ambetter. FROM home state health

Provider and Billing Manual

2021

Ambetter.HomeStateHealth.com

AMBPROV20-MO-C-00024

Ambetter from Home State Health is underwritten by Celtic Insurance Company. © 2020 Home State Health Plan, Inc. All rights reserved.

Table of Contents

HOW TO USE THIS PROVIDER MANUAL ---------- 8

NONDISCRIMINATION OF HEALTH CARE SERVICE DELIVERY--------- 9

KEY CONTACTS AND IMPORTANT PHONE NUMBERS ---------- 10

SECURE PROVIDER PORTAL ---------- 12

Functionality----------12

Disclaimer ----------12

CREDENTIALING AND RECREDENTIALING---------- 13

Eligible Providers ----------14

Non Registered CAQH Providers ----------14

Credentialing Committee ----------14

Recredentialing----------14

Practitioner Right to Review and Correct Information----------15

Practitioner Right to Be Informed of Application Status----------15

Practitioner Right to Appeal or Reconsideration of Adverse Credentialing Decisions ----------15

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER -------- 16

Provider Types That May Serve As PCPs----------16

Member Panel Capacity----------16

Member Selection or Assignment of PCP ----------16

PCP Coordination of Care to Specialists----------17

Appointment Availability and Wait Times----------18

Travel Distance and Access Standards ----------19

Covering Providers----------19

Provider Phone Call Protocol ----------19

Provider Data Updates and Validation ----------20

Hospital Responsibilities----------20

AMBETTER BENEFITS ---------- 21

Overview----------21

Additional Benefit Information ----------22

Integrated Deductible Products ----------22

Non- Integrated Deductible Products ----------23

Maximum Out-of-pocket Expenses ---- 23
Free Visits ---- 23
Covered Services ---- 24
Notification of Pregnancy ---- 24
Adding a Newborn or an Adopted Child ---- 25
Non-Covered Services ---- 25
Transplant Services ---- 25
Tribal Provider (AIAN) American Indian Alaska Native ---- 26
MEMBER BENEFITS, MEMBER IDENTIFICATION CARD, ELIGIBILITY, AND COST SHARES ---- 27
Member Benefits ---- 27
Member Identification Card ---- 27
Preferred Method to Verify Benefits, Eligibility, and Cost Shares ---- 27
Other Methods to Verify Benefits, Eligibility and Cost Shares ---- 28
Importance of Verifying Benefits, Eligibility, and Cost Shares ---- 29
Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs) ---- 29
MEDICAL MANAGEMENT ---- 30
Utilization Management ---- 30
Medically Necessary ---- 30
Timeframes for Prior Authorization Requests and Notifications ---- 30
Utilization Determination Timeframes ---- 31
Services Requiring Prior Authorization ---- 31
Procedure for Requesting Prior Authorizations ---- 32
Advanced Imaging ---- 33
Cardiac Imaging ---- 33
Physical Medicine Program ---- 34
National Imaging Associates Authorizations ---- 34
Pharmacy ---- 34
Second Opinion ---- 35
Preventive Health Care ---- 35
Retrospective Review ---- 36
Emergency Care ---- 36
Care Management and Concurrent Review ---- 37

CLAIMS ---------- 40
Verification Procedures ---------- 40
Clean Claim Definition ---------- 41
Non-Clean Claim Definition ---------- 41
Upfront Rejections vs. Denials ---------- 41
Timely Filing ---------- 42
Refunds and Overpayments ---------- 42
Who Can File Claims? ---------- 43
Electronic Claims Submission ---------- 43
Online Claim Submission ---------- 46
Paper Claim Submission ---------- 46
Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA) ---------- 48
Corrected Claims, Requests for Reconsideration or Claim Disputes ---------- 49
Risk Adjustment and Correct Coding ---------- 51
Claim Reconsiderations Related To Code Editing and Editing ---------- 55
CODE EDITING ---------- 57
CPT and HCPCS Coding ---------- 57
International Classification of Diseases (ICD-10) ---------- 58
Revenue Codes ---------- 58
Edit Sources ---------- 58
Code Editing Principles ---------- 59
Invalid Revenue to Procedure Code Editing ---------- 62
Inpatient Facility Claim Editing ---------- 62
Administrative and Consistency Rules ---------- 63
Prepayment Clinical Validation ---------- 63
Claim Reconsiderations Related To Code Editing ---------- 65
Viewing Claims Coding Edits ---------- 66
Automated Clinical Payment Policy Edits ---------- 66
Clinical Payment Policy Appeals ---------- 67
THIRD PARTY LIABILITY ---------- 68
BILLING THE MEMBER ---------- 69
Covered Services ---------- 69
Non-Covered Services ---------- 69

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs) ----------70
Failure to Obtain Authorization ----------70
No Balance Billing ----------70
MEMBER RIGHTS AND RESPONSIBILITIES ---------- 71
Member Rights ----------71
Member Responsibilities ----------72
PROVIDER RIGHTS AND RESPONSIBILITIES ---------- 74
Provider Rights ----------74
Provider Responsibilities ----------74
CULTURAL COMPETENCY ---------- 77
Language Services ----------78
Provider Accessibility Initiative ----------79
Americans with Disabilities Act (ADA) ----------79
COMPLAINT PROCESS ---------- 83
Complaint/Grievance ----------83
Provider Complaint/Grievance and Appeal Process ----------83
Member Complaint/Grievance and Appeal Process ----------84
Mailing Address ----------84
QUALITY IMPROVEMENT PLAN ---------- 85
Overview ----------85
QAPI Program Structure ----------85
Quality Assessment and Performance Improvement Program Scope and Goals ----------86
Performance Improvement Process ----------89
Quality Rating System ----------89
Provider Satisfaction Survey ----------91
Qualified Health Plan (QHP) Enrollee Survey ----------91
Provider Performance Monitoring and Incentive Programs ----------91
REGULATORY MATTERS ---------- 92
Medical Records ----------92
Access to Records and Audits by Ambetter from Home State Health ----------94
EMR Access ----------94
Medical Records Release ----------94

Medical Records Transfer for New Members ---- 94
Federal And State Laws Governing the Release of Information ---- 94
National Network ---- 95
Section 1557 of the Patient Protection and Affordable Care Act ---- 96
FRAUD, WASTE AND ABUSE ---- 97
FWA Program Compliance Authority and Responsibility ---- 98
False Claims Act ---- 98
Physician Incentive Programs ---- 98
APPENDIX ---- 100
Appendix I: Common Causes for Upfront Rejections ---- 100
Appendix II: Common Cause of Claims Processing Delays and Denials ---- 101
Appendix III: Common EOP Denial Codes and Descriptions ---- 101
Appendix IV: Instructions for Supplemental Information ---- 102
Appendix V: Common Business EDI Rejection Codes ---- 103
Appendix VI: Claim Form Instructions ---- 105
Appendix VII: Billing Tips and Reminders ---- 105
Appendix VIII: Reimbursement Policies ---- 135
Appendix IX: EDI Companion Guide Overview ---- 138
STATE MANDATED REGULATORY REQUIREMENTS ---- 157
Arkansas ---- 157
Arizona ---- 157
Florida ---- 158
Georgia ---- 159
Illinois ---- 160
Indiana ---- 164
Kansas ---- 165
Missouri ---- 166
Mississippi ---- 169
North Carolina ---- 169
New Hampshire ---- 175
Nevada ---- 176
Ohio ---- 179
Pennsylvania ---- 182

South Carolina ---------- **183**
Tennessee ---------- **185**
Texas ---------- **185**

WELCOME

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

Ambetter’s Health Insurance Marketplace plans target a consumer population of lower income, previously uninsured individuals and families who, prior to having this health insurance, may have been Medicaid-eligible or unable to access care due to financial challenges.

Partnering with Ambetter provides an opportunity for you to access a previously untapped consumer population by providing coverage to those who qualify for generous premium and cost sharing subsidies. Ambetter has been very successful in attracting and retaining our target population, and continues to focus on engaging and acquiring these subsidy-eligible consumers through its unique plan designs, incentive programs, and effective communication.

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

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

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

HOW TO USE THIS PROVIDER MANUAL

Ambetter is committed to assisting its provider community by supporting their efforts to deliver well-coordinated and appropriate health care to our members. Ambetter is also committed to disseminating comprehensive and timely information to its providers through this provider manual regarding Ambetter's operations, policies, and procedures. Updates to this manual will be posted on our website at ambetter.homestatehealth.com. Additionally, providers may be notified via bulletins and notices posted on the website and potentially on Explanation of Payment notices. Providers may contact our Provider Services department at 1-855-650-3789 to request that a copy of this manual be mailed to you. In accordance with the Participating Provider Agreement, providers are required to comply with the provisions of this manual. Ambetter routinely monitors compliance with the various requirements in this manual and may initiate corrective action, including denial or reduction in payment, suspension, or termination if there is a failure to comply with any requirements of this manual.

Dental and Vision Provider Manuals

Envolve Dental and Routine Vision provider manuals are available on the Secure Provider Portal. Providers may visit envolvedental.com or www.envolvevision.com and log on or contact us for these provider manuals.

Ancillary Provider Manuals

Additional provider manuals are available on the Secure Provider Portal. Providers may visit the following and log on or contact us for these provider manuals:

- **Envolve (RX)**
- **RX ADvanced**
- **Teledoc**
- **Babylon**
- **NIA**
- **Evicore**
- **Ash (AZ)**
- **Home Town Health**
- **Logisticare Ambulance Emergency Non-Emergency and Non-Medical Vendor**
- **USMM**
- **MEDXM**

NONDISCRIMINATION OF HEALTH CARE SERVICE DELIVERY

Ambetter complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant member materials and physical locations that serve our members.

All providers who join the Ambetter Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

Ambetter requires providers to deliver services to Ambetter members without regard to race, color, national origin, age, disability or sex. Providers must not discriminate against members based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of member financial responsibility from Ambetter members.

- Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96- hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission. The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours). Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.") The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply. All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

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	
Ambetter from Home State Health	Ambetter from Home State Health 11720 Borman Dr. Saint Louis, MO 63146 Phone: 1-855-650-3789 TTY/TDD: 1-877-250-6113 ambetter.homestatehealth.com

Department	Phone	Fax/Web Address
Provider Services	1-855-650-3789	NA
Member Services		NA
Medical Management Inpatient and Outpatient Prior Authorization		1-855-690-5433
Concurrent Review/Clinical Information		1-855-690-5433
Admissions/Census Reports/ Facesheets		1-855-690-3789
Care Management		1-855-396-2562
Behavioral Health Prior Authorization		1-855-690-5433
24/7 Nurse Advice Line		NA
Pharmacy Solution		1-800-977-4170
Advanced Imaging, cardiac, and therapy (MRI, CT, PET, Myocardial Perfusion Imaging, MUGA Scan, Echocardiology, stress echocardiology, Outpatient PT, OT, ST) (NIA)	1-800-424-4794	NA
Cardiac Imaging (NIA)	1-855-650-3789	NA
Envolve Vision		**EnvolveVision.com**
Envolve Dental		**EnvolveDental.com**
Interpreter Services		NA

HEALTH PLAN INFORMATION		
To report suspected fraud, waste and abuse	1-866-685-8664	NA
EDI Claims assistance	1-800-225-2573 ext. 6075525	e-mail: **EDIBA@centene.com**

SECURE PROVIDER PORTAL

Ambetter offers a robust Secure Provider Portal with functionality that is critical to serving members and to ease administration for the Ambetter product for providers. The Portal can be accessed at ambetter.homestatehealth.com.

Functionality

- All users of the Secure Provider Portal must complete a registration process.
- Once registered, providers may:
  - Check eligibility and view member roster
  - View the specific benefits for a member
  - View members remaining yearly deductible and amounts applied to plan maximums
  - View status of all claims that have been received, regardless of how submitted
  - Update provider demographic information (address, office hours, etc.)
  - For primary care providers, view and print patient lists. The patient list will indicate the member's name, id number, date of birth, care gaps, disease management enrollment, and product in which they are enrolled
  - Submit authorizations and view the status of authorizations that have been submitted for members
  - View, submit, copy and correct claims
  - Submit 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 and receive secure messages with Ambetter staff
  - Access both patient and provider analytic tools

Manage Account Access allows you to perform functions as an account manager such as adding portal accounts needed in your office.

Disclaimer

Providers agree that all health information, including that related to patient conditions, medical utilization and pharmacy utilization available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

CREDENTIALING AND RECREDENTIALING

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

If a practitioner/provider already participates with Ambetter from Home State in the Medicaid or a Medicare product, the practitioner/provider will NOT be separately credentialed for the Ambetter product.

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

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

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation
- Completed ownership and control disclosure form
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage
- Current controlled substance registration certificate, if applicable
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see Ambetter members
- Completed and signed W-9 form (initial credentialing only)
- Current educational commission for foreign medical graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants
- Signed and dated release of information form not older than 120 days
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable

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

- License through appropriate licensing agency;
- Board certification, or residency training, or professional education, where applicable;
- Malpractice claims and license agency actions through the national practitioner data bank (NPDB);
- Federal sanction activity, including Medicare/Medicaid services (OIG-Office of Inspector General).

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

Once the clean application is received, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting in accordance to state and federal regulations.

Eligible Providers

All eligible providers are required to complete the credentialing process. All eligible providers must be recredentialed every 36 months.

- Professional providers: MD, DO, PsyD, PHD, AUD, BCBA, OD, DC, CNM, DPM, LCSW, LCPC, LMFT, PA, APN, APRN ANP and CNP, CNS, RD, LAC and DN
- Institutional providers: Hospitals and Ancillary

Non Registered CAQH Providers

Primary care providers cannot accept member assignments until they are fully credentialed.

Practitioners/Providers are required to self-register with CAQH ProView at https://proview.caqh.org. The CAQH will email the provider a Welcome kit with registration instructions. Practitioners/Providers receive a personal CAQH Provider ID, allowing them to register on the CAQH website at https://proview.caqh.org and obtain immediate access to the ProView database via the Internet.

Once obtaining authenticating key information, practitioners/providers will have the opportunity to create their own unique user name as well as password to begin utilizing the system at any time.

Credentialing Committee

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

Recredentialing

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

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

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

Practitioner Right to Review and Correct Information

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

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

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

Practitioner Right to Be Informed of Application Status

All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact their Provider Relations Representative.

Practitioner Right to Appeal or Reconsideration of Adverse Credentialing Decisions

Applicants who are existing providers and who are declined continued participation due to adverse 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 30 days of 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 in accordance with state and federal regulations.

Written requests to appeal or for reconsideration of adverse credentialing decisions should be sent to the attention of the Credentialing Manager listed on the denial letter.

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Provider Types That May Serve As PCPs

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

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

Member Panel Capacity

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

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

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

If a PCP has reached the capacity limit for their practice and wants to make a change to their open panel status, the PCP must notify Ambetter 30 days in advance of their inability to accept additional members. Notification can be in writing or by calling the Provider Services Department 1-855-650-3789. A PCP must not refuse new members for addition to their panel unless the PCP has reached their specified capacity limit.

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

Member Selection or Assignment of PCP

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

1. **A previous relationship with a PCP.** If a member has not designated a PCP within the first 30 days of being enrolled in Ambetter, Ambetter will review and assign the member to that PCP.
2. **Geographic proximity of PCP to member residence.** The auto-assignment logic is designed to select a PCP for whom the members will not travel more than the required access standards.

3. **Appropriate PCP type.** The algorithm will use age, gender, and other criteria to identify an appropriate match, such as children assigned to pediatricians.

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

The member may change their PCP at any time with the change becoming effective no later than the beginning of the month following the member's request for change. Members are advised to contact the Member Services Department at 1-855-650-3789 for further information.

Withdrawing from Caring for a Member

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

PCP Coordination of Care to Specialists

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

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

Specialist Provider Responsibilities

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

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

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

Appointment Availability and Wait Times

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

Appointment Type	Access Standard
Physical and Behavioral Health Providers	
Routine care without physical or behavioral symptoms (e.g. well child exams, routine physicals)	Within thirty (30) calendar days
Routine care with physical or behavioral symptoms (e.g. persistent rash, recurring high grade temperature)	Within one (1) week or five (5) business days, whichever is earlier
Urgent Care appointments for physical or behavioral illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services)	Within 24-hours
Aftercare appointments (physical or behavioral)	Within seven (7) calendar days after hospital discharge
Behavioral Health and Substance Abuse Emergent	Immediately (non-life threatening within 6 hours)
Pregnant Women	
First trimester appointments	Within seven (7) calendar days of first request
Second trimester appointments	Within seven (7) calendar days of first request

Wait Time Standards for All Provider Types

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

Travel Distance and Access Standards

Ambetter offers a comprehensive network of PCPs, specialist physicians, hospitals, behavioral health care providers, diagnostic and ancillary services providers to ensure every member has access to covered services.

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

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

Covering Providers

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

Provider Phone Call Protocol

PCPs and specialist providers **must**:

- Answer the member's telephone inquiries on a timely basis
- Schedule appointments in accordance with appointment standards and guidelines set forth in this manual
- Schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients
- Identify and, when possible, reschedule cancelled and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments)
- Adhere to the following response times for telephone call-back wait times:
    - After hours for non-emergent, symptomatic issues: within thirty minutes
    - Same day for all other calls during normal office hours
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours
- Have protocols in place to provide coverage in the event of a provider's absence
- Document after-hours calls in a written format in either in the member's medical record or an after-hours call log and then transfer to the member's medical record

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

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

Provider Data Updates and Validation

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

Additionally, Ambetter, and our contracted vendors, perform regular audits of our provider directories. This may be done through outreach to confirm your practice information. Access to care is critical to ensuring the health and well-being of our members, and in order to provide reliable access to care, it is important to respond to the outreach. Without a response, we are unable to accurately make your information available to patients and you may be at risk of being removed from the Ambetter from Home State Health Provider Directory.

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

Hospital Responsibilities

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

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit;
- Obtain authorizations for all inpatient and selected outpatient services listed in the Pre-Auth Needed tool available at ambetter.homestatehealth.com, except for emergency stabilization services;
- Notify the Medical Management department by either calling or sending an electronic file of the ER admission within one business day; the information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service, and member's phone number;
- Notify the Medical Management department of all admissions via the ER within one business day;
- Notify the Medical Management department of all newborn deliveries within one day of the delivery; notification may occur by our Secure Provider Portal, fax, or by phone; and
- Adhere to the standards set in the Timeframes for Prior Authorization Requests and Notifications table in the Medical Management section of this manual.

AMBETTER BENEFITS

Overview

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

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

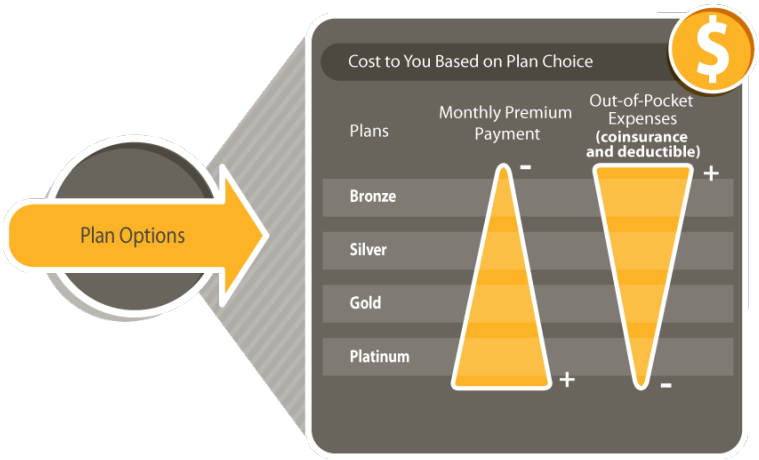
The EHBs outlined in the Affordable Care Act are as follows:

- Preventive and wellness services and chronic disease management
- Maternity and newborn care
- Pediatric services including pediatric vision
- Outpatient or ambulatory services
- Laboratory services
- Various therapies (such as physical therapy and devices)
- Hospitalization
- Emergency services
- Mental health and substance use services, both inpatient and outpatient
- Prescription drugs

Ambetter covers services described in the Schedule of Benefits and Evidence of Coverage (EOC) document for each Ambetter plan type. If there are questions as to a covered service or required prior authorization, please contact Ambetter Provider Services at 1-855-650-3789.

Detailed information about benefits and services can be found in the current year EOC available at ambetter.homestatehealth.com on the “Our Health Plans” page.

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



Our products are marketed under the following names:

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

Additional Benefit Information

Ambetter has a variety of PPO, HMO, and EPO benefit plans offerings based on geographic location. Depending on the benefit plan and any subsidies that the member may receive, plans contain copays, coinsurance, and deductibles (cost shares). As stated elsewhere in this manual, cost shares may be collected at the time of service. Review the "Verifying Member Benefits, Eligibility, and Cost Shares" section of this manual to determine if the Ambetter Member has an HMO, EPO, or PPO plan.

PPO

To receive the highest level of benefits at the lowest cost share amounts, members who are enrolled with Ambetter PPO plans are incented to utilize in-network participating providers. If a member receives care from an out-of-network provider they will receive benefit and they can be balanced bill for additional charges above what has been reimbursed from the health plan. Members and providers can identify participating providers by visiting our website at ambetter.homestatehealth.com and clicking on Find-A-Provider.

HMO

Members who are enrolled in HMO plans with Ambetter must utilize in-network participating providers. Members and providers can identify other participating providers by visiting our website at ambetter.homestatehealth.com and clicking on Find-A-Provider. When an out-of-network provider is utilized, except in the case of emergency services, the member will be 100% responsible for all charges.

Integrated Deductible Products

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

- A member will reach the deductible first, then pay coinsurance until they reach the maximum out-of-pocket for their particular plan
- Copays will be collected before the deductible for services that are not subject to the deductible
- Other copays are subject to the deductible, and the copay will be collected only after the deductible is met
- Services counting towards the integrated deductible include: medical costs, physician services, hospital services, essential health benefit covered services including pediatric vision and mental health services, and pharmacy benefits
- Claims information including the accumulators will be displayed on the Secure Provider Portal

Non- Integrated Deductible Products

Some Ambetter products contain a non-integrated deductible, meaning that the medical and prescription deductible are not combined. In such plans:

- A member will reach the medical deductible separately from the prescription deductible, then pay coinsurance until they reach the maximum out-of-pocket for their particular plan
- Copays will be collected before the deductible for services that are not subject to the deductible
- Other copays are subject to the deductible, and the copay will be collected only after the deductible is met
- Services that will not count towards the non-integrated prescription deductible include: medical costs, physician services, hospital services, essential health benefit covered services including pediatric vision and mental health services, and any other medical benefits
- Claims information including the accumulators will be displayed on the Secure Provider Portal

Maximum Out-of-pocket Expenses

All Ambetter benefit plans contain a maximum out-of-pocket expense. Maximum out-of-pocket is the highest or total amount that must be paid by the member toward the cost of their health care (excluding premium payments). Maximum out-of-pocket costs can be determined on the Member's Evidence of Coverage available through ambetter.homestatehealth.com on the "Our Health Plans" page. Below are some rules regarding maximum out-of-pocket expenses?

- A member will reach the deductible first, and will continue to pay coinsurance/copay then pay coinsurance until they reach the maximum out-of-pocket for their Ambetter benefit plan.
- Copays will be collected before and after the deductible is met; or until the maximum out-of-pocket is met.
- Only medical costs/claims are applied to the deductible. (For those benefit plans that contain routine adult vision and routine dental coverage, these expenses would not count towards the deductible).
- All out-of-pocket costs, including copays, deductibles, and coinsurance apply to the maximum out-of-pocket. (As mentioned previously, this excludes premium payments).

Free Visits

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

- These three free visits only apply to the evaluation and management (E and M) codes provided by a Primary Care Provider or Behavioral Health Provider.
- Preventive care visits are not included in the free visits. As mentioned above, in accordance with the ACA, preventive care is covered at 100% by Ambetter, separately from the free visits.
- The Secure Provider Portal at ambetter.homestatehealth.com has functionality to "accumulate or count" free visits. It is imperative that providers always verify eligibility and benefits.

Covered Services

Please visit the Ambetter website for information on services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Medical Management & Prior Authorization" section of this manual for more information about clinical determination and prior authorization procedures.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Secure Provider Portal or calling Ambetter Member and Provider Services.

