buckeye health plan™
Advantage

2016 Provider and Billing Manual

A Medicare Advantage Program

BuckeyeHealthPlan.com

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INTRODUCTION

Welcome to Buckeye Health Plan Advantage. Thank you for participating in our network of participating physicians, hospitals and other healthcare professionals.

This Provider Manual is a reference guide for providers and their staff providing services to members who participate in our Medicare Advantage and/or our Medicare Advantage Special Needs Program, Buckeye Health Plan Advantage.

OVERVIEW

Buckeye Health Plan Advantage is a licensed health maintenance organization (HMO) contracted with the Centers for Medicare and Medicaid Services (CMS) to provide medical and behavioral health services to dual eligible members.

Advantage is designed to achieve four main objectives:

- Full partnership between the member, their physician and their Advantage Case Manager
- Integrated case management (medical, social, behavioral health, and pharmacy)
- Improved provider and member satisfaction
- Quality of life and healthy outcomes

All of our programs, policies, and procedures are designed with these objectives in mind. These objectives mirror and support the objective of CMS and state guidelines to provide covered healthcare services to low-income, elderly and physically disabled members.

Advantage takes the privacy and confidentiality of our member's health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and CMS regulations. The services provided by the contracted Advantage network providers are a critical component in terms of meeting the objectives above. Our goal is to reinforce the relationship between our members and their primary care physician (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care using contracted hospitals and specialists. The PCP is responsible for coordinating our member's health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the Member about their health status, medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

Advantage appreciates your partnership in achieving these objectives.

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	www.BuckeyeHealthPlan.com	
Health Plan address	Buckeye Health Plan Advantage 4349 Easton Way Suite 200 Columbus, OH 43219	
Phone Numbers	**Phone**	**TTY/TDD**
Buckeye Health Plan Advantage	1-866-389-7690	1-800-750-0750
Department	**Phone**	**Fax**
Provider Services	1-866-296-8731	1-866-786-0482
Member Services	1-866-389-7690	
Medical Management Inpatient and Outpatient Prior Authorization	1-866-389-7690	1-877-861-6722
Concurrent Review/Clinical Information	1-866-389-7690	1-844-893-2203
Admission/Census Reports/Facesheets	1-866-389-7690	1-877-861-6722
Care Management	1-866-389-7690	1-844-866-7712
Behavioral Health Prior Authorization	1-877-730-2117	
24/7 NurseWise (Nurse Advice Line)	1-866-246-4358	
Argus Pharmacy Services (Pharmacies)	1-877-935-8021	
U.S. Script (Prescribers)	1-866-399-0928	1-877-941-0480
NIA www.RadMD.com	1-866-296-8731	1-866-786-0482
OptiCare (vision) www.Opticare.com	1-800-334-3937	
Interpreter Services	1-866-389-7690	
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

MEDICARE REGULATORY REQUIREMENTS

As a Medicare contracted provider, you are required to follow a number of Medicare regulations and CMS requirements. Some of these requirements are found in your provider agreement. Others have been described throughout the body of this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare members in any way based on the health status of the member.
- Providers must ensure that members have adequate access to covered health services.
- Providers may not impose cost sharing on members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow members to directly access screening mammography and influenza vaccinations.
- Providers must provide female members with direct access to women's health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Advantage will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in you Participation Agreement if greater than 60 days. Providers agree to notify Advantage according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operations are convenient to the member and do not discriminate against the member for any reason. Providers will ensure necessary services are available to members 24 hours a day, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Advantage members without CMS approvals of the materials and forms.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- Providers will work with Advantage procedures to inform our members of healthcare needs that require follow-up and provide necessary training in self-care.
- Providers will document in a prominent part of the member's medical record whether the member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care.
- Providers must cooperate with Advantage to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.
- Providers must cooperate with Advantage in notifying members of provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any Advantage medical policies, QI programs and medical management procedures.
- Providers will cooperate with Advantage in disclosing quality and performance indicators to CMS.
- Providers must cooperate with Advantage procedures for handling grievances, appeals, and expedited appeals.
- Providers must fully disclose to all members before providing a service, if the service may not be covered by Advantage. The member must sign an agreement of this understanding. If the member does not, the claim may be denied and the provider will be liable for the cost of the service.

- Providers must allow CMS or its designee access to records related to Advantage services for a period of ten (10) years following termination of this agreement.
- Provider must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
- Provider shall provide services in accordance with Advantage policy: (a) for all members, for the duration of the Advantage contract period with CMS, and (b) for members who are hospitalized on the date the CMS contract with Advantage terminates, or, in the event of an insolvency, through discharge.
- Provider shall disclose to Advantage all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS.

SECURE WEB PORTAL

Advantage offers a robust Secure Web Portal with functionality that will be critical to serving members and to ease administration for the Advantage 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 atwww.buckeyehealthplan.com

Functionality

All users of the Secure Web Portal must complete a registration process. If you are already a registered user on the Buckeye Health Plan Advantage Provider 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 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.)
- View and print patient lists (primary care providers). 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
- Send secure messages to Buckeye Health Plan Advantage staff

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Credentialing and Re-Credentialing

The Credentialing and re-Credentialing process exists to verify that participating practitioners and providers meet the criteria established by Buckeye Health Plan Advantage, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with Buckeye Health Plan Advantage in the Medicaid product with Buckeye Health Plan Advantage, the practitioner/provider will NOT be separately credentialed for the Advantage product.

Notice: *In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Advantage 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 a state utilizes a standardized Credentialing form 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 Advantage 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 Ohio
- Current specialty board certification certificate, if applicable
- Curriculum vitae detailing, at a minimum, the previous 5 years of work history. This is needed if the work history section on the application is not completed reflecting the most recent 5 years. An explanation is also required for Initial Credentialing applications gaps of employment over six months.
- Signed and dated release of information form not older than 120 days
- Current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable

Advantage will primary source verify the following information submitted for Credentialing and re-Credentialing :

- 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)
- Hospital privileges in good standing or alternate admitting arrangements, where applicable
- Federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General)

For providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Re-Credentialing 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 held at least quarterly 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.

Site reviews are performed at provider offices and facilities when the member complaint threshold of two complaints in six months is met. A site review evaluates:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/treatment record keeping

Re-Credentialing

Advantage conducts practitioner/provider re-Credentialing at least every 36 months from the date of the initial Credentialing decision and most recent re-Credentialing 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, Advantage conducts provider performance monitoring activities on all network practitioners/providers. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against practitioners/providers in between Credentialing cycles. Additionally, Advantage reviews monthly reports released by the Office of Inspector General to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Advantage 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 Advantage to evaluate their Credentialing and/or re-Credentialing 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 re-Credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted 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 the following timeframe to provide a written explanation detailing the error or the difference in information to the Credentialing Committee within thirty (30) days of the initial notification.

The Credentialing Committee will then include this information as part of the Credentialing or re-Credentialing 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 1-866296-8731.

Practitioner Right to Appeal Adverse Re-Credentialing Determinations

Applicants who are existing providers and who are declined continued participation due to adverse re-Credentialing 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 thirty (30) days of the date of the notice.

New applicants who are declined participation may request a reconsideration within thirty (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 sixty (60) days form the receipt of the additional documentation.

PROVIDER RELATIONS

Primary Care Providers

The Primary Care Provider ("PCP") is the cornerstone of Advantage's delivery model. The PCP serves as the "medical home" for the member. The "medical home" concept should assist in establishing a patient-provider relationship and ultimately better health outcomes. The PCP is responsible for providing all primary care services for Advantage's members including but not limited to:

- Supervision, coordination, and provision of care to each assigned member
- Initiation of referrals for medically necessary specialty care
- Maintaining continuity of care for each assigned member
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services
- Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral

Our case managers will partner with the PCP not only to ensure the member receives any necessary care but to also assist the PCP in providing a "medical home" for the patient.

All PCP's may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the member's choice, Advantage does not guarantee a PCP will receive a set number of patients. A PCP must contact their Provider Relations Specialist if they choose to change their panel size or close their panel and only accept established patients. If Advantage determines a PCP fails to maintain quality, accessible care, then Advantage reserves the right to close the PCP panel if necessary and re-assign members to a new PCP.

Specialty Care Physicians

The Specialty Care Physician or Specialist agrees to partner with the member's PCP and Case Manager to deliver care. A key component of the specialist's responsibility is to maintain ongoing communication with the member's PCP. Most visits to specialists do not require a prior authorization. Most specialists will require a written referral from the member's PCP; however, the referral is not required for the claim to be reimbursed by Advantage. Specialists can elect to limit their practice to established patients only upon request to their Provider Relations Specialist.

Female members can self-refer to an OB/GYN for their annual well-woman checkup or for care related to pregnancy.

Specialty Care Physicians include, but are not limited to:

- Cardiology
- Gynecology and Women's Services
- Endocrinology

- Gastroenterology
- Geriatrics
- Neurology
- Nephrology
- Oncology
- Ophthalmology
- Orthopedics
- Podiatry
- Pulmonology
- Rheumatology
- Urology

Hospitals

Buckeye Health Plan Advantage has contracted with several hospitals in the counties we serve; however any facility can be used in the case of an emergency. We also contract with other facilities such as rehabilitation facilities and ambulatory surgery centers to assist our members. It is important that our contracted providers have privileges at a contracted facility or have an agreement with a hospitalist group to care for their member when hospitalized. Please see the Provider Directory for a list of contracted hospitals in each county.

Ancillary Providers

Ancillary providers cover a wide range of services from therapy services to laboratory. The following is a sample of ancillary providers:

- Durable Medical Equipment
- Hospice Care
- Home Health
- Laboratory
- Prosthetics and Orthotics
- Radiology
- Therapy (Physical, Occupational, Speech)

APPOINTMENT AVAILABILITY

The following standards are established regarding appointment availability:

- **A full-time practice** is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.
- Routine appointments and physicals should be available within 30 days of request

- Primary care urgent appointments (non-life threatening) should be available within one week of request
- **Urgent care** should be available within 24 hours.
- **Urgent Specialty care** within 24 hours of referral.
- Referrals to Specialist should be made within 4 weeks of request
- **Emergency care** should be received immediately and available 24 hours a day.
- **Persistent symptoms** must be treated no later than the end of the following working day after initial contact with the PCP.
- Non urgent care – sick calls should be available within 72 hours of request.
- **Prenatal Care** patients should be seen within the following timeframes:

  1. Three (3) weeks of a positive pregnancy test (home or laboratory)
  2. Three (3) weeks of identification of high-risk
  3. Seven (7) days of request in first and second trimester
  4. Three (3) days of first request in third trimester
- **Behavioral healthcare** must be provided immediately for emergency services, within 24 hours of the request for urgent care, and within ten (10) days of the request for routine care.

Telephone Arrangements

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the enrollee telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by an enrollee.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special enrollee needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient.
- Response time for telephone call-back waiting times:
  - after hours telephone care for non-emergent, symptomatic issues within 30 to 45 minutes;
  - same day for non-symptomatic concerns;
  - crisis situations within 15 minutes;
- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and transferred to the patient's medical record.

Note: If after hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.

Advantage will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program.

Training Requirements

The following Training courses are required by CMS as well as Buckeye Health Plan Advantage.

