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## Overview

The Billing section is designed to keep you and your office staff up to date on how to do business with us. Included are topics such as submitting Clean Claims, submitting proper codes used for accurate disbursement, and information and requirements pertaining to your National Provider Identifier (NPI). In addition, this section contains important information about electronic transaction channels, including clearinghouse options for electronic claims submission and the NaviNet<sup>®</sup> web portal, our secure Provider portal that expedites processing and payment.

## Referrals

Referrals are required for HMO and POS Members when using their in-network (referred) benefits. One of the important functions Primary Care Physicians (PCP) perform is coordinating the care an HMO Member receives from other health care Providers. Detailed information on Referrals can be found in the *Administrative Procedures* section of this manual.

### PCP Referral guidelines by product

AmeriHealth HMO
<ul style="list-style-type: none"> <li>Members must select a PCP from the AmeriHealth network.</li> <li>Referrals are required, except for OB/GYN services, including subspecialties. See the <i>OB/GYN</i> section for more information.</li> </ul>
<b>Products include:</b> <ul style="list-style-type: none"> <li>AmeriHealth HMO</li> <li>AmeriHealth HMO Coinsurance</li> <li>AmeriHealth HMO Flex Programs</li> </ul>
AmeriHealth POS
<ul style="list-style-type: none"> <li>Members must select a PCP from the AmeriHealth network.</li> <li>Referrals are required for Members to receive the highest level of benefits, except for OB/GYN services, including subspecialties. See the <i>OB/GYN</i> section for more information.</li> </ul>
<b>Products include:</b> <ul style="list-style-type: none"> <li>AmeriHealth POS</li> <li>AmeriHealth POS Coinsurance</li> <li>AmeriHealth POS Flex Programs</li> </ul>

AmeriHealth — Direct POS (PA only)
<ul style="list-style-type: none"> <li>▪ Members must select a PCP from the AmeriHealth network.</li> <li>▪ Referrals are required only for the following services:               <ul style="list-style-type: none"> <li>– laboratory* — PCPs and specialists should continue to use the laboratory requisition form</li> <li>– occupational therapy*</li> <li>– physical therapy*</li> <li>– podiatry</li> <li>– routine radiology*</li> <li>– spinal manipulations*</li> </ul> </li> <li>▪ Members receive the highest level of benefits when they obtain Referrals for the services noted above. For all other services, Referrals are not required.</li> </ul>
<b>Products include:</b> <ul style="list-style-type: none"> <li>▪ AmeriHealth — Direct POS Flex Copay Series</li> <li>▪ AmeriHealth — Direct POS Flex Deductible Series</li> </ul>

*\*For capitated services, PCPs should refer the Member to their designated site, unless the Member requests a Referral to receive these services from another Participating Provider.*

The following products are not HMO products and do *not* require the Member to select a PCP or obtain Referrals. However, Members receive the highest level of benefits when they seek care from Providers who participate in the AmeriHealth network:

- AmeriHealth PPO (DE only)
- AmeriHealth PPO Flex (DE only)
- Comprehensive Major Medical (CMM) (DE only)

*Note:* Certain services require Preapproval. AmeriHealth will not consider services for payment without the necessary Preapproval. Refer to [www.amerhealth.com/preapproval](http://www.amerhealth.com/preapproval) for a list of services that require Preapproval.

## Authorizations

Admitting Physicians are responsible for obtaining Preapproval at least five days prior to a scheduled admission and notifying the facility of the Preapproval number. The hospital must contact AmeriHealth prior to the admission to verify eligibility and the Preapproval number. All pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital Preapproval.

The following authorization types must be requested through NaviNet: medical/surgical procedures cardiac rehabilitation; chemotherapy/infusion; durable medical equipment (DME); Emergency hospital admission notification; home health (dietitian/home health aide/occupational therapy/physical therapy/skilled nursing/social work/speech therapy); home infusion; outpatient speech therapy; pulmonary rehabilitation; sleep studies.

*Note:* Customer Service representatives are no longer able to initiate the authorizations listed above.

Refer to the *Care Management and Coordination* and *Administrative Procedures* sections for more information about obtaining Preapproval.

## Prior authorization criteria and forms for pharmacy benefits

Participating Providers are required to contact FutureScripts®, our pharmacy benefits manager, to obtain prior authorization for pharmacy-related benefits for all Members who have prescription drug coverage through AmeriHealth. For a complete list of pharmacy-related benefits that require prior authorization, see the *Pharmacy* section of this manual.