Preventive Services

In accordance with the Affordable Care Act, all preventive services which meet U.S Preventive Services Task Force (USPSTF) guidelines are covered at 100%. That is, there is no member cost share (copay, coinsurance, or deductible) applied to preventive health services which meet USPSTF A and B ratings. All preventative diagnosis codes must be billed in the primary position of the claim form. . A complete listing of preventive care services, recommendations and guidelines can be found at www.Healthcare.gov/center/ regulations/prevention.html

-

Diagnostic services, treatment, or services deemed as Medically Necessary to correct or improve defects, physical or mental illnesses, and conditions discovered during a screening or testing must be provided or arranged for either directly or through referrals. Any condition discovered during the screening examination or screening test requiring further diagnostic study or treatment provided will fall within the Member's Covered Benefit Services. Member may have additional out-of-pocket cost share responsibility above standard coverage for the initial preventive services. Members should be referred to an appropriate source of care for any required services that are not Covered Services.

For a listing of services that are covered at 100% and associated preventative benefits, please visit ambetter.homestatehealth.com.

Notification of Pregnancy

Knowledge is power, and the more information we have about our Ambetter patients, the more personalized services we can provide. The Notification of Pregnancy is the main avenue for Ambetter to obtain information on our shared pregnant patients to provide them with resources and personalized care services. What is the Notification of Pregnancy? The NOP is a form you or your office staff can complete at a patient's first prenatal visit in your office. This form gets submitted to Ambetter.

Why does Ambetter need this? Ambetter uses this form to help us reach our pregnant patients and provide them care management services.
Ambetter uses the NOP information to determine which services are needed by each patient. As there are limited resources, risk stratification (high, medium, and low risk) based on the NOP helps our most 'high risk' patients get additional care management services and support.
Moms with Ambetter who have a submitted NOP get a welcome letter to introduce them to our Smart Start for Baby program, the Mother's Guide to Pregnancy Book to provide tips on taking care of themselves while pregnant, a wellness survey to help them stay healthy during their pregnancy, and more.
Completed NOP forms should be submitted via the secure portal at provider.homestatehealth.com
Providers should notify Marketplace/SBEs immediately of any member who are expecting. We do not require that a physician or other healthcare provider obtain prior authorization for the delivery of the newborn. However, an inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization. Please refer to the provider authorization tool ambetter.homestatehealth.com to check if any authorizations are required for additional services.

Adding a Newborn or an Adopted Child

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

Non-Covered Services

Please refer to the member Evidence of Coverage for a listing of non-covered (excluded) services.

Transplant Services

Please refer to the member Evidence of Coverage for a listing of covered and non-covered (excluded) services related to transplants.

Transplants are a covered benefit when a member is accepted as a transplant candidate. *Prior authorization* must be obtained through the *"Center of Excellence",* before an evaluation for a transplant. *We* may require additional information such as testing and/or treatment before determining medical necessity for the transplant benefit. *Authorization* must be obtained prior to performing any related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

Claims submission shall be followed related to transplant services is available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage provided by the same insurer each will have their benefits paid by their own coverage program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollees benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this contract will be provided for you. However, no benefits will be provided for the recipient.
- If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

For additional questions or information on Prior Authorizations please review the Medical Management section of this manual for guidelines.

Tribal Provider (AIAN) American Indian Alaska Native

For Indian Health Services (I.H.S) and Tribal 638 facilities, most services are paid at the Office of Management and Budget (OMB) Rate, using the UB claim form and either a revenue code for dental clinic (0512) or for physical health clinic (0519). For a Behavioral Health practitioner service revenue code 0919 is used. Some services are not part of the Office of Management Budget rate and are billed on the CMS 1500 form and paid at regular fee schedule rates.

Ambetter American Indian and Alaska Natives members may use an Indian health care as a primary care provider or choose to use a network primary care provider to get health care services. To avoid paying extra, member must obtain a referral from their Indian health care provider or from the network primary care provider for any specialty or other services not provided by your Indian health care provider.

Ambetter claims billed by a network primary care provider or specialist on behalf of an American Indian and Alaska Native member are required to bill with modifier Q4 to indicate that these services are an extension of services not provided by an Indian health care provider, but billed by a network primary care provider or specialist.

Ambetter requires that all Tribal 638 facilities billing on CMS 1500 forms be billed with a place of service as recognized by CMS, https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set, indicated below:

- 05 Indian Health Service Free-Standing Facility. (A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (Effective January 1, 2003).
- 06 Indian Health Service Provider-Based Facility. (A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (Effective January 1, 2003).
- 07 Tribal 638 Free-Standing Facility. (A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. (Effective January 1, 2003).
- 08 Tribal 638 Provider-Based Facility. (A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (Effective January 1, 2003).

Ambetter requires that all other Non- Indian Health Services (I.H.S) or Tribal providers billing on UB and CMS 1500 forms be billed in a place of services as recognized by CMS, https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

MEMBER BENEFITS, MEMBER IDENTIFICATION CARD, ELIGIBILITY, AND COST SHARES

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

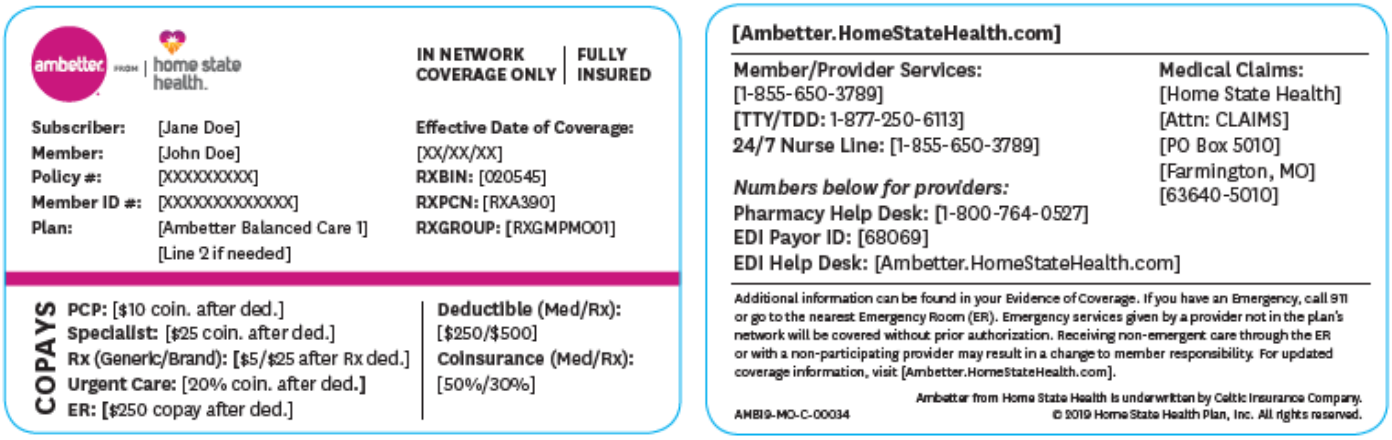
Member Benefits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). In addition to verifying member benefits, eligibility and cost share, there may be further steps needed to help Ambetter members maximize their benefit coverage before treatment is rendered. Ambetter.homestatehealth.com offers a Pre-Auth Check tool to determine if a pre-authorization is needed before services are rendered. This tool can be located at the ambetter.homestatehealth.com under the "For Providers" section of the site. This is in addition to other helpful tools and information Ambetter offers. Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Secure Provider Portal or calling Ambetter Member and Provider Services.

Member Identification Card

All members will receive an Ambetter member identification card.

Below is a sample member identification card. The ID card may vary due to the features of the health plan selected by the member.



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

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

Preferred Method to Verify Benefits, Eligibility, and Cost Shares

To verify member benefits, eligibility, and cost share information, the preferred method is the Ambetter Secure Provider Portal found at ambetter.homestatehealth.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.

When searching for eligibility on the Secure Provider Portal, you will see one of the following statuses:

Additional information regarding member premium grace period rules may be found further down in this manual.

Other Methods to Verify Benefits, Eligibility and Cost Shares

24/7 Toll Fee Interactive Voice Response (IVR) Line at 855-650-3789	The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
Provider Services at 1-855-650-3789	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.

Importance of Verifying Benefits, Eligibility, and Cost Shares

Benefit Design

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

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

Vision Benefits

NOTE: Not all benefit designs include vision.

Vision benefits (if applicable) are administered through Envolve Vision, a subsidiary of Centene Corporation. This includes services rendered by certain provider types including Optometrists, Opticians, Ophthalmologists, and Pediatric Ophthalmologists. Please contact Envolve Vision for benefit, authorization and claims submission requirements.

Benefits may vary. Envolve provides real-time claims administration. Providers can use Envolve's website at http://visionbenefits.envolvehealth.com to sign in for 24/7 access to verify eligibility, benefits, submit claims, check claim status, view policies and procedures, and print EOBs. For additional information, contact Envolve vision at 1-800-531-2818

Dental Benefits

NOTE: Not all benefit designs include dental.

Contact Envolve Dental at 1-855-434-9240 for member benefits, authorization and claims information.

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

A provision of the Affordable Care Act requires that Ambetter allow members receiving Advance Premium Tax Credit's (APTC) a three month grace period to pay premiums before coverage is terminated.

Members for whom Ambetter is not receiving an (APTC) will have a grace period of 30 days.

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

MEDICAL MANAGEMENT

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

Utilization Management

The Ambetter Utilization Management initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. The Utilization Management Program's goals are to provide covered services that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care. Ambetter does not reward providers, employees who perform utilization reviews, or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Prior authorization is the request to the Utilization Management Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. Failure to obtain authorization will result in denial of coverage.

Medically Necessary

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

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

Timeframes for Prior Authorization Requests and Notifications

The following timeframes are required of the ordering provider for prior authorization and notification:

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five (5) business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five (5) business days prior to the elective outpatient service date
Emergent inpatient admissions	Notification within one (1) business day of admission

Observation – <48> hours or less	Notification within one (1) business day for non-participating providers
Observation – greater than <48> hours	Requires inpatient prior authorization within one (1) business day
Maternity admissions	Notification within one (1) business day of admission
Newborn admissions	Notification within one (1) business day of admission
Neonatal Intensive Care Unit (NICU) admissions	Notification within one (1) business day of admission
Outpatient Dialysis	Notification within one (1) business day
Organ transplant initial evaluation	Prior Authorization required at least 30 calendar days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 calendar days prior to receiving clinical trial services.

Utilization Determination Timeframes

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

Type	Timeframe
Prospective/Urgent	Within 24 hours of receipt of request for services
Prospective/Non-Urgent	Within 36 hours, which shall include one working day of obtaining all necessary information, not to exceed 14 calendar days.
Concurrent/Urgent	Within one working day of obtaining all necessary information. Extension: up to 72 hours (3 calendar days) if all information is not received with request.
Concurrent/Non-Urgent	Within one working day of obtaining all necessary information. Extension: up to 72 hours (3 calendar days) if all information is not received with request.
Retrospective	Within 30 calendar days

Services Requiring Prior Authorization

To verify if a service requires prior authorization, please visit the Ambetter website at ambetter.homestatehealth.com and use the “Pre-Auth Needed?” tool under For Providers – Provider Resources, or call the Utilization Management Department with questions. Failure to obtain the required prior authorization or pre-certification will result in a denied claim. Note: All out of network services require prior authorization, excluding emergency room services.

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

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

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

Procedure for Requesting Prior Authorizations

Medical and Behavioral Health

Secure Portal

The preferred method for submitting authorizations is through the Secure Provider Portal at ambetter.homestatehealth.com .The provider must be a registered user on the Secure Provider Portal. If a provider is already registered for the Secure Provider Portal for one of our other products, that registration will grant the provider access to Ambetter. If the provider is not already a registered user on the Secure Provider Portal and needs assistance or training on submitting prior authorizations, the provider should contact their dedicated Provider Partnership Manager. Other methods of submitting the prior authorization requests are as follows:

Phone

- Call the Medical Management Department at 855-650-3789. Our 24/7 Nurse Advice line can assist with urgent prior authorizations after normal business hours.

FAX

- Fax prior authorization requests utilizing the Prior Authorization fax forms posted on the Ambetter website at ambetter.homestatehealth.com. Please note: faxes will not be monitored after hours and will be responded to on the next business day. Please contact our 24/7 Nurse Advice Line at 855-650-3789 for after hour urgent admissions, inpatient notifications, or requests.

Medical and Behavioral Health

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

- Member's name, date of birth and ID number;
- Provider's Tax ID, NPI number, taxonomy code, name, and telephone number;
- Facility name if the request is for an inpatient admission or outpatient facility services;
- Provider location if the request is for an ambulatory or office procedure;
- The procedure code(s); Note: If the procedure codes submitted at the time of authorization differ from the services actually performed, it is **required** within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 855-650-3789 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, targeted admission date, and information related to the newborn or neonate.

Advanced Imaging

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

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA/CCTA,
- MRI/MRA, and
- PET.

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization;
- It is the responsibility of the ***ordering*** physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

Cardiac Imaging

Ambetter utilizes NIA to assist with the management of cardiac imaging benefits, including cardiac imaging, assessment, and interventional procedures.

Habilitation and Rehabilitation Services

As part of a continued commitment to further improve habilitation and rehabilitation services, Ambetter is using National Imaging Associates (NIA) to provide prior authorization services and utilization management for outpatient physical, occupational and speech therapy services. NIA focuses on assisting providers in managing habilitation, and rehabilitation services in the most effective way possible.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by NIA's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through NIA. There is no need to send patient records in advance. NIA will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between Ambetter and NIA, Ambetter oversees the NIA Therapy Management program and continues to be responsible for claims adjudication. If NIA therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

Prior authorization is required for the following therapy procedures:

- Physical Therapy, Occupational Therapy, Speech Therapy

Key Provisions:

- It is the responsibility of the ***ordering*** physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

Physical Medicine Program

To help ensure that physical medicine services (physical, occupational and speech therapy) provided to our members are consistent with nationally recognized clinical guidelines, Ambetter has partnered with National Imaging Associates, Inc. (NIA) to implement a prior authorization program for physical medicine services. Effective January 1, 2021, NIA provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Ambetter members.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by NIA's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through NIA. There is no need to send patient records in advance. NIA will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between Ambetter and NIA, Ambetter oversees the NIA Therapy Management program and continues to be responsible for claims adjudication. If NIA therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

Should you have questions, please contact Ambetter Provider Services at 1-855-650-3789.

National Imaging Associates Authorizations

Prior authorization request may be obtained via our Ambetter Provider portal online at ambetter.homestatehealth.com. NIA also provides an interactive website (www.RadMD.com) which may be used to obtain on-line authorizations. For urgent authorization requests please call 800-308-2615 and follow the prompt for radiology authorizations.

Pharmacy

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

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

- Which drugs are covered, including restrictions, prior authorization requirements, and limitations;
- The pharmacy management program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can make an exception request; and;
- How Ambetter conducts generic substitution, therapeutic interchange, and step-therapy.
- The Ambetter formulary does not:
    - Require or prohibit the prescribing or dispensing of any medication;
    - Substitute for the professional judgment of the physician or pharmacist; or
    - Relieve the physician or pharmacist of any obligation to the member.

The Ambetter formulary will be approved initially by the Ambetter Pharmacy and Therapeutics Committee (P&T), led by the Pharmacist and Medical Director, with support from community-based primary care providers and specialists. Once established, the Formulary will be maintained by the P & T Committee, through quarterly meetings, to ensure Ambetter members receive the most appropriate medications. The Ambetter formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the Formulary Change Request policy can be used as a method to address the request. The Ambetter P & T Committee reviews the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the formulary are available on our website, ambetter.homestatehealth.com Providers may also call Provider Services for hard copies of the formulary.

Envolve Pharmacy Solutions is simplifying the prescriber process with a streamlined prior authorization process that can be accessed online through CoverMyMeds. CoverMyMeds automates drug prior authorizations for any medication and allows prescribers to begin the process electronically. This site can be accessed at pharmacy.envolvehealth.com/pharmacists under the "CoverMyMeds" link.

Second Opinion

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

Preventive Health Care

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

- Medically necessary maternity care;
- Preventive care (well care) and general examinations;
- Gynecological care; -or
- Follow-up visits for the above services.

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

Retrospective Review

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

Emergency Care

Emergency care means medical services provided after the sudden or unexpected onset of a medical condition manifesting itself by acute symptoms, including injury caused by an accident, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's life or health would be placed in serious jeopardy;
- Vital bodily functions would be seriously impaired; and
- There would be serious and permanent dysfunction of a bodily organ or part.

Utilization Review Criteria

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

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

Medical Services	InterQual® Adult, Clinical Policies and Pediatric Guidelines and internally developed criteria by Ambetter health care professionals and related specialists.
Behavioral Health Services	InterQual® Behavioral Health Criteria (Adult and Geriatric or Child and Adolescent Psychiatry) and internally developed criteria by Ambetter behavioral health care professionals and related specialists.
High Tech Imaging	Internally developed criteria by National Imaging Associates (NIA). Criteria developed by representatives in the disciplines of radiology,

	internal medicine, nursing and cardiology. The criteria are available at www.RadMD.com.
Substance Use Disorder Services	American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org.

Ambetter's Medical Director, or other health care professionals who have appropriate clinical expertise in treating the member's condition or disease, review all potential adverse determinations and will make a decision in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from InterQual® or other criteria as mentioned above. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 855-650-3789. Providers have the opportunity to discuss any adverse decisions with an Ambetter physician or other appropriate reviewer at the time of the notification to the requesting provider of an adverse determination. The Medical Director may be contacted by calling Ambetter at 855-650-3789 and asking for the Medical Director. An Ambetter Care Manager may also coordinate communication between the Medical Director and the requesting provider

Participants or healthcare professionals, with the Participant's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Ambetter
Attn: Appeals Department
11720 Borman Drive
Saint Louis, MO 63146

Care Management and Concurrent Review

Care Management

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 is member-centered, goal-oriented, culturally relevant, and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner.

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

Ambetter will provide individual Care Management services for members who have high-risk, high-cost, complex, or catastrophic conditions. The Ambetter Care Manager will work with all involved providers to coordinate care and provide referral assistance and other care coordination as required. The Ambetter Care

Manager may also assist with a member's transition to other care, as indicated, when Ambetter benefits end.

Start Smart for Your Baby® (Start Smart) is a Care Management program available to members who are pregnant or who have just had a baby. Start Smart is a comprehensive program that covers all phases of the pregnancy, postpartum, and newborn periods including perinatal and postnatal depression. The program includes mailed educational materials for newly identified pregnant members and new mothers after delivery. The initial mailing also includes an Edinburgh Depression Screening which is scored and members identified as needing assistance with depression are contacted for care management services.

Telephonic Care Management by registered nurses, licensed mental health professionals and social services specialists as well as Marketplace Coordinators is available. Ambetter's Care Managers work with the member to create a customizable plan of care in order to promote healthcare as well as adherence to Care Management plans. Care Managers will coordinate with physicians, as needed, in order to develop and maintain a plan of care to meet the needs of all involved.

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

Concurrent Review

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

Health Management

Health management is the concept of reducing health care costs and improving quality of life for individuals with a chronic condition through ongoing integrated care. Health management supports the physician or practitioner/patient relationship and plan of care; it emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Envolve PeopleCare

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

- Adult and pediatric asthma
- Coronary artery disease (CAD)
- Adult and pediatric diabetes
- High blood pressure and high cholesterol management

- Low back pain
- Tobacco cessation

To refer a member for Care or Health Management, call 855-650-3789.

Ambetter's Member Wellbeing Survey

Ambetter members are requested to complete a Wellbeing Survey upon enrollment with us. Ambetter utilizes the information to better understand the member's health care needs in order to provide customized, educational information and services specific to their needs. Ambetter members can login to their secure online account at ambetter.homestatehealth.com to complete their Wellbeing survey or they can call our Member Services at 1-855-650-3789

Ambetter's My Health Pays Member Rewards Program

Our My Health Pays™ rewards program gives members the opportunity to earn reward dollars for taking charge of their health. This program provides incentives when they take advantage of their preventive care benefits by helping them earn reward dollars.

When members take an active role in their healthcare, you can help them experience healthier outcomes.

Members earn My Health Pays™ rewards by completing healthy behaviors. These include:

- Completing their Member Wellbeing Survey, which verifies demographic information and health information;
- Getting their annual wellness exam;
- Receiving their flu vaccine in the fall;
- Plus much more! Visit our website for more information ambetter.homestatehealth.com;
- These rewards are automatically added to a Visa® Prepaid Card or My Health Pays™ rewards card. Members can redeem their rewards to help offset costs such as:
    - Doctor copays***[1]

[1] ***My Health Pays™ rewards cannot be used for pharmacy copays.

CLAIMS

The appropriate Center for Medicare and Medicaid Services (CMS) billing form is required for paper and electronic data interchange (EDI) claim submissions. The appropriate CMS billing forms are CMS 1450 for facilities and CMS 1500 for professionals. In general, Ambetter follows the CMS billing requirements for paper, EDI, and secure web-submitted claims. Ambetter is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials. Reimbursement Policy can be viewed on our website and in the Appendix of this Manual.

Verification Procedures

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

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or the claim is submitted on our Secure Provider Portal, individually or in a batch.
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.
- Member ID and date of birth combination must exactly match a participating Ambetter member.
- Claims must contain the CLIA number when CLIA is waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA is waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- Taxonomy codes are required. Please see further details in this Manual for taxonomy requirements.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission codes are valid for:
    - Date of Service
    - Provider Type and/or provider specialty billing
    - Age and/or sex for the date of service billed
    - Bill type
- All Diagnosis Codes are to their highest number of digits available.
- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
    - F2 – International Unit
    - GR – Gram
    - ME – Milligram
    - ML – Milliliter
    - UN – Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.

- For a CMS 1500 Claim Form, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
- All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
- N – No
- U – Unknown
- W – Not Applicable
- Y – Yes

- Member is eligible for services under Ambetter during the time period in which services were provided.
- Services are provided by a participating provider, or if provided by an "out of network" provider, authorization is 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 is given for services that require prior authorization by Ambetter.
- Third party coverage is clearly identified and appropriate COB information is 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 are followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

Clean Claim Definition

A clean claim means a claim for payment of health care expenses that is submitted on a CMS 1500 or a CMS 1450 (UB04) claim form, in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with all required fields completed in accordance with Ambetter's published claim filing requirements.

Non-Clean Claim Definition

A clean claim shall not include a claim:

- that contains invalid or missing data elements, a claim that has been suspended in order to get more information from the provider, or a claim that requires manual intervention/processing
- For which Ambetter requires additional information in order to resolve the claim.

Upfront Rejections vs. Denials

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the

Companion Guide located in Appendix IX of this manual. A list of common upfront rejections is located in Appendix I of this manual. Upfront rejections do not enter our claims adjudication system, so there is no Explanation of Payment (EOP) for these claims. The provider receives a letter or a rejection report if the claim is submitted electronically. If a claim is rejected, the identified issue must be corrected and the claim resubmitted as an original claim.

Denial

If all edits pass and the claim is accepted, it is entered into the system for processing**.** A **denial** is defined as a claim that passes edits and is entered into the system, but is billed with invalid or inappropriate information causing the claim to deny. In this case, an EOP is sent that includes the denial reason. A list of common delays and denials is found with explanations in Appendix II.

Timely Filing

Initial Claims		Reconsiderations or Claim Dispute/Appeals		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Par	Non-Par	Par	Non-Par	Par	Non-Par
180 days	365 days	180 days	365 days	180 days From the primary payers EOP date to the date received.	365 days From the primary payers EOP date to the date received.

- **Initial Claims** - Days are calculated from the Date of Service (DOS) to the date received by Ambetter or from the EOP date. For observation and inpatient stays, the date is calculated from the date of discharge.
- **Claims Dispute/Appeals** - Days are calculated from the date of the Explanation of Payment issued by Ambetter to the date received.
- **Coordination of Benefits** - Days are calculated from the date of Explanation of Payment from the primary payers to the date received.

Refunds and Overpayments

Ambetter routinely audits all claims for payment errors. Claims identified to have been underpaid or overpaid will be reprocessed appropriately. Providers are responsible for reporting overpayments or improper payments to Ambetter. Providers have the option of requesting future offsets to payments or may mail refunds and overpayments, along with supporting documentation (copy of the remittance advice along with affected claims identified), to the following address:

Ambetter from Home State Health
11720 Borman Dr.
Saint Louis, MO 63146

Or for behavioral health:

Ambetter from Home State Health
Attn: Claims Recovery Team
P.O. Box 952790
Saint Louis, MO 63195-2790

Who Can File Claims?