- Annual Waste, Abuse and Fraud Training within 90 days of contracting
- Annual Compliance Training within 90 days of contracting
- Annual Model of Care Training within 90 days of contracting
- Cultural Competency
- Other State Required Training

Information on training opportunities will be posted on our website at www.buckeyehealthplan.com.

BUCKEYE HEALTH PLAN ADVANTAGE BENEFITS

The list below is not an all-inclusive list of covered services. All services are subject to benefit coverage, limitations and exclusions as described in the applicable Advantage coverage guidelines.

The table below lists the covered services for members. This is not an exhaustive list and is provided herein for quick reference only. Please visit our Secure Web Portal at www.buckeyehealthplan.com or contact Provider Services at www.buckeyehealthplan.com with any questions you may have regarding benefits.

Buckeye Health Plan Advantage	
CY2015 Brief Overview of Benefits	
Monthly Premium	$0 - $28.60
Maximum Out Of Pocket	$3,400
Includes Part D	Yes – See Below
Part B Deductible (see below for services that apply to the Part B Deductible)	$0-$147
Inpatient Hospital Care	$0 or: $1,260 Deductible for each benefit period $0 coinsurance for Days 1-60 $315 coinsurance for Days 61-90 $630 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over the member’s lifetime) Beyond lifetime days, member is responsible for all costs

Buckeye Health Plan Advantage	
CY2015 Brief Overview of Benefits	
Inpatient Mental Health Care	$0 or: $1,260 Deductible for each benefit period $0 coinsurance for Days 1-60 $315 coinsurance for Days 61-90 $630 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over the member's lifetime) Beyond lifetime days, member is responsible for all costs
Skilled Nursing Facility (SNF)	$0 or: $0 copay for days 1 through 20 $157.50 coinsurance per day for days 21 through 100 *Beyond day 100, member is responsible for all costs
Home Health	$0 copay for Medicare-covered home health visits
Hospice	Must enroll in a Medicare-certified hospice program. Hospice services and Part A and Part B services related to the terminal condition are paid for by Original Medicare, not Advantage plan. See EOC for additional details
Doctor Visits	*Primary care physician visit: 0% or 20% of the cost *Specialist visit: 0% or 20% of the cost
Chiropractic Services	0% or 20% of the cost for Medicare-covered chiropractic visits
Podiatry Services	*0% or 20% of the cost for each Medicare-covered podiatry visit
Outpatient Mental Health Care, including Partial Hospitalization Program	0% or 20% for the cost of: – each Medicare-covered individual therapy visit – each Medicare-covered group therapy visit – Medicare-covered partial hospitalization program services
Outpatient Substance Abuse Care	0% or 20% for the cost of: – each Medicare-covered individual substance abuse outpatient treatment visit – each Medicare-covered group substance abuse outpatient treatment visit
Outpatient Hospital Services	0% or 20% of the cost of each Medicare-covered ambulatory surgical center visit 0% or 20% of the cost of each Medicare-covered outpatient facility visit

Buckeye Health Plan Advantage	
CY2015 Brief Overview of Benefits	
Ambulance Services	0% or 20% of the cost for Medicare-covered Ambulance benefits
Emergency Care	0% or 20% of the cost (up to $65) for Medicare-covered emergency room visits If member is admitted to the hospital within 3 days for the same condition, ER copay is waived.
Urgently Needed Care	0% or 20% of the cost for Medicare-covered urgently needed care visits
Outpatient Rehabilitation Services (Occupational Therapy, Physcial Therapy, Speech/Language Therapy), including Cardiac and Pulmonary Rehabilitation Services	*0% or 20% of the cost for: – Medicare-covered Occupational Therapy visits – Medicare-covered Physical Therapy and/or Speech and Language Pathology visits – Medicare-covered Cardiac Rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks) – Medicare-covered Pulmonary rehab services
Durable Medical Equipment (DME)	0% or 20% of the cost of Medicare-covered durable medical equipment
Prosthetic Devices	0% or 20% of the cost for: – Medicare-covered prosthetic devices – Medicare-covered medical supplies related to prosthetics, splints and other devices
Diabetes Program and Supplies	*$0 copay for Medicare-covered Diabetes self-management training *0% or 20% of the cost for Medicare-covered Diabetes monitoring supplies *0% or 20% of the cost for Medicare-covered Therapeutic shoes or inserts
Diagnostic Tests, X-rays, Lab Services, and Radiology Services	*$0 copay for: – Medicare-covered lab services – *0% or 20% of the cost for: – Medicare-covered diagnositc procedures & testsMedicare-covered X-rays – Medicare-covered diagnostic radiology services (not including x-rays) – Medicare-covered therapeutic radiology services
Cardiac & Pulmonary Rehabilitation Services	*0% or 20% of the cost for: – Medicare-covered Cardiac Rehabilitation Services – Medicare-covered Intensive Cardiac Rehabilitation Services – Medicare-covered Pulmonary Rehabilitation Services

Buckeye Health Plan Advantage	
CY2015 Brief Overview of Benefits	
Preventive Services	$0 copay for all preventive services covered under Original Medicare at zero cost-sharing. Plan covers a physical exam annually.
Kidney Disease & Conditions	*0% or 20% of the cost of Medicare-cov ered renal dialysis *$0 copay for Medicare-covered kidney disease education services
Outpatient Prescription Drugs	0% or 20% of the cost of Medicare-covered Part B chemotherapy drugs and other Part B drugs
Dental Services	$0 copay for the following preventive dental benefits: – 2 oral exams every year – 2 cleanings every year – 1 fluoride treatment every year – 1 dental X-ray every year 0% or 20% of the cost for Medicare-covered dental benefits Comprehensive Benefits Not Covered.
Hearing Services	Exam to diagnose and treat hearing and balance issues: 0% or 20% of the cost Routine hearing exam (for up to 1 every year): $0 copay Hearing aid fitting/evaluation (for up to 1 every year): $0 copay 1 Hearing aid: $0 copay $500 every year for hearing aids.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 0% or 20% of the cost Routine eye exam (for up to 1 every year): $0 copay Contact lenses: $0 copay Eyeglasses (frames and lenses): $0 copay Eyeglasses or contact lenses after cataract surgery: 0% or 20% of the cost $200 every year for contact lenses and eyeglasses (frames and lenses).
Wellness Education and other Supplemental Benefits & Services	*Nursing Hotline *$0 copay for Emergency Medical Response Device
Over-The-Counter Items	$0 copay for covered OTC items,$70 per quarter for OTC items Unused amounts do not carry from one quarter to the next.
Transportation	$0 copay for up to 30 one-way trips to plan-approved locations every year
Acupuncture & Other Alternative Therapies	Not Covered

Buckeye Health Plan Advantage	
CY2015 Brief Overview of Benefits	
Part D Prescription Drug Coverage	
Annual Deductible	$0 or $66 on Tiers 2 - 4
Tier 1 – One month supply Generic	$0, $1.20, or $2.65 copay, or 15% of the total cost
Tier 2 – One month supply Preferred Brand	$0 copay, $3.60 or $6.60 copay, or 15% of the total cost
Tier 3 – One month supply Non-Preferred Brand	$0 copay, $3.60 or $6.60 copay, or 15% of the total cost
Tier 4 – One month supply Injectable	$0 copay, $3.60 or $6.60 copay, or 15% of the total cost

The following is a partial list of services not covered under Parts A and B, however, may be covered under a supplemental benefit:

- Acupuncture
- Hearing Aids
- Cosmetic Surgery
- Healthcare while traveling outside of the United States
- Routine Foot Care
- Routine Dental Care
- Routine Eye Care
- Custodial Care

VERIFYING MEMBER BENEFITS, ELIGIBILITY, AND COST SHARES

It is imperative that providers verify benefits, eligibility, and cost shares each time an Advantage member is scheduled to receive services. All members will receive an Advantage member identification card.

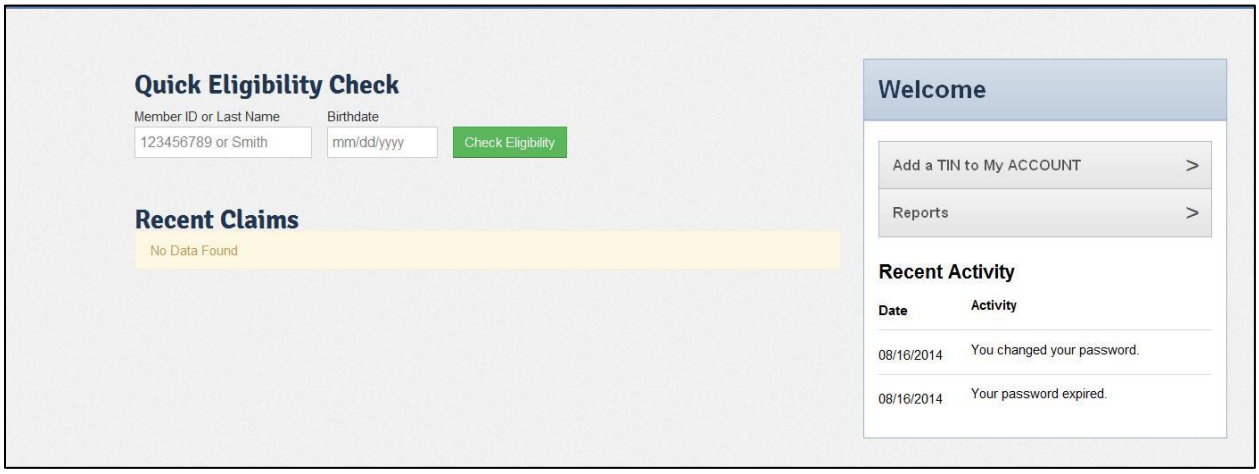
Member Identification Card

Below is a sample 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 Advantage secure web portal found at www.buckeyehealthplan.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

24/7 Toll Fee Interactive Voice Response (IVR) Line at 1-866-389-7690	The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
Provider Services at 1-866-296-8731	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.

MEDICAL MANAGEMENT

Model of Care

The Model of Care defines the care management framework, procedures and operational systems that provide access, coordination and structure needed to provide services and care to Buckeye Health Plan Advantage members.

Purpose

To improve quality, reduce costs, and improve the member experience:

- Ensure members have full access to the services they are entitled
- Improve the coordination between the federal government and state requirements
- Develop innovative care coordination and integration models
- Eliminate financial misalignments that lead to poor quality and cost shifting

Model of Care Elements include:

- Description of the Member Population
- Care Coordination
- Provider Network
- Quality Measurements and Performance Improvement

Model of Care Process:

- Every dual member receives a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member's medical, psychosocial, cognitive, and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Buckeye Health Plan Advantage the case manager for follow up.

