



Provider Manual ***for*** ***Tier 1*** ***Participating Providers***

- ***Billing Information***
- ***Appeal Process***
- ***Quality Management Program***

2009

Billing and Reimbursement Instructions for Tier 1 Providers

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How to File a Claim for Professional Services for **Tier 1 Providers**

The criteria for submitting professional claim forms for a Tier 1 participating provider is summarized in the table below:

Who:	When:	Where:	How:
<ul style="list-style-type: none"> • All SmartHealth Tier 1 participating providers • All Medicare supplemental claims 	<p>Claim form must be received by ABS within 24 months from the date of service.</p> <p>Claims submitted for secondary payment must be received 6 months from the date the primary payer processed the claim.</p>	<p>Submit all claims to:</p> <p>ABS for SmartHealth P.O. Box 37705 Oak Park, MI 48237-7705</p>	<p>All claims must be typed on HCFA 1500 claim forms.</p> <p>Electronic submission of claims available under Payer ID 38259**</p>

**Vendors to process electronic claims: CAREVU, Web MD/Envoy, THIN, MCSI, ENS, ProxyMed, claimsnet.com, McKesson and NDC.

To avoid rejected claims, please be sure to include the following data elements:

- Member ID # (including TJP Prefix)
- Patient's name
- Patient's birth date and sex
- Insured's Group #
- Indication of Auto - Employment - Emergency related condition (when applicable)
- Authorization Number - include referral or authorization when applicable
- Name of Referring Physician. If the patient self-referred, type "self"
- Diagnosis code
- Date of Service
- Procedure Code (CPT or HCPCS when applicable, with appropriate modifiers)
- Billed Charges
- # of units
- Total Charges
- Provider Tax ID #
- Provider NPI #
- Provider's billing address and phone number

Claims received missing any of the above referenced data elements will be returned to the provider for completion.

Tier 2 Providers – file claims to Blue Cross Blue Shield, using TJP as the alpha prefix, according to local Blue Cross rules.

Billing Requirements for Preventive Services

Annual Physical

Annual Routine Physicals have no copayment when SmartHealth enrollees seek services from a Tier 1 SmartHealth physician.

- Bill annual physical exams using Preventive Medicine codes in the range of 99381 through 99397, based on age appropriateness.

The preventive medicine code will be the indicator that a copayment is waived for the exam.

Annual Gynecological Exam

Annual gynecological exams, including pap smear, have no copayment when SmartHealth enrollees seek services from a Tier 1 SmartHealth physician.

- Bill annual well woman exams using appropriate Preventive Medicine code with the **diagnosis of V72.31** to designate the visit as an annual well exam. The diagnosis code is the indicate that a copayment is waived.

Mid-Level Providers

Nurse Practitioners can now bill for services under their own name and NPI, and will be reimbursed at 85% of the fee schedule.

Physician Assistants must bill under the supervising physician's name and NPI number.

Provider Reimbursement Rules

- Tier 1 Claims are processed and paid by Automated Benefit Services (ABS)
- Claims submitted with all required data elements will be processed within 45 days from receipt of the claim.
- An explanation of payment (EOP) will accompany payment for each service billed.
- Here's a sample:

								EXPLANATION OF BENEFITS													
								Date:													
								Page:													
								EOB No:													
								EOB No:													
								Ident:													
Provider Name:																					
Provider Address:																					
Attn: (Provider Name)																					
This is an explanation of payment for services rendered.																					
Claim/Patient Breakdown																					
Claim Number	Acct # / Patient Name	Date of Birth	Date of Service	Proc	Charge	Ded/Coins	Inelig	Paid	Ref												
Ref	Explanation																				
<table border="1" style="border-collapse: collapse;"> <tr> <th style="width: 15%;">Total</th> <th style="width: 15%;">Charge</th> <th style="width: 15%;">Ded/Coins</th> <th style="width: 15%;">Inelig</th> <th style="width: 15%;">Paid</th> <th style="width: 15%;"> </th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>										Total	Charge	Ded/Coins	Inelig	Paid							
Total	Charge	Ded/Coins	Inelig	Paid																	

Provider Payment Inquiry Process

Payment inquiries are welcomed for claims that have been submitted for dates of service that are greater than 60 days old.