All providers who have rendered services for Ambetter members can file claims. It is important that providers ensure Ambetter has accurate and complete information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Representative that the following information is current in our files:

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

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

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

Electronic Claims Submission

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

Ambetter c/o Centene EDI Department
1-800-225-2573, extension 6075525
Or by e-mail at EDIBA@centene.com

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

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

The Ambetter Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at ambetter.homestatehealth.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 have additional data record requirements.

Electronic Claim Flow Description & Important General Information

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

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Ambetter. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Ambetter, and the clearinghouse returns an acceptance report to the sender immediately.

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

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

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

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

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

Invalid Electronic Claim Record Upfront Rejections/Denials

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

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

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

Specific Ambetter Electronic Edit Requirements – 5010 Information

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

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

Corrected EDI Claims

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

Exclusions

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

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

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Submitting Claims Through A Clearinghouse: Ambetter Payer ID number for all clearinghouses (Medical and Behavioral Health) is **68069.**	We use Availity as our primary clearinghouse, which provides us with an extensive network of connectivity. You are free to use whatever clearinghouse you currently do as Availity maintains active connections with a large number of clearinghouses.

Action	Contact
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at EDIBA@Centene.com.
Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com.
Remittance Advice Questions:	Contact Ambetter Provider Services or the Secure Provider Portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Ambetter Provider Service in writing include an updated W9.

Important Steps to a Successful Submission of EDI Claims:

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

Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Ambetter has made it easy and convenient to submit claims directly using the Secure Provider Portal at ambetter.homestatehealth.com.

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

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

Paper Claim Submission

The mailing address for first time claims (Medical and Behavioral Health) corrected claims and requests for reconsideration:

Ambetter

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

The mailing address for claim disputes/appeals (Medical and Behavioral Health):

Ambetter
Attn: Claim Dispute
P.O. Box 5010
Farmington, MO 63640-5010

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

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected. If a paper claim has been rejected, the provider should correct the error and resubmit the paper claim as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

Acceptable Forms

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

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

Important Steps to Successful Submission of Paper Claims

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for physicians or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard and handwritten claim forms will be rejected back to the provider.
3. Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (e.g. 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.

5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service. Refer to Ambetter Taxonomy (PDF) located on our website ambetter.homestatehealth.com.
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
7. Ensure all Diagnosis Codes are coded to their highest number of digits available.
8. Ensure member is eligible for services during the time period in which services were provided.
9. Ensure provider receives authorization to provide services to the eligible member, when appropriate.
10. Ensure an authorization is given for services that require prior authorization by Ambetter.
11. Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.
12. Ensure all paper claim forms are typed or printed with either 10- or 12-point Times New Roman font. Do not use highlights, italics, bold text, ink stamps, or staples for multiple page submissions.
13. Ensure print is properly aligned on the form. Ambetter utilizes OCR software to convert paper forms to EDI transactions and misaligned information may not process correctly and result in a rejected claim.

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.

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

Ambetter partners with specific vendors to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment. Providers are able to enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA, or contact Provider Services.

Benefits include:

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

For more information, please visit our provider home page on our website at ambetter.homestatehealth.com. If further assistance is needed, please contact our Provider Services Department at 1-855-650-3789.

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 the original explanation of payment or denial. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 180 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1. A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays, or errors by Ambetter or the Federal and/or State regulatory body.
2. The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide their ID Card or information;
    - The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered; and
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

Relevant Claim Definitions

- **Corrected claim** – A provider is *changing* the original claim.
- **Request for reconsideration** – A provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
- **Claim dispute/appeal** – A provider disagrees with the outcome of the request for reconsideration.

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

1. Submit a corrected claim via the Secure Provider Portal. Follow the instructions on the portal for submitting a correction.
2. Submit a corrected claim electronically via a clearinghouse.
    - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = **Original Claim Number**
    - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = **Original Claim Number**
3. Submit a corrected paper claim to:

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

- Upon submission of a corrected paper claim, the original claim number must be **typed** in field 22 (CMS 1500) and in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (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. Providers may elect to call to Provider Services. This method is for requests for reconsideration that do not require submission of supporting or additional information. An example of this is when a provider believes a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that particular rate.
2. Providers may use the Request for Reconsideration form found on our website (preferred method).
3. Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a CMS 1450 (UB-04 form). The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.
4. It is not necessary to attach a copy of the submitted claim.

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

Ambetter
Attn: Request for Reconsideration
P.O. Box 5010
Farmington, MO 63640-5010

When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP.

Claim Dispute

A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute from is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.

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

Ambetter
Attn: Claim Dispute
P.O. Box 5010
Farmington, MO 63640-5010

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

Risk Adjustment and Correct Coding

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

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

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

Coding of Claims/ Billing Codes

Ambetter requires claims to be submitted using codes from the current version of ICD-10-CM, 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 is inappropriate for the age of the member.
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary.
- Code billed is inappropriate for the location or specialty billed.

- Code billed is a part of a more comprehensive code billed on same date of service.
- Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Ambetter.
- Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. Submit separate claims for the mother and newborn(s).

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

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

For more information regarding billing codes, coding, and code auditing/editing, please contact Ambetter Provider Services or visit ambetter.homestatehealth.com. The clinical and payment policies are located under the "Provider Resources" link.

Clinical Lab Improvement Act (CLIA) Billing Instructions

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

Paper Claims

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

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

EDI

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

-Or-

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

*Note

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

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

Web

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

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

Taxonomy Code Billing Requirement

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

The verbiage associated with Reject 91 is as follows: Invalid or Missing Taxonomy Code. Please contact Provider Services to resolve this issue.

Below are three scenarios involving the Taxonomy Code Billing Requirement.

Scenario One: Rendering NPI is <u>different</u> than the Billing NPI

CMS 1500 Form

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

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

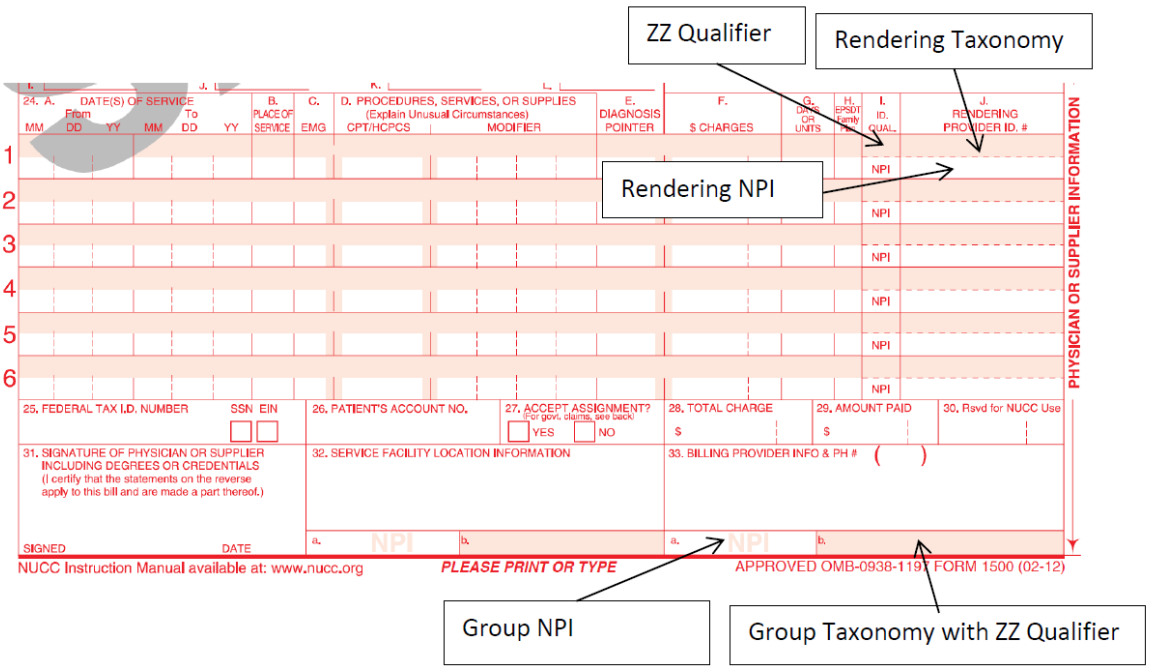
Scenario Two: Rendering NPI and Billing NPI are the same

CMS 1500 Form

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

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") Billing Provider Group FTIN(EI)/SSN(SY) e.g. **REF*EI*999999999**	Box 33b	2000A	PRV03
		2010AA	REF01 REF02

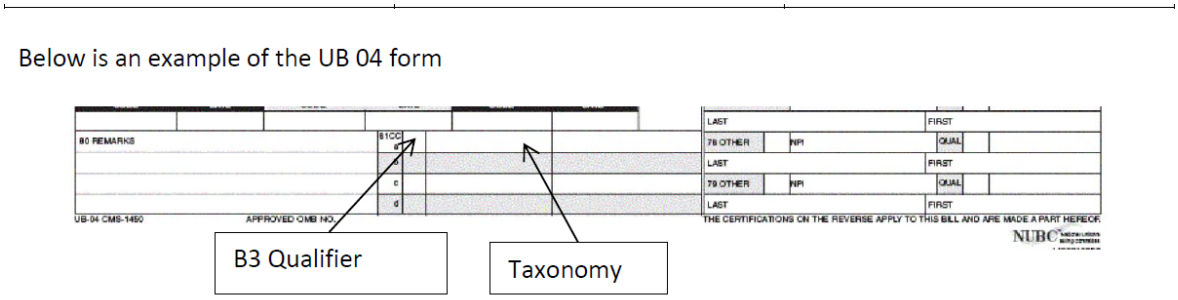
Below is an example of the fields relevant to Scenario One and Scenario Two above.



Scenario Three: Taxonomy Requirement for UB 04 Forms

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

Below is an example of the UB 04 form:



Claim Reconsiderations Related To Code Editing and Editing

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

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

CODE EDITING

Ambetter uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier and place of service codes against correct coding guidelines. While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, Ambetter uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. Ambetter may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

Ambetter may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

CPT and HCPCS Coding

The Healthcare Common Procedure Coding System (HCPCS) is a set of health care procedure codes based on the American Medical Association's (AMA) Current Procedural Terminology (CPT). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding.

1. ***Level I HCPCS Codes (CPT):*** This code set is maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are updated (added, revised, and deleted) on an annual basis.

2. ***Level II HCPCS Codes*:** The Level II set of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics, etc.). The Level II set is an alphanumeric coding system which is maintained by CMS. These codes are updated on an annual basis.

3. ***Miscellaneous/Unlisted Codes:*** These codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous or unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If records are not received, the provider will receive a denial indicating that medical records are required. The medical documentation should clearly define the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) to accurately describe the service or procedure rendered. Clinical validation also includes identifying and reviewing other procedures and services billed on the claim that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. ***Temporary National Codes*:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are

considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.

5. ***Modifiers:*** Modifiers are used to indicate additional information about the HCPCS or CPT code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

ICD-10 is an alphanumeric system used by providers to classify diagnoses and symptoms. These codes consist of three to seven digits, which allows for a high level of specificity in coding a wide range of health problems.

Revenue Codes

These 4-digit numeric codes are utilized by institutional providers to represent services, procedures, and/or supplies provided in a hospital or facility setting. Claims submitted with revenue codes should indicate a corresponding procedure code.

Edit Sources

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

- The following sources are utilized in determining correct coding guidelines for the software: Centers for Medicare & Medicaid Services (including National Correct Coding Initiative (NCCI) Policy Manual and Claims Processing Manual guidelines as well as current PTP and MUE tables)

- American Medical Association (CPT, HCPCS, and ICD-10 guidelines and publications including CPT manual, AMA website, CPT Assistant, CPT Insider's View, etc.)

- Public domain specialty provider associations (such as American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons, American College of Obstetricians and Gynecologists, etc.).

- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals)

- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, MLN Matters and Provider Transmittals

- Health Plan policies and provider contract considerations

- In addition to nationally-recognized coding guidelines, the software has flexibility to allow business rules that are unique to the needs of individual product lines

Code Editing and the Claims Adjudication Cycle

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

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

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

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

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

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

Code Editing Principles

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

Unbundling Edits

PTP Practitioner and Hospital Edits

CMS has designated certain combinations of codes that are generally not separately reimbursable on the same date of service. These are known as Procedure-to-Procedure (PTP) and/or Column 1/Column II edits. Within the PTP edit category, there are Practitioner edits (applicable to claims submitted by physicians, non-physician practitioners, and ambulatory surgical centers) and Hospital edits (applicable to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, speech-language pathology, and comprehensive outpatient rehabilitation facilities).

The procedure code listed in column I is the most comprehensive code; reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component to the successful outcome of the column I code.

While these code pairs should not be billed together under most circumstances, there are circumstances when an NCCI-associated modifier may be appended to the column II code to indicate a significant and separately identifiable or distinct service. When these modifiers are used, prepay clinical validation will be performed to ensure that services are reported appropriately. For more information on the PTP edits, please visit www.cms.gov.

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

An MUE is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, nature of the service/procedure, nature of the analyte, equipment prescribing information and clinical judgment. Not all HCPCS/CPT codes have an MUE limit.

Code Bundling Rules Not Sourced To CMS

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

Procedure Code Unbundling

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

Mutually Exclusive Editing

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

Incidental Procedures

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

Global Surgical Period Editing/Medical Visit Editing

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

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

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

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

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

Global Maternity Editing

Procedures with "MMM"

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

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

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

Multiple Code Rebundling

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

Frequency and Lifetime Edits

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

Duplicate Edits

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

National Coverage Determination Edits

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

Anesthesia Edits

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

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

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

Co-Surgeon/Team Surgeon Edits

Evaluates claims billed with a co-surgeon or team surgeon that normally do not require a co-surgeon/team surgeon. CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

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

Bilateral Edits

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

Replacement Edits

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

Missing Modifier Edits

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

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of postoperative follow up. Admissions to non-acute care facilities (such as skilled nursing facilities)

are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Administrative and Consistency Rules

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

- ***Procedure code invalid rules:*** Evaluates claims for invalid procedure and revenue or diagnosis codes
- ***Deleted Codes:*** Evaluates claims for procedure codes which have been deleted
- ***Modifier to procedure code validation:*** Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers such as -24, -25, -26, -57, -58 and -59.
- ***Age Rules:*** Identifies procedures inconsistent with member's age
- ***Gender Procedure:*** Identifies procedures inconsistent with member's gender
- ***Gender Diagnosis***: Identifies diagnosis codes inconsistent with member's gender
- ***Incomplete/invalid diagnosis codes:*** Identifies incomplete or invalid diagnosis codes

Prepayment Clinical Validation

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

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

Modifier -59

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

injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

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

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

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated;

- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.

- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

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

Modifier -25

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

The NCCI policy manual states that “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

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

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

Claim Reconsiderations Related To Code Editing

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

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

The reconsideration may include this type of information:

- Statement of why the service is medically necessary
- Medical evidence which supports the proposed treatment
- How the proposed treatment will prevent illness or disability
- How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness
- How the proposed treatment will assist the patient to maintain functional capacity
- A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary
- How the recommended service has been successful in other patients

Viewing Claims Coding Edits

Code Auditing Tool

A web-based code editing reference tool designed to “mirror” how code editing products evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on the Secure Provider Portal. You can access the tool in the Claims Module by clicking “Claim Editing Tool” in the 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 to ensure accurate billing

The tool reviews the codes entered to determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

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

The code editing assistant can be accessed from the Secure Provider Portal.

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

Automated Clinical Payment Policy Edits

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system. Once adopted by the health plan, these policies are posted on the health plan’s Secure Provider Portal.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.xxx in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.xxx in the reference number of the policy.

The majority of clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (EX) code is applied to the service line billed with the disallowed procedure. This EX code can be viewed on the provider’s explanation of payment.

- xE: Procedure Code is Disallowed with this Diagnosis Code(s) Per Plan Policy.

Clinical Payment Policy Appeals

Clinical payment policy denials may be appealed on the basis of medical necessity. Providers who disagree with a claim denial based on a clinical payment policy, and who believe that the service rendered was medically necessary and clinically appropriate, may submit a written reconsideration request for the claim denial using the provider claim reconsideration/appeal/dispute or other appropriate process as defined in the health plan's provider manual. The appeal should include this type of information:

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.
4. How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.
6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
7. How the recommended service has been successful in other patients.

THIRD PARTY LIABILITY

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

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

BILLING THE MEMBER

Covered Services

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

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

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

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

Non-Covered Services

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

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

Billing for "No-Shows"

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

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

For purposes of this discussion, please note the following:

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

Failure to Obtain Authorization

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

No Balance Billing

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

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

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

1. To participate with providers in making decisions about their health care. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options.
2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.
3. To receive the benefits for which the member has coverage.
4. To be treated with respect and dignity.
5. To privacy of their personal health information, consistent with state and federal laws, and Ambetter policies.
6. To receive information or make recommendations, including changes, about Ambetter's organization and services, the Ambetter network of providers, and member rights and responsibilities.
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care provider about what might be wrong (to the level known), treatment, and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life and health are in serious danger.
8. To make recommendations regarding the Ambetter member's rights, responsibilities and policies.
9. To voice complaints or appeals about: Ambetter, any benefit or coverage decisions Ambetter makes, Ambetter coverage, or the care provided.
10. To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and to be informed by the provider(s) of the medical consequences.
11. To see their medical records.
12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Ambetter rules and guidelines. Ambetter will notify members at least 60 days before the effective date of the modifications. Such notices shall include the following:
    - Any changes in clinical review criteria,
    - A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.
13. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, gender identity and sex stereotyping.
16. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.

17. To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability.
18. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care provider or other provider. The primary care provider or other provider must discuss different treatment plans with the member. The member must make the final decision.
19. To select a primary care provider within the network. The member has the right to change their primary care provider or request information on network providers close to their home or work.
20. To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care provider.
21. To have access to an interpreter when the member does not speak or understand the language of the area.
22. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.
23. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:
    - Living Will
    - Health Care Power of Attorney
    - "Do Not Resuscitate" Orders

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

Member Responsibilities

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

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

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients who are Ambetter members and other healthcare workers with dignity and respect.

2. To receive accurate and complete information and medical histories for members' care.

3. To have their patients, who are Ambetter members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.

4. To expect other network providers to act as partners in members' treatment plans.

5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.

6. To make a complaint or file an appeal against Ambetter and/or a member.

7. To file a grievance on behalf of a member, with the member's consent.

8. To have access to information about Ambetter quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.

9. To contact Provider Services with any questions, comments, or problems.

10. To collaborate with other health care professionals who are involved in the care of members.

11. To not be excluded, penalized, or terminated from participating with Ambetter for having developed or accumulated a substantial number of patients in Ambetter with high cost medical conditions.

12. To collect member copays, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments,
    - Provide information regarding the nature of treatment options,
    - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered,
    - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
2. To treat members with fairness, dignity, and respect.
3. To not discriminate against members on the basis of race, color, gender, 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 their medical record.
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
15. To follow all state and federal laws and regulations related to patient care and rights.
16. To participate in Ambetter data collection initiatives, such as HEDIS and other contractual or regulatory programs, and allow use of provider performance data.
17. To review clinical practice guidelines distributed by Ambetter.
18. To comply with the Ambetter Medical Management program as outlined herein.
19. To disclose overpayments or improper payments to Ambetter.
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
21. To obtain and report to Ambetter information regarding other insurance coverage the member has or may have.
22. To give Ambetter timely, written notice if provider is leaving/closing a practice.
23. To contact Ambetter to verify member eligibility and benefits, if appropriate.
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.

25. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
26. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds.
27. To provide hours of operation to Ambetter members which are no less than those offered to other commercial members.

CULTURAL COMPETENCY

Ambetter views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Ambetter is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

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

- Facilitate member access to Cultural and Linguistic Services, including Informing members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services
    - To support informing members of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance the top 15 languages utilized in Arizona as identified by the ACA 1557, and include at least one tagline in 18 point font.
- Provide medical care with consideration of the members' primary language, race ethnicity and culture
- Participate in cultural competency training annually and ensure that office staff routinely interacting with members have also been given the opportunity to participate in, and have participated in, cultural competency training
- Ensure that 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, gender identity, sexual orientation, and other characteristics that may influence the member's perspective on health care

- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

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

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

For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: https://cccm.thinkculturalhealth.hhs.gov/
- Think Cultural Health's website includes classes, guides and tools to assist you in providing culturally competent care. The website is: http://www.thinkculturalhealth.hhs.gov/
- The Health Care Literacy website which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at http://www.ahrg.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-tookit/index.html

Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition against national Origin Discriminations, the President's Executive Order 131166, section 1557 of the Patient Protection and Affordable care Act, The Health Plan and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to Ambetter members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if cultural and linguistic needs are not met.

Language services include

- Telephonic interpretation
- Oral translation (reading of English material in a members preferred language)
- Face to Face non-English interpretation
- American Sign language
- Auxiliary aids including alternate formats such as large print and braille
- Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for a member, contact Ambetter provider services. For Face to Face and American Sign Language requests, contact Ambetter provider services as soon as possible, or at least 5 business days before the appointment. All providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center at: 1-866-796-0542 or TTY 711.

Restrictions Related to Interpretation or Facilitation of Communication

- Providers may not request or require an individual with limited English proficiency to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- Providers may not use an accompanying adult or minor child to interpreter or facilitate communication
- Exceptions to these expectations include:
    - In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
    - Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.
- Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

Provider Accessibility Initiative

Ambetter from Home State Health is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Ambetter from Home State Health through an onsite Accessibility Site Review (ASR).

- Ambetter from Home State Health's expectation, as communicated through the provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Ambetter from Home State Health providers.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity.
- Denial of the benefits of services, programs or activities of a public entity.
- Discrimination by any such entity. Ambetter from Home State Health providers must provide physical access, accommodations, and accessible equipment for members with physical or mental disabilities as required by 42 CFR Section 438.206(c)(3).

Providers are required to comply with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). Ambetter from Home State Health must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the provider is architecturally and programmatically accessible to persons with disabilities. "Physical access," also referred to as "architectural access," refers to a person with a disability's ability to access buildings, structures, and the environment. "Programmatic access" refers to a person with a disability's ability to access goods, services, activities and equipment.

If any disability access barriers are identified, the provider agrees, in writing, to remove the barrier to make the office, facility, or services accessible to persons with disabilities within one hundred eighty (180) days after the barrier has been identified.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats, including but not limited to: an in-person interpreter upon a member's request; telephone, relay, or video remote interpreting 24 hours a day seven days a week; or through other formats, such as real-time captioning or augmentative & alternative communication devices, that ensure effective communication.
- Provide Member-Informing Materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages, and provided through a variety of other means. This may include but not be limited to: oral interpretation for other languages upon request; accessible formats (e.g. documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; and easy-to-understand materials provided in a manner that takes into account different levels of health literacy.
- Provide services, programs, or activities that are readily accessible to and useable by members with disabilities. This includes but is not limited to accessible: medical care facilities, diagnostic equipment, and examination tables & scales; and modification of policies, practices, and procedures (e.g. modify policies to permit the use of service animals or to minimize distractions and stimuli for members with mental health or developmental disabilities).
- Inform members of the availability of these cultural, linguistic, and disability access services at no cost to members on brochures, newsletters, outreach and marketing materials, other materials that are routinely disseminated to members, and at member orientation sessions and sites where members receive covered services.
- Ambetter from Home State Health and participating providers shall also facilitate access to these services, and document a request and/or refusal of services in the health plan and the provider's member data system.

Important Points to Remember: Word Choice

- Avoid words with negative connotations like “handicapped”, “afflicted”, “crippled”, “victim”, “sufferer”, etc.
- Do not refer to individuals by their disability. A person is not a condition.
- Emphasize “person first” terminology:
    - Handicapped = A PERSON with a disability
    - Deaf = A PERSON who is deaf
    - Mute = A PERSON without speech
    - Confined/Wheelchair-Bound = A PERSON who uses a wheelchair
- If you happen to not have a disability at this time in your life, that DOES NOT make you “normal” or “able-bodied”. It makes you “non-disabled”.

Call your Provider Relations Representative at 1-855-650-3789 for more information.

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

Disability is any substantial limitation of one or more of a person’s daily life activities and may be present from birth or may occur during a person’s lifetime. Any individual meeting any of these conditions is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of members with disabilities to receive the same quality of care as other persons.