Individualized Care Plan (ICP)

The Individualized Care Plan is developed in conjunction with the member; the member's authorized representative, authorized family members, managing physician and other members of the health care team including the Interdisciplinary Care Team (ICT). The Individualized Care plan includes:

- Problems, Interventions and Goals
- Specific services and benefits to be provided
- Measureable Outcomes

Members receive monitoring, service referrals, and condition specific education. Case Manager's and PCP's work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP). Centene disseminates evidence-based clinical guidelines and conducts studies to:

- Measure member outcomes
- Monitor quality of care
- Evaluate the effectiveness of the Model of Care (MOC)

Interdisciplinary Care Team (ICT)

The Buckeye Health Plan Advantage Case Managers will coordinate the member's care with the Interdisciplinary Care Team (ICT). The ICT is generally comprised of multidisciplinary clinical and nonclinical staff chosen by the member. Our integrated care management approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. The purpose of the ICT is to coordinate the plan of care with the member. Our program is member centric with the PCP being the primary ICT point of contact. Provider responsibilities include:

- Accepting invitations to attend member's ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record when received

Collaborating and actively communicating with:

- Buckeye Health Plan Advantage Case Managers
- Members of the Interdisciplinary Care Team (ICT)
- Members and caregivers
- Inpatient Care: Case managers will coordinate with facilities to assist members with coordinating an appropriate discharge plan meeting the member's needs. Buckeye Health Plan Advantage will then notify the PCP of the transition of care and anticipated discharge date to ensure members receive the appropriate follow-up care.
- Transition of Care: Managing transition of care for discharged members may include but is not limited to face to face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan.
- Provider ICT Responsibilities: Provider responsibilities include accepting ICT meeting invitations on members when possible, maintain copies of the ICP, ICT worksheets and transition of care notifications in the member's medical record, and collaborating with Buckeye Health Plan Advantage case managers, ICT, and members or caregivers.
- ICT Training: All internal and external ICT members will be trained annually on the current Model of Care.

Utilization Management

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 nationally recognized standards of care.

National Coverage Determinations (NCDs)

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals. Key manuals for coverage include the: a) Medicare National Coverage Determinations Manual; b) Medicare Program

Integrity Manual; and, c) Medicare Benefit Policy Manual. CMS updates program manuals through program transmittals and also sends updated information via articles through the Medicare Learning Network located in the Outreach & Education section of the CMS website.

Local Coverage Determinations (LCDs)

CMS contractors (e.g., Medicare Administrative Contractors or MACs) develop and issue LCDs to provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

Prior authorization/Preservice Organization Determinations

- Buckeye Health Plan Advantage can submit organization determination requests by mail, phone or fax. Buckeye Health Plan Advantage requires prior authorization for
  - All non-emergent and non-urgent inpatient admissions;
  - All non-emergent or non-urgent out-of-network services (except out-of-area renal dialysis);
  - Service requests identified in the Medicare authorization guidelines available on the provider portal.

For initial and continuation of services, Buckeye Health Plan Advantage has appropriate review criteria for authorization reviews and organization determinations, which include, but are not limited to: Medicare National and Local Coverage Determinations (NCD, LCD); when appropriate determination rendered by Buckeye Health Plan Advantage Medical Director; Nationally Recognized Medical Necessity Criteria, Buckeye Health Plan Advantage e.g. InterQual, and Health Plan clinical policies

The organization determination process provides authorization numbers, effective dates for the authorization and specifies the services being authorized. The requesting Provider will be notified verbally via telephone, fax, mail, of the authorization determination. In the event of an adverse determination, we will notify the Member and the Member's Representative or Provider, as appropriate.

Standard Organization Determinations

Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 14 calendar days after we receive the request for service. An extension may be granted for 14 additional calendar days if the member requests an extension, or if we justify the need for additional information and documents that the delay is in the best interest of the member.

Expedited Organization Determinations

Expedited organization determinations are organization determination request when the member or his or her Physician believes that waiting for a decision under the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the Member's health condition requires, but no later than 72 hours after receiving the Member's or Physician's request. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if we justify a need for additional information and documents how the delay is in the best interest of the member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received.

Timeframes for Prior Authorization Requests and Notifications

The following timeframes are required for prior authorization and notification:

Service Type	Timeframe
Elective/scheduled admissions	Required five (5) business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification requested within one (1) business day

Services Requiring Prior Authorization

Please visit the Buckeye Health Plan Advantage website at www.BuckeyeHealthPlan.com and use the Pre-Screen Tool or call the Authorization Department with questions. 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.**

www.buckeyehealthplan.com

Prior Authorization List

Service	Description
All Out Of Network Services require Prior Authorization except emergency care, out-of-area urgent care, or out-of-area dialysis	
Ambulance	• Fixed-wing aircraft • Non-emergent Transportation
Behavioral Health Services includes Substance Use Disorder	• Inpatient Psychiatric • Partial hospitalization • Intensive Outpatient Therapy • Psychological Testing • Neuropsychological Testing • Electroconvulsive Therapy (ECT) • Substance Use Disorder Treatment/Rehabilitation
Clinical Trials-Notification Only	Please notify us of the Medicare Approved Clinical Trial by phone or fax at the numbers above.
Cosmetic Procedures	Includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. (Medicare Definition)

Service	Description
Drug Testing (effective 11/01/2014)	Prior Authorization required for all Quantitative tests for drugs of abuse, EXCEPT for those conducted in the ER, inpatient hospital, or urgent care locations OR those conducted in children less than 6 years old.
Durable Medical Equipment (DME)	Includes but not limited to: • Custom Wheelchairs • Power Wheelchairs • BIPAP • CPAP • Hospital Bed/Mattress • Lift Devices including Hoyer • Infusion Pumps • Oxygen • TENS Units • Ventilators • Wound Vacuum (Negative Pressure) Devices • Bone growth stimulator • Vagus nerve stimulator **To determine if other DME codes require prior authorization, please refer to:** www.buckeyehealthplan.com
Experimental/Investigational Services	Any item or service potentially considered investigational or experimental must be authorized in advance.
Genetic Counseling and Testing	Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins.
Home Health Services	• Home IV Infusion • Occupational Therapy • Physical Therapy • Speech Therapy • Skilled Nursing Visits • Social Work Visits
Hospice	Please notify us of outpatient or inpatient hospice by phone or fax at the numbers above.
Infertility	Includes the following: • Drug Therapy • Testing • Treatment

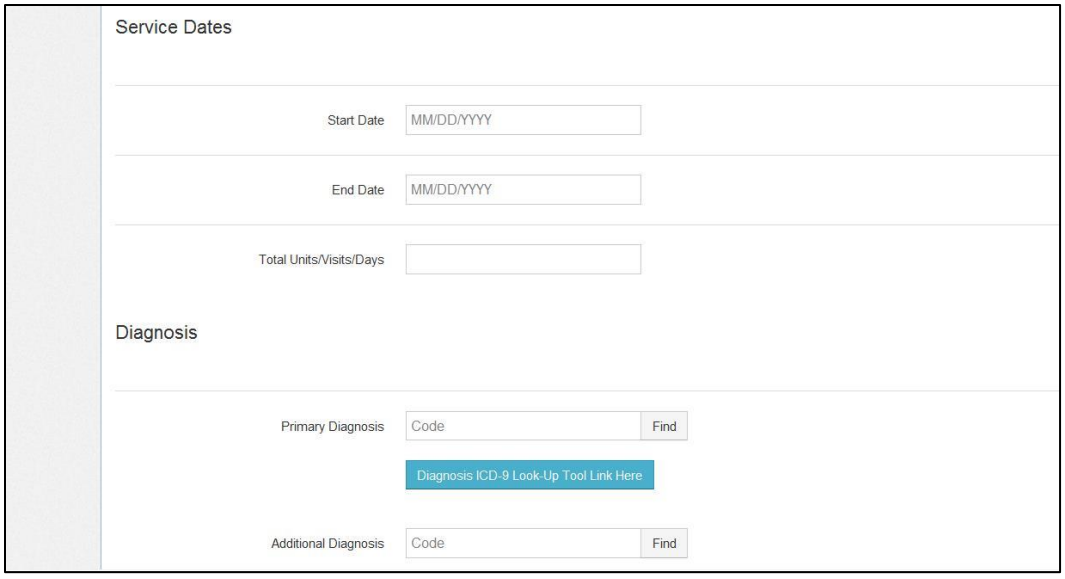
Service	Description
Inpatient Admission: Elective or Scheduled	• Acute Inpatient Hospital • Inpatient Rehabilitation Hospital • Long Term Acute Care Hospital (LTAC) • Skilled Nursing Facility (SNF)
Orthotics/Prosthetics	To determine if Orthotic and Prosthetic codes require prior authorization, please refer to : www.buckeyehealthplan.com
Observation Stay	Prior Authorization required if >24 hours
Outpatient therapy performed at free standing facility or outpatient hospital	• Occupational Therapy (OT) • Physical Therapy (PT) • Speech-Language Therapy (ST) • Pulmonary Rehab Therapy *Medicare has $1,900 cap for PT & ST combined, and $1,900 cap for OT, per calendar year*
Pain Management	• Facet Injections • Trigger Point Injections • Epidural Injections
Medicare Part B Drugs	Please see Medicare Part B Prior Authorization List
Radiation Therapy (effective 01/01/2015)	Includes but not limited to: • Stereotactic Radiotherapy • Intensity modulated radiotherapy (IMRT) • Proton Beam Therapy • Neutron Beam Therapy
Radiology	TX, GA, OH, FL: Visit **www.radmd.com** • MRI • PET • MRA • CT • Cardiac Imaging: TEXAS only
Sleep Studies	• Surgery • Treatment

Service	Description
Surgeries, regardless of place of service	• Abortion • Bariatric Surgery • Blepharoplasty • Breast Augmentation (except following mastectomy) • Breast Reduction • Cochlear Implant • Excision of Lesion • Facial Osteotomy • Hysterectomy • Mastectomy for Gynecomastia • Oral Surgery – Temporomandibular Joint Surgery • Otoplasty • Reconstructive and Plastic Surgery • Rhinoplasty • Sacral Nerve Neuromodulation • Scar Revision • Septoplasty • Spinal surgeries including fusion, stabilization, discectomy • Uvulopalatopharyngoplasty/Uvulopharyngoplasty • Veins (ablation, ligation, stripping, sclerotherapy)
Transplants	• All transplant evaluations and procedures, including but not limited to evaluation, transplant consult visits, HLA typing, donor search, and transplant procedure.

Procedure for Requesting Prior Authorizations

Medical

The preferred method for submitting authorization requests is through the Secure Web Portal at www.buckeyehealthplan.com. The provider must be a registered user on the Secure Web Portal. (If a provider is already registered for the Secure Web Portal for one of our other products, that registration will grant the provider access to Advantage). If the provider is not already a registered user on the Secure Web 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:

- Fax prior authorization request utilizing the Prior Authorization fax forms posted on the Advantage website at www.buckeyehealthplan.com. Please contact Nursewise® at 1-866-246-4358 for after hour urgent admissions, inpatient notifications or requests; or
- Phone the Medical Management Department at 1-866-246-4358. Nursewise®, our 24/7 Nurse Advice line, can assist with authorizations after normal business hours.

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 web 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 recommended that within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-866-389-7690. 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

- For obstetrical admissions, the date and method of delivery, estimated date of confinement and information related to the newborn or neonate.

Behavioral Health Services

Advantage has delegated the management of covered mental health and substance use disorder services to Cenpatico. If you provide behavioral health services for members, 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 covered pharmacy services for Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage Preferred Drug List, the Argus (Pharmacy Benefit Manager) Provider Manual and Medication Request/Exception Request forms.