The process to contact ABS concerning Tier 1 claim issues is as follows:

When:	How:	What's Needed:	When can a response be expected:
60 days after the date of service	By Phone: 888-492-6811	A copy of the outstanding claim for reference. Please limit call to 4 claims.	Immediate
60 days after the date of service	By Fax Recall: 888-492-6811	Follow prompts; enter contract number, tax ID number and fax number	Within 2-3 minutes, a return fax will detail the 6 mos claims history for your tax id.
60 days after the date of service	By Mail: ABS PO Box 37705 Oak Park, MI 48237	An original claim form stamped "status inquiry" in red ink in the upper right hand corner.	Within 21 days from receipt of the inquiry.

ABS is committed to resolving all claim inquiries in an efficient manner. In the event a provider is unable to finalize a payment inquiry after 30 days from the initial request, please contact the ABS Customer Service Supervisor. Documentation of the original request is required in order to address the service delay. Resolution can be expected within 10 business days.

Please have the following information available when calling the claims manager:

Type of Inquiry:	Information Required:
Written	A copy of the status inquiry claim
Phone	The date of the original inquiry Name of the assisting ABS service representative Status of the claim at the time of the call Expected outcome

* A member may not be billed for covered services (other than a co-pay) until after the provider has received an explanation of payment from ABS.

Provider Requests for Adjustment to Processed Claims

Processed claims will be considered for a payment adjustment for the circumstances listed below:

- Original claim was submitted with incorrect information
- Payment was made to the incorrect provider
- Payment was made at the incorrect contracted amount
- Payment was not made due to a processing error
- Coordination of Benefits was calculated incorrectly
- Provider received a duplicate payment

Follow these steps to initiate an adjustment request:

What's needed:	How to initiate:		Timeframe to submit:	Timeframe to process:
1. Copy of EOP 2. Reason for request 3. Supporting documentation 4. Copy of original claim (if applicable)	By phone: Processing errors may be handled over the phone. Call provider service for assistance.	Written: Fill out request form and attach the required data. Mail to ABS	Requests for adjustments will only be considered up to 180 days from the date the claim was processed.	Adjustment requests will be processed within 30 days from receipt of all necessary information. A final copy of the adjustment request will be returned to the requesting provider when completed.

ABS is committed to resolving all claim inquiries in an efficient manner. In the event a provider is unable to finalize a payment inquiry after 30 days from the initial request, please contact the ABS Customer Service Supervisor. Documentation of the original request is required in order to address the service delay. Resolution can be expected within 10 business days.

Please have the following information available when calling the claims manager:

Type of Inquiry:	Information Required:
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* A member may not be billed for covered services (other than a co-pay) until after a provider has received an explanation of payment from ABS.

Quality Management Program

The Quality Management Program is designed to provide the framework for assessing and improving the quality of clinical care and services provided to SmartHealth members. The Program has been developed in conjunction with Ascension Health's missions, values and philosophy. The program encompasses a wide range of evaluation and monitoring activities that include the following components:

- ◆ A governing body
- ◆ An appeals process
- ◆ A provider sanction program
- ◆ Annual evaluation of the Medical Management Program
- ◆ Monitoring of the timeliness of decisions – authorization process, notification procedures
- ◆ Monitoring of utilization data to detect potential under- and over-utilization (ensuring appropriate service and coverage)
- ◆ Evaluation of the consistency with which the health care professionals involved in utilization review make decisions
- ◆ Provider/member satisfaction with the Medical Management Program and the health plan as a whole

Appeal Process

Pre-Service/Concurrent Care/Time-Sensitive Claim and Non-Covered Benefits

The provider and/or member may initiate an appeal of an adverse benefit determination. The Plan requires one level of review for pre-service Concurrent Care and Time-Sensitive Claims and for Non-Covered Benefits. Civil action may be brought in court if the claim remains denied after the required one level appeal review. A voluntary second level appeal may be submitted, but is not required.