Common Methods to Ensure Equal Communication and Access to Information:

1. Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded other members
    a. Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location
2. Provision for a presence of sign language interpreters to enable full communication with deaf or hard of hearing members who use sign language
3. Provision for making auditory information (E.G. automated messages) available via alternative means
    a. Written communication or secure web-based methods may be used as possible substitutes
4. Provision for communicating with deaf or hard of hearing members by telephone
    a. Use of telephone relay services (TRS), video relay services (VRS), a TDD, or use of secure electronic means

Policies for Scheduling and Waiting:

1. Policies that allow scheduling additional time for the duration of appointments for members with disabilities who may require it

    a. Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
2. Policies to enable members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival
    a. Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious
3. Policies to allow flexibility in appointment times for members who use paratransit
    a. Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability
4. Policies to enable compliance with federal law that guarantees access to provider offices for people with disabilities who use service animals
    a. Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Conducting the Examination

1. Training of healthcare providers in operation of accessible equipment
    a. Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral

1. Current or potential members including people with disabilities should only be referred to another provider for established medical reasons or specialized expertise.
    a. Referral results in a delay of treatment and subjects members to additional time, expense, and reduces member choice of providers.
2. Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which members are referred.
    a. Members may be unable to comply with medical referrals if referred location is not accessible and/or not prepared to provide the recommended service

COMPLAINT PROCESS

Complaint/Grievance

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

Provider Complaint/Grievance and Appeal Process

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

Ambetter
Attn: Claim Disputes
P.O. Box 5010
Farmington, MO 63640-5010

Member Appeals

Pre-service Member Appeals must follow the Appeal process below. A member must designate in writing to Ambetter for a provider to act on behalf of the member regarding the appeal process.

An Appeal is the mechanism which allows providers the right to appeal actions of Ambetter such as a prior authorization denial, or if the member is aggrieved by any rule, policy, procedure, or decision made by Ambetter. A member has 180 calendar days from Ambetter's notice of action to file the appeal. Ambetter shall acknowledge receipt of each appeal within 10 business days after receiving an appeal. Ambetter shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Ambetter receives the appeal. Ambetter may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Ambetter demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Ambetter shall provide written notice to the member for the delay.

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

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

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

Member Complaint/Grievance and Appeal Process

To ensure Ambetter member's rights are protected, all Ambetter members are entitled to a Complaint/Grievance and Appeals process. The procedures for filing a Complaint/Grievance or Appeal are outlined in the Ambetter member's Evidence of Coverage. Additionally, information regarding the Complaint/Grievance and Appeal process can be found on our website at ambetter.homestatehealth.com or by calling Ambetter at 855-650-3789.

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

1. The member should contact our Member Services department at 1-855-650-3789. The Member Services representative will assist the member.
2. If the member continues to be dissatisfied, they may file a formal complaint/grievance. Again, our Member Services department is available to assist with this process. Information regarding this process can be found at ambetter.homestatehealth.com.
3. Depending on the nature of the complaint/grievance, the member will be offered the right to appeal our decision. At the conclusion of this formalized process, the member will receive written confirmation of the determination. Ambetter will complete the appeal process in the timeframes as specified in rules and regulation.
4. The member has the right to appeal to an external independent review organization.
5. A member may designate in writing to Ambetter that a provider is acting on behalf of the member regarding the complaint/grievance and appeal process.

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

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

Mailing Address

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

Ambetter
11720 Borman Dr.
Saint Louis, MO 63146

QUALITY IMPROVEMENT PLAN

Overview

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

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

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

QAPI Program Structure

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

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

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

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of

opportunities to improve member outcomes; and the education of members, providers, and staff regarding the QI, UM, and Credentialing and recredentialing programs.

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

- Credentialing Committee
- Grievance and Appeals Committee
- Population Health and Clinical Committee
- Performance Improvement Team
- Quality Outcomes Workgroup
- Pharmacy and Therapeutics Committee
- Delegate Vendor Operations Committee
- Subcommittees may also include the Member Advisory Committee, Physician Advisory Committee, Hospital Advisory Committee, and the Community Advisory Committee, based on plan needs and state requirements.

Practitioner Involvement

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

Quality Assessment and Performance Improvement Program Scope and Goals

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

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

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service

- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member experience
- Patient safety
- Primary care provider changes
- Pharmacy
- Provider and plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including under and over utilization

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

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

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

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

- To establish and maintain a health system that promotes continuous quality improvement
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice

- To select areas of study based on demonstration of need and relevance to the population served
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time
- To utilize Management Information Systems (MIS) in data collection, integration, tracking, analysis and reporting of data that reflects performance on standardized measures of health outcomes
- To allocate personnel and resources necessary to:
  - support the quality improvement program, including data analysis and reporting
  - meet the educational needs of members, providers, and staff relevant to quality improvement efforts
- To seek input and work with members, providers, and community resources to improve quality of care
- To oversee peer review procedures that will address deviations in medical management and health care practices, and devise action plans to improve services
- To establish a system to provide frequent, periodic quality improvement information to participating providers in order to support them in their efforts to provide high quality health care
- To recommend and institute “focused” quality studies in clinical and non-clinical areas, where appropriate
- To conduct and report annual CAHPS surveys and certified HEDIS results for Ambetter members
- To achieve and maintain NCQA accreditation
- To monitor for compliance with regulatory and NCQA requirements

Practice Guidelines

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

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

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

Patient Safety and Quality of Care

Patient safety is a key focus of the Ambetter QAPI Program. Monitoring and promoting patient safety is integrated throughout activities across the plan but primarily through identification of potential and/or actual

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

Performance Improvement Process

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

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

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

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

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

Quality Rating System

Healthcare Effectiveness Data and Information Set (HEDIS)

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

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

HEDIS Rate Calculations

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and behavioral 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-10,and HCPCS codes can reduce the necessity of medical record reviews (see the ambetter.homestatehealth.com and HEDIS brochure (posted on ambetter.homestatehealth.com) for more information on reducing HEDIS medical record reviews). HEDIS measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c values, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who Conducts Medical Record Reviews (MRR) for HEDIS

Ambetter may contract with an independent national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are conducted on an ongoing basis with a particular focus from January through May each year. At that time, a sample of your patient's medical records may be selected for review; you will receive a call and/or a letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

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

How can providers improve their HEDIS scores?

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

- ***Submit claims and encounter data using CPT codes related to HEDIS*** measures such as diabetes, eye exam, and blood pressure, where appropriate.

If you have any questions, comments, or concerns related to the annual HEDIS project or medical record reviews, please contact the Quality Improvement Department at 1-877-684-1169.

Provider Satisfaction Survey

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

Qualified Health Plan (QHP) Enrollee Survey

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

Provider Performance Monitoring and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the level and cost-effectiveness of care. Ambetter will manage a provider performance monitoring program to capture data relating to healthcare access, costs, and level of care that Ambetter members receive.

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

REGULATORY MATTERS

Medical Records

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

Process for submitting Medical Records

Ambetter requires members' medical record data for a wide variety of operational and analytical processes that help to improve quality, reduce risk, and lower costs of care for the members being served. These processes include but are not limited to quality (e.g., HEDIS) and risk adjustment data tracking, clinical and population health stratification and prioritization, and continuity of care and care planning purposes. In addition, Ambetter requires medical record data relating to its members for purposes of complying with a wide array of regulatory and statutory data reporting requirements. Making these data available to Ambetter in the form of Electronic Medical Record (EMR) data reduces costs for both the provider and Ambetter.

At Ambetter's request, Provider will make commercially reasonable efforts to make EMR data relating to Ambetter's members available and accessible to Ambetter within a reasonable time frame requested by Ambetter via: 1) electronic access to APIs (Application Programming Interfaces), 2) use of HL7 and FHIR data transfer protocols, and/or 3) data-formatted content delivered via Continuity of Care Document (CCD) data specifications. Alternatively, at Ambetter's request or authorization, Provider may provide EMR data to Ambetter by other means, including but not limited to text file, image, or PDF, which may be transferred through SFTP (Secured File Transfer Protocol) or available for download via a secure web portal.

Ambetter reserves the right to assess a penalty of up to $30.00 per unmet medical record request on providers that fail to provide medical records as reasonably requested by Health Plan.

Required Information

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

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

- Member's name, and/or medical record number must be on all chart pages.

- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Ambetter practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant members 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.

Access to Records and Audits by Ambetter from Home State Health

Subject only to applicable state and federal confidentiality or privacy laws, the provider shall permit Ambetter from Home State Health or its designated representative access to provider's records, at provider's place of business in this state during normal business hours, or remote access of such records, in order to audit, inspect, review, perform chart reviews, and duplicate such records. If performed on site, access to records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least 10 business days prior written notice by Ambetter from Home State Health or its designated representative, but not more than 30 days following such written notice.

EMR Access

Providers will grant Ambetter from Home State Health access to the provider's Electronic Medical Record (EMR) system in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the Ambetter from Home State Health for this access.

Medical Records Release

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

All release of specific clinical or medical records for substance use disorders must meet federal guidelines at 42 CFR Part 2 and any applicable state laws.

Medical Records Transfer for New Members

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

Federal And State Laws Governing the Release of Information

The release of certain information is governed by a myriad of federal and/or state laws.

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

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

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

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

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

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

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

Ambetter takes privacy and confidentiality seriously. We have established processes, policies, and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Ambetter Compliance Officer by phone at 855-650-3789 or in writing (refer to address below) with any questions about our privacy practices.

Ambetter
11720 Borman Dr.
Saint Louis, MO 63146

National Network

Ambetter is a national network where contracted providers may provide covered services to covered persons in accordance with the Ambetter provider manual. In addition, the following requirements sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Commercial-Exchange/Qualified Health Plan product. Any additional regulatory requirements that may apply to the coverage agreements or covered persons enrolled in or covered by this product may be set forth in the provider manual or another attachment. To the extent that a coverage agreement, or a covered person, is subject to the law cited in the parenthetical at the end of a provision on the Schedules, such provision will apply to the rendering of covered services to a covered person with such coverage agreement, or to such covered person, as applicable:

Commercial-Exchange Regulatory Requirements:

(Arkansas) NovaSys Health, Inc.

(Arizona)	Health Net of Arizona, Inc.
(Florida)	Sunshine State Health Plan, Inc.
(Georgia)	Peach State Health Plan, Inc.
(Illinois)	IlliniCare Health Plan, Inc.
(Indiana)	Coordinated Care Corporation, d/b/a Managed Health Services - IN
(Kansas)	Sunflower State Health Plan, Inc.
(Mississippi)	Magnolia Health Plan, Inc.
(Missouri)	Home State Health Plan, Inc.
(New Hampshire)	Granite State Health Plan, Inc.
North Carolina	Ambetter of North Carolina, Inc.
(Ohio)	Buckeye Community Health Plan, Inc.
(Pennsylvania)	Pennsylvania Health & Wellness, Inc.
(South Carolina)	Absolute Total Care, Inc.
(Texas)	Superior Health Plan, Inc.
(Washington)	Coordinated Care of Washington, Inc.

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

For more information please visit http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

FRAUD, WASTE AND ABUSE

Ambetter takes the detection, investigation, and prosecution of fraud and abuse very seriously and has a Fraud, Waste, and Abuse (FWA) program that complies with the federal and state laws. Ambetter, in conjunction with its parent company, Centene, operates a Fraud, Waste, and Abuse unit. Ambetter routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the billing and claims section of this manual. The Centene Special Investigation Unit (SIU) also performs retrospective audits, which, in some cases, may result in taking actions against providers who commit fraud, waste, and/or abuse. 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
- Announced or unannounced onsite audit investigations
- Corrective action plan
- Any other remedies available to rectify

Some of the most common FWA 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
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

Ambetter auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like-specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Ambetter will seek recovery of all overpayments. Depending on the number of services provided during the review period, Ambetter may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

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

FWA Program Compliance Authority and Responsibility

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

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

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives 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, Ambetter must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program
- Type of Incentive Arrangement
- Amount and type of stop-loss protection
- Patient panel size
- Description of the pooling method, if applicable
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral, and other services
- The calculation of substantial financial risk (SFR)

- Whether Ambetter does or does not have a Physician Incentive Program
- The name, address, and other contact information of the person at Ambetter who may be contacted with questions regarding Physician Incentive Programs

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

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

If you have questions regarding the Physician Incentive Program regulations, please contact your Provider Partnership Manager.

APPENDIX

I. Common Causes for Upfront Rejections

II. Common Causes of Claim Processing Delays and Denials

III. Common EOP Denial Codes

IV. Instructions for Supplemental Information CMS 1500 (02/12) Form, Shaded Field 24a-G

V. Common HIPAA Compliant EDI Rejection Codes

VI. Claim Form Instructions

VII. Billing Tips and Reminders

VIII. Reimbursement Policies

Appendix I: Common Causes for Upfront Rejections

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

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small.
- Member Date of Birth is missing.
- Member Name or Identification Number is missing.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from required fields. Example: "Statement From" or “Service From" dates.
- Type of Bill is invalid.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail is missing.
- Date of Service is prior to member’s effective date.
- Admission Type is missing (Inpatient Facility Claims – CMS 1450 (UB-04), field 14).
- Patient Status is missing (Inpatient Facility Claims – CMS 1450 (UB-04), field 17).
- Occurrence Code/Date is missing or invalid.
- Revenue Code is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- A missing CLIA Number in Box 23 or a CMS 1500 for CLIA or CLIA waived service.
- Incorrect Form Type used.

- A missing taxonomy code and qualifier in box 24 I, 24 J, or Box 33b on the CMS 1500 form or Box 81 CC on the CMS 1450 (UB04) form (see further requirements in this Manual).

Appendix II: Common Cause of Claims Processing Delays and Denials

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

Appendix III: Common EOP Denial Codes and Descriptions

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

EX Code	Description
18	DENY: DUPLICATE CLAIM SERVICE
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
46	DENY: THIS SERVICE IS NOT COVERED
0B	ADJUST: CLAIM TO BE RE-PROCESSED CORRECTED UNDER NEW CLAIM NUMBER
A1	DENY: NO AUTHORIZATION ON FILE THAT MATCHES SERVICE(S) BILLED
AB	ACE LINE ITEM REJECTION
AQ	ACE CLAIM LEVEL RETURN TO PROV. MUST CALL PROV SERVICES FOR MORE DETAIL
AT	ACE CLAIM LEVEL REJECTION
fq	DENY: RESUBMIT CLAIM UNDER FQHC RHC CLINIC NPI NUMBER
IM	DENY: MODIFIER MISSING OR INVALID
M3	DENY: NO ASSOCIATED FACILITY CLAIM RECEIVED
w1	Co-surgeon/team surgeon disallowed per CMS surgical billing guidelines
w2	Assistant & primary surgeon procedure codes must match per CMS
w3	Assistant, co-surgeon, or team surgeons not typically required per CMS
w4	Inappropriate level of E/M service billed per AMA guidelines

w5	Primary service is denied; therefore, add-on service is denied per AMA
w6	State-Specific Guideline: Procedure code to Revenue code mismatch
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
xE	Procedure code is disallowed with this diagnosis code(s) per plan policy
xf	MAXIMUM ALLOWANCE EXCEEDED
y1	DENY: SERVICE RENDERED BY NON AUTHORIZED NON PLAN PROVIDER
ya	DENIED AFTER REVIEW OF PATIENT'S CLAIM HISTORY
yf	HCI partially approved units; Claim needs manual pricing
yq	Duplicate claims or multiple providers billing same/similar code(s)
yr	Incorrect procedure code for diagnosis per NCD/CMS
ys	Reimbursement included in another code per CMS/AMA/Medical Guidelines
yt	Incorrect Procedure code for member age or gender per CMS/AMA/Plan
yu	Incorrect CPT/HCPCS/REV/Modifier or unlisted code based on CPT/CMS guidelines
yv	Outpatient services included in inpatient admit per CMS/Plan Guidelines
yw	Not covered or eligible service per CMS or Plan Guidelines
yx	Included in global surgical or maternity package per CMS or ACOG
yy	Reimbursement reduction based on CPT and/or CMS
yz	Incorrect use of modifier -26 or -TC based on CMS
Za	DENY - PROVIDER BILLING ERROR
ZW	After review, previous decision upheld; See provider 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.
        - 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. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

Appendix V: Common Business EDI Rejection Codes

The codes on the following 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 Description
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS;Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS;Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc

Error ID	Error Description
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
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
91	Missing or Invalid Taxonomy Code
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

Appendix VI: Claim Form Instructions

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

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

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

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 used.
- Anesthesia claims may not be billed that contain both modifier QK-medical direction by a physician AND modifier QX-qualified non-physician anesthetist with medical direction by a physician.

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 must 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.
- Ambulance Claims: Need to be submitted on a CMS 1500 form. Any Ambulance claim submitted on a CMS 1450 (UB-04) 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 32X or 34X
- Must be billed in location 12
- Both Rev and CPT codes are required.
- Each visit must be billed individually on separate service line.
- Therapy services require a modifier.
- Nursing services require a modifier.

Long Term Acute Care Facilities (LTACs)

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

Maternity Services

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

Modifiers

Appropriate uses of 25, 26, 96, 97, CO, CQ, 73, 74, TC, 50, GN, GO, GP, TD, and TE:

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

  Well-Child and sick visit performed on the same day by the same physician. *NOTE: 25 modifiers are not appended to non E&M procedure codes, e.g. lab.

- **26 Modifier** – should never be appended to an office visit CPT code.
  - Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes.
  - Inappropriate use may result in a claim denial/rejection.
- **96/97 Modifier** – used for all habilitative services & rehabilitative services. Note: Must be billed in addition to the GN, GO, GP modifier in the secondary

position.

- CQ/CO Modifier- used for assistant therapist. Note: Must be billed in addition to the GN, GO, GP (Primary Modifier) 96 & 97 (Secondary Modifier) CQ or CO (Third Modifier Position).
- **TC Modifier** – used to indicate the technical component of a test or study is performed.
  - Inappropriate use may result in a claim denial/rejection
- **50 Modifier** – indicates a procedure performed on a bilateral anatomical site.
  - Procedure must be billed on a single claim line with the 50 modifier and quantity of one.
  - RT and LT modifiers or quantities greater than one should not be billed when using modifier 50
- **GN, GO, GP Modifiers** – rehabilitative therapy modifiers required for speech, occupational, and physical therapy. Note: This must be billed in the primary modifier position.
- **TD and TE Modifiers** - nursing modifiers required for nursing services
- 73 and 74 - Cancelled procedure before and after anesthesia administered.

Supplies

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

Present on Admission (POA)

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

Rehabilitation Services – Inpatient Services

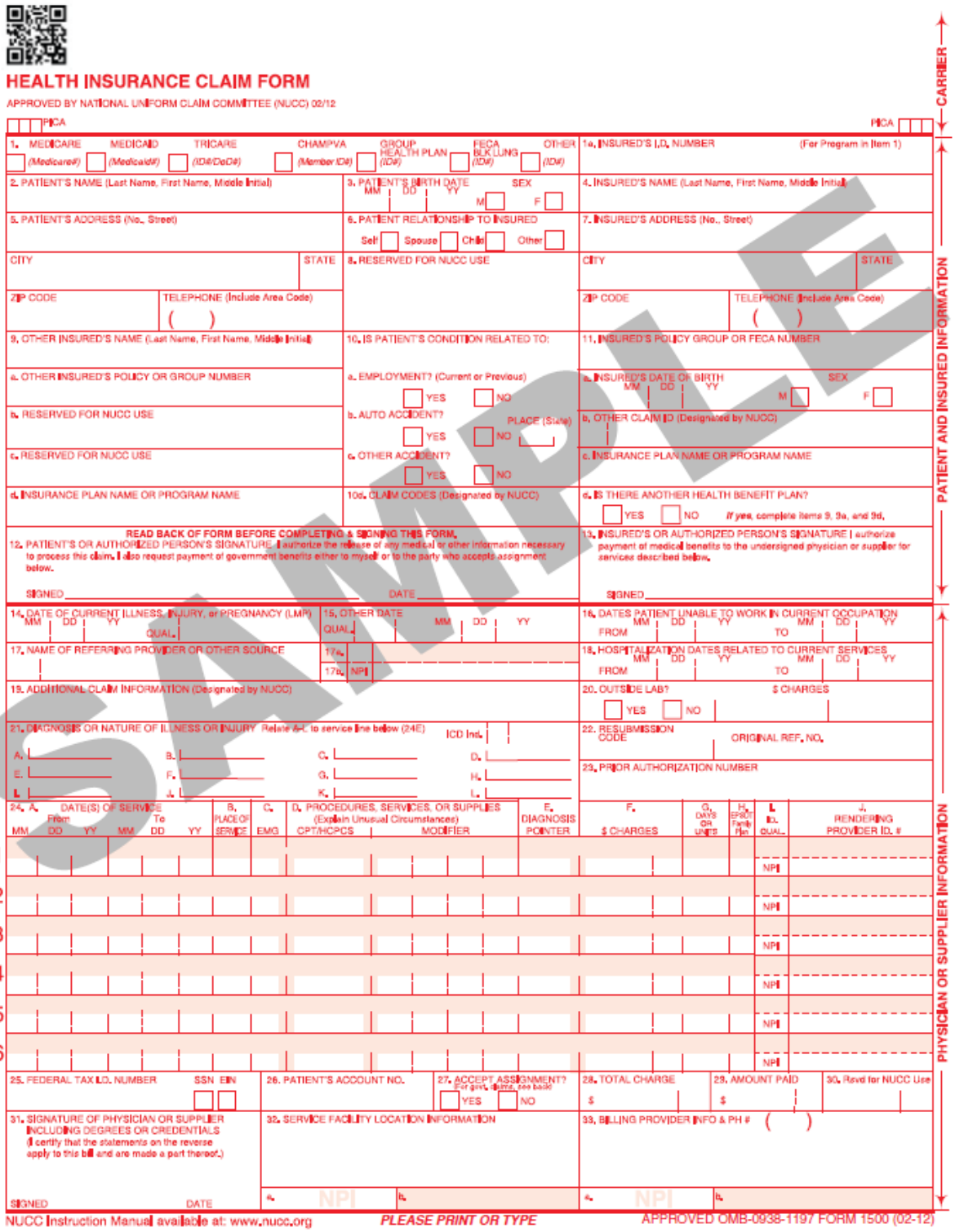
- Functional status indicators must be submitted for inpatient Rehabilitation Services.

Telemedicine

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

Completing a CMC 1500 Claim Form

Please see the following example of a CMS 1500 form.



HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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 indicates the payer to whom the claim is being filed.	R
1a	INSURED'S I.D. NUMBER	The 11-digit identification number on the member's Ambetter I.D. Card	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Ambetter I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Ambetter I.D. Card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
6	PATIENT'S RELATION TO INSURED	If patient is self, 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).	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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 or 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

Field #	Field Description	Instruction or Comments	Required or Conditional
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **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 PERSON'S 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

Field #	Field Description	Instruction or Comments	Required or Conditional
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRINGPHYSICIAN 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	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Required for inpatient stay. Enter R for inpatient. Enter C for all other.	R/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-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

Field #	Field Description	Instruction or Comments	Required or Conditional
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)
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
24A 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
24B 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

Field #	Field Description	Instruction or Comments	Required or Conditional
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D 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. 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.	R
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-10-CM 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-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 (e.g. 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 (1).	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

Field #	Field Description	Instruction or Comments	Required or Conditional
24 J Shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider Taxonomy Code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., 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 an Ambetter recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) claim form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed on 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 (e.g. 10.00), enter 00 in the area to the right of the vertical line.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Ambetter. Ambetter programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g. 10.00), enter 00 in the area to the right of the vertical line.	C
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).	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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 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 (e.g. (555)555-5555). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
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 CMS 1450 (UB-04) Claim Form

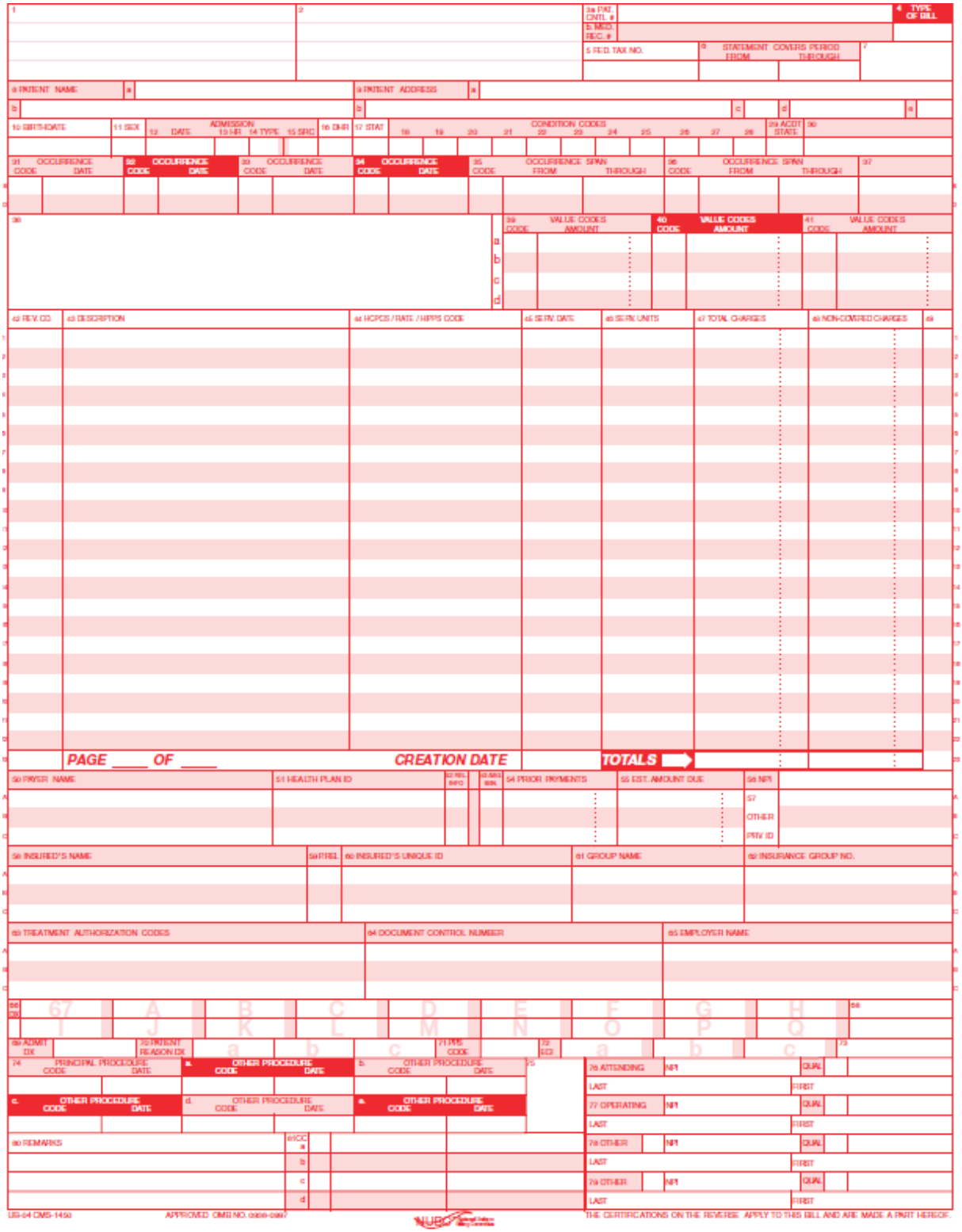
A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement by Ambetter. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services,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

CMS 1450 (UB-04) Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

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

UB-04 Claim Form Example



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 Ambetter I.D. card	Not Required
		8b – Enter the patient's last name, first name, and middle initial as it appears on the Ambetter ID card. Use a comma or space to separate the last and first names. Titles: (Mr., Mrs., etc.) should not be reported in this field.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		Prefix: No space should be left after the prefix of 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	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R

Field #	Field Description	Instruction or Comments	Required or Conditional
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: Physician Referral 1 Clinic Referral 2 Health Maintenance Referral (HMO) 3 Transfer from a hospital 4 Transfer from Skilled Nursing Facility 5 Transfer from another health care facility 6 Emergency Room 7 Court/Law Enforcement 8 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 -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	C
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the “through” date for	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		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 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)	

Field #	Field Description	Instruction or Comments	Required or Conditional
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 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.	C
37	(UNLABELED FIELD)	REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
39-41 a-d	VALUE 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 (e.g. 10.00), enter 00 in the area to the right of the vertical line.	C
General Information Fields 42-47	SERVICE LINE DETAIL	UB-04 fields 42-47have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, and48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate Revenue Codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of Revenue Codes and instructions. Enter accommodation Revenue Codes first followed by ancillary Revenue Codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the Revenue Code entered in the service line of field 42.	R
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e. PAGE “1” OF “1”). (Limited to 4 pages per claim)	C

Field #	Field Description	Instruction or Comments	Required or Conditional
Field #	**Field Description**	**Instruction or Comments**	**Required or Conditional**
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 one (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 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required
50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	HEALTH PLAN IDENTIFCATION NUMBER		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Ambetter is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Ambetter Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
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-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-10-CM Volume 1 & 3 for the date of service. Diagnosis Codes submitted must be valid ICD-10 Codes for the date of service and carried out to its highest level of specificity – 4th or"5th" 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-10-CM Volume 1 & 3 for the date of service. Diagnosis Codes submitted must be valid ICD-10 Codes for the date of service and carried out to its highest level of specificity – 4th or"5 th" digit. "E" codes and most "V" are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid Diagnosis Codes will be denied.	R
70	PATIENT REASON CODE	Enter the ICD-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-10 Codes for the date of service and carried out to its highest digit – 4 th or"5 th". "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

Field #	Field Description	Instruction or Comments	Required or Conditional
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-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-10 Procedure Code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
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	REQUIRED when a surgical procedure is performed.	C

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

Error ID	Error Description
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS;Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS;Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc

Error ID	Error Description
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
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
91	Missing or Invalid Taxonomy Code
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

Appendix VIII: Reimbursement Policies

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

Admissions for Same or Related Diagnoses

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

Calculating Anesthesia

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

Certified Nurse Midwife (CNM) Rules

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

EKG Payment

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

Physician Site of Service

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

Diagnostic Testing Of Implants

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

Hospital-Acquired Conditions and Provider Preventable Conditions

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

Lesser Of Language

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

Multiple Procedure Rules for Surgery and Endoscopic

Where multiple outpatient surgical or scope procedures are performed on a member during a single occasion of surgery, reimbursement will be as follows:

- The procedure for which the allowed amount is greatest will be reimbursed at 100%.
- The procedures with second and third greatest allowed amounts will each be reimbursed at 50%.
- Any additional procedures will not be eligible for reimbursement.

Multiple Procedure Rules for Radiology

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

Physician Assistant (PA) Payment Rules

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

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

Provider-Based Billing

Provider-based billing will not be reimbursed as it is included as part of the compensation for professional fees. Neither the payor nor the member shall be responsible for such provider-based billing. Provider-based billing is the amount charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility, and includes but is not limited to services billed using Revenue Codes 510-519.

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

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

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

Reimbursement Service Grouping

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

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

Surgical Physician Payment Rules

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

Incomplete Colonoscopy Rule

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

Injection Services

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

Unpriced Codes

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

Rental or Purchase Decisions

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

Payment for Capped Rental Items during Period of Continuous Use

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

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

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

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

Transcutaneous Electrical Nerve Stimulator (TENS)

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

Appendix IX: EDI Companion Guide Overview

The Companion Guide provides Ambetter trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P); and ASC X12N/005010x223 Health Care Claim: Institutional (837I). The Ambetter Companion Guide documents any assumptions, conventions, or data issues that may be specific to Ambetter business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Ambetter 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 Ambetter. This document provides information on Ambetter-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 is not 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 Ambetter and its trading partners. Refer to the TPA for guidelines pertaining to Ambetter legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Ambetter 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.**

Express permission to use X12 copyrighted materials within this document has been granted.

Rules of Exchange

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

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1, 999). 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.

277CA Health Care Claim Acknowledgement

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Ambetter 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, Ambetter 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, Ambetter checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payer ID

New Trading Partners

New trading partners should access https://sites.edifecs.com/index.jsp?Ambetter, register for access, and perform the steps in the Ambetter trading partner program. The EDI Support Desk (EDIBA@Ambetter.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 Ambetter 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.

Coordination of Benefits (COB) Processing

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

Code Sets

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

Corrections and Reversals

The 837 defines what values submitters must use to signal 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.

Data Format/Content

Ambetter 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

Ambetter 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 suggested for use by Ambetter 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.

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. Ambetter 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

- Ambetter will not accept more than 97 service lines per CMS 1450 (UB-04) claim.
- Ambetter will not accept more than 50 service lines per CMS 1500 claim.
- Ambetter will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300-REF02) is limited to 30 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. Ambetter 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. Ambetter expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Ambetter will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Ambetter 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 Loop 2310B/NM1*82.

Referring Provider

Ambetter has no specific requirements for Referring Provider information.

Atypical Provider

Atypical 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. ***NOTE: If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.***

Subscriber Identifiers

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

Claim Identifiers

Ambetter 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. Ambetter 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

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

- Method A – the trading partner will push transactions to the Ambetter FTP server and Ambetter will push outbound transactions to the Ambetter FTP server.
- Method B – The trading partner will push transactions to the Ambetter FTP server and Ambetter will push outbound transactions to the trading partner's FTP server.
- Encryption

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

Direct Submission

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

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Ambetter 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 – Ambetter Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Ambetter business edit errors are returned on the Ambetter 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 Ambetter Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	Ambetter Business Edits (See audit report rejection reason codes and explanation.)	Ambetter Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Ambetter Business Edits	277CA

277CA/Audit Report Rejection Codes

Error Code	Rejection Reason
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Provider
07	Invalid Mbr DOB & Provider
08	Invalid Mbr & Provider
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS

Error Code	Rejection Reason
12	Provider 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 Code
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 Diagnosis Code
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag Code
25	Invalid Mbr; Invalid Prv; Invalid Diag Code
26	Mbr not valid at DOS; Invalid Diag Code
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag Code
29	Provider not valid at DOS; Invalid Diag Code
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; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid Future Service Date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag

Error Code	Rejection Reason
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
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	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS;Invalid Diag;Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc

Error Code	Rejection Reason
74	Services performed prior to Contract Effective Date
75	Invalid units of service
76	Original Claim Number Required
77	Invalid Claim Type
78	Diagnosis Pointer- Not in sequence or incorrect length
81	Invalid units of service, Invalid Prv
83	Invalid units of service, Invalid Prv, Invalid Mbr
89	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
91	Invalid Missing Taxonomy or NPI/Invalid Prov
92	Invalid Referring/Ordering NPI
93	Mbr not valid at DOS; Invalid Proc
96	GA OPR NPI Registration-State
A2	Diagnosis Pointer Invalid
A3	Service Lines- Greater than 97 Service lines submitted- Invalid
B1	Rendering and Billing NPI are not tied on State File- IN rejection
B2	Not enrolled with MHS IN and/or State with rendering NPI/TIN on DOS. Enroll with MHS and Resubmit claim
B5	Invalid CLIA
C7	NPI Registration- State GA OPR
C9	Invalid/Missing Attending NPI
HP/H1/H2	ICD9 after end date/ICD10 sent before Eff Date/Mixed ICD versions

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 indicates the payer to whom the claim is being filed.	R
1a	INSURED'S I.D. NUMBER	The 11-digit identification number on the member's Ambetter I.D. Card	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Ambetter I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Ambetter I.D. Card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
6	PATIENT'S RELATION TO INSURED	If patient is self, 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).	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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 or 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

Field #	Field Description	Instruction or Comments	Required or Conditional
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **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 PERSON'S 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

Field #	Field Description	Instruction or Comments	Required or Conditional
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRINGPHYSICIAN 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	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Required for inpatient stay. Enter R for inpatient. Enter C for all other.	R/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-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

Field #	Field Description	Instruction or Comments	Required or Conditional
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)
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
24A 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
24B 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

Field #	Field Description	Instruction or Comments	Required or Conditional
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D 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. 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.	R
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-10-CM 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-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 (e.g. 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 (1).	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

Field #	Field Description	Instruction or Comments	Required or Conditional
24 J Shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider Taxonomy Code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers: Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., 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 an Ambetter recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) claim form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed on 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 (e.g. 10.00), enter 00 in the area to the right of the vertical line.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Ambetter. Ambetter programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g. 10.00), enter 00 in the area to the right of the vertical line.	C
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).	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
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 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 (e.g. (555)555-5555). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
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

STATE MANDATED REGULATORY REQUIREMENTS

Arkansas

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

AR-1 Continuity of Care. If the Payor becomes insolvent, each Participating Provider shall continue to provide services to Covered Persons for the duration of the period after the Payor's insolvency for which the premium payment has been made and until any Covered Persons that are inpatients at the time of the Payor's insolvency are discharged from the inpatient facilities. (ARK. CODE ANN. § 23-76-118(c)(2))

AR-2 Hold Harmless. In the event the Payor fails to pay for Covered Services as set forth in the Agreement, each Participating Provider agrees that no Covered Person is liable to the Participating Provider for any sums owed by the Payor. In addition, the Participating Provider agrees that the Participating Provider and any agent, trustee, or assignee of the Participating Provider shall not maintain an action at law against a Covered Person to collect sums owed to them by the Payor nor shall they make any statement, either written or oral, to any Covered Persons that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the Payor. (ARK. CODE ANN. §§ 23-76-119(c)(1), 23-76-119(c)(3), 23-76-118(b))

AR-3 Network Access. Each Participating Provider authorizes Company to sell, lease, assign, convey, and otherwise grant access to Company's network and related contracted reimbursement rates to other entities, including, without limitation, Payors. (ARK. CODE ANN. § 23-63-113(b)(1))

Arizona

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

AZ-1 No Gag Clause. Neither the Payor nor HMO shall restrict or prohibit a Participating Provider's good faith communication with the Participating Provider's patients concerning any such patient's health care or medical needs, treatment options, health care risks or benefits. HMO shall not terminate or

refuse to renew the Agreement, or a Participating Provider's participation in this Product Attachment, solely because the Participating Provider in good faith does any of the following: (a) advocates in private or in public on behalf of a patient; (b) assists a patient in seeking reconsideration of a decision made by the Payor to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority. (ARIZ. REV. STAT. §§ 20-118; 20-1061).

AZ-2 Hold Harmless. If the Payor fails to pay for Covered Services as set forth in the Covered Person's Coverage Agreement, the Covered Person is not liable to the Participating Provider for any amounts owed by the Payor and the Participating Provider shall not bill or otherwise attempt to collect from the Covered Person the amount owed by the Payor. (ARIZ. REV. STAT. § 20-1072)

AZ-3 Continuation of Care After Insolvency. Each Participating Provider shall provide Covered Services to Covered Persons at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after the Payor is declared insolvent, until the earliest of the following: (a) the expiration of the period during which the Payor is required to continue benefits as described in ARIZ. REV. STAT. § 20-1069(A); (b) notification from the receiver pursuant to ARIZ. REV. STAT. § 20-1069(F) or a determination by the court that the Payor cannot provide adequate assurance it will be able to pay the Participating Provider's claims for Covered Services that were rendered after the Payor is declared insolvent; (c) a determination by the court that the insolvent Payor is unable to pay the Participating Provider's claims for health care services that were rendered after the Payor is declared insolvent; (d) a determination by the court that continuation of the Agreement would constitute undue hardship to the Participating Provider; or (e) a determination by the court that the Payor has satisfied its obligations to all Covered Persons under the applicable Coverage Agreements. (ARIZ. REV. STAT. § 20-1074(B))

Florida

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

FL-1 Orders of the OIR. Pursuant to State law, the Agreement will be canceled upon issuance of an order by the Office of Insurance Regulation ("***OIR***"). (Fla. Stat. § 641.234(3))

FL-2 Notice of Termination. Provider shall give sixty (60) days' advance written notice to Health Plan and the OIR before canceling the Agreement for any reason. Provider agrees that nonpayment for goods or services rendered by the Provider to the Health Plan is not a valid reason for avoiding the 60-day advance notice of cancellation. Health Plan will provide 60 days' advance written notice to the Provider and the OIR before canceling, without cause, the Agreement, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency. (Fla. Stat. § 641.315(2))

FL-3 Notice of Consumer Assistance. Each Participating Provider shall post a consumer assistance notice prominently displayed in the reception area of the Participating Provider and clearly noticeable by all

patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of AHCA, the Subscriber Assistance Program, and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of Health Plan's grievance department shall be provided upon request. (Fla. Stat. § 641.511(11))

FL-4 Covered Person Hold Harmless. If Health Plan is liable for services rendered to a Covered Person by a Participating Provider, Health Plan is liable for payment of fees to the Participating Provider and the Covered Person is not liable for payment of fees to the Participating Provider. For purposes of this Section, Health Plan is liable for services rendered to a Covered Person by a Participating Provider if the Participating Provider follows Health Plan's authorization procedures and receives authorization for a Covered Service for a Covered Person, unless the Participating Provider provided information to Health Plan with the willful intention to misinform Health Plan. A Participating Provider or any representative of a Participating Provider may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of Health Plan or a Payor for payment of services for which Health Plan or the Payor is liable, if the Participating Provider in good faith knows or should know that Health Plan or the Payor is liable. This prohibition applies during the pendency of any claim for payment made by the Participating Provider to Health Plan or the Payor for payment of the services and any legal proceedings or dispute resolution process to determine whether Health Plan or the Payor is liable for the services if the Participating Provider is informed that such proceedings are taking place. It is presumed that a Participating Provider does not know and should not know that Health Plan or a Payor is liable unless: (a) the Participating Provider is informed by Health Plan or the Payor that it accepts liability; (b) a court of competent jurisdiction determines that Health Plan or a Payor is liable; (c) the OIR or Agency for Health Care Administration ("***AHCA***") makes a final determination that Health Plan or a Payor is required to pay for such services subsequent to a recommendation made by the Subscriber Assistance Panel pursuant to Fla. Stat. § 408.7056; or (d) AHCA issues a final order that Health Plan or a Payor is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to Fla. Stat. § 408.7057. (Fla. Stat. §§ 641.315(1); 641.3154) Sunshine State Health Plan, Inc. - PPA – All Products 5/20/16 Page 156 of 343

Georgia

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

GA-1 Physician Specific Provisions. If a Participating Provider is a physician, the following apply.

GA-1.1 If the Agreement or a Participating Provider's participation is terminated by Health Plan thereby affecting any Covered Person's opportunity to continue receiving health care services from the Participating Provider under the Coverage Agreement, any such Covered Person who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from the Participating Provider for a period of up to sixty (60) days from the date of the termination of the Agreement. Any Covered Person who is pregnant and

receiving treatment in connection with that pregnancy at the time of the termination of that Covered Person's Participating Provider's Agreement shall have the right to continue receiving health care services from the Participating Provider throughout the remainder of that pregnancy, including six (6) weeks' post-delivery care. During such continuation of coverage period, the Participating Provider shall continue providing such services in accordance with the terms of the Agreement applicable at the time of the termination, and Health Plan or Payor, as applicable, shall continue to meet all obligations of such Participating Provider's Agreement. The Covered Person shall not have the right to the continuation provisions provided in this Section if the Participating Provider's Agreement is terminated because of the suspension or revocation of the Participating Provider's license or if Health Plan determines that the Participating Provider poses a threat to the health, safety, or welfare of Covered Persons. (GA. CODE ANN. § 33-20A-61(a))

GA-1.2 Notwithstanding the foregoing, if a Participating Provider terminates their Agreement thereby affecting any Covered Person's opportunity to continue receiving health care services from that Participating Provider under the Coverage Agreement, any such Covered Person who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to receive health care services from that Participating Provider for a period of up to sixty (60) days from the date of the termination of the Participating Provider's Agreement. Any Covered Person who is pregnant and receiving health care services in connection with that pregnancy at the time of the termination of that Covered Person's Participating Provider's Agreement shall have the right to continue receiving health care services from that Participating Provider throughout the remainder of that pregnancy, including six (6) weeks' post-delivery care. During such continuation of coverage period, the Participating Provider shall continue providing such services in accordance with the terms of the Agreement applicable at the time of the termination, and Health Plan and Payor, as applicable, shall continue to meet all obligations of such Participating Provider's Agreement. The Covered Person shall not have the right to the continuation provisions provided in this Section if the Participating Provider terminates their Agreement because of the suspension or revocation of the Participating Provider's license or for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of Covered Persons. (GA. CODE ANN. § 33-20A-61(b))

Illinois

REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IL-1 Hold Harmless. If the Participating Provider is a hospital, the Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor of amounts due the Participating Provider under the Agreement or this Product Attachment, insolvency of the Payor any breach of the Agreement or this Product Attachment by the Payor, shall the Participating Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Covered Person, persons acting on the Covered Person's behalf (other than the Payor), the employer or group contract holder for Covered Services provided pursuant to the Agreement or this Product Attachment except for the payment of applicable co-payments or deductibles for Covered Service or fees for services not covered by the Payor. The requirements of this clause will survive any termination of the

Agreement or this Product Attachment for services rendered prior to such termination, regardless of the cause of such termination. The Covered Persons, the persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder will be third party beneficiaries of this Section. This Section supersedes any oral or written agreement now existing or hereafter entered into between the Participating Provider and the Covered Person, persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder. (215 ILL. COMP. STAT. 125/2-8(a); ILL. ADMIN. CODE § 5421.50(e))

IL-2 Quality Assurance. Each Participating Provider (and any of their or its subcontractors) shall provide, arrange for, or participate in the quality assurance programs mandated by the Health Maintenance Organization Act, as may be amended. (215 ILL. COMP. STAT. 125/2-8(b))

IL-3 Examination by the Director. Each Participating Provider agrees that the Director of Public Health may make an examination concerning the quality of health care services provided under the Agreement and this Product Attachment as often as the Director deems it necessary for the protection of the interest of the people of the State, but not less frequently than once every three (3) years. Each Participating Provider shall submit his, hers or its books and records relating to Health Plan and the Payor to examination and in every way facilitate them. Each Participating Provider acknowledges that, for the purpose of examinations, the Director of Insurance and the Director of Public Health may administer oaths to and examine the principals of the Participating Provider concerning their or its business. (215 ILL. COMP. STAT. 125/5-4)

IL-4 Termination.

IL-4.1 Each Participating Provider shall provide at least sixty (60) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment with cause, as may be defined in the Agreement or Provider Manual, and at least ninety (90) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment without cause. (ILL. ADMIN. CODE § 5421.50(a)(5))

IL-4.2 Health Plan shall provide at least sixty (60) days' notice to the Participating Provider of the nonrenewal or termination of the Agreement or its, their participation under this Product Attachment. Notwithstanding the foregoing, immediate written notice of non-renewal or termination may be provided by Health Plan without sixty (60) days' notice if the Participating Provider's license has been disciplined by a State licensing board. (215 ILL. COMP. STAT. 134/20)

IL-4.3 Each Participating Provider acknowledges that notification procedures for termination of the Agreement or this Product Attachment are set forth in the Agreement, this Product Attachment and the Provider Manual. Each Participating Provider agrees that such termination provisions require: (a) not less than thirty (30) days prior written notice by either party who wishes to terminate the Agreement without cause; (b) Health Plan may immediately terminate the Agreement for cause (except as otherwise expressly required by IL-4.1); and (c) if the Participating Provider acts as a primary care physician under a Coverage Agreement requiring a gatekeeper option, the Participating Provider must provide the Payor with a list of all Covered Persons using such Participating Provider as a gatekeeper within five (5) working days after the date that the Participating Provider either gives or receives notice of termination. (ILL. ADMIN. CODE § 2051.290(f))

IL-5 Provider Responsibility. Each Participating Provider acknowledges that the specific Covered Services for which the Participating Provider will be responsible, including any discount services, copayments, benefit maximums, limitations and exclusions, as well as any discount amount or discounted

fee schedule reflecting discounted rates, are set forth in the Agreement (which includes the Provider Manual and all Attachments). (ILL. ADMIN. CODE § 2051.290(a))

IL-6 Administrative Policies. Each Participating Provider shall comply with applicable administrative policies and procedures of Health Plan and the Payor including, but not limited to credentialing or recredentialing requirements, utilization review requirements and referral procedures. (ILL. ADMIN. CODE § 2051.290(b))

IL-7 Records. When payments are due to the Participating Provider for services rendered to a Covered Person, the Participating Provider must maintain and make medical records available: (a) to the Payor for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Covered Persons; (b) to appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints; and (c) to show compliance with the applicable State and federal laws related to privacy and confidentiality of medical records. (ILL. ADMIN. CODE § 2051.290(c))

IL-8 Licensure. Each Participating Provider shall be licensed by the State, and notify Health Plan immediately whenever there is a change in licensure or certification status. (ILL. ADMIN. CODE § 2051.290(d))

IL-9 Admitting Privileges. If the Participating Provider is a physician, the Participating Provider shall have admitting privileges in at least one hospital with which Health Plan has a written provider contract. Health Plan shall be notified immediately of any changes in privileges at any hospital or admitting facility. Each Participating Provider acknowledges that Health Plan may make reasonable exceptions for a Participating Provider who, because of the type of clinical specialty, or location or type of practice, does not customarily have admitting privileges. (ILL. ADMIN. CODE § 2051.290(e))

IL-10 Continuity of Care.