The Advantage Preferred Drug List formularyis 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
- How Buckeye Health Plan Advantage conducts generic substitution, therapeutic interchange and step-therapy

The Buckeye Health Plan Advantage formulary does not:

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

The Buckeye Health Plan Advantage formulary will be approved initially by the Buckeye Health Plan Advantage 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 formulary will be maintained by the P & T Committee, using quarterly meetings, to ensure that Buckeye Health Plan Advantage members receive the most appropriate medications. The Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage P & T Committee would review 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, www.buckeyehealthplan.com. Providers may also call Provider Services for hard copies of the formulary.

The majority of prescriptions will be covered based on the Medicare formulary. In addition, Buckeye Health Plan Advantage will assist with the following:

- Transitions of prescription drugs
- Quality Assurance
- Utilization Management (Prior Authorization Requirements)
- Exceptions and Appeals
- Locate a pharmacy near you
- Information about any formulary changes
- Out Of Network Coverage

Transition Policy

Under certain circumstances Advantage can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, members must meet the requirements below:

- The drug the member has been taking is no longer on the Advantage formulary or — the drug is now restricted in some way
- The member must be in one of the situations described below:
  - For those members who were enrolled with Buckeye Health Plan Advantage last year and are not in a long-term care facility: We will cover a temporary supply of the drug one time only during the first 90 days enrolled in Buckeye Health Plan Advantage of the calendar year. This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.
  - For those members who are new to Buckeye Health Plan Advantage and are not in a long-term care facility: Buckeye Health Plan Advantage will cover a temporary supply of the drug one time only during the first 90 days of the membership in Buckeye Health Plan Advantage . This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.
  - For those who are new Buckeye Health Plan Advantage members, and are residents in a long-term care facility: We will cover a temporary supply of the drug during the first 90 days of membership in Buckeye Health Plan Advantage. The first supply will be for a maximum of a 31-day supply, or less if the prescription is written for fewer days. If needed, we will cover additional refills during the first 90 days in Buckeye Health Plan Advantage up to a maximum of 91 – 98 day supply.
  - For those who have been a member of Buckeye Health Plan Advantage for more than 90 days, are a resident of a long-term care facility and need a supply right away; Buckeye Health Plan Advantage will cover one 31-day supply or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply. An exception or prior authorization should also be requested at the time the prescription is filled.

Prior Authorization Requirements

Buckeye Health Plan Advantage has a team of doctors and pharmacists to create tools to help provide quality coverage to Buckeye Health Plan Advantage members. The tools include, but are not limited to: prior authorization criteria, clinical edits and quantity limits. Some examples include:

- **Age Limits:** Some drugs require a prior authorization if the member's age does not meet the manufacturer, FDA, or clinical recommendations.

- **Quantity Limits:** For certain drugs, Buckeye Health Plan Advantage limits the amount of the drug we will cover per prescription or for a defined period of time.
- **Prior Authorization:** Buckeye Health Plan Advantage requires prior authorization for certain drugs. (Prior Authorization may be required for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through our exceptions process.) This means that approval will be required before prescription can be filled. If approval is not obtained, Advantage may not cover the drug.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the generic version, unless the brand-name drug was requested. If the brand-name drug is not on the formulary an exception request may be required for coverage. If the brand-name drug is approved, the member may be responsible for a higher co-pay.

Buckeye Health Plan Advantage can make an exception to our coverage rules, please refer to the Comprehensive Formulary. When requesting a utilization restriction exception, submit a supporting statement along with a completed Request for Medicare Prescription Drug Coverage Determination form which can be found at www.buckeyehealthplan.com. In order to ensure your patient receives prompt, you must use the Medicare specific Advantage form and fax it to the number identified on the form. Generally, Buckeye Health Plan Advantage must make a decision within 72 hours of getting the supporting statement. Providers can request an expedited (fast) exception if the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, Buckeye Health Plan Advantage must provide a decision no later than 24 hours after receiving the prescriber's or prescribing doctor's supporting statement.

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 Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage Utilization Management Department.

Women's Health Care

Female members may see a network provider, who is contracted with Buckeye Health Plan Advantage to provide women's health care services directly, without prior authorization for:

- Medically necessary maternity care
- Covered reproductive health services
- Preventive care (well care) and general examinations particular to women
- Gynecological care
- 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 Advantage's prior authorization requirements.

Utilization Determination Timeframes

Utilization management decision making is based on appropriateness of care and service and the covered benefits of the plan. Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage. 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 Buckeye Health Plan Advantage if you would like a copy of the policy for utilization management timeframes.

Level of Urgency

Type	Timeframe
Expedited	As soon as medically required; within 72 hrs. of request (including weekends and holidays)
Expedited Extension	Determination will be extended up to 14 additional calendar days if an extension is requested
Standard	As soon as medically indicated; max 14 calendar days from receipt of request
Standard Extension	Determination will be extended up to 14 additional calendar days if an extension is requested
Concurrent	As soon as medically indicated; usually within 1 business day of request depending on the plan's policy
Retro	Within 30 calendar days of receipt of post – service request

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 Advantage was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Advantage 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.

Medically Necessary

The fact that a physician may prescribe, authorize, or direct a service does not itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a member or provider within 30 days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Advantage clinical staff. Determinations will be made utilizing guidelines based care, appropriate utilization management policies, and by applying clinical judgment and experience. Medical policies are developed

through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website.

Medically necessary services are generally accepted medical practices provided in light of conditions present at the time of treatment. These include services which are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate, and cost-effective setting give the nature of the diagnosis and severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the "Grievance Process" section of the provider manual.

Emergency Medical Condition

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Utilization Review Criteria

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

- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- InterQual®
- Health Plan Clinical Policy

The Buckeye Health Plan Advantage Medical Director reviews, or other health care professionals that 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 NCD, LCD, InterQual® or other criteria as mentioned above. Buckeye Health Plan Advantage's Clinical Policies are posted at www.buckeyehealthplan.com. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-866-389-7690. Providers have the opportunity to discuss any adverse decisions with a Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage at 1-866-389-7690 and asking for the Medical Director. A Buckeye Health Plan Advantage

Care Manager may also coordinate communication between the Medical Director and the requesting provider.

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

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.

An initial Health Risk Assessment (HRA) will be completed by phone or in person within 90 days of the member's enrollment date. The HRA will be the basis of the Care Plan and will be available for your review via the Provider Portal. Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage Care Manager will contact the PCP, and/or, managing physician if the member is not following the plan of care or requires additional services.

All Buckeye Health Plan Advantage members with identified needs are assessed for Care Management enrollment. Members with needs may be identified via clinical rounds, referrals from other Buckeye Health Plan Advantage staff members, via hospital census, via direct referral from Providers, via self-referral or referral from other Providers.

Care Management Process

Buckeye Health Plan Advantage's Care Management for high risk, complex or catastrophic conditions contains the following key elements:

- Screen and 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 the Buckeye Health Plan Advantage 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 ensuring 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 the Buckeye Health Plan Advantage Care Management: Providers are asked to contact a Buckeye Health Plan Advantage Care Manager to refer a member identified in need of Care Management intervention.

ENCOUNTERS AND CLAIMS

Encounter Reporting

What is an Encounter versus a Claim?

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example, if you are the PCP for a Buckeye Health Plan Advantage Member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a "proxy claim") on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. It is mandatory that your office submits encounter data. Buckeye Health Plan Advantage utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by CMS. Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP. Providers are required to submit either an encounter or a claim for each service that you render to a Buckeye Health Plan Advantage Member.

CLAIMS

In general, Buckeye Health Plan Advantage follows the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Advantage 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 Advantage 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).
- 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 Advantage 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 Advantage.
- 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 is a claim that does not require external investigation or development to obtain information not available on the claim form or on record in the health plan's systems in order to adjudicate the claim. Clean claims must be filed within the timely filing period.

Non-Clean Claim Definition

Any claim that does not meet the definition of a clean claim is considered a non-clean claim. Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate 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 the Appendix 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

Participating providers must submit first time claims within 12 months or one calendar year of the date of service. Claims received outside of this timeframe will be denied for untimely submission.

All corrected claims, requests for reconsideration or claim disputes from participating providers must be received within 180 days from the date of explanation of payment or denial is issued.

Who Can File Claims?

All providers who have rendered services for Buckeye Health Plan Advantage members can file claims. It is important that providers ensure Buckeye Health Plan Advantage 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:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Group National Provider Identifier (NPI) (if applicable)
- Tax Identification Number (TIN)
- Taxonomy code (This is a REQUIRED field when submitting a claim)
- Physical location address (as noted on current W-9 form)
- Billingname and address (as noted on current W-9 form)

We recommend that providers notify Buckeye Health Plan Advantage 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.

Electronic Claims Submission

Providers are encouraged to submit clean claims and encounter data electronically. Buckeye Health Plan Advantage can receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP) and deliver it securely to providers electronically or in paper format, dependent on provider preference. For more information on electronic claims and encounter data filing and the clearinghouses Buckeye Health Plan Advantage has partnered with, contact:

Buckeye Health Plan Advantage
c/o Centene EDI Department
1-800-225-2573, extension 6075525
or by e-mail at: 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.

Buckeye Health Plan Advantage has the ability to receive coordination of benefits (COB or secondary) claims electronically. Advantage follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

The Buckeye Health Plan Advantage Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at www.BuckeyeHealthPlan.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 Buckeye Health Plan Advantage, all EDI claims must first be forwarded to one of Buckeye Health Plan Advantage'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 Buckeye Health Plan Advantage. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Buckeye Health Plan Advantage and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage.

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 Advantage 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 Advantage. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in 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 Electronic Edit Requirements – 5010 Information

- Institutional Claims – 837Iv5010 Edits
- Professional Claims – 837Pv5010 Edits

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 i.e. 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 i.e., custom DME, prosthetics. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review i.e. 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 i.e., oxygen, motorized wheelchairs.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Submitting Claims through clearinghouses Buckeye Health Plan Advantage Payer ID number for all clearinghouses (Medical and Cenpatico) is 68069	• Allscripts/Payerpath • Availity • Caparo • Claim Remedi • Claimsource • CPSI • DeKalb • Emdeon • First Health Care • Gateway EDI • GHNonline • IGI • MDonLine • Physicians CC • Practice Insight

Action	Contact
	• 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 Provider Services or the Secure Provider Portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Service in writing (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 that the provider is set up in the Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage, and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Buckeye Health Plan Advantage. 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, Buckeye Health Plan Advantage has made it easy and convenient to submit claims directly to Buckeye Health Plan Advantage on the Secure Provider Portal at www.BuckeyeHealthPlan.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 Web 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:

Buckeye Health Plan Advantage
P.O. Box 3060
Farmington, MO 63640-3060

Buckeye Health Plan Advantage encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available in the Appendix section of this Manual. 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

Buckeye Health Plan Advantage 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. Buckeye Health Plan Advantage 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. 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.
2. 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.
3. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
4. Ensure all Diagnosis Codes are coded to their highest number of digits available
5. Ensure member is eligible for services during the time period in which services were provided.
6. 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.
7. Ensure an authorization has been given for services that require prior authorization by Advantage.

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

All requests for corrected claims, reconsiderations or claim disputes must be received within 180 days from the date of explanation of payment or denial is issued. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 180 days unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- 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 Buckeye Health Plan Advantage or the Federal and/or State regulatory body.
- 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:
  - The provider's records document that the member refused or was physically unable to provide his or her ID Card or information
  - The provider can substantiate that he or she continually pursued reimbursement from the patient until eligibility was discovered
  - The provider has not filed a claim for this member prior to the filing of the claim under review

Below are relevant definitions.

