Nurse Midwife (CNM) Rules

Payment for CNM services is made at 100% of the contracted rate.

EKG Payment

EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Physician Site of Service

Physicians will be paid at Physician rate only at the following Sites of Service: Office, Home, Assisted Living Facility, Mobile unit, walk in retail health clinic, urgent care facility, birthing center, nursing facility, SNFs, independent clinic, FQHC, Intermediate HC Facility, Resident Substance Abuse Facility, Nonresident Substance Abuse Facility, Comprehensive OP Rehab facility, ESRD Facility, State or Local Health Clinic, RHC, Indy lab, Other POS.

Diagnostic Testing Of Implants

Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Hospital-Acquired Conditions and Provider Preventable Conditions

Payment to a contracted Provider under the compensation schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a contracted provider for “hospital-acquired conditions” and for “provider preventable conditions” as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

Lesser Of Language

Pay Provider lesser of the Providers allowable charges or the contracted rate.

Multiple Procedure Rules for Surgery and Endoscopic

Where multiple outpatient surgical or scope procedures are performed on a member during a single occasion of surgery, reimbursement will be as follows. The procedure for which the allowed amount is greatest will be reimbursed at 100%. The procedures with second and third greatest allowed amounts will each be reimbursed at 50%. Any additional procedures will not be eligible for reimbursement.

Multiple Procedure Rules for Radiology

Multiple procedure radiology codes follow Multiple Procedure discount rules: 100%/50%/50%, max three radiology codes.

Physician Assistant (PA) Payment Rules

Physician assistant services are paid at 85% of what a physician is paid under the Ambetter Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid 85% of what a physician is paid under the Ambetter Physician Fee Schedule.
- PA assistant-at-surgery services at 85% of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Provider-Based Billing

Provider-based billing will not be reimbursed as they are included as part of the compensation for professional fees. Neither the payor nor the member shall be responsible for such provider-based billing. Provider-based billing are amounts charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility, and include but are not limited services billed using revenue codes 510-519.

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Payment Rules

In general, NPs and CNSs are paid for covered services at 85% of what a physician is paid under the Ambetter Physician Fee Schedule.

- NP or CNS assistant-at-surgery services at 85% of what a physician is paid under the Ambetter Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Ambetter Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Reimbursement Service Grouping

If either payor or provider determines in good faith that a change made by payor to a reimbursement service grouping has (or is reasonably expected to have) an adverse financial impact that is more than an immaterial effect (e.g., an increase or decrease in provider’s overall reimbursement of three percent or more), such party may notify the other party of such determination within the 365-day period following the date on which such change is made. Following the timely giving of such notice, payor will evaluate the effect of such change and, notwithstanding anything to the contrary contained elsewhere in the provider agreement (or schedule or attachment), Payor will implement appropriate adjustments, if any, to the

reimbursement amounts with the intention of making the change in the reimbursement service groupings cost neutral and to offset for the adverse financial impact. Payor will notify provider, in writing, of the adjustments made.

Surgical Physician Payment Rules

For surgeries billed with either modifier 54, 55, 56, or 78 pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.

Incomplete Colonoscopy Rule

Incomplete colonoscopies should be billed with CPT 45378 and modifier 53. This will pay 25% of the fee schedule rate for the incomplete procedures. The rest of the claim pays according to the fee schedule.

Injection Services

Injection service codes must pay separately if no other physician service is paid and when not billed with office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Unpriced Codes

In the event that the CMS/Medicare does not contain a published fee amount, an alternate "gap fill" source is utilized to determine the fee amount. Unlisted codes are subject to the code edit and audit process and will require the submission of medical records.

Rental or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Payment for Capped Rental Items During Period Of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than 13 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 13 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Ambetter coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers new medical necessity.

If the beneficiary changes suppliers during or after the 13-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 13th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 13-month period. If the supplier changes after the 10th month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

An entire month's rent may not be paid when a patient is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Transcutaneous Electrical Nerve Stimulator (TENS)

In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of two months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two months rental.