IL-10-1 Each Participating Provider agrees to accept the responsibilities for continuation of Covered Services in the event of termination of the Agreement, to the extent that an extension of benefits is required by law or regulation, or that continuation is voluntarily provided by the Payor. (ILL. ADMIN. CODE § 2051.290(g))

IL-10-2 Except in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board, each Participating Provider shall continue to provide Covered Services to Covered Persons in an ongoing course of treatment with that Participating Provider for a transitional period following termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment: (a) for ninety (90) days from the date of the notice to the Covered Person of the termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment if the Covered Person has an ongoing course of treatment; or (b) if the Covered Person has entered the third trimester of pregnancy at the time of the termination or non-renewal, through delivery and the provision of postpartum care directly related to the delivery. For transitional periods exceeding thirty (30) days, each Participating Provider agrees: (a) to continue to accept reimbursement from the Payor at the rates applicable prior to the start of the transitional period; (b) to adhere to the Payor's quality assurance requirements and to provide to the Payor necessary medical information related to such care; and (c) to otherwise adhere to the Payor's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorization's for treatment. (215 ILL. COMP. STAT. 134/25)

IL-11 Assignment. The rights and responsibilities under the Agreement or this Product Attachment cannot be sold, leased, assigned, assumed or otherwise delegated by either party without the prior written consent of the other party. By participating under this Product Attachment, Provider and each Participating Provider is hereby deemed to consent to any assignment or assumption of the Agreement or this Product Attachment by Health Plan, including any assignment or assumption in connection with any purchase of Health Plan by another administrator or insurer. The parties acknowledge that any assignee must comply with all the terms and conditions of the documents being assigned, including all appendices, policies and fee schedules. (ILL. ADMIN. CODE § 2051.290(h))

IL-12 Insurance. Each Participating Provider has and will maintain adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to Health Plan. The Participating Provider shall give Health Plan at least fifteen (15) days advance notice of cancellation of such insurance, and shall notify Health Plan within no less than ten (10) days after the Participating Provider's receipt of notice of any reduction or cancellation of the required coverage. (ILL. ADMIN. CODE §§ 5421.50(a)(7); 2051.290(i))

IL-13 Non-Discrimination. Each Participating Provider shall provide health care services without discrimination against any beneficiary on the basis of participation in a Coverage Agreement, source of payment, age, sex, ethnicity, religion, sexual, health status or disability. (ILL. ADMIN. CODE § 2051.290(j))

IL-14 Financial Responsibility. Each Participating Provider shall collect applicable copayments, coinsurance and/or deductibles (if any) from Covered Persons as provided by the Covered Person's Coverage Agreement, and shall provide notice to Covered Persons of their personal financial obligations for services that are not Covered Services including any amount of applicable discounts or, alternatively, a fee schedule that reflects any discounted rates. (ILL. ADMIN. CODE § 2051.290(k))

IL-15 Availability. Except as otherwise provided in the Provider Manual, each Participating Provider shall provide Covered Services on a twenty-four (24) hour per day, seven (7) day per week basis. (ILL. ADMIN. CODE § 2051.290(l))

IL-16 Payment. Each Participating Provider acknowledges that a clear description of the Payor's payment obligations to the Participating Provider are set forth in the Agreement and this Product Attachment, which includes the Compensation Schedule attached at Exhibit 1. (ILL. ADMIN. CODE § 2051.290(m))

IL-17 Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) provides a description of the administrative services, if any, the Health Plan or Payor will perform and the types of information (e.g., financial, enrollment, utilization) that will be submitted to the Participating Provider, as well as other information that is accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(n))

IL-18 Benefit Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) identifies the method that Participating Providers may use to access Health Plan, each Payor, or their designees to obtain benefit information and adequate notice of change in benefits and copayments. Health Plan will arrange for each Payor's operational policies to be accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(o))

IL-19 Dispute Resolution. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) sets forth the applicable internal appeal or arbitration procedures for settling contractual disputes or disagreements between the Participating Provider and the Health Plan. (ILL. ADMIN. CODE § 2051.290(p))

Indiana

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IN-1 Continuation of Care. Upon the request of a Covered Person, the Participating Provider shall continue to treat and provide Covered Services to the Covered Persons for up to sixty (60) days following the termination of the Agreement or, in the case of a pregnant Covered Person in the third trimester of pregnancy, throughout the term of the pregnancy. If Participating Provider is a hospital, the Participating Provider shall provide continue to treat and provide Covered Services to Covered Persons until the earlier of: (i) the sixtieth (60th) day following the termination of the Agreement or (ii) the Covered Person is released from inpatient status at the Participating Provider. During a continuation period under this Section, the Participating Provider (i) shall continue accepting the terms and conditions of the Agreement, together with applicable deductibles and copayments, as payment in full; and (ii) is prohibited from billing the Covered Person for any amounts in excess of the Covered Person's applicable deductible or copayment. This Section does not apply in the event that the Agreement is terminated by Health Plan due to a quality of care issue. (IND. CODE § 27-13-36-6)

IN-2 Hold Harmless. In the event the Payor fails to pay for health care services as specified by the Agreement, the Covered Person is not liable to the Participating Provider for any sums owed by the Payor. Each Participating Provider (and any trustee, agent, representative, or an assignee of a Participating Provider) may not bring or maintain any legal action against a Covered Person to collect sums owed by the Payor. Except as provided below in this Section, if Participating Provider of brings or maintains a legal action against a Covered Person for an amount owed to the Participating Provider by the Payor, the Participating Provider is liable to the subscriber or enrollee for costs and attorney's fees incurred by the Covered Person in defending the legal action. The Participating Provider shall not be liable to the Covered Person for costs and attorney's fees described in the preceding sentence if the Participating Provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that the Payor did not owe the sums the Participating Provider sought to collect from the Covered Person. (IND. CODE §§ 27-13-15-1(a)(4); 27-13-15-3)

IN-3 Termination. Provider and each Participating Provider shall give the Health Plan at least sixty (60) days advance written notice of its, their termination of the Agreement; provided, however, that if Provider or the Participating Provider provide thirty percent (30%) or more of the Payor's services, then Provider and each Participating Provider shall give at least one hundred twenty (120) days advance written notice of its, their termination of the Agreement. (IND. CODE §§ 27-13-17-1)

IN-4 Third Party Access. The Agreement applies to network rental arrangements. One purpose of the Agreement is selling, renting or giving Health Plan rights to the services of the Participating Provider, and the third party accessing the Participating Provider's services is any of the following: (i) a Payor or a third-party administrator or other entity responsible for administering claims on behalf of the Payor; (ii) a preferred provider organization or preferred provider network, including a physician-hospital organization, (iii) an

entity engaged in the electronic claims transport between Health Plan and the Payor. Any such third party that is granted access is obligated to comply with all of the applicable terms of Health Plan's contract with the Participating Provider. In addition, any of the following third parties may be granted access to the Participating Provider's services: (A) an employer or another entity providing coverage for health care services to the employer's or entity's employees or members and the entity has a contract with Health Plan or Health Plan's Affiliate for the administration or processing of claims for payment or service provided under the Agreement; or (B) an Affiliate of Health Plan or an entity providing administrative IN PPA – Confidential and Proprietary Page 137 of 278 PPA base agreement 01.29.15

Kansas

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

KS-1 Hold Harmless. Provider and each Contracted Provider agree that a Covered Person is not liable to Provider or any Contracted Provider for any amounts owed by the Payor for Covered Services under the applicable Coverage Agreement that are not paid by the Payor. Any action by Provider or Contracted Provider to collect or attempt to collect from a Covered Person any sum owed by the Payor to Provider or a Contracted Provider is deemed to be an unconscionable act within the meaning of KAN. STAT. ANN. § 50-627, and any amendments thereto. (KAN. STAT. ANN. § 40-3209(b))

KS-2 Examination by Insurance Commissioner. Provider and each Contracted Provider shall provide access to their respective affairs, books and records to the State insurance commissioner including any delegate or duly authorized agent thereof for examination in accordance with State law. (KAN. STAT. ANN. § 40-3211)

KS-3 Emergency Services. To the extent that a Coverage Agreement requires prior authorization before receiving payment for treatment of an emergency medical condition, neither Provider nor any Contracted Provider shall hold a Covered Person under such Coverage Agreement financially responsible for payment for such services if such prior authorization is not sought or received. (KAN. STAT. ANN. § 40-3229(c))

KS-4 Treatment Decisions. The parties acknowledge and agree that nothing in the Agreement or this Attachment prohibits or restricts a Contracted Provider from discussing or disclosing to any Covered Person any medically appropriate health care information that such Contracted Provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by a Company or Payor to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of the Covered Person within any utilization review or grievance processes established by a Company or Payor. (KAN. STAT. ANN. § 40-4604)

KS-5 Financial Incentives. The parties acknowledge and agree that nothing in the Agreement or this Attachment, including but not limited to the Compensation Schedule, serves as a direct or indirect

inducement to reduce or limit the delivery of medically necessary services to a Covered Person. (KAN. STAT. ANN. § 40-4605)

KS-6 Use of Name. Provider and each Contracted Provider hereby authorize each Company and Payor to use their respective names, telephone numbers, addresses, availability and a description of services in listings of Participating Providers. (KAN. STAT. ANN. §§ 40-3214, 40-4606(c))

KS-7 Grievance Procedures. Provider and each Contracted Provider shall participate in the grievance procedures established under or in connection with the applicable Coverage Agreement. (KAN. STAT. ANN. § 40-3229(d))

Missouri

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

MO-1 Intermediary Defined. For purposes of this Schedule, the term “Intermediary” has the meaning given such term in Missouri Revised Statutes § 354.600(13), which as of the Effective Date, means a person authorized to negotiate and execute provider contracts with a Payor on behalf of health care providers or on behalf of a network.

MO-2 Limitations. No Payor or other entity shall restrict a Contracted Provider from discussing or disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation or test, the decision of a Payor or its delegate to authorize or deny services, or the process that a Payor or any person contracting with the Payor uses or proposes to use to authorize or deny health care services or benefits. (MO. REV. STAT. § 354.441)

MO-3 Hold Harmless. Each Contracted Provider agrees that in no event, including but not limited to nonpayment by a Payor or any Intermediary, insolvency of a Payor or any Intermediary, or breach of the Agreement, shall the Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or other person, other than Payor or an Intermediary, if any, acting on behalf of the Covered Person for services provided pursuant to this Attachment. This Attachment does not prohibit Provider or a Contracted Provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the Coverage Agreement, or fees for non-covered services delivered on a fee-for-service basis to Covered Persons. This Attachment does not prohibit the Provider or a Contracted Provider, except for a health care professional who is employed full time on the staff of a Payor and has agreed to provide service exclusively to the Payor’s Covered Persons and no others, and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as Provider or Contracted Provider has clearly informed the Covered Persons that the Payor may not cover or continue to cover a specific service or services. Except as provided herein, this Attachment does not prohibit Provider or a Contracted Provider from pursuing any

available legal remedy, including, but not limited to, collecting from any insurance carrier providing coverage to a Covered Person. This provision survives the termination of the Agreement or this Attachment regardless of the reason for termination. (MO. REV. STAT. § 354.606.2)

MO-4 Continuation of Services. In the event of a Payor's or Intermediary's insolvency or other cessation of operations, Provider and each Contracted Provider shall continue to provide Covered Services to the affected Covered Person through the period for which premiums have been paid to the Payor on behalf of such Covered Person or until such Covered Person's discharge from an inpatient facility, whichever time is greater. (MO. REV. STAT. § 354.606.3)

MO-5 Independent Contractor Relationship. The relationship among the parties is that of independent contractors. (MO. CODE REGS. TIT. 20, § 400-7.080)

MO-6 Assignment. The Agreement may not be assigned, sublet, delegated or transferred by Provider without the prior written consent of (MO. REV. STAT. § 354.606.13)

MO-7 Non-Discrimination. Provider and each Contracted Provider shall accept Covered Persons for treatment and shall not intentionally segregate Covered Persons in any way from other persons receiving services. Provider and each Contracted Provider shall provide Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, status as a private purchaser or as a participant in a publicly financed program income status, program membership, or physical or behavioral disability, except where medically indicated. (MO. REV. STAT. § 354.606.14)

MO-8 Notice of Termination; List of Covered Persons. The parties agree that any notice of termination of the Agreement or this Attachment given by a party or a Contracted Provider must state the reason for the termination. The Agreement or a Contracted Provider's participation in this Product may only be terminated by a party or the Contracted Provider without cause by giving the others the minimum amount of prior written notice set forth in the Agreement, which in no event can be less than sixty (60) days prior written notice for a termination without cause. Within fifteen (15) business days of the date that a Contracted Provider either gives or receives notice of termination, the Contracted Provider shall provide the Payor with a list of all Covered Persons who are patients of Contracted Provider. (MO. REV. STAT. § 354.609.1)

MO-9 Continue Care upon Termination. After the effective date of termination of a Contracted Provider's participation in this Product, this Attachment will remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon termination of a Contracted Provider's participation in this Product, the Contracted Provider shall (i) continue to provide Covered Services to each Covered Person in this Product during the longer of the ninety (90) day period following the date of termination or such other period as may be required by laws, regulations, standards or requirements applicable to such Covered Person's Coverage Agreement, and, if requested by a Company shall continue to provide Covered Services to each Covered Person in this Product until such Covered Person is assigned or transferred to another Participating Provider in this Product, and (ii) continue to comply with and abide by all of the terms and conditions of the Agreement and this Schedule B, including, but not limited to, Section MO-3 above, in connection with the provision of such Covered Services during such continuation period. During the continuation period, the Contracted Provider shall be compensated in accordance with this Attachment for Covered Services rendered to a Covered Person after termination and shall accept such compensation as payment in full. This provision survives the termination of the Contracted Provider's participation in this Product. (MO. REV. STAT. § 354.612)

MO-10 Compel to Furnish Records. Each Contracted Provider shall furnish to each Payor and Company all documentation required by them in order to monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of the Contracted Provider to provide all Covered Services to Covered Persons in this Product. (MO. REV. STAT. § 354.603.1(3))

MO-11 Access to Entire Network. A Payor shall not act in a manner that unreasonably restricts a Covered Person's access to the Payor's entire contracted provider network, unless otherwise provided in or contemplated by the Coverage Agreement or Payor Contract. (MO. REV. STAT. § 354.603)

MO-12 Provider Notification. Through the Provider Manual, Provider and each Contracted Provider acknowledge that they will be notified of a Company's and Payor's administrative procedures, and on an ongoing basis of specific Covered Services for which the Contracted Provider is responsible, including limitations or conditions on services. Each Contracted Provider is responsible for collecting applicable coinsurance, co-payments and deductibles, if any, from Covered Persons. (MO. REV. STAT. §§ 354.606.1, 354.606.17)

MO-13 Provider Review or Hearing. When expressly required by applicable law or otherwise deemed appropriate by a Company, and if timely requested by Provider, the Company or Payor will provide Provider or the applicable Contracted Provider with an opportunity for a review or hearing as required by Missouri law and in accordance with Company's or Payor's applicable procedures. For purposes of this Section MO-13 only, a "termination" of the Agreement or a "termination" of Provider's or a Contracted Provider's participation in this Product is different than a "non-renewal" of the Agreement or a "non-renewal" of Provider's or a Contracted Provider's participation in this Product. (MO. REV. STAT. § 354.609)

MO-14 30 Day Review of Contract. Contract Provider hereby acknowledges that Provider and the Contracted Providers were allowed at least thirty (30) days to review the Agreement and its Attachments (including this Schedule B) prior to Provider's execution. (MO. REV. STAT. § 354.609)

MO-15 Intermediaries. If Provider is an Intermediary, the provisions set forth below apply.

MO-15.1 Provider shall, and shall require each Contracted Provider to, comply with the Agreement and its Attachments (including this Schedule B), and applicable law, including but not limited to Sections 354.600 to 354.636 of the Missouri Revised Statutes, as amended.

MO-15.2 If required by a Company. Provider shall transmit utilization documentation and claims paid documentation to the Company.

MO-15.3 Provider shall maintain all books, records, financial information and documentation of services provided to Covered Persons at its principal place of business within Missouri and preserve them for no less than five (5) years in a manner that facilitates regulatory review.

MO-15.4 Provider shall allow a Company and regulatory authorities access to the books, records, financial information and any documentation of services provided to Covered Persons, as necessary to determine compliance with Sections 354.600 to 354.636 of the Missouri Revised Statutes, as amended.

MO-15.5 Provider agrees that a Company has the right, in the event of Provider's insolvency, to require assignment to the Company of the provisions of a Contracted Provider's contract with Provider addressing the Contracted Provider's obligation to furnish Covered Services.

Mississippi

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

MS-1 Hold Harmless. Each Participating Provider agrees that if the Payor fails to pay for health care services as set forth in the Agreement, the Covered Person shall not be liable to the Participating Provider for any sums owed by the Payor. Each Participating Provider agrees that the Participating Provider, and any agent, trustee or assignee of the Participating Provider shall not maintain any action at law against a Covered Person to collect sums owed by the Payor. (MISS CODE ANN. §§ 83-41-325(13), 83-41-325(15))

MS-2 Continuity of Care. Each Participating Provider agrees that in the event of insolvency of the Payor, the Participating Provider will continue to provide services to Covered Persons for the duration of the period after the Payor's insolvency for which premium payment has been made and until the Covered Persons' discharge from inpatient facilities. (MISS CODE ANN. § 83-41-325(16)(b))

MS-3 Termination. If the Participating Provider terminates the Agreement or their or its participation under the Product Attachment, the Participating Provider shall give Health Plan at least sixty (60) days advance written notice of termination. (MISS CODE ANN. § 83-41-325(17))

MS-4 Examination. Each Participating Provider agrees that (a) the Commissioner of Insurance may make an examination of the affairs of the Participating Provider as often as is reasonably necessary for the protection of the interests of the people of this State; and (b) the State Health Officer may make an examination concerning the quality assurance shall make an examination of the affairs of the Participating Provider as often as is reasonably necessary for the protection of the interests of the people of this State. Each Participating Provider shall submit their or its books and records for such examination and in every way facilitate the completion of the examination. Each Participating Provider agrees that, for the purpose of examinations, the Commissioner of Insurance and the State Health Officer may administer oaths to and examine the principles of the Participating Provider concerning its, their business in accordance with existing insurance laws, rules and regulations. (MISS CODE ANN. § 83-41-337)

North Carolina

STATE REGULATORY REQUIREMENTS

This section sets forth the provisions that are required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, or a Participation Provider is subject to the law cited in the parenthetical at the end of a provision in this section, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person or Participating Provider, as applicable.
The Parties shall comply with the State requirements set forth below.

NC-1 Entire Agreement. The Agreement and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties in accordance with this Section NC-1 and the "Entire Agreement" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(1))

NC-2 Definitions. Except as set forth in this Section NC-2, the definitions of technical insurance or managed care terms used in the Agreement are generally set forth in the "Definitions" Article of the Agreement. To the extent applicable, such definitions contain references to certain other documents distributed to providers (e.g., the Provider Manual), and are consistent with the definitions included in the evidences of coverage issued in connection with the Coverage Agreements. (11 N.C. ADMIN. CODE 20.0202(2))

When appearing in this Product Attachment or the Agreement, the following quoted and bolded terms (and the plural thereof, when appropriate) have the meaning set forth below with respect to the Individual Market Product.

a. "***Emergency Medical Condition***" and "***Emergency Services***" or "***Emergency Care***" have the meaning set forth in N.C. GEN. STAT. § 58-3-190(g), which as of the Effective Date, "Emergence Services" (sometimes referred to herein as Emergency Care) means those health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department, and "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of an individual, or with respect to a pregnant member, the health of the member or their unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

b. "***Medical Necessity***" or "***Medically Necessary***" or "***Medically Necessary Services or Supplies***" has the definition set forth at N.C. GEN STAT. § 58-3-200(b), which, as of the Effective Date, is as follows: those Covered Services (or supplies) that are: (1) provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease, and, except as allowed under N.C. GEN. STAT. § 58-3-255 (regarding coverage of clinical trials), not for experimental, investigational, or cosmetic purposes; (2) necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (3) within generally accepted standards of medical care in the community; and (4) not solely for the convenience of the insured (i.e., the Covered Person), the insured's family, or the provider.