- Corrected claim – A provider is CHANGING the original claim
- Request for Reconsideration – Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
- Claim Dispute/Appeal – 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:

- Submit a corrected claim via the secure Provider Portal - Follow the instructions on the portal for submitting a correction.
- 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
- Submit a corrected paper claim to:

Buckeye Health Plan Advantage
Corrections, Reconsiderations or Appeals
PO BOX 3060
Farmington, MO 63640-3060

- 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. Form - Providers may utilize the Request for Reconsideration form found on our website (preferred method).
2. 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.
3. Written Letter - 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.

Requests for reconsideration and any applicable attachments must be mailed to:

Buckeye Health Plan Advantage
Corrections, Reconsiderations or Appeals
PO BOX 3060
Farmington, MO 63640-3060

Claim Dispute/Appeals

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:

Buckeye Health Plan Advantage
Corrections, Reconsiderations or Appeals
PO BOX 3060
Farmington, MO 63640-3060

If the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Buckeye Health Plan Advantage shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied status in accordance with law and regulation.

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

Buckeye Health Plan Advantage 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 different Payers to different bank accounts, as desired

For more information, please visit our provider home page on our website at www.BuckeyeHealthPlan.com. If further assistance is needed, please contact our Provider Services department at 1-877-935-8020.

Risk Adjustment and Correct Coding

Risk adjustment is a critical and a requirement defined in CFR42 (Section 42 of the Code of Federal Regulations) and the Medicare Modernization Act, that will help ensure the long-term success of the Medicare Advantage program. Accurate calculation of risk adjustment requires accuracy, documentation completeness, 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, CPT, DSM-IV, and HCPCs code sets. Services rendered after October 1, 2015 are required, per CMS, to be billed using ICD-10 and DSM-V coding guidelines. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity using the 4th and 5th digits, when applicable and defensible through chart audits and medical assessments
- Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment, or management

- Ensure that medical record documentation is clear, concise, consistent, complete and legible and meets CMS signature guidelines (each encounter must stand alone)
- Submit claims and encounter information according to the requirements specified in your contract or this provider manual
- Alert Buckeye Health Plan Advantage of any erroneous data submitted and follow Buckeye Health Plan Advantage ’s policies to correct errors as set forth in your contract or this provider manual
- Provide ongoing training to your staff regarding appropriate use of ICD coding for reporting diagnoses

Coding Of Claims/ Billing Codes

Buckeye Health Plan Advantage 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 the 4^{th} and 5^{th} digit as appropriate (ICD-9)
- 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 Buckeye Health Plan Advantage.

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 Buckeye Health Plan Advantage Provider Services.

Code Auditing and Editing

Buckeye Health Plan Advantage uses HIPAA compliant code auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting. The software will detect, correct, and document coding errors on provider claims submissions prior to payment. The software analyzes CPT, HCPCS, Diagnosis codes and modifiers against correct coding principles established by the AMA and CMS. Moreover, the software contains additional edit logic that is sourced from medical and provider societies for billing rules for their membership on correct coding principles. These policies are based on correct coding principles established by the AMA and CMS clinical policies for correct coding. Claims billed in a manner that do not adhere to the standards of the code auditing software will be denied or pended for further review by a coding analyst.

The code auditing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – The software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA website, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE edits). In addition to using the AMA's CPT Manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, and analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Service - identifies services that have been unbundled

Example: Unbundling lab panel. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

CODE	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, Automated and automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

Explanation: 80053, 85025, and 84443 are included in the lab panel code 80050; therefore, they are not separately reimbursable. Those claims lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

CODE	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, Automated and automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

Explanation: 80053, 85025, and 84443 are included in the lab panel code 80050; therefore, they are not separately reimbursable. Those claim lines containing the component codes are denied, and CPT code 80050 is added to a new service line and recommended for reimbursement.

Bilateral - Identical procedures performed on bilateral anatomical site during same operative session.

CODE	Description	Status
69436 DOS=01/01/10	Tympanostomy	Allow
69436 50 DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Reduce payment

Duplicate Services- Submission of same procedure more than once on same date of service that cannot be, or normally not, performed more than once on same day.

Example: Excluding a Duplicate CPT

CODE	Description	Status
72010	Radiologic exam, spine, entire, survey, study anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey, study anteroposterior & lateral	Disallow

Explanation:

- Procedure 72010 includes radiologic examination of the lateral and anterposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.
- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services (E/M) - Submission of E/M services either within a global surgery period or on the same date of service as another E/M service.

Global Surgery:

Procedures that are assigned a 90 day global surgery period are designated as major surgical procedures; those assigned a 10 day or 0 day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90 day) and minor surgical procedures (10 day), are not recommended for separate reporting because they are part of the global services.
- Evaluation and management services, submitted with minor surgical procedures (0 day), are not recommended for separate reporting or reimbursement because these services are part of the global services.

Example: Global Surgery Period

CODE	Description	Status
27447 DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 DOS=06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Typically 15 minutes are spent face-to-face w/patient &/or family	Disallow

Explanation:

- Procedure Code 27447 has a global surgery period of 90 days.
- Procedure Code 99213 is submitted with a date of service that is within the 90 day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Example: E/M with Minor Surgical Procedures

CODE	Description	Status
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
99213 DOS=01/23/10	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent	Disallow

CODE	Description	Status
	w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Typically 15 minutes are spent face-to-face w/patient &/or family	

Explanation:

- Procedure 11000 (0 day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Same Date of Service

One evaluation and management service is recommended for reporting on a single date of service.

Example: Same Date of Service

CODE	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Typically 40 minutes are spent face-to-face with patient and/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Typically 30 minutes are spent face-to-face with patient/family.	Disallow

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation.

Note:

Modifier – 24 is used to report an unrelated evaluation and management service by the same physician during a post- operative period.

Modifier – 25 is used to report a significant, separately identifiable Evaluation and Management service by the same physician or other qualified health care professional on the same day of a procedure. The evaluation and management service will be reviewed through the code edit and audit process and may require the submission of medical records. The following guidelines are utilized to determine whether or not a modifier 25 was used appropriately:

- If the E and M service is the first time a 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
- If a provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required E and M services to determine the patient's need.

Providers should assign all applicable diagnosis code(s) that indicate the need for additional E and M services. E and M codes appended with a modifier 25 will not automatically be reimbursed. Medical records will be required to support the billing of the modifier.

Modifier- 50 is used to indicate a procedure performed on bilateral anatomical sites and applied to a surgical, radiological or diagnostic procedure.

Modifier – 59 is used to report distinct procedures/services not normally reported together, but appropriately billable under the circumstances. Procedures/services reported with modifier 59 will be reviewed through the code edit and audit process and may require the submission of medical records. The following guidelines will be utilized to determine if a modifier 59 was used correctly:

- The diagnosis codes 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.

Providers should assign to the claim all applicable diagnosis and procedure codes and utilize all applicable anatomical modifiers designating which areas of the body were treated. Procedures/services appended with a modifier 59 will not automatically be reimbursed. Medical Records will be needed to support the billing of the modifier.

Modifier- 79 is used to report an unrelated procedure or service by the same physician or other qualified health care professional during the post-operative period.

Modifiers- Codes added to the main procedure code to indicate the service has been altered by a specific circumstance:

Modifier- 26 (Professional Component)

Definition: Modifier- 26 identifies the professional component of a test or study.

- If modifier – 26 is not valid for the submitted procedure code, the procedure code is not recommended for separating reporting.

- When a claim line is submitted without the modifier – 26 in a facility setting (for example: POS 21, 22, 23, 34), the rule will replace the service line with a new line with the same Procedure Code and the modifier – 26 appended.

Example:

CODE	Description	Status
78278 POS = Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS = Inpatient	Acute gastrointestinal blood loss imaging	Allow

Explanation:

- Procedure code 78278 is valid with modifier – 26.
- Modifier – 26 will be added to procedure code 78278 when submitted without a modifier – 26.

Modifier – 80 and -82 (Assistant Surgeon)

Definition: This edit identifies claim lines containing Procedure Codes billed with an assistant surgeon modifier that typically do not require as assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Explanation:

- Procedure Code 42820 is not recommended for assistant surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure.

Other Edits

The following provides examples of other types of edits that will be used during the adjudication process:

- Validity edits – edits due to invalid data submitted, for example:
  - ICD-CM diagnosis codes – Wrong codes
  - HCPCS procedure codes without Revenue codes (for APC)
  - Invalid age – Inappropriate procedures for the age of the member
  - Invalid sex – Inappropriate procedure for the gender of the member
  - Diagnosis/procedure and age or sex conflicts – Inappropriate procedure for the age and gender of the member
- Volume/unit edits—Medically Unlikely Edits – Example: the code audit and edit process will review the number of doses billed for allergen immunotherapy. This is based upon chapter 15 of the Medicare Benefits Policy Manual
- Claim lacks required device or procedure code

- Specific nuclear medicine services on claims that do not contain specific radiopharmaceuticals
- National Correct Coding Initiative (CCI) Edits
- Outpatient Code Editor (OCE) Edits

Claim Reconsiderations related to Code Auditing and Editing

As mentioned previously in this Manual, if you disagree with a code audit 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 audit or edit will be upheld.

CPT Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I Codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Code Editing Assistant

A web-based code auditing reference tool designed to “mirror” how the code auditing product(s) evaluate code and code combinations during the auditing 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 Auditing 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 have been used to determine an edit.** The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations. The tool is a guideline and the results displayed do not guarantee how the claim will be processed.

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.

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, Buckeye Health Plan Advantage will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

BILLING THE MEMBER

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 Buckeye Health Plan Advantage.

No Balance Billing

Providers may not seek payment from Buckeye Health Plan Advantage members for the difference between the billed charges and the contracted rate paid by Buckeye Health Plan Advantage.

Non-Covered Services

Contracted providers may only bill Buckeye Health Plan Advantage 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 Buckeye Health Plan Advantage;
- 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 Buckeye Health Plan Advantage at the time it was provided, even if Buckeye Health Plan Advantage did not pay the provider for the service because the provider did not comply with Buckeye Health Plan Advantage requirements.

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 Advantage policies
6. To receive information or make recommendations, including changes, about Advantage's organization and services, the Advantage 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 physician 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 Advantage member's rights, responsibilities and policies
9. To voice complaints or appeals about: Advantage, any benefit or coverage decisions Advantage makes, Advantage 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 physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Advantage rules and guidelines. Advantage will notify members 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 physician or other provider. The primary care physician or other provider must discuss different treatment plans with the member. The member must make the final decision
19. To select a primary care physician within the network. The member has the right to change their primary care physician 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 physician
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 Advantage 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 Advantage. 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 physician. The member should establish a relationship with their primary care physician. The member may change their primary care physician verbally or in writing by contacting the Advantage 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 Advantage 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 physician 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 physician
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 Advantage coverage, the member must provide this information to Advantage
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 Advantage 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 Advantage 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 Advantage 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 Advantage 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 Advantage for having developed or accumulated a substantial number of patients in Advantage with high cost medical conditions
12. To collect member cost shares 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 Advantage data collection initiatives, such as HEDIS and other contractual or regulatory programs
17. To review clinical practice guidelines distributed by Advantage
18. To comply with the Advantage Medical Management program as outlined herein
19. To disclose overpayments or improper payments to Advantage
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 Advantage information regarding other insurance coverage the member has or may have
22. To give Advantage timely, written notice if provider is leaving/closing a practice
23. To contact Advantage 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 Advantage members which are no less than those offered to other Medicare patients

CULTURAL COMPETENCY

Advantage 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.