Appendix IX: EDI Companion Guide

EDI Companion Guide Overview

The Companion Guide provides Centene trading partners with guidelines for submitting 5010 version of 837 Professional Claims. The Centene Companion Guide documents any assumptions, conventions, or data issues that may be specific to Centene business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Centene and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Centene. This document provides information on Centene- specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at <http://store.x12.org>.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Centene and its trading partners. Refer to the TPA for guidelines pertaining to Centene legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Centene business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. **If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.**

Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Centene.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the TA1 Interchange Acknowledgement or the 999 Functional Acknowledgements. A TA1 Acknowledgement is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgement may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgement

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgement

The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction Sets.

The IK5 segment in the Functional Acknowledgement may contain an A, E, or R. An 'A' indicates the entire transaction set was accepted. While an 'R' indicates the entire transaction set was rejected. However, an 'E' may be used if the transaction set was accepted but within the transaction set there were claims which may have rejected or have a warning message. Rejected claims will be identified with a CTX segment in between the IK3 & IK4 segments.

277CA Health Care Claim Acknowledgement

The 277CA Health Care Claim Acknowledgement provides a more detailed explanation of the transaction set. Centene also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. **NOTE: The STC03 – Action Code will only be a “U” if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.**

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Centene checks five values within the ISA for redundancy:

- ISA06
- ISA08
- ISA09
- ISA10
- ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of “025” (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Centene checks the ST02 value (the Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted. Duplicate Transaction Sets (ST/SE) return a 999 Functional Acknowledgement with an IK502 value of “23” (Transaction Set Control Number not unique within the Functional Group).

837 Professional/Institutional Health Care Claim - Envelope CENTENE							
IS - Interchange Control Header		GS - Functional Group Header		GE - Functional Group Trailer		IEA - Interchange Control Trailer	
ISA01	00	GS01	HC	GE01	refer to TR3	IEA01	refer to TR3
ISA02	refer to TR3	GS02	SENDER ID	GE02	refer to TR3	IEA02	refer to TR3
ISA03	00	GS03	421406317				
ISA04	refer to TR3	GS04	refer to TR3				
ISA05	ZZ	GS05	refer to TR3				
ISA06	SENDER ID	GS06	refer to TR3				
ISA07	30	GS07	X				
ISA08	421406317	GS08	005010X22 3A2				
ISA09	refer to TR3		For 837I				
ISA10	refer to TR3	GS08	005010X22 2A1				
ISA11	^(5E)		For 837P				
ISA12	00501						
ISA13	refer to TR3						
ISA14	refer to TR3						
ISA15	refer to TR3						
ISA16	refer to TR3						

NOTE: Critical Batching and Editing Information

**Unique group control number (GS06) MUST NOT be duplicated within 365 days by Trading Partner ID (GS02); files containing duplicate or previously received group control numbers will be rejected.*

New Trading Partners

New trading partners should access <https://sites.edifecs.com/index.jsp?centene>, register for access, and perform the steps in the Centene trading partner program. The EDI Support Desk (EDIBA@Centene.com) will contact you with additional steps necessary upon completing your registration.

Claims Processing

Acknowledgements

Senders receive four types of acknowledgement transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge health care claims, and the Centene Audit Report. At the claim level of a transaction, the only acknowledgement of receipt is the return of the Claim Audit Report and/or a 277CA. **NOTE: Trading Partners will not be provided a 997 once they begin submitting 5010 version of transactions.**

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Centene recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

Centene requires that 837I COB be submitted at the Claim level loop (2300). 837P at the Detail level (2400) for all COB transactions.

All Sum of paid amount (AMT02 in loop 2320) and all line adjustment amounts (CAS in 2320 & 2340) must equal the total charge amount (CLM). Additionally, the service charge amount must equal the value of all drug charges (sum of CTP03 and CTP04 in 2410).

If the claim was adjudicated by another payer identified in the 2330B loop the AMT – Payer Paid Amount and AMT – Remaining Patient Liability must be completed.