For Medically Necessary services, nothing herein precludes a Payor from comparing the cost effectiveness of alternative services or supplies when determining which of the services or supplies will constitute Covered Services.

c. "***Intermediary***" has the definition set forth at 11 N.C. ADMIN. CODE 20.0101(b)(4), which, as of the Effective Date, is as follows: an entity that employs or contract with health care providers for the provision of health care services, and that also contracts with a network plan carrier, including the Company or a Payor, or its intermediary.

d. **"*Utilization Review"*** or **"*utilization review"*** means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include: (a) ambulatory review - utilization review of services performed or provided in an outpatient setting; (b) case management - a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions; (c) certification - a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness; (d) concurrent review - utilization review conducted during a patient's hospital stay or course of treatment; (e) discharge planning - the formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility; (f) prospective review - utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification; (g) retrospective review - utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in N.C. GEN. STAT. § 58-3-190 has been met; (h) second opinion - an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

NC-3 Term. The term of the Agreement is set forth in the "Term" provision of the Agreement, and the term of this Product Attachment is set forth in Section 6 of this Product Attachment. (11 N.C. ADMIN. CODE 20.0202(3))

NC-4 Written Notice of Termination; Grounds for Termination. The requirements for written notice of termination and each Party's grounds for termination are generally set forth in the "Term and Termination" Article of the Agreement. (11 N.C. ADMIN. CODE 20.0202(4))

NC-5 Continuity of Care. Each Participating Provider shall continue to provide services to Covered Persons after termination of the Agreement or in the event of a Payor's or Intermediary's insolvency in accordance with the "Effect of Termination" provision of the Agreement and this Section NC-5, including, but not limited to, when inpatient care of a Covered Person is ongoing until patient is ready for discharge. In addition, in the event of a Payor's or Intermediary's insolvency, each Participating Provider shall continue to provide services to Covered Persons during the period for which premium has been paid. Each Participating Provider will cooperate with Company regarding the transition of administrative duties and records. To the extent that services are provided or arranged for on prepaid basis, each Participating

Provider shall continue to provide inpatient care until the Covered Person is ready for discharge. (11 N.C. ADMIN. CODE 20.0202(5); N.C. GEN. STAT. § 58-67-120)

NC-6 Credentials. Each Participating Provider shall maintain licensure, accreditation, and credentials sufficient to meet Company's and/or Payor's credential verification program requirements, which are set forth in the Policies. Each Participating Provider shall notify Company of subsequent changes in status of any information relating to the Participating Provider's professional credentials in accordance with this Section NC-6 and the "Notice of Certain Events" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(6))

NC-7 Insurance. Each Participating Provider shall maintain professional liability insurance coverage in an amount acceptable to Health Plan and will inform Health Plan of subsequent changes in status of professional liability insurance on a timely basis in accordance with this Section NC-7 and the "Insurance" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(7))

NC-8 Hold Harmless.

a. No Participating Provider shall bill a Covered Person for Covered Services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a Participating Provider and a Covered Person from agreeing to continue non-Covered Services at the Covered Person's own expense, as long as the Participating Provider has notified the Covered Person in advance that the Payor may not cover or continue to cover specific services and the Covered Person chooses to receive the service. This Section NC-8 survives termination of the Agreement for any reason, including Plan insolvency. Each Participating Provider is responsible for collecting any applicable deductibles, copayments, coinsurance, and fees for non-Covered Services from Covered Persons. (11 N.C. ADMIN. CODE 20.0202(8))

b. In the event Payor fails to pay for Covered Services as set forth in the Agreement, the Covered Person shall not be liable to the Participating Provider for any sums owed by the Payor. No other provisions of the Agreement will, under any circumstances, change the effect of the foregoing. No Participating Provider, or agent, trustee, or assignee thereof, may maintain any action at law against a Covered Person to collect sums owed by the Payor. (N.C. GEN. STAT. § 58-67-115(a))

NC-9 Call Coverage. Each Participating Provider shall arrange for call coverage or other backup to provide service in accordance with the Payor's standards for provider accessibility, which are set forth in the Agreement, the Provider Manual or the Policies. (11 N.C. ADMIN. CODE 20.0202(9))

NC-10 Eligibility. A mechanism for Participating Providers to verify the eligibility of Covered Persons (based on current information held by Company or Payor, as applicable) before rendering health care services will be made available in accordance with the "Eligibility Determinations" section of the Agreement. (11 N.C. ADMIN. CODE 20.0202(10))

NC-11 Records. Each Participating Provider shall: (a) maintain confidentiality of Covered Person medical records and personal information as required by N.C. Gen. Stat. Title 58, Article 39 and other health records as required by all applicable law; (b) maintain adequate medical and other health records according to industry and Company and/or Payor standards; and (c) make copies of such records available to

Company, Payors and the North Carolina Department of Insurance in conjunction with its regulation of Company or Payor. (11 N.C. ADMIN. CODE 20.0202(11))

NC-12 Grievance Procedures. Each Participating Provider shall cooperate with Covered Persons in grievance procedures in accordance with this Section NC-12, the Policies of Company or Payor, and the Agreement. (11 N.C. ADMIN. CODE 20.0202(12))

NC-13 Discrimination Prohibition. Each Participating Provider shall not discriminate against any Covered Person on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage. (11 N.C. ADMIN. CODE 20.0202(13))

NC-14 Compensation. The methodology to be used as a basis for payment (for example, Medicare DRG reimbursement, discounted fee for service, withhold arrangement, HMO provider capitation, or capitation with bonus) to the Participating Provider under the Agreement is set forth in the Compensation Schedule set forth or described in one or more Attachments to the Agreement. (11 N.C. ADMIN. CODE 20.0202(14))

NC-15 Data. Company will provide certain data and other information to the Participating Provider, if applicable, such as: (a) performance feedback reports or information, if compensation is related to efficiency criteria, or (b) information on benefit exclusions, administrative and utilization management requirements, credential verification programs, quality assessment programs, and provider sanction policies and/or program. Company will also provide advance notice of changes in such requirements in accordance with the Agreement in order to allow Participating Providers time to comply with such changes. (11 N.C.
ADMIN. CODE 20.0202(15))

NC-16 Programs. Each Participating Provider shall comply with Company's or Payor's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs. Notwithstanding the foregoing or any other provision of the Agreement, none of these programs override the professional or ethical responsibility of the Participating Provider or interfere with the Participating Provider's ability to provide information or assistance to their patients. (11 N.C. ADMIN.
CODE 20.0202(16))

NC-17 Use of Name. Each Participating Provider authorizes Company or Payor to use of the name of the Participation Provider or the Participating Provider's group in the provider directory distributed to Covered Persons in accordance with this Section NC-17 and the "Use of Name" provision of the Agreement. Company or Payor, as applicable, will include the name of the Participating Provider or the Participating Provider's group in the provider directory. (11 N.C. ADMIN. CODE 20.0202(17))

NC-18 Disputes. The process to be followed to resolve contractual differences between the Health Plan and/or Company, as applicable (including any Company acting as Payor), and a Participating Provider is set forth in the "Dispute Resolution" Article of the Agreement. (11 N.C. ADMIN. CODE 20.0202(18))

NC-19 Assignment. The Participating Provider's duties and obligations under the Agreement may not be assigned, delegated, or transferred without the prior written consent of Health Plan. Health Plan shall notify the Participating Provider, in writing, of any duties or obligations that are to be delegated or transferred by Participating Provider, before the delegation or transfer (i.e., Health Plan will send prior written notice of the delegation or transfer to the Participating Provider). (11 N.C. ADMIN. CODE 20.0202(19))

NC-20 Intermediary Contracts. If Provider is an Intermediary, the following apply. (11 N.C.

ADMIN. CODE 20.0204(b))

a. Provider's contracts with health care providers will comply with, and include the applicable provisions of, 11 N.C. ADMIN. CODE 20.0202, which, as of the Effective Date, are set forth in this Exhibit.

b. Company and Payor each retains its legal responsibility to monitor and oversee the offering of services to Covered Persons and the Payor retains its financial responsibility to Covered Persons.

c. Provider is prohibited from subcontracting its services without the written permission of Health Plan.

d. Company or Payor may approve or disapprove the participation of each health care provider contracted with Provider for inclusion in or removal from the network (i.e., the status as a Participating Provider with respect to a Coverage Agreement).

e. Provider shall make available for review by the Department of Insurance all provider contracts and subcontracts held by Provider.

f. If Provider assumes risk from Health Plan, pays its health care providers on a risk basis or is responsible for claims payment to its providers, (1) Provider shall provide Health Plan will documentation of utilization and claims payment, and maintain accounting systems and records necessary to support the arrangement; (2) Provider will cooperate with Health Plan in order for it to arrange for financial protection of itself and Covered Persons through such approaches as hold harmless language, retention of signatory control of the funds to be disbursed, or financial reporting requirements; and (3) to the extent provided by law, the Department of Insurance will have access to the books, records and financial information to examine activities performed by Provider on behalf of Health Plan. Provider shall maintain such books and records in the State of North Carolina.

g. Provider shall comply with all applicable statutory and regulatory requirements that apply to the functions delegated by Health Plan and assumed by Provider.

NC-21 Intentionally Omitted.

NC-22 Notices. The name or title and address for notices to each Party under the Agreement, including notices of proposed amendments, are set forth in the "Notices" provision of the Agreement. (N.C. GEN. STAT. § 58-50-275).

NC-23 Amendments. Health Plan may amend the Agreement (including any Product Attachment) by sending written notice of the proposed amendment to the notices contact of the Provider set forth in the Agreement. Unless Provider notifies Health Plan in writing of its objection to such amendment during the sixty (60) day period following receipt of the proposed amendment, Provider will be deemed to have accepted the amendment. If Provider objects to a proposed amendment, then the proposed amendment is not effective and the Health Plan may terminate the Agreement (and/or the applicable Product Attachment(s)) upon sixty (60) days' written notice to Provider. In addition, Health Plan and Provider may amend the Agreement at any time through mutual written agreement, documented by the signatures of duly authorized representatives of the Parties. (N.C. GEN STAT. § 58-50-280).

NC-24 Recovery of Overpayments. Health Plan shall provide at least thirty (30) days advance written notice to Provider of any offset made to future payments in connection with an overpayment recovery, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery.

NC-25 Compliance with Applicable Laws. This Product Attachment and the Agreement are intended to comply with all laws applicable to the Individual Market Product Attachment and, to the extent applicable to the Individual Market Product, Health Plan, Payors and Participating Providers, as applicable, shall comply with such laws, including N.C. GEN. STAT. § 58-3-225.

New Hampshire

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

NH-1 Notice of Changes. Each Participating Provider shall notify the Health Plan of changes in the status of any items listed in N. H. REV. STAT. § 420-J:4 at any time. The Provider Manual should be consulted for the appropriate individual or department of Health Plan to whom such change should be reported. (N. H. REV. STAT. §420-J:4.(IV))

NH-2 Hold Harmless. Each Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor, insolvency of the Payor, or breach of the Agreement or this Product Attachment, shall the Participating Provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a Covered Person or a person acting on behalf of the Covered Person (other than the Payor) for services provided pursuant to the Agreement and this Product Attachment. Neither the Agreement nor this Product Attachment prohibit the Participating Provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the Coverage Agreement, or fees for services that are not Covered Services delivered on a fee-for-service basis to Covered Persons. Nor does the Agreement or this Product Attachment prohibit the Participating Provider and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as the Participating Provider has clearly informed the Covered Person that the Payor may not cover or continue to cover a specific service or services. Except as provided in this Section, neither the Agreement nor this Product Attachment prohibit the Participating Provider from pursuing any available legal remedy. Each Participating Provider further agrees that: (a) this Section will survive the termination of the Agreement or its, their participation under this Product Attachment regardless of the cause giving rise to termination and will be construed to be for the benefit of the Covered Person; and that (b) this Section supersedes any oral or written contrary agreement now existing or hereafter entered into between the Participating Provider and a Covered Person or persons acting on their behalf. Any modifications, additions or deletions to this Section will become effective on a date no earlier than fifteen (15) business days after the Commissioner has received written notice of such proposed changes. (N. H. REV. STAT. § 420-J:8(I))

NH-3 Fee Schedule Changes. Health Plan shall not make a material change to the Compensation Schedule set forth at Exhibit 2 to this Product Attachment without providing the Participating Provider with at least sixty (60) days' notice prior to the effective date of such change. (N. H. REV. STAT. § 420-J:8(VIII)(d))

NH-4 Participating in Reviews. Health Plan shall not remove the Participating Provider from its network or refuse to renew the Participating Provider with its network for participating in a Covered Person's internal grievance procedure or external review. (N. H. REV. STAT. § 420-J:8(X))

NH-5 Continuity of Care. Each Participating Provider shall continue to provide Covered Services to Covered Persons for a period of sixty (60) days following the date of termination of the Agreement or its, their participation under this Product Attachment, except in the event that such termination is for unprofessional behavior. Each Participating Provider agrees that such services will be provided and paid for in accordance with the terms and conditions of the Covered Person's Coverage Agreement and the Agreement and this Product Attachment. (N. H. REV. STAT. § 420-J:8(XI))

NH-6 Referrals. Each Participating Provider acknowledges that neither the Agreement nor this Product Attachment requires any Participating Provider that is employed by a hospital or any affiliate to refer patients to providers also employed or under contract with the hospital or any affiliate. Nothing in this Section will be construed to prohibit the Payor from providing coverage for only those services that are Medically Necessary and subject to the terms and conditions of the Covered Person's Coverage Agreement. (N. H. REV. STAT. § 420-J:8(XIV))

Nevada

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

NV-1 Parties' Responsibilities. The parties agree that the Agreement, together with its Attachments and the Provider Manual, adequately and completely describes the responsibilities of Health Plan, Provider and each Participating Provider. (NEV. ADMIN. CODE § 695C.190.1)

NV-2 Hold Harmless. Provider and each Participating Provider release Covered Persons from liability for the cost of Covered Services rendered pursuant to the Coverage Agreement, except for any nominal payment made by the Covered Person for a service that is not covered under the Coverage Agreement. (NEV. ADMIN. CODE § 695C.190.2)

NV-3 Term. As set forth in the "Term and Termination" Article of the Agreement, the term of the Agreement is for not less than one year, subject to any right of termination stated in the Agreement. (NEV. ADMIN. CODE § 695C.190.3)

NV-4 Quality Assurance Program. Each Participating Provider shall participate in the programs of Company and Payor to assure the quality of health care provided to Covered Persons by Participating Providers. (NEV. ADMIN. CODE § 695C.190.4)

NV-5 Provision of Services. Each Participating Provider shall provide all Medically Necessary services required by the Coverage Agreement and the Agreement to each Covered Person for the period for which a premium has been paid to Payor. (NEV. ADMIN. CODE § 695C.190.5)

NV-6 Insurance. Each Participating Provider shall provide evidence of a contract of insurance against loss resulting from injuries resulting to third persons from the practice of their profession or a reasonable substitute for it as determined by Health Plan. (NEV. ADMIN. CODE § 695C.190.6)

NV-7 Records. Each Participating Provider who is a physician shall transfer or otherwise arrange for the maintenance of the records of Covered Persons who are their patients if the Participating Provider leaves the panel of physicians associated with Health Plan. (NEV. ADMIN. CODE § 695C.190.7)

NV-8 Schedule for Claims Payment. Payors and each Participating Provider agree to the schedule for the payment of claims set forth in NEV. REV. STAT. § 695C.185. (NEV. REV. STAT. § 695C.187.1)

NV-9 Amendments. The Agreement may be modified at any time pursuant to a written amendment executed by both parties. Except as otherwise provided by this Section NV-9, the Agreement may be modified by Health Plan giving to Provider at least 45 days' written notice of the modification of the schedule of payments, including any changes to the Compensation Schedule applicable to the Participation Provider's practice. If the Provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the Provider objects in writing to the modification within the 45-day period, the modification will not become effective unless agreed to by both parties in writing. (NEV. REV. STAT. §§ 689A.035; 689B.015; 689C.435; 695C.125; 695G.430)

NV-10 Continuation of Care. Subject to the conditions described in NEV. REV. STAT. §§ 689A.04036.2(a) and 689A.04036.4 (individual health insurance), those described in NEV. REV. STAT. §§ 689B.0303.2(a) and 689B.0303.4 (group health insurance), those described in NEV. REV. STAT. §§ 695C.1691.2(a) and 695C.1691.4 (coverage by a health maintenance organization), or those described in NEV. REV. STAT. §§ 695G.164.2(a) and 695G.164.4 (coverage by a managed care plan), as applicable, if a Covered Person is receiving medical treatment for a medical condition from a Participating Provider and the Agreement, or the Participating Provider's participation under the Agreement or in a particular Product, is terminated during the course of the medical treatment, each Participating Provider agrees: (a) to provide medical treatment with regard to the Covered Person under the terms of the Agreement, including, without limitation, the rates of payment for providing medical service, as those terms existed before such termination; and (b) to not to seek payment from the Covered Person for any medical service provided by the Participating Provider that the Participating Provider could not have received from the Covered Person were the provider still a Participating Provider; and (c) the coverage required by this Section NV-10 will be provided until the later of the 120th day after the date of termination or, if the medical condition is pregnancy, the 45th day after: (i) the date of delivery; or (ii) if the pregnancy does not end in delivery, the date of the end of the pregnancy. (NEV. REV. STAT. §§ 689A.04036; 689B.0303; 695C.1691; 695G.164)

NV-11 Notice of Termination. Either party must give the other party at least ninety (90) days' prior notice of termination of the Agreement. (NEV. ADMIN. CODE § 689B.160)

NV-12 Intermediary Contracts. If Provider is a Delivery System Intermediary that accepts risk and assumes financial liability from Health Plan for any Covered Services provided to Covered Persons, this Section NV-12 will apply. A "***Delivery System Intermediary***" has the definition set forth at NEV. ADMIN. CODE § 695C.025, which, as of the Effective Date, is as follows, with certain exclusions: a partnership, association, corporation or other legal entity which enters into a contract with a health maintenance organization to provide health care services, including an entity jointly owned and controlled by a hospital and a physician and an entity primarily owned and controlled by physicians. The health care providers with which the Delivery System Intermediary contracts to furnish health care services to Covered Persons of the health maintenance organization are referred to in this Section NV-12 as "***DSI Providers***".

a. Provider shall provide to the Health Plan a written report, at least quarterly, which identifies the total payments made or owed by Provider to DSI Providers in sufficient detail to enable Company or Payor and the Nevada Commissioner of Insurance to determine whether the payments have been made in a timely manner and in compliance with the applicable provisions of Nevada law. Health Plan will review such reports. (NEV. ADMIN. CODE §§ 695C.505.1 - 695C.505.2)

b. Company or Payor and the Nevada Commissioner of Insurance are authorized, upon reasonable prior notice, to audit, inspect and copy the Provider's books, records and any other evidence of its operations to determine whether it has complied with the applicable provisions of Nevada law, including any regulations adopted pursuant thereto. (NEV. ADMIN. CODE §§ 695C.505.3- 695C.505.4)

c. Provider shall maintain working capital in the form of cash or equivalent liquid assets in an amount equal to at least the lesser of: (a) five hundred thousand dollars ($500,000); or (b) the operating expenses paid for two months calculated by using the monthly average of the operating expenses for the prior six months. As used in this subsection, "operating expenses" means the expenses of the Provider, except money paid or owed to DSI Providers for health services provided pursuant to the Agreement. (NEV. ADMIN. CODE § 695C.505.5)

d. Payor will assume financial responsibility for any Clean Claims that are presented for payment to the Provider by DSI Providers for Covered Services and not paid by the Provider as provided by law and the Agreement. (NEV. ADMIN. CODE § 695C.505.6)

e. Each contract with a Covered Person will be entered into directly with Company or Payor, and not with Provider. (NEV. ADMIN. CODE § 695C.505.7)

f. The responsibilities that Provider assumes are set forth in the Agreement. Provider shall comply with the requirements of the quality assurance programs established by Company or Payors pursuant to NEV. ADMIN. CODE § 695C.400. (NEV. ADMIN. CODE § 695C.505.8)

g. Health Plan shall review, not less than quarterly, Provider's compliance with the provisions of the Agreement. (NEV. ADMIN. CODE § 695C.505.9)

h. If the Provider provides health care services on behalf of more than one entity, Provider shall maintain separate records for each entity. (NEV. ADMIN. CODE § 695C.505.10)

i. Health Plan may terminate its relationship with any DSI Provider with appropriate notice as specified in the Agreement. (NEV. ADMIN. CODE § 695C.505.11)

j. Each contract between Provider and a DSI Provider will be assigned to Health Plan if the Provider fails to pay for Covered Services. (NEV. ADMIN. CODE § 695C.505.12)

k. Any DSI Provider who has a financial interest of more than 10 percent in Provider is prohibited from participating on a utilization review committee or taking any action to change an authorization made by the utilization review committee or an authorized physician. (NEV. ADMIN. CODE § 695C.505.13)

l. Provider shall provide Health Plan, the Commissioner and the State Board of Health with a list of the names of those persons who have a financial interest in Provider and the amount of each person's financial interest. Any change in the financial interests of the Provider must be reported to Health Plan, the Commissioner and the State Board of Health within ten (10) working days after the change. (NEV. ADMIN. CODE § 695C.505.14)

m. Provider is prohibited from assigning the Agreement to any other organization without the prior approval of Health Plan, which is subject to the filing of a material modification of operation pursuant to NEV. REV. STAT. § 695C. 140. (NEV. ADMIN. CODE § 695C.505.15)

n. If Provider hires a company to manage its affairs, Provider or that company shall provide Health Plan with a surety bond or deposit of cash or securities in the amount of $250,000 for the faithful performance of the obligations of the company. (NEV. ADMIN. CODE § 695C.505.16)

o. If, pursuant to the Agreement, Provider evaluates the credentials of Participating Providers, Provider shall comply with the requirements established by Health Plan for evaluating the credentials of providers. (NEV. ADMIN. CODE § 695C.540)

Ohio

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Individual Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OH-1 Services. The Provider Manual describes (a) the specific health care services for which each Participating Provider is responsible, including limitations or conditions on such services (if any); (b) the rights and responsibilities of Health Plan and a Payor, and of the Participating Providers, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements,

and any applicable federal or state programs; and (c) the specifics of any obligation on a Participating Provider that is a primary care provider to provide, or to arrange for the provision of, Covered Services twenty-four (24) hours per day, seven (7) days per week. The procedures for the resolution of disputes arising out of the Agreement are sent forth in the Agreement or Provider Manual. (OHIO REV. CODE §§ 1751.13(C)(1); 1751.13(C)(4); 1751.13(C)(10); 1751.13(C)(11))

OH-2 Covered Person Hold Harmless. Each Participating Provider agrees that in no event, including but not limited to nonpayment by Health Plan or the Payor, insolvency of Health Plan or the Payor, or breach of the Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person or person to whom health care services have been provided, or person acting on behalf of the Covered Person, for Covered Services provided pursuant to the Agreement. This does not prohibit the Participating Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against Health Plan, the Payor or their respective successors. This Section shall survive the termination of the Agreement with respect to Covered Services provided under the Agreement during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of the Payor. (OHIO REV. CODE §§ 1751.13(C)(2); 1751.13(C)(12); 1751.60(C))

OH-3 Continuity of Care. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement in the event of Health Plan's or the Payor's insolvency or discontinuance of operations. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement as needed to complete any Medically Necessary procedures commenced but unfinished at the time of Health Plan's or the Payor's insolvency or discontinuance of operations. The completion of a Medically Necessary procedure shall include the rendering of all Covered Services that constitute Medically Necessary follow-up care for that procedure. The foregoing does not require the Participating Provider to continue to provide any Covered Service after the occurrence of any of the following: (a) the end of the thirty-day period following the entry of a liquidation order under Chapter 3903 of the Ohio Revised Code; (b) the end of the Covered Person's period of coverage for a contractual prepayment or premium; (c) the Covered Person obtains equivalent coverage with another health insuring corporation or insurer, or the Covered Person's employer obtains such coverage for the Covered Person; (d) the Covered Person or the Covered Person's employer terminates coverage under the Coverage Agreement or Payor Contract; (e) a liquidator effects a transfer of Health Plan's or the Payor's obligations under the contract under Section 3903.21(A)(8) of the Ohio Revised Code. (OHIO REV. CODE § 1751.13(C)(3))

OH-4 Records. Each Participating Provider shall keep confidential and make available those health records maintained by the Participating Provider to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to Covered Persons. Each Participating Provider shall make these health records available to appropriate State and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of Covered Persons. Each Participating Provider shall comply with applicable State and federal laws related to the confidentiality of medical or health records. (OHIO REV. CODE § 1751.13(C)(5))

OH-5 Assignment. The contractual rights and responsibilities under the Agreement may not be assigned or delegated by the Participating Provider without the prior written consent of Health Plan. (OHIO REV. CODE § 1751.13(C)(6))

OH-6 Insurance. Each Participating Provider shall maintain adequate professional liability and malpractice insurance, and shall notify Health Plan not more than ten (10) days after the Participating Provider's receipt of notice of any reduction or cancellation of such coverage. (OHIO REV. CODE § 1751.13(C)(7))

OH-7 Covered Person Rights. Each Participating Provider shall observe, protect, and promote the rights of Covered Persons as patients. Each Participating Provider shall provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the Participating Provider appropriately does not render services due to limitations arising from the Participating Provider's lack of training experience, or skill, or due to licensing restrictions. (OHIO REV. CODE §§ 1751.13(C)(8); 1751.13(C)(9))

OH-8 Definitions. The terms used in the Agreement and defined by Chapter 1751 of the Ohio Revised Code are to be construed when used in the Agreement in a manner consistent with those statutory definitions (OHIO REV. CODE § 1751.13(C)(13))

OH-9 Payor's Role. Each Participating Provider acknowledges that the Payor is a third-party beneficiary to the Agreement, and that each Payor retains the right to approve or disapprove the participation of the Participating Provider with respect to any provider panel or network available for a particular Coverage Agreement. (OHIO REV. CODE § 1751.13(F))

OH-10 Oversight. Each Participating Provider acknowledges Health Plan's statutory responsibility to monitor and oversee the offering of Covered Services to Covered Persons. (OHIO REV. CODE § 1751.13(G))

OH-11 Third Party Access. The Agreement applies to network rental arrangements. One purpose of the Agreement is selling, renting or giving Health Plan rights to the services of the Participating Provider, including other preferred provider organizations, and the third party accessing the Participating Provider's services is any of the following: (i) a Payor or a third-party administrator or other entity responsible for administering claims on behalf of the Payor; (ii) a preferred provider organization or preferred provider network that receives access to the Participating Provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the Participating Provider that is in compliance with Ohio Rev. Code § 3963.02(A)(1)(c), and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the Participating Provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iii) an entity that is engaged in the business of providing electronic claims transport between Health Plan and the Payor or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of Health Plan's contract with the Participating Provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iv) an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with Health Plan or its Affiliate for the administration or processing of claims for payment for services provided pursuant to the Agreement with the Participating Provider; or (v) an entity that is an Affiliate or subsidiary of Health Plan or is providing administrative services to, or receiving administrative services from, Health Plan or an Affiliate or subsidiary of Health Plan. (OHIO REV. CODE § 3963.02)

OH-12 Summary Disclosure Form. The summary disclosure form, attached hereto as Schedule A-1, is incorporated herein by this reference. (OHIO REV. CODE § 3963.03)

Pennsylvania

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

PA-1. Hold Harmless. Each Participating Provider hereby agrees that in no event, including, but not limited to non-payment by the Payor, Payor insolvency or breach of the Agreement, shall Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or persons other than Payor acting on their behalf for services listed in this Agreement. This provision does not prohibit collection of supplemental charges or copayments on the Payor's or Participating Provider's behalf made in accordance with the terms of the applicable Coverage Agreement. Each Participating Provider further agrees that (a) the hold harmless provisions herein will survive the termination of the Agreement or this Product Attachment regardless of the cause giving rise to termination and will be construed to be for the benefit of the Covered Person and that (b) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Participating Provider and Covered Person or persons acting on a Covered Person's behalf. Any modification, addition, or deletion to the provisions of this Section will become effective on a date no earlier than fifteen (15) days after the Secretary of Health of the Commonwealth of Pennsylvania has received written notice of such proposed changes. (31 PA. CODE § 301.122)

PA-2. Inpatient Continuation of Benefits. If a Payor becomes insolvent, each Participating Provider shall continue to provide services to Covered Persons for the duration of the period after the Payor's insolvency for which premium payment has been made and until the any Covered Persons that are inpatients at the time of the Payor's insolvency are discharged from the inpatient facilities. (31 PA. CODE § 301.123(b)(2))

PA-3. Termination by Participating Provider. Each Participating Provider shall provide at least sixty (60) days' notice to Payor if Participating Provider terminates the Agreement or termination of their or its participation under the Agreement or this Product Attachment. (31 PA. CODE § 301.124)

PA-4. Managed Care Plans; Continuation of Benefits. This Section 4 applies only with respect to Coverage Agreements that constitute "managed care plans", as defined at 40 PA. STAT. § 991.2102 and 31 PA. CODE § 154.2, which generally involve the use of a gatekeeper and incentives for Covered Persons to use Participating Providers. If Company or a Payor terminates the Agreement or a Participating Provider's participation under the Agreement or this Product Attachment, each Participating Provider shall continue to provide services to Covered Persons in an ongoing course of treatment (as that term is defined in 31 PA. CODE § 154.2) with the Participating Provider, at the Covered Person's option, for a transitional period of up to sixty (60) days from the date the Covered Person's is notified of the termination by Company or Payor. With respect to those Covered Persons in the second or third trimester of pregnancy at the time

of notice of termination, such transitional period will extend through postpartum care related to the delivery. If Company or a Payor terminates the Agreement or a Participating Provider's participation under the Agreement or this Product Attachment for cause, including breach of contract, fraud, criminal activity or posing a danger to a Covered Person or the health, safety or welfare of the public, as determined by the Company or Payor, the Company or Payor is not responsible for health care services provided to Covered Persons following the date of termination. (40 PA. STAT. § 991.2117)

PA-5. Participating Provider's Participation. The Health Plan shall not sanction, terminate or fail to renew the health care provider's participation for any of the following reasons:

PA-5.1 Discussing the process that the managed care plan or any entity contracting with the managed care plan uses or proposes to use to deny payment for a health care service;

PA-5.2 Advocating for medically necessary and appropriate care with or on behalf of the enrollee, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations or tests;

PA-5.3 Discussing the decision of any managed care plan to deny payment for a health care service;

PA-5.4 Filing a grievance on behalf of and with the written consent of an enrollee, or helping an enrollee file a grievance.