## The NaviNet® web portal

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NaviNet, a Health Insurance Portability and Accountability Act (HIPAA)-compliant Web-based connectivity solution offered by NaviNet, Inc., is a fast and efficient way to interact with us to streamline various administrative tasks associated with our Members' health care. By providing a gateway to our systems at AmeriHealth, NaviNet enables you to submit and receive information electronically with increased speed, efficiency, and accuracy. The portal also supports HIPAA-compliant transactions.

For detailed information on NaviNet, see the *Administrative Procedures* section of this manual.

## Clear Claim Connection™

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Clear Claim Connection is a Web-based code auditing reference tool designed to mirror how ClaimCheck® evaluates code combinations during the auditing of professional claims. Clear Claim Connection enables AmeriHealth to disclose its claim auditing rules and clinical rationale inherent to the ClaimCheck system. Through this tool, you can view the justifications and clinical rationale on why code combination logic was applied to a professional claim processed in the base claims processing system. Providers can access this tool through NaviNet by selecting *Claim Inquiry and Maintenance* from the Plan Transactions menu or on our website at [www.amerihealth.com/providers/claims\\_and\\_billing/clear\\_claim\\_connection.html](http://www.amerihealth.com/providers/claims_and_billing/clear_claim_connection.html).

Upgrades to ClaimCheck are scheduled twice yearly, typically in the spring and fall. Edits are based on recommendations (sourced) by various nationally accepted authorities, including the American Medical Association, CPT® (Current Procedure Terminology), Centers for Medicare & Medicaid Services (CMS), and national specialty societies.

ClaimCheck and Clear Claim Connection are updated regularly for consistency with medical and claim payment policy, new procedure codes, current health care trends, and/or medical and technological advances. ClaimCheck clinical relationship logic is applied based on the date a claim is processed, reprocessed, or adjusted in our claims processing system. This logic is not applied based on the date the service was performed. Therefore, claims that are reprocessed or adjusted for any reason may receive a different editing outcome from ClaimCheck based on the clinical relationship logic that is in effect at the time the claim adjustment occurs. Notwithstanding the foregoing, it is understood that a specific claim payment policy may supersede the terms of ClaimCheck with respect to the subject of that claim payment policy only. Detailed disclosures of all ClaimCheck code edits are available through Clear Claim Connection, which is accessible through NaviNet.

## Provider Automated System

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Providers can use the Provider Automated System, our speech-enabled, automated phone service, to complete common administrative tasks such as Member eligibility, claims status, authorizations, Referrals, and encounter submissions. For detailed instructions on how to use this system, visit [www.amerihealth.com/providerautomatedsystem](http://www.amerihealth.com/providerautomatedsystem). Additional information about when to use the Provider Automated System is located in the *Administrative Procedures* section of this manual.

*Note:* The Provider Automated System does not support behavioral health information. For information regarding behavioral health, call Magellan Behavioral Health, Inc. at 1-800-688-1911.

## **Billing/reimbursement requirements**

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Providers are required by the HIPAA Transactions and Code Sets Rules to use only codes that are valid at the time a service is provided from the following coding systems:

- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases – Ninth Revision – Clinical Modification (ICD-9-CM)

National entities, including the American Medical Association, CMS, and the U.S. Department of Health and Human Services (HHS), release scheduled updates to CPT, HCPCS, and ICD-9-CM procedure/diagnosis codes, respectively. We monitor those schedules and react according to the following timeline:

- **CPT:** Biannual release of codes with effective dates of January 1 and July 1.
- **HCPCS:** Quarterly release of codes with effective dates of January 1, April 1, July 1, and October 1.
- **ICD-9-CM:** Biannual release of codes with effective dates of April 1 and October 1.

*Note:* Timeline reflects schedule of the dictating entity and, therefore, may be subject to change.

### **CPT and HCPCS billing codes**

Procedures must be billed using the five-digit numeric CPT codes from the Physician's CPT manual. Attachments or written descriptions of the services being performed will not be considered a proper billing procedure. Documentation in the Member's medical report must clearly support the procedures, services, and supplies coded on the health insurance form.

*Note:* Some CPT codes may be included in global fees to facilities and therefore are not eligible for separate reimbursement. You may bill the facility in those instances.

Some services or procedures performed by health care professionals are not found in the CPT coding system. If a specific CPT code cannot be located, check for a reportable HCPCS code. Unlisted procedure codes *should not be used* unless a more specific code is not available.

### **Unlisted procedure codes**

Each section of the CPT coding system includes codes for reporting unlisted procedures. They may be new procedures that have not yet been assigned a CPT code, or they may simply be a variation of a procedure that precludes using the existing CPT code. Because unlisted procedure codes are subject to manual medical review, processing may take longer than usual.