Primary and secondary coverage for the same claim will not be processed simultaneously. Claims that contain both primary and secondary coverage must be broken down into two claims. File the primary coverage first and submit the secondary coverage after the primary coverage claim has been processed. Submitters can be assured that the primary coverage claim has been processed upon receipt of the EOP or ERA. A secondary coverage claim that is submitted prior to the processing of its preceding primary coverage claim will be denied, based on the need for primary insurance information.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- 5 = "Late Charges Only" Claim
- 7 = Replacement of Prior Claim
- 8 = Void/Cancel of Prior Claim

Data Format/Content

Centene accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.

- Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after the patient's service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

Centene accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters used by Centene are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation. *Please note that the pipe symbol (|) and or line feed cannot be used as delimiters.*

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Centene requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Centene will not accept more than 97 service lines per claim.
- Centene will not accept negative values in AMT fields.
- Centene will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300-REF02) is limited to 20 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Centene sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Centene expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances,

Centene will accept a “Mutually Defined” (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Centene EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than 2310B.

Referring Provider

Centene has no requirement for Referring Provider information beyond that prescribed by the X12 implementation guide (TR3).

Atypical Provider

A typical providers are not always assigned an NPI number, however, if an Atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop.

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber’s card in the 2010BA element.

Claim Identifiers

Centene issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. ***When submitting a claim adjustment, this number must be submitted in the Original Reference Number (ICN/DCN) segment, 2300, REF02.***

Centene returns the submitter’s Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Centene encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Centene offers two options for connectivity via FTP.

- Method A – the trading partner will push transactions to the Centene FTP server and Centene will push outbound transactions to the Centene FTP server.
- Method B – The Trading partner will push transactions to the Centene FTP server and Centene will push outbound transactions to the trading partner’s FTP server.

Encryption

Centene offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS (Note this method only applies with connecting to Centene's Secure FTP. Centene does not support retrieve files automatically via HTTPS from an external source at this time.) If PGP or SSH keys are used they will be shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

Direct Submission

Centene also offers posting an 837 batch file directly on the Provider Portal website for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Centene business rules requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table below, and are also available as a comprehensive list in the 837 Professional Claims – Centene Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Centene business edit errors are returned on the Centene Claims Audit Report.

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 Centene Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	Centene Business Edits <i>(see audit report rejection reason codes and explanation.)</i>	Centene Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Centene Business Edits.	277CA

837: Data Element Table

The 837 Data Element Table identifies only those elements within the X12 5010 Technical Report implementation guide that requirement comment within the context of Centene business processes. The 837 Data Element Table references the guide by loop name, segment name and identifier, element name and identifier. The Data Element Table also references the Centene Business Edit Code Number if there is an edit applicable to the data element in question. The Centene Business Edit Code numbers appear on the Claims Audit Report, along with a narrative explanation of the edit. For a list of the error messages and their respective code numbers, see 'Audit Report - Rejection Reason Codes and Explanation' above.

The Centene business rule comments provided in this table do not identify if elements are required or situational according to the 837 Implementation guides. It is assumed that the user knows the designated usage for the element in question. Not all elements listed in the table below are required, but if they are, the table reflects the values Centene expects to see.

837 Health Care Claim					
Loop ID	Segment Type	Segment Designator	Element ID	Data Element	Centene Business Rules
2010AA	NM1	Billing Provider Name			
			NM103- NM105	Name Last	Centene processes all alpha characters, dashes, spaces, apostrophes, or periods. No other special characters are allowed.
			NM104	Name First	If NM102 = '2' then this element should be blank.
2010BA	NM1	Subscriber Name			
			NM103- NM105	Name (Last, First, Middle)	Centene processes all alpha characters, dashes, spaces, apostrophes, or periods. No other special characters are allowed.
			NM109	ID Code	The member ID number should appear as it does on the membership card.
	DMG	Demographic Information			
			DMG03	Gender Code	Centene will only accept 'M', 'F', and 'O' values.
2010BB	NM1	Payer Name			
			NM103- NM105	Name Last	Centene processes all alpha characters, dashes, spaces, apostrophes, or periods. No other special characters are allowed.
			NM103	Last Name or Organization Name	Use the health plan listed under the Payer ID section of this document.
2300	REF	Payer Claim Control Number			
			REF02	Reference Identification Qualifier	If CLM05-3 = '7' or '8' REF02 must contain the original claim number.