South Carolina

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

SC-1 Percentage Copayments and Deductibles. Each Participating Provider agrees that percentage copayments and deductibles paid by Covered Persons are applied to the negotiated rates set forth in the Agreement or lesser charge of such Participating Provider. Nothing in this Section precludes a Payor from offering a Coverage Agreement that contains fixed dollar copayments and deductibles. (S.C. CODE ANN. § 38-71-241)

SC-2 Continuation of Care.

SC-2.1 As used in this Section SC-2: (a) "continuation of care" means the provision of in-network level benefits for services rendered by certain out-of-network providers for a definite period of time in order to ensure continuity of care for Covered Persons for a serious medical condition; and (b) "serious medical condition" means a health condition or illness, that requires medical attention, and where failure to

provide the current course of treatment through the current provider would place the person's health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy. Such attestation by the treating physician must be made upon the request of the patient and in a written form approved by the South Carolina Department of Insurance or prescribed through regulation, order, or bulletin. (S.C. CODE ANN. § 38-71-243(A))

SC-2.2 Each Participating Provider agrees that continuation of care will be provided for ninety (90) days or until the termination of the benefit period, whichever is greater. Each Participating Provider agrees continuation of care will not be provided if suspension or revocation of the Participating Provider's license occurs. (S.C. Code Ann. §§ 38-71-243(A) and (B))

SC-2.3 If the If the Agreement is terminated or nonrenewed, the Participating Provider shall comply with the following requirements: (a) except as required by this Section, the benefits payable for Covered Services rendered during the continuation of care are subject to the terms and conditions of the Coverage Agreement; (b) the Participating Provider shall not require a Covered Person to pay a deductible or copayment that is greater than the in-network rate for Covered Services rendered during the continuation of care; (c) the Participating Provider shall accept as payment in full for services rendered within in the continuation of care the negotiated rate under the Agreement; (d) except for an applicable deductible or a copayment, the Participating Provider shall not bill or otherwise hold a Covered Person financially responsible for services rendered in the continuation of care and furnished by such Participating Provider, unless the Participating Provider has not received payment in accordance with State law; (e) upon receipt of the patient's request accompanied by the physician's attestation on the prescribed form, the Participating Provider and the Covered Person will be notified by the Payor or its delegate of the Participating Provider's date of termination from the network and of the continuation of care provisions as provided for in this Section; and (f) the Participating Provider acknowledges that the Payor determines whether a Covered Person qualifies for continuation of care and may request additional information in reaching such determination. (S.C. CODE ANN. § 38-71-243(C))

SC-3 Limitations. Each party to the Agreement is responsible for the legal consequences and costs of their or its own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party. (S.C. CODE ANN. § 38-71-1740)

SC-4 Hold Harmless. Each Participating Provider agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Covered Persons or persons acting on their behalf, for health care services which are rendered to such Covered Persons by the Participating Provider, and which are covered benefits under the Covered Person's Coverage Agreement. The Participating Provider agrees this provision extends to all Covered Services furnished to the Covered Person during the time they are enrolled in, or otherwise entitled to benefits promised by the Payor. The Participating Provider agrees this provision further applies in all circumstances including, but not limited to, non-payment by the Payor and insolvency of the Payor. This provision does not prohibit collection of copayments from Covered Persons by the Participating Provider in accordance with the terms of the Coverage Agreement issued by the Payor. The Participating Provider further agrees that this provision shall be construed to be for the benefit of Covered Persons of the Payor and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Participating Provider and such Covered Persons, or persons acting on their behalf. (S.C. CODE ANN. § 38-38-130B)

Tennessee

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

For Providers and Contracted Providers in the State of Tennessee, Health Plan or Celtic Insurance Company, an Affiliate, may issue the Coverage Agreement that applies to a Covered Person. In such case the following provisions may apply to the Covered Person or the Participating Provider as applicable.

TN-1 Hold Harmless. Participating Provider agrees that the Agreement contains a hold harmless clause that relieves a Covered Person from any liability for services rendered by Participating Providers except for reasonably copayment and non-Covered Services. (TENN. CODE § 56-32-105(c))

TN-2 Network Access by Third Parties. Participating Provider agrees authorizes the Health Plan to enter into an agreement with third parties allowing each third party to exercise the Health Plan's and/or Payor's rights and responsibilities under the Agreement as if the third party were the Health Plan. (TENN. CODE § 56-60-105)

Texas

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

A. Health Plan Requirements. For a Commercial-Exchange Product that is a Health Plan Product, Participating Providers and Health Plan are required to comply with the provisions of Schedule A-1 and A-2 (State-Mandated Provisions) as applicable to their Agreement, with the following exception described below:

1. Section 5 (Compliance with Prompt Payment Regulations) shall be revised to delete the reference to "Medicaid Covered Persons" and to replace it with "Covered Persons" and revised to replace the phrase "within thirty (30) days of its receipt" with "within forty-five (45) days of its receipt."

B. Insurance Company Requirements. For a Commercial-Exchange Product for which the Payor is not Health Plan, Participating Providers and the Payor are required to comply with the following provisions:

The following provisions are only applicable to HMO product lines:

TX-1 Batched Claims. No Payor or delegate or clearinghouse of a Payor or delegate may refuse to process or pay an electronically submitted clean claim, as that term is defined in Tex. Ins. Code Ann. § 843.336, as may be amended, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim. (TEX. INS. CODE ANN. §§ 843.323; 1301.0641)

TX-2 Upon the giving or receipt of any notice to termination or non-renewal of a Participating Provider's participation under a Coverage Agreement, the Participating Provider will immediately provide the Health Plan or Payor with a list of the Covered Persons currently being treated by the Participating Provider. If the Health Plan or Payor terminates the participation of a Participating Provider under a Coverage Agreement, the Health Plan, Payor or its delegate will provide notice to each Covered Person currently being treated by the affected Participating Provider of the impending termination of the Participating Provider's participation as a Participating Provider under the Covered Person's Coverage Agreement. If Provider or a Participating Provider terminates the participation of the Participating Provider under a Coverage Agreement, the Participating Provider will provide notice to each Covered Person currently being treated by the affected Participating Provider of the impending termination of the Participating Provider's participation as a Participating Provider under the Covered Person's Coverage Agreement. (TEX. INS. CODE ANN. §§ 1301.152; 1301.160)

TX-3 Podiatrists. If a Participating Provider is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners, the provisions set forth in this Section apply. The Participating Provider may request, and the Payor shall provide not later than the thirtieth (30th) day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the Participating Provider receives or will receive under this Attachment. The Payor may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules. The Participating Provider may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the Coverage Agreement. (TEX. INS. CODE ANN. §§ 843.311, 1301.062)

TX-4 Claim Submission; Prompt Payment.

TX-4.1 As required by applicable State law, Provider and each Participating Provider shall submit a claim no later than the ninety-fifth (95th) day after the date of service. A claim not submitted within such time frame may be denied for payment, unless the failure to submit the claim in compliance with this section is a result of a catastrophic event that substantially interferes with the normal business operations of the Provider or the Participating Provider. Neither Provider nor a Participating Provider (or any delegate) shall submit a duplicate claim for payment before the forty-sixth (46th) day after the date the original claim was submitted. (TEX. INS. CODE ANN. §§ 843.337, 1301.102)

TX-4.2 Except as otherwise provided in applicable State law, Payor shall determine whether a clean claim submitted by Provider or a Participating Provider for Covered Services is payable

not later than the forty-fifth (45th) day after the date on which a clean claim in a nonelectronic format is received, or not later than the thirtieth (30th) day after the date on which a clean claim in an electronic format is received. Except as otherwise provided in applicable State law, Payor shall pay clean claims submitted by Provider or a Participating Provider for Covered Services on or before the later of (i) the forty-fifth (45th) day after the date on which the claim for payment is received with the documentation reasonably necessary to process the claim, or (ii) the last day in the time period specified in the Agreement or the Provider Manual for payment of claims. (TEX. INS. CODE ANN. §§ 843.336-843.354; 1301.064, and 1301.101-109)

TX-5 Waiver of Electronic Claims. When expressly required by applicable State law, a waiver of any requirement under the Agreement or this Product Attachment for the electronic submission of a claim made with respect to a Coverage Agreement may be obtained in accordance with the process set forth in the Provider Manual. (TEX. INS. CODE ANN. § 1213.003)

TX-6 Gag Clause. Neither Health Plan nor Payor shall limit, prohibit, or attempt to prohibit Provider or a Participating Provider from discussing with or communicating in good faith with Covered Persons that are patients or a person designated by a Covered Person that is a patient with respect to: (a) information or opinions regarding the Covered Person's health care, including the patient's medical condition or treatment options; (b) information or opinions regarding the terms, requirements, or services of the Coverage Agreement as they relate to the medical needs of the Covered Person; or (c) the termination of the Agreement or the fact that the Participating Provider will otherwise no longer be providing medical care, dental care, or health care services under the Coverage Agreement. Neither Health Plan nor Payor shall in any manner penalize, terminate, or refuse to compensate for Covered Services a Provider or Participating Provider for communicating in a manner protected by this section with a current, prospective, or former patient that is a Covered Person, or a person designated by a patient that is a Covered Person. (TEX. INS. CODE ANN. §§ 843.363, 1301.067)

TX-7 Complaint Resolution. The Agreement or Provider Manual, as applicable, sets forth or identifies the mechanism to be used utilized in resolving complaints initiated by a Covered Person, Provider or a Participating Provider. (TEX. INS. CODE ANN. § 1301.055)

TX-8 Discounted Fees. Provider and each Participating Provider agree that to the extent that Provider or a Participating Provider is compensated on a discounted fee basis, the Covered Person may be billed only on the discounted fee and not the full charge for services. (TEX. INS. CODE ANN. § 1301.061)

TX-9 Overpayments. Neither Health Plan nor Payor may recover an overpayment to Provider or a Participating Provider if, not later than the one hundred eightieth (180th) day after the date the Participating Provider receives the payment, the Payor, Health Plan or one of their delegates provides written notice of the overpayment to Provider or the Participating Provider that includes the basis and specific reasons for the request for recovery of funds, and either Provider or the Participating Provider makes arrangements for repayment of the requested funds on or before the forty-fifth (45th) day after the date the notice is received. (TEX. INS. CODE ANN. §§ 843.350, 1301.132)

TX-10 Access by Payors. Pursuant to this Agreement and notwithstanding anything herein to the contrary, Health Plan has Provider's permission and express authority to provide access to the health care products and services to be provided pursuant hereto, and the contractual discounts provided for herein, to any and all persons who are Payors, including without limitation, Health Plan, and all group customers of Health Plan (including self-funded employers and other organizations). Health Plan may sell, lease, or

otherwise transfer information regarding the payment or reimbursement terms of this Agreement (and its Addenda and Attachments) to such persons and Payors. Health Plan will provide prior notification to Provider of the persons and Payors to whom access is granted by providing the name of the Payor by electronic mail, through its provider newsletter or on its provider website; provided, however, Provider acknowledges that prior adequate notice has been provided with respect to Health Plan, and all self-funded groups existing as of the date hereof. Provider expressly acknowledges that Health Plan may provide the persons and Payors described above with access to Health Plan's rights and responsibilities under this Agreement. On request of Provider or a Contracted Provider, Health Plan will provide information necessary to determine whether a particular person has been authorized to access the Provider's or a Contracted Provider's health care services and the contractual discounts provided for herein. To the extent required by applicable law, this Agreement specifies the applicable fee schedule for each Product and/or line of business contemplated by this Agreement. Each person or Payor granted access to the health care products and services and the contractual discounts hereunder must comply with all applicable terms, limitations, and conditions of this Agreement. Health Plan will provide such person or Payor with reasonable access, including electronic access, during normal business hours for the review of this Agreement, which access will be allowed only for the purposes of complying with the terms of this Agreement or applicable state law. Pursuant to its signature on the Product Attachments attached hereto, Provider provides its express authority with respect to each line of business and the fee schedule applicable to each such line of business.

The following provisions are only applicable to EPO product line:

TX-11 Contracting with Others. This Agreement does not restrict a participating provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaborative, or HMOs. (28 TEX. ADMIN. CODE § 3.3703(a)(1))

TX-12 Limitation on Participation. Any term or condition of this Agreement limiting participation on the basis of quality considerations shall be construed to be consistent with established standards of care for the applicable profession. (28 TEX. ADMIN. CODE § 3.3703(a)(2))

TX-13 Provider Privileges. In the case of participating providers who provide a significant portion of care in a hospital or institutional provider setting, this Agreement may require the possession of practice privileges at participating hospitals or institutions, provided, however, if no participating hospital or facility offers privileges to a certain class of physicians or providers, the lack of hospital or facility provider privileges may not be a basis for denial of participation as a participating provider to such physicians or providers of that class. (28 TEX. ADMIN. CODE § 3.3703(a)(3))

TX-14 Staff Membership or Privileges. A physician or provider is not required to enter into a participating provider agreement as a condition of staff membership or privileges at a particular hospital or facility. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges. (28 TEX. ADMIN. CODE § 3.3703(a)(4))

TX-15 Billing for Unnecessary Care. A participating provider will not bill the member for unnecessary care, if the care has been determined to be unnecessary, provided, however, the participating provider will not be required to pay for hospital, institutional, laboratory, x-ray, or like charges resulting from the provision of services lawfully ordered by a physician or provider, even though such service may be determined to be unnecessary. (28 TEX. ADMIN. CODE § 3.3703(a)(5))

TX-16 Referrals to Other Providers. This Agreement does not impose restrictions on the classes of physicians and providers who may refer a member to another physician or provider. This Agreement does not require a referring physician or provider to bear the expenses of a referral for specialty care in or out of the participating provider network. (28 TEX. ADMIN. CODE § 3.3703(a)(6))

TX-17 Financial Incentives. Financial incentives will not be provided to a physician or a provider that act directly or indirectly as an inducement to limit medically necessary services. The requirements of TX-16 (above) and this Paragraph TX-17 do not prohibit the savings from cost-effective utilization of health services from being shared with participating providers in the aggregate. (28 TEX. ADMIN. CODE § 3.3703(a)(7))

TX-18 Resolution of Complaints. This Agreement provides for a mechanism for the resolution of complaints initiated by a member, a physician, physician group, or provider, which mechanism provides for reasonable due process including, in an advisory role only, a review panel selected in accordance with Section 3.3706(b)(2) of the PPO/EPO Regulations. (28 TEX. ADMIN. CODE § 3.3703(a)(8))

TX-19 Hold Harmless. A provider, physician, or physician group will not be required to execute a hold harmless clause that shifts the tort liability resulting from acts or omissions of Health Plan to the participating provider. (28 TEX. ADMIN. CODE § 3.3703(a)(9))

TX-20 Member Billing. Any participating provider who is compensated on a discounted fee basis agrees to bill the member only on the discounted fee and not the full charge. (28 TEX. ADMIN. CODE § 3.3703(a)(10))

TX-21 Prompt Payment. Health Plan will comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to members. (28 TEX. ADM. CODE § 3.3703(a)(11))

TX-22 Continuity of Care. Health Plan and the participating provider will comply with Tex. Ins. Code §§1301.152 - 1301.154, relating to continuity of care. (28 TEX. ADM. CODE §3.3703(a)(12))

TX-23 Member Communication. Health Plan will not, as a condition of this Agreement or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former member, or a person designated by a member, information or an opinion: (a) regarding the member's health care, including the member's medical condition or treatment options; or (2) in good faith regarding the provisions, terms, requirements, or services of the health insurance coverage as they relate to the member’s medical needs. Health Plan may not in any way penalize, terminate the participation of, or refuse to compensate for covered services, a physician or health care provider for discussing or communicating with a current, prospective, or former member, or a person designated by a member. (28 TEX. ADM. CODE § 3.3703(a)(13))

TX-24 Economic Profiles. To the extent Health Plan conducts, uses or relies upon economic profiling to terminate physicians or providers from a plan, it will make available to a physician or provider on request the economic profile of that physician or provider, including the written criteria by which the physician’s or provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or provider's practice that may account for variations from expected costs. (28 TEX. ADMIN. CODE § 3.3703(a)(14))

TX-25 Quality Assessments. To the extent Health Plan engages in quality assessments, it will do so in accordance with the requirements of applicable law through a panel of at least three physicians selected by Health Plan from among a list of participating physicians. The participating physicians in the applicable service area shall provide the list of physicians to Health Plan. (28 TEX. ADMIN. CODE § 3.3703(a)(15))

TX-26 Immunization and Vaccination Protocol. A participating physician is not required to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to a member by a pharmacist. (28 TEX. ADMIN. CODE § 3.3703(a)(16))

TX-27 Immunizations and Vaccinations by Pharmacist. A pharmacist will not be prohibited from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Tex. Occ. Code Chapters 551-566 and 568-569, and applicable rules promulgated thereunder. (28 TEX. ADMIN. CODE § 3.3703(a)(17))

TX-28 Member Notice Upon Termination. If the participating provider voluntarily terminates this Agreement, the participating provider must provide reasonable notice to the member, and Health Plan will provide assistance to the participating provider in assuring that such notice is provided. (28 TEX. ADMIN. CODE § 3.3703(a)(18))

TX-29 Termination Review. Written notice will be provided to the participating provider on termination of this Agreement by Health Plan, and such notice will include the participating provider's right to request a review. (TEX. ADMIN. CODE § 3.3703(a)(19))

TX-30 Information on Compensation. The participating provider is entitled, upon request, to all information necessary to determine that the participating provider is being compensated in accordance with the terms of this Agreement. The participating provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made for covered services that are rendered to members. Health Plan may provide the required information by any reasonable method through which the participating provider can access the information, including e-mail, website, computer disks, paper, or access to an electronic database. Health Plan will provide the fee schedules and other required information by the 30th day after receipt of the request.

a. This information will include a specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by the participating provider, including the information required in Section 3.3703(a)(20) of the PPO/EPO Regulations.

b. In the case of a reference to source information as the basis for fee computation that is outside the control of Health Plan, such as state Medicaid or federal Medicare fee schedules, the information will clearly identify the source and explain the procedure by which the participating provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

c. Nothing herein may be construed to require Health Plan to provide specific information that would violate any applicable copyright law or licensing agreement. However, Health Plan will supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the

information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made for covered services that are rendered to members.

d. No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided will be effective as to the participating provider, unless Health Plan provides at least 90 calendar days written notice to the participating provider identifying with specificity the amendment, revision or substitution. Health Plan will not make retroactive changes to claims payment procedures or to any of the information required to be provided as described above.

e. A participating provider that receives the information described above (i) may not use or disclose the information for any purpose other than for practice management, billing activities, other business operations, or communications with a governmental agency involved in the regulation of health care or insurance; (ii) may not use the information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to a member or to misrepresent any aspect of the services; and (iii) may not rely upon the information as a representation that a member is covered for that service under the terms of the member's policy or certificate.

f. A participating provider that receives the information described above may terminate this Agreement on or before the 30th day after the date the participating provider receives the information without penalty or discrimination with respect to the participation in other health care products or plans of Health Plan. If a participating provider chooses to terminate the Agreement, Health Plan is required to assist the participating provider in providing the notice required by Paragraph 18 above. (28 TEX. ADMIN. CODE § 3.3703(a)(20))

TX-31 Other Health Benefit Coverage. A participating provider must retain in its records updated information concerning a member's other health benefit plan coverage. (28 TEX. ADMIN. CODE § 3.3703(a)(21))

TX-32 Claim Submission. Upon request by a participating provider, Health Plan agrees that it and its clearinghouse will not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this paragraph, the term batch submission is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. (28 TEX. ADMIN. CODE § 3.3703(a)(22))

TX-33 Referral Information. A referring physician or provider, or a designee, must disclose to the member (a) that the physician, provider, or facility to whom the member is being referred might not be a participating provider; and (b) if applicable, that the referring physician or provider has an ownership interest in the facility to which the member is being referred. The notice specified in (a) will allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and will not limit access to nonparticipating providers. (28 TEX. ADMIN. CODE § 3.3703(a)(23) and (24))

TX-34 Overpayments. The participating provider who receives an overpayment from a member must refund the amount of the overpayment to the member not later than the 30th day after the date the participating provider determines that an overpayment has been made. (28 TEX. ADMIN. CODE § 3.3703(a)(25))

TX-35 Facility Based Physician Groups. A participating hospital or facility must provide notice to Health Plan of the termination of a contract with a facility-based physician group (that is a participating provider) as soon as reasonably practicable, but not later than the fifth business day following termination of the contract. (28 TEX. ADMIN. CODE § 3.3703(a)(26))

TX-36 Referrals to Out-Of-Network Providers. Except for instances of emergency care, a participating provider referring a member to a hospital or facility for surgery must (a) notify the member of the possibility that out-of-network providers may provide treatment and that the member may contact Health Plan for more information; (b) notify Health Plan that surgery has been recommended; and (c) notify Health Plan of the hospital or facility that has been recommended for the surgery. (28 TEX. ADMIN. CODE § 3.3703(a)(27))

TX-37 Referrals to Out-Of-Network Facilities. Except for instances of emergency care, when scheduling surgery, a hospital or facility must (a) notify the member of the possibility that out-of-network providers may provide treatment and that the member may contact Health Plan for more information; and (b) notify Health Plan that surgery has been scheduled. (28 TEX. ADMIN. CODE § 3.3703(a)(28))