All unlisted/not otherwise classified (NOC) codes must be submitted with the appropriate narrative description of the actual services rendered on the CMS-1500 claim form in order to be processed. For claims that are electronically submitted, refer to the HIPAA Companion Guides available at [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

For paper-submitted claims, additional information regarding the narrative description of the specific services provided should be submitted on the CMS-1500 claim form in the shaded area extending from field 24A through 24G, directly above the NOC/unlisted procedure code. If a description is not provided, the entire claim will be rejected with a message to resubmit with a narrative description.

For electronically-submitted 837P claims, the NOC descriptions should be filled into the 2400 loop and NTE segment using the Additional Information Qualifier "ADD".

### ***Pricing procedure for unlisted or NOC services***

This pricing and processing procedure for unlisted or NOC Covered Services is used for all products covered under your Provider Agreement.

- We maintain a database of historical pricing decisions for similar services previously reviewed and priced by AmeriHealth. If available, an appropriate fee in this database may be used to price the current claim.
- If the database does not have pricing for the current claim, then the claim is reviewed by us for a pricing decision. We may request that the Provider submits additional information to facilitate pricing the claim. The additional information requested may include, but is not limited to, an operative report, a letter of Medical Necessity, an office note, and/or an actual manufacturer's invoice. Providers should submit additional information only if specifically requested to do so by AmeriHealth. Upon being recommended for payment and processing, claims are priced using our standard pricing methodology, which is designed to consider new procedures, and are processed in accordance with applicable claim payment policies and exclusions and limitations in benefits contracts.
- Providers who disagree with a specific unlisted/NOC service pricing determination should follow the normal appeals process described in the appropriate *Appeals* section of this manual.

Providers are reminded to always use the most appropriate codes when submitting claims. Claims submitted with NOC codes when a valid CPT or HCPCS code exists may be denied.

### ***National Drug Code submissions***

Pharmacy and medical claims for all unlisted and nonspecific drug codes (without a corollary CPT or HCPCS code) require submission of a National Drug Code (NDC) in the correct format and location to properly adjudicate these claims consistent with our group benefits plans. If the NDC is not submitted in an 11-digit format or is missing, the claim will not be processed and will be returned to you for correction. The 11-digit format is 5-4-2 and is found on most drug packaging. This format serves a functional purpose: The first segment of the NDC identifies the labeler/manufacture; the second segment identifies the product, strength, dosage form, and formulation; and the third segment identifies the package size of the drug.

A complete list of unlisted and nonspecific codes that require the submission of an NDC to properly process the claim is available at [www.amerthealth.com/providers/claims\\_and\\_billing/claim\\_requirements](http://www.amerthealth.com/providers/claims_and_billing/claim_requirements).

*Note:* Compound drugs should be reported with (1) an unlisted and/or nonspecific (CPT or HCPCS) code and (2) the NDC with the most expensive ingredient.

### **Report diagnosis codes to the highest degree of specificity**

We require that all Providers report diagnosis codes to the highest degree of specificity according to the most current *ICD-9-CM Coding Manual*. This requirement applies to all claims and encounters. It reflects:

- the need for better diagnostic information for quality and medical management;
- the decision to make our coding policy more consistent with other major carriers and with CMS ICD-9-CM coding guidelines;
- the decision by CMS to determine Medicare Advantage premiums based on the severity of illness of enrolled Members. Supporting documentation in the Member's medical record must clearly support the procedures, services, and supplies coded on the claim form.

The following are guidelines for diagnosis coding:

- Most ICD-9-CM codes require the fourth or fifth digits. There are only about 100 valid three-digit codes.
- Most ICD-9-CM coding manuals include a color-coded system to designate diagnosis codes that require additional digits beyond the basic three digits. Refer to your *ICD-9-CM Coding Manual* for specific instructions regarding the fourth or fifth digit.
- Always include the fourth or fifth digit when indicated in the *ICD-9-CM Coding Manual*.
- Always report with the highest level of specificity possible for an individual patient.

**Exceptions:** The following Providers are *not* required to report ICD-9-CM diagnosis codes to the highest degree of specificity: home health agencies, independent laboratories, independent physiological laboratories, general dentists, orthodontists, endodontists, pedodontists, pharmacies, DME suppliers, ambulance services, orthotic and prosthetic suppliers, and home infusion Providers.