Advantage 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 Advantage'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
- 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

Advantage 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
- Providing an Advantage 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)

Americans with Disabilities Act

Buckeye Health Plan Advantage strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services

The term "disability" means, with respect to an individual -

- A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- A record of such an impairment; or
- Being regarded as having such an impairment.

an individual meets any one of these three tests, he or she is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

General Requirements

General prohibitions against discrimination.

- No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability --
  - Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
  - Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
  - Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;
  - Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
  - Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
  - Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;
  - Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Buckeye Health Plan Advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.
- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
  - That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
  - That have the purpose or effect of defeating or
  - substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
  - That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.
- A public entity may not, in determining the site or location of a facility, make selections --
  - That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

  - That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.

- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
  - Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
  - A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
    - Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
    - Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
  - A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.
  - A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

MEMBER GRIEVANCES AND APPEALS

Grievances

Members must follow the complaint or dispute (grievance) process as listed below when a member is dissatisfied with the manner in which Buckeye Health Plan Advantage or a delegated entity, provides healthcare services. Grievances may include:

- Timeliness
- Appropriateness
- Access to provided health services

- Setting of health services
- Procedures
- Items
- Standards for delivery of care

Members or their representative may submit a grievance verbally or in writing via phone, mail, facsimile, electronic mail or in person within 60 calendar days after the event. If the grievance meets the necessary criteria, a resolution is delivered to the member as expeditiously as the member's case requires, based on health status, but no later than 24 hours for expedited grievances and 30 calendar days. Extensions of up to 14 calendar days can be granted for standard grievances if the enrollee requests the extension or if Advantage justifies the need for additional information and the delay is in the best interest of the member.

Appeals

Members or their representatives may file a formal appeal if they are dissatisfied with a medical care or drug coverage decision made by Buckeye Health Plan Advantage. Appeals must be submitted within 60 days of the decision. Expedited determinations will be made on medical care or drug coverage not yet received if standard deadlines can cause serious harm to the member's health. Written appeals must be mailed to:

Buckeye Health Plan Advantage
Attn: Appeals and Grievances
P.O. Box 3060
Farmington, MO 63640

For process or status questions, members or their representatives can contact Member Services at *1-866-389-7690.*

PROVIDER COMPLAINT PROCESS

Provider Complaint/Grievance and Appeal Process

Claim Complaints must follow the Dispute Process and then Complaint Process below. Medical necessity and authorization denial complaints are handled in the Appeals Process below. Please note that claim payments are not appealable. These must be handled via the Claim Dispute and Complaint Process. Claim Disputes may be mailed to:

Buckeye Health Plan Advantage
PO Box 3060
Farmington, MO 63640-5000

Complaint/Grievance

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Advantage's policies, procedure, or any aspect of Advantage's functions. Advantage logs and tracks all complaints/grievances whether received verbally or in writing. A provider has thirty (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, Advantage shall provide a written notice to the provider within thirty (30) calendar days from the received date of Advantage'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 Advantage such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Advantage. A provider has thirty (30) calendar days from Advantage's notice of action to file the appeal. Advantage shall acknowledge receipt of each appeal within ten (10) business days after receiving an appeal. Advantage 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 thirty (30) calendar days from the date Advantage receives the appeal. Advantage may extend the timeframe for resolution of the appeal up to fourteen (14) calendar days if the member requests the extension or Advantage 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, Advantage shall provide written notice to the member for the delay.

Expedited appeals may be filed with Advantage 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 seventy-two (72) hours from the initial receipt of the appeal. Advantage may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if Advantage provides 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.

QUALITY IMPROVEMENT PLAN

Overview

Advantage'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 using 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 incorporates a continuous cycle for assessing the level of care and service form members through 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. Advantage requires all practitioners and providers to cooperate with all QI activities, as well as to allow Advantage to use practitioner and/or provider performance data to ensure success of the QI program.

Advantage will arrange for 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, Advantage 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 Advantage 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 Advantage Board of Directors (BOD) has the ultimate oversight for the care and service provided to members. The BOD 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 to:

- 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 Re-Credentialing programs.

The following sub-committees report directly to the QIC:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- Performance Improvement Team
- Member, Provider and Community Advisory Committees
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)

Practitioner Involvement

Advantage recognizes the integral role that practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Advantage promotes 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 Advantage members. The Advantage 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.

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

To that end, the Advantage QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection and prevention
- Information management
- Marketing practices
- Member enrollment and disenrollment
- Member grievance system
- Member satisfaction
- Member services
- Network performance
- Organizational structure
- Patient safety (including hospitals, ambulatory care centers and office-based surgery sites to endorse and adopt procedures for verifying correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol TM developed by The Joint Commission)
- Primary care provider changes
- Pharmacy

- Provider and plan accessibility
- Provider availability
- Provider complaint system
- Provider network adequacy and capacity
- Provider satisfaction
- Provider services
- Quality management
- Records management
- Selection and retention of providers (Credentialing and re-Credentialing)
- Utilization management, including under and over utilization

Practice Guidelines

Advantage, whenever possible, adopts preventive and clinical practice guidelines (CPG) from recognized sources, for the provision of acute, chronic and behavioral health services relevant to the populations served. Guidelines will be presented to the Quality Improvement Committee (QIC) for appropriate physician review and adoption. Guidelines will be updated at least every two years or upon significant new scientific evidence or changes in national standards.

Advantage adopts clinical practice guidelines for at least two non-preventive acute or chronic medical conditions. Centene also adopts at least two behavioral health conditions (preventive or non-preventive) relevant to the population. At least two of the adopted CPGs directly correspond with two disease management programs offered by Advantage. Guidelines will be based on health needs of population and/or opportunities for improvement as identified through the QAPI program.

Clinical Practice guidelines (CPG) may include, but are not limited to:

- Asthma Guidelines
- Diabetes Care Guidelines
- Sickle Cell Guidelines

Centene also adopts applicable preventive health guidelines.

Preventive Health guidelines may include, but are not limited to:

- Adult Preventive Health Guidelines
- Immunization Guidelines

Copies of these guidelines are available on our website at www.buckeyehealthplan.com.

All guidelines are reviewed annually for updating and/or when new scientific evidence or national standards are published.

Advantage’s QAPI program assures that Practice Guidelines meet the following:

- Adopted guidelines are approved by Advantage’s QIC bi-annually

- Adopted guidelines are evidence-based and include preventive health services
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than bi-annually.
- Guidelines are disseminated to Providers in a timely manner via the following appropriate communication settings:
  - Provider orientations and other group sessions
  - Provider e-newsletters
  - Online via the HEDIS Resource Page
  - Online via the Provider Portal
  - Targeted mailings

Guidelines are posted on Advantage's website or paper copies are available upon request by contacting Advantage's QI Department.

Patient Safety and Level of Care

Patient Safety is a key focus of the Advantage QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual level of care events. A potential level of care issue is any alleged act or behavior that may be detrimental to the level 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. Advantage 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 Quality Improvement (QI) Department of potential level of care issues. Adverse events may also be identified through claims based reporting and analyses. Potential level 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 level 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 Advantage 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 Advantage to monitor improvement over time.

Annually, Advantage 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.

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

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

Additionally, Advantage develops and implements chronic care improvement programs and quality improvement projects required by CMS. Advantage encourages all providers to participate in these initiatives.

MEDICARE STAR RATINGS

The Centers for Medicare and Medicaid Services (CMS) developed the Medicare Star Ratings in order to provide information to consumers about Medicare Advantage Health Plans and to reward top-performing health plans. CMS rates the quality of service and care provided by Medicare Advantage Health Plans based upon a five-star rating scale. This scale is comprised of: Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, and the Medicare Health Outcomes Survey (HOS).

How can providers help to improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or when recommended
- Continue to talk to your patients and document interventions regarding topics such as: fall prevention; bladder control; and the importance of physical activity
- Create office practices to identify noncompliant patients at the time of their appointment
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members
- Review the gap in care files listing members with open gaps which is available on our secure portal
- Identify opportunities for you or your office to have an impact

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. CMS utilizes HEDIS rates to evaluate the effectiveness of a managed care plan's ability to demonstrate an improvement in preventive health outreach to its members.

HEDIS Rate Calculations

HEDIS rates are 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 Breast Cancer Screening (routine mammography), Colorectal Cancer Screening (colonoscopy, sigmoidoscopy or FOBT), Use of Disease Modifying Anti-Rheumatic Drugs for Members with Rheumatoid Arthritis, Osteoporosis Management in Women Who Had a Fracture, 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 effective October 1, 2015) and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include: Adult BMI Assessment, Comprehensive Diabetes Care (screenings and results including HbA1c, nephropathy, dilated retinal eye exams, and blood pressures), and Controlled Blood Pressure (blood pressure results <140/90 for members with high blood pressure).

Who conducts Medical Record Reviews (MRR) for HEDIS?

Buckeye Health Plan Advantage may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. Prompt cooperation with the MRR process 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 Buckeye Health Plan Advantage that 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 Advantage Claims and encounter data is the most efficient way to report HEDIS.
- *Submit claims and encounter data correctly, accurately, and on time.* If services rendered are not filed or billed accurately, 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.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-866-389-7690.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and 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 and gives a general indication of how well the plan is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the member received an annual flu vaccine
- Whether members perceive they are getting needed care including specialist and prescriptions
- How quickly members were able to get appointments and care

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; helping Medicare beneficiaries make informed health care choices. Advantage must participate in the Medicare Health Outcomes Survey. HOS questions that may reflect on the service of providers includes:

- Whether the member perceives their physical or mental health is maintained or improving
- Whether the member has seen their physician and discussed starting, increasing, or maintaining their level of physical activity
- If provider has discussed fall risks and bladder control with the member

REGULATORY MATTERS

Medical Records

Advantage providers must keep accurate and complete patient medical records which are consistent with 42 CFR §456 and National Committee for Quality Assurance (NCQA) standards, and financial and other records pertinent to Advantage members. Such records will enable providers to render the most appropriate level of health care service to members. They will also enable Advantage 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. Advantage requires providers to maintain all records for members for at least ten (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 physician or 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 Advantage 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 Advantage 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.

Medical Records Audits

Advantage will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Advantage will provide written notice prior to conducting a medical record review.

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, the federal Health Insurance Portability and Accountability Act (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";
- **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 Advantage network are independently obligated to know, understand and comply with these laws.

Advantage 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 Advantage Compliance Officer by phone at 1-866-389-7690 or in writing (refer to address below) with any questions about our privacy practices.

Buckeye Health Plan Advantage
4349 Easton Way Suite 200
Columbus, OH 43219

WASTE, ABUSE, AND FRAUD

Advantage 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. Advantage, in conjunction with its parent company, Centene, operates a waste, abuse and fraud unit. Advantage 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
- 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
- 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. Advantage takes all reports of potential waste, abuse or fraud very seriously and investigates all reported issues.