First Level Appeal

Pre-Service/Concurrent Care Claim

The appeal request must be submitted in writing, within 180 days from the date of receipt of the initial decision. Concurrent Care appeals should be submitted in time to continue the course of treatment. An explanation of why the claim should not have been denied and any additional information, materials or documentation that supports the claim should be sent via fax or mail to:

SmartHealth Appeals Committee
c/o St. John Health Managed Care, Appeals Coordinator
28000 Dequindre Road
Warren, MI 48092-2468
Fax: (586) 753 – 0981

Time-Sensitive Claim

Submit the appeal as soon as possible. Request for an expedited review may be written or submitted orally by the Provider. All necessary information may be provided by telephone, fax or any other expeditious method that is available.

Non-Covered Benefit

The appeal request must be submitted in writing within 180 days after receipt of the initial decision. Include all supporting information and submit to:

SmartHealth Post-Service Appeals Committee
c/o St. John Health Managed Care
28000 Dequindre
Warren, MI 48092-2486

Second Level Appeal (Voluntary)

The request for appeal must be made within 60 days of the date of receipt of the Level I Appeal denial. All appeals must be made in **writing** and sent with any additional related information or documentation that supports the claim to the following address:

SmartHealth Regional Advisory Committee
c/o St. John Health Managed Care, Appeals Coordinator
28000 Dequindre
Warren, MI 48092-2468

Appeal Process – Post Service

A member or provider may initiate a Post-Service Appeal for any service that has already been provided and for which an adverse benefit determination has been made.

There are two required levels of review. Civil action may be brought in court if the claim remains denied after the required levels of review.

First Level Appeal

The request for appeal must be submitted in **writing** within 180 days from the date of receipt of the initial decision. An explanation of the reasons why the claim should not have been denied and any additional supporting information, materials or documentation should be sent via mail to:

SmartHealth Post-Service Appeals Committee

c/o Automated Benefit Services

PO Box 37705

Oak Park, MI 48237-7705

Fax: (586) 693-4820

Second Level Appeal

The request for appeal must be initiated within 60 days after date of receipt of the Level I appeal denial. All appeals must be submitted in **writing** and sent with additional related information to:

SmartHealth Regional Advisory Committee

c/o St. John Health Managed Care, Appeals Coordinator

28000 Dequindre

Warren, MI 48092-2468

Provider Sanction Policy

Adherence to the policies and procedures set forth in this manual will be monitored for all SmartHealth Tier 1 Network Providers.

The sanction policy will be applied to the following situations:

1. Billing of a member for:
 - Copying of medical records
 - Services that are covered medical expenses of the health plan
 - Balance billing
 - Services rendered past the filing limit of the claim
2. Failure to follow the established guidelines for any service requiring authorization
3. Refusal to release medical information (patient records) upon the written request of:
 - Any agent or representative of SmartHealth Medical Management Department
 - A member or his/her authorized representative (to allow for continuity of care)
4. Collecting coinsurance/deductible payments from a member prior to having received an explanation of payment voucher from ABS

The Sanction policy is progressive; each occurrence runs sequentially through the corrective action policy with no specific timeframe between occurrences. The policy is as follows:

First Occurrence: A sanction letter is sent to the physician/office (via registered mail) identifying the occurrence. The physician is asked to rectify the situation and report the outcome.

Second Occurrence: A call is placed to the physician/office from the SmartHealth Medical Director for personal review of the policy. A follow up letter is sent to the physician/office acknowledging understanding of the proper plan guidelines.

Third Occurrence: Financial penalty of \$250.00 is imposed against the provider. Notification letter is sent registered mail, return receipt. Payment is due in 10 business days from the date of the letter.

Fourth Occurrence: Physician is recommended for deparicipation from SmartHealth Tier 1 affiliation after review and approval of the Regional Governance Committee. A notification letter is sent registered mail, return receipt. Physician will be notified of the appeal process in the letter.