### **HIPAA 5010 and ICD-10**

The HHS stipulates that any health care entity that submits electronic health care transactions, such as claims submissions, eligibility, and remittance advice, must comply with the X12 Version 5010 standards. HIPAA 5010 Companion Guides are available at [www.amerihealth.com/ediforms](http://www.amerihealth.com/ediforms) to assist you in submitting HIPAA 5010-compliant transactions.

In addition, on August 24, 2012, HHS announced its final rule regarding the compliance date for the International Classification of Diseases, 10th Edition (ICD-10) diagnosis and procedure codes, officially moving it to October 1, 2014. All covered entities must comply with ICD-10 by this new date of October 1, 2014. HHS has adopted this new compliance date in an effort to allow additional time for Providers to ensure compliance.

AmeriHealth urges you to continue preparing for the transition to ICD-10 by completing an impact assessment of the ICD-10 transition. AmeriHealth will continue to provide ongoing communication, outreach, and education to Providers as the industry prepares for one of the biggest mandated medical data code set initiatives in history.

Visit [www.amerihealth.com/icd10](http://www.amerihealth.com/icd10) for more information about the upcoming ICD-10 billing requirements and for a list of frequently asked questions.

## **Billing guidelines**

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Included in this section is billing information specific to certain types of services, including diagnostic ultrasounds, interrupted maternity care, observation services, office-based services, radiologic guidance, routine gynecological exams, and surgery claims.

### **Diagnostic ultrasounds (for Pennsylvania Members)**

Certain participating specialist types are eligible to provide specific diagnostic ultrasounds to HMO and PPO Members. HMO Members do not require a Referral from their PCPs for diagnostic ultrasound services provided by the OB/GYN specialists listed below.

*Note:* Although these specialists are eligible to provide these services in some Service Areas, we have an arrangement in which we pay the hospital a global payment when the service is provided in the outpatient hospital. In these instances, the Physician's statement of remittance (SOR) will indicate that the Physician must seek reimbursement from the hospital.

The eligible procedure code/diagnosis code combinations are as follows:



Reason for ultrasound	Specialists/ Place of service	Procedure codes	Diagnosis codes
High-risk pregnancy	Perinatal, maternal fetal medicine (MFM)/office and hospital	76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 76819, 76820, 76821	V23.0 – V23.9
Rule out ectopic pregnancy	OB/GYN, reproductive endocrinology and infertility (REI) specialist, and MFM/office and hospital	76815, 76817, 76830, 76856, 76857	633.00 – 633.91, 761.0, 761.4, 635.70 – 635.92, V61.70
Rule out intrauterine pathology	OB/GYN and REI	76831, 58340	As appropriate
First-trimester screening	MFM	76801, 76802, when billed in conjunction with 76813 or 76814	V28.3
Fetal anomalies	MFM	76813, 76814, 76825, 76826, 76827, 76828	As appropriate
Infertility*	Reproductive endocrinologist/office	76830, 76857	256.1, 256.8, 256.9

\*Covered Services may vary by the Member's benefits plan.

### ***Outpatient hospital***

Additionally for HMO Members, hospitals that are not the Member's capitated radiology site may perform and be reimbursed for the following listed services. If the hospital is the capitated radiology site for the Member, these Covered Services are included in the capitation payment and no additional payment will be made.

Reason for ultrasound	Place of service	Procedure codes	Diagnosis codes
High-risk pregnancy	Outpatient hospital	76801, 76802, 76805, 76810, 76811, 76812, 76815, 76816, 76817, 76818, 76819, 76820, 76821	V23.0 – V23.9
Rule out ectopic pregnancy	Outpatient hospital	76815, 76817, 76830, 76856, 76857	633.00 – 633.91, 761.0, 761.4, 635.70 – 635.92, V61.70
First-trimester screening	Outpatient hospital	76801, 76802, when billed in conjunction with 76813 or 76814	V28.3

### Interrupted maternity care

If you provide prenatal visits alone to any AmeriHealth Member, please bill those services with the appropriate CPT code as follows:

- **Fewer than four visits.** If you provided fewer than four visits total, bill in the following way:
  - **First visit:** Bill 99205 (new patient) or 99215 (established patient).
  - **Second and third visits:** Most second and third visits typically require only a level-three office visit. Exclusively billing these visits at higher levels than Medically Necessary is not an appropriate billing practice and is subject to post-payment review.
- **Four to six visits.** If you provided a total of four to six visits, bill *only* 59425.
- **Seven or more visits.** If you provided a total of seven or more visits, bill *only* 59426.