OIG/GSA Exclusion –As a provider in our network, the plans expectation is that you will check the exclusion list as outlined below for all your staff, volunteers, temporary employees, consultants, Board of Directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901

Providers' implementation of Waste, Abuse and Fraud safeguards to identify excluded providers and entities.

Medicare payment may not be made for items or services furnished or prescribed by an excluded provider or entity. Plans shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) or the General Services Administration (GSA). Advantage will review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties List (EPLS) prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or First Tier, Downstream or Related entities (FDR), and monthly thereafter.

If anyone is identified, providers are required to notify Advantage immediately so that if needed Advantage can take appropriate action. Providers may contact the Advantage Compliance officer at Buckeye Health Plan Advantage.

WAF Program Compliance Authority and Responsibility

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

The Advantage 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:

- knowingly presenting, or causing to be presented a false claim for payment or approval
- knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
- conspiring to commit any violation of the False Claims Act
- falsely certifying the type or amount of property to be used by the Government
- certifying receipt of property on a document without completely knowing that the information is true
- knowingly buying Government property from an unauthorized officer of the Government
- 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, Advantage 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 Advantage does or does not have a Physician Incentive Program
- the name, address and other contact information of the person at Advantage 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.

First-Tier and Downstream Providers

Through written agreement, Advantage may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 to First-Tier, downstream, and delegated entities. These functions and responsibilities include but are not limited to contract administration and management, claims submission, claims payment, Credentialing and re-Credentialing , network management, and provider training. Advantage oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities' performance is inadequate. Advantage will ensure written agreements which specify these responsibilities by Advantage and the delegated entity are clear and concise. Agreements will be kept on file by Advantage for reference.

APPENDIX

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), or 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.

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	Definition
0B	ADJUST: CLAIM TO BE REPROCESSED CORRECTED UNDER NEW CLAIM NUMBER
0I	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER
1D	DENY: DISCHARGE STATUS INVALID FOR TYPE OF BILL
52	DENY - PAYMENT INCLUDED IN ALLOWANCE FOR ANOTHER PROCEDURE
57	DENY - AUTHORIZATION LIMITATION EXCEEDED
64	DENY - PROCEDURE INCONSISTENT WITH DIAGNOSIS
65	DENY-MISSING OR INVALID INFORMATION
71	DENY-MEMBER NOT ELIGIBLE ON DATE OF SERVICE
76	DENY - MAXIMUM BENEFIT HAS BEEN PAID

EX Code	Definition
78	DENY: INVALID OR MISSING PLACE OF SERVICE LOCATION
82	DENY-NON COVERED SERVICES
83	DENY - DUPLICATE OF PREVIOUS SUBMITTED CLAIM
A1	APC - OCE LINE ITEM REJECTION
A2	APC - OCE LINE ITEM DENIAL
A4	APC - OCE CLAIM LEVEL RETURN TO PROVIDER (RTP)
A5	APC - OCE CLAIM LEVEL REJECTION
AN	DENY - SERVICE DENIED FOR NO AUTHORIZATION ON FILE
BT	DENY:TYPE OF BILL INVALID
C5	DENY:CODE REPLACED BASED ON CODE AUDITING
dh	DENY - NON-EMERGENCY OUT OF AREA SERVICES ARE NOT COVERED
DZ	DENY: RESUBMIT WITH CORRECTED COUNT
EB	DENIED BY MEDICAL SERVICES
EC	DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE
Es	INVALID OR MISSING REQUIRED ESRD OR HHA \CLAIMS DATA
FT	INVALID FORM TYPE FOR PROCEDURE(S) SUBMITTED
Hn	HHA GROUPER INVALID OR NO TREATMENT AUTHORIZATION CODE
Jq	ORIGINAL CHECK NOT CASHED-PAY TO/ADDRESS VERIFICATION NEEDED
MR	MODIFIER REQUIRED FOR PROCEDURE
NN	MODIFIER NOT REQUIRED FOR THIS PROCEDURE
NV	DENY: PLEASE RESUBMIT WITH INVOICE FOR SERVICES RENDERED
PM	DENY - INVALID PROCEDURE MODIFIER COMBINATION SUBMITTED
QR	DENY: ADJUSTMENT WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT
S9	DENY - CODE BILLED IS NOT COVERED FOR PROVIDER TYPE
TF	DENY - FILING LIMIT EXCEEDED
x2	SERVICE(S) OR SUPPLIES DURING GLOBAL SURGICAL PERIOD
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
ya	DENY: DENIED AFTER REVIEW OF PATIENT S CLAIM HISTORY
ye	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
YO	DENY: ADD ON CODE BILLED WITHOUT PRIMARY PROCEDURE
ZW	AFTER REVIEW, 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 dollars signs (ex. 1000.00; 123.45).

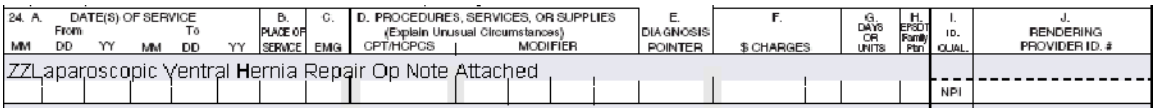
Additional Information for Reporting NDC:

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

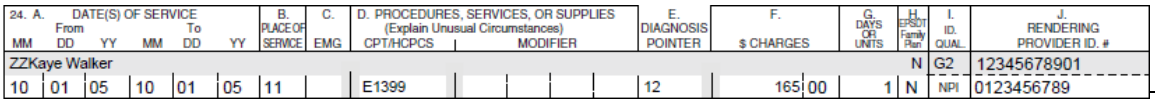
- Qualifier
- NDC Code
- One space
- Unit/basis of measurement qualifier
  - F2- International Unit
  - ME – Milligram
  - UN – Unit
  - GR – Gram
  - ML - Milliliter

- 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

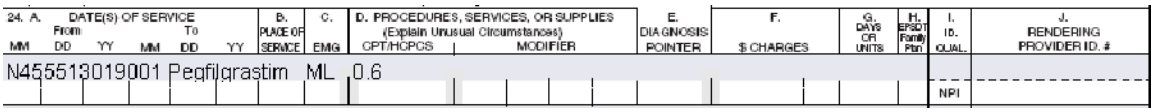


24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral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

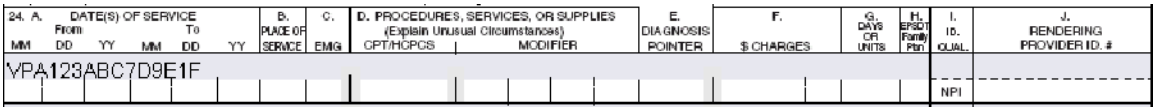


24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker							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

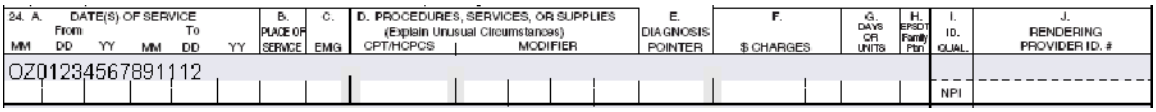
NDC Codes



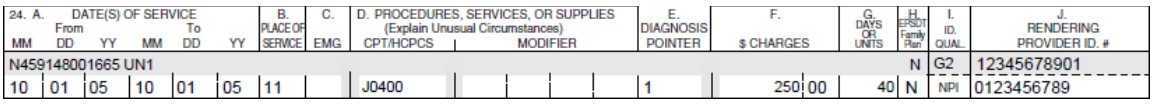
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N455513019001 Pegfilgrastim						ML		0.6						NPI	



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
VPA123ABC7D9E1F														NPI	



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
OZ01234567891112														NPI	



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

Appendix V: Common HIPAA Compliant 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

ERROR_ID	ERROR_DESC
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
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
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

ERROR_ID	ERROR_DESC
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;
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
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.

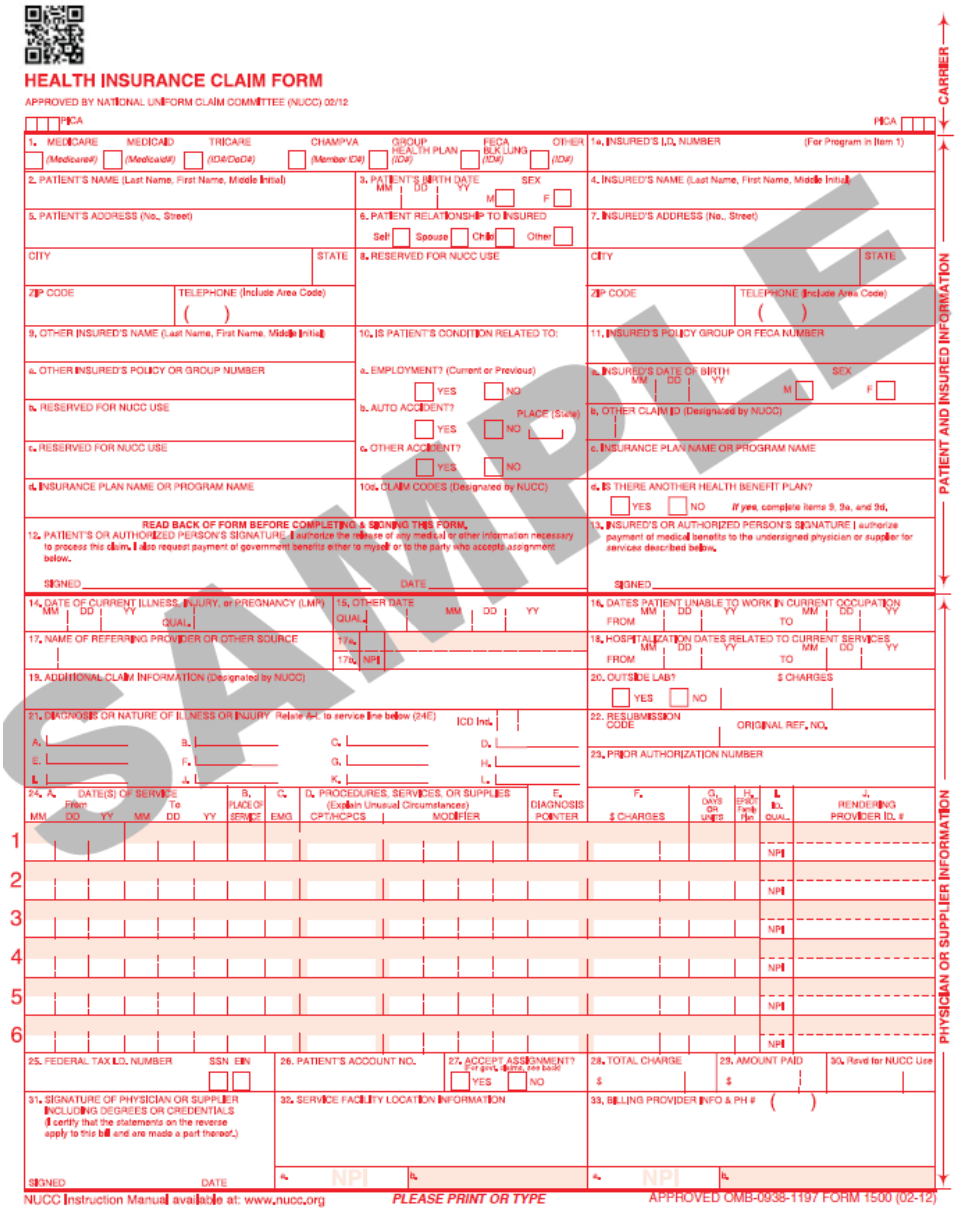
Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided

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

Completing A CMS 1500 Claim Form

Updated format (Form 1500 (02-12)) can be accepted as of Jan. 1, 2014, and is required after October 1, 2014.