### Observation services

When a Physician provides service to a Member at an observation level of care, the Physician should use the following Evaluation and Management (E&M) codes when billing for these services to ensure accurate processing of the claim:

- |         |         |
|---------|---------|
| ▪ 99217 | ▪ 99234 |
| ▪ 99218 | ▪ 99235 |
| ▪ 99219 | ▪ 99236 |
| ▪ 99220 |         |

We recognize the appropriate use of observation services (i.e., observation status and observation level) to monitor patients and treat medical conditions on an outpatient basis and to evaluate a patient's need for acute inpatient admission. Observation services are outpatient services that include diagnosis, treatment, and stabilization of patients from a minimum of six to a maximum of 24 hours, per InterQual<sup>®</sup> guidelines.

AmeriHealth uses guidelines for decision-making from InterQual to determine which patients have severity of illness and intensity of service requirements that are appropriate for observation. Observation services can be provided in any location within a facility.

### Office-based services

If an office-based service (e.g., an office visit or outpatient consultation) is performed by a professional Provider in an office-based setting within a facility or on a facility campus, the facility is not eligible for reimbursement and should not bill for the service. Only the professional Provider is eligible for reimbursement for the service provided to the Member. The facility is not eligible to receive reimbursement for a room charge even though a professional Provider office may be located within the facility.

### Radiologic guidance of a procedure

The following reimbursement methodologies apply to claims processing of radiologic guidance and/or supervision and interpretation of a procedure:

- Radiologic guidance and/or supervision and interpretation are performed by either the same professional Provider who performs the surgical procedure or a different professional Provider.
- Radiologic guidance and/or supervision and interpretation of a procedure that is performed in conjunction with a Covered procedure are eligible for separate reimbursement consideration by AmeriHealth.

When the same Provider performs and reports both the radiologic and the diagnostic or therapeutic procedures, both procedures are eligible for reimbursement consideration to the Provider. However, both of the following requirements must be met:

- Both the radiologic guidance and/or supervision and interpretation service and the procedure for which it is performed must be covered for the radiologic guidance and/or supervision and interpretation to be eligible for separate reimbursement consideration.
- Documentation in the medical record must reflect the radiologic guidance and/or supervision and interpretation procedure performed by the Physician. The medical record must be available to us upon request. Providers should not submit medical records to us unless otherwise requested.

More information about Claim Payment Policy #00.10.36: Radiologic Guidance of a Procedure can be viewed at [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy).

### **Routine gynecological exams**

OB/GYNs and capitated PCPs who bill above capitation for routine gynecological exams should report diagnosis code V72.31 with the applicable preventive E&M CPT codes 99384 – 99387 and 99394 – 99397 or with HCPCS codes S0610 and S0612 for reimbursement consideration. Do not bill both a preventive CPT and an annual gynecological exam HCPCS code for the same date of service. Only one will be paid. Problem visits may be billed along with a preventive service code for same date of service, if appropriate.

Routine gynecological exams reported with ICD-9-CM code V72.32 for the CPT codes 99384 – 99387 and 99394 – 99397 are not eligible for additional payment outside the standard capitation amount. HCPCS codes S0610 and S0612 may still be reported with ICD-9-CM code V72.32 when appropriate.

For reference, the diagnosis code narratives are as follows:

- **V72.31:** Routine gynecological examination.
- **V72.32:** Encounter for Papanicolaou cervical smear to confirm findings of a recent normal smear following initial abnormal smear.

For more information, refer to the *OB/GYN* section of this manual.

### **Surgery claims**

Providers are required to follow the appropriate billing procedures as they relate to multiple surgeries, assistant surgery, and co-surgery.

#### ***Multiple surgeries***

- **Performed on the same date of service.** Surgeons must bill multiple surgical procedures for the same date of service on a single claim.
- **Performed on different dates of service.** To avoid claim underpayments, surgeons must bill multiple surgical procedures for different dates of service as separate claims.

#### ***Assistant and co-surgery***

For surgical procedures performed by both a primary surgeon and an assistant surgeon or co-surgeon, separate claim submissions are required. The primary surgeon and assistant surgeon or co-surgeon must report separate claims.

- **Performed on same date of service.** Multiple surgical procedures performed on the same date of service must be reported on a single claim (i.e., one claim for each surgeon).

- **Performed on different dates of service.** To the extent that a surgeon, assistant surgeon, or co-surgeon performs multiple surgical procedures on different dates of service, each date of service must be reported on its own claim.

Inappropriate billing may result in erroneous claim payments. For more information regarding assistant surgery, co-surgery, and multiple surgery guidelines, refer to their respective claim payment policies, which are