Please see the following example of a CMS 1500 form.



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 field. Enter “X” in the box noted “Other”	R
1a	INSURED’S I.D. NUMBER	The 9-digit identification number on the member’s 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 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 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.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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

Field #	Field Description	Instruction or Comments	Required or Conditional
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
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

Field #	Field Description	Instruction or Comments	Required or Conditional
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
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	HOSPITALIZATIO N 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	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring	If auth = C If CLIA = R

Field #	Field Description	Instruction or Comments	Required or Conditional
	NUMBER	referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	(If both, always submit the CLIA number)
24a-j General Information	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. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. 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. The un-shaded area of a claim line is for the entry of claim line item detail.		
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.	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	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.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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

Field #	Field Description	Instruction or Comments	Required or Conditional
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., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
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 a member 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 ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing when Buckeye Health Plan Advantage is listed as secondary or tertiary. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). 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.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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. Second line -Enter the street address. Do not use	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		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 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission	
33a	GROUP BILLING NPI	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.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

Completing A UB-04 Claim Form

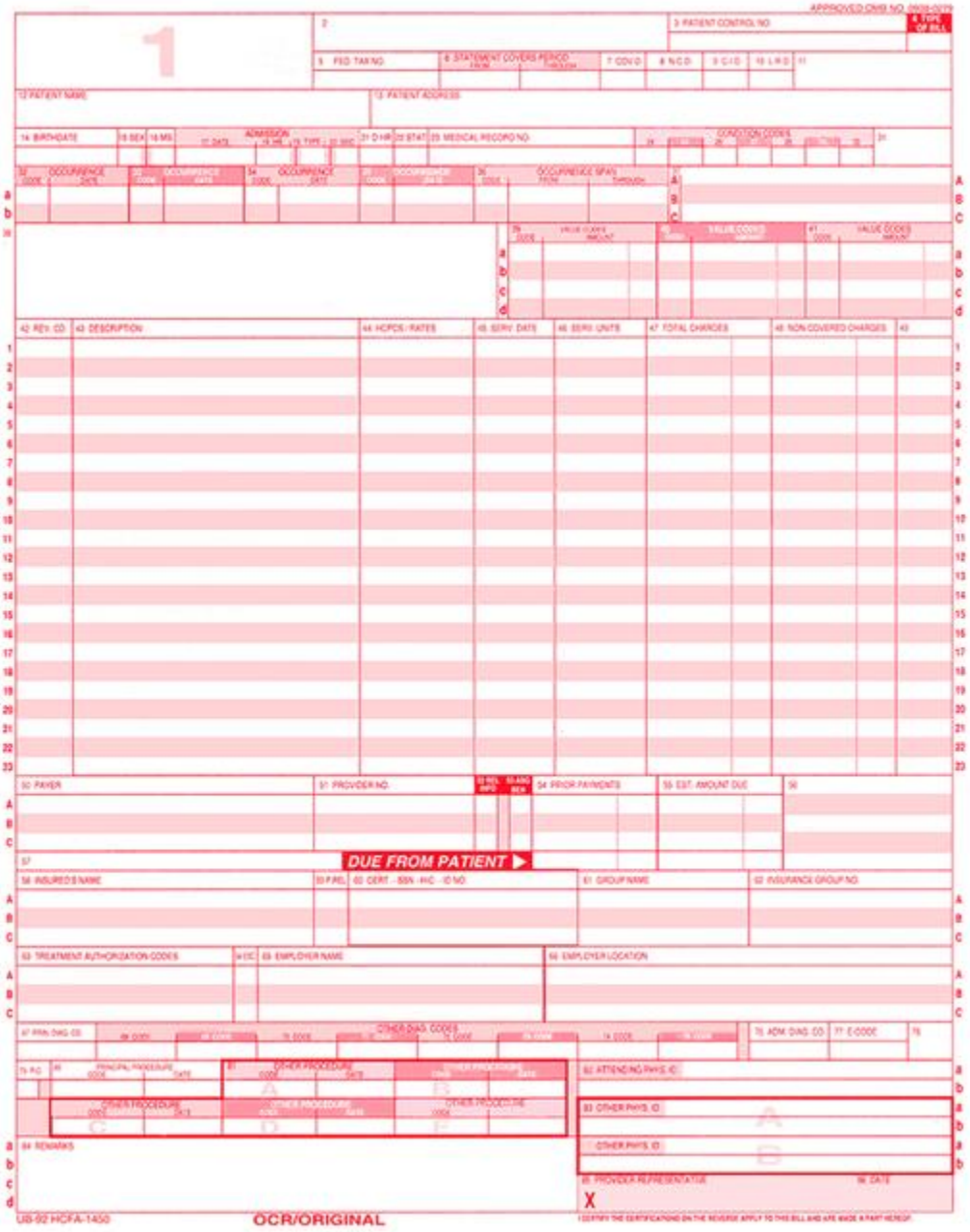
A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Buckeye Health Plan Advantage. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient 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 Buckeye Health Plan Advantage or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

Below is an example of a UB-04 form



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: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd 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 I.D. card	Not Required
		8b – enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names. **Titles:**_(Mr., Mrs., etc.) should not be reported in this field. **Prefix:** No space should be left after the prefix of	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		a name (e.g. McKendrick. H) **Hyphenated names:** Both names should be capitalized and separated by a hyphen (no space) **Suffix:** a space should separate a last name and suffix. 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	0012:00 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

FIELD #	Field Description	Instruction or Comments	Required or Conditional
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. For Type of admission 1,2,3, or 5: 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 For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	R
16	DISCHARGE HOUR	Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 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	C

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		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	
17	PATIENT STATUS	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: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 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	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
Field 17 continued		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
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for 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. 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.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes	C

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. 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.	
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	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. 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. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. 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 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.	C
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	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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
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	NON-COVERED	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the	C

FIELD #	Field Description	Instruction or Comments	Required or Conditional
Line 1-22	CHARGES	service line. Do not list negative amounts.	
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 IDENTIFCATION 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 Buckeye Health Plan Advantage 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
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	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		listed in field 50.	
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 Buckeye Health Plan Advantage 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
67 A-Q	OTHER DIAGNOSIS CODE	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. 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. Note: Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	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	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		Volume 1& 3 for the date of service. 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. Note: Claims with missing or invalid diagnosis codes will be denied.	
70	PATIENT REASON CODE	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. 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. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	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. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-9 Procedure Codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C

FIELD #	Field Description	Instruction or Comments	Required or Conditional
75	UNLABLED		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C
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.	C

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	
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
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	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 Buckeye Health Plan Advantage effective date, should be correctly coded and submitted to the payer responsible.

- Services provided to the member on or after their Buckeye Health Plan Advantage effective date, should be correctly coded and submitted to Buckeye Health Plan Advantage.

Modifiers

- Appropriate Use of – 25, 26, TC, 50, GN, GO, GP
- **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
- **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

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.

Outpatient Hospital Laboratory Services

- Bill Type 141 – Must be utilized when a non-inpatient or non-outpatient hospital member's specimen is submitted for analysis to the Hospital Outpatient Laboratory. The Member is not physically present at the hospital.
- Bill Type 131 and Modifier L1 – Must be utilized when the hospital only provides laboratory tests to the Member and the Member does not also receive other hospital outpatient services during the same encounter. Must also be utilized when a hospital provides a laboratory test during the same encounter as other hospital outpatient services that are clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered is by a different practitioners than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.
- Services not billed following the above guidelines will be denied as EX code AT.

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, Buckeye Health Plan Advantage follows Medicare reimbursement policies. Instances that vary from Medicare include:

Physician Rules

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.

Endoscopic Multiple Procedure Rules

When you have two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608) - identify the primary code within the family, and then apply multiple procedure discounts to the two primary codes. Secondary codes are not paid because you consider the total payment for each set of endoscopies as one service.

When you have two related endoscopies and a third, unrelated procedure - identify the primary code in the related endoscopies. Then apply multiple procedure discounts to the unrelated code and the identified primary code. The secondary code is not paid because you consider the total payment for each set of endoscopies as one service.

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.

Lesser Of Language

Pay Provider lesser of the Providers allowable charges or the negotiated rate

Multiple Procedure Rules For Surgery

Payment should be paid at 100%/50%/50%, starting with procedure ranked highest. Max of 3 procedures.

Procedures 4+ are subject to manual review and payment if appropriate.

Multiple Procedure Ranking Rules

If two or more multiple surgeries are of equal payment value and bill charges do not exceed the payment rate, rank them in descending dollar order billed pay based on multiple procedure discounts.

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 8% of what a physician is paid under the Buckeye Health Plan Advantage Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid 85% of what a physician is paid under the Buckeye Health Plan Advantage Physician Fee Schedule.
- PA assistant-at-surgery services at 85 percent 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.

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 Buckeye Health Plan Advantage Physician Fee Schedule.

- NP or CNS assistant-at-surgery services at 85% of what a physician is paid under the Buckeye Health Plan Advantage Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Buckeye Health Plan Advantage 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.

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 MOD 53. This will pay 25% of the FS rate for the incomplete procedures. The rest of the claim pays according to the FS.

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 RBRVS does not contain a published fee amount, an alternate “gap fill” source is utilized to determine the fee amount. If there is no fee available on the alternate “gap fill” source, Buckeye Health Plan Advantage will reimburse 40% of billed charges less any applicable copay, coinsurance or deductible, unless contracted differently. 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 15 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 15 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 Buckeye Health Plan Advantage 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 15-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 15th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 15-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 2 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).

Completion of this form is not necessary in Washington

837 Professional/Institutional Health Care Claim - Envelope CENTENE

IS - Interchange Control Header	
ISA01	***00***
ISA02	*refer to TR3*
ISA03	***00***
ISA04	*refer to TR3*
ISA05	***ZZ***
ISA06	***SENDER ID***
ISA07	***30***
ISA08	***421406317***
ISA09	*refer to TR3*
ISA10	*refer to TR3*
ISA11	***^ (5E)***
ISA12	***00501***
ISA13	*refer to TR3*
ISA14	*refer to TR3*
ISA15	*refer to TR3*
ISA16	*refer to TR3*

GS - Functional Group Header	
GS01	***HC***
GS02	***SENDER ID***
GS03	***421406317***
GS04	*refer to TR3*
GS05	*refer to TR3*
GS06	*refer to TR3*
GS07	***X***
GS08	***005010X223A2 For 837I***
GS08	***005010X222A1 For 837P***

GE - Functional Group Trailer	
GE01	*refer to TR3*
GE02	*refer to TR3*

IEA - Interchange Control Trailer	
IEA01	*refer to TR3*
IEA02	*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 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 (see audit report rejection reason codes and explanation.)	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.

837 Health Care Claim					
Loop ID	**Segment Type**	**Segment Designator**	**Element ID**	**Data Element**	**Centene Business Rules**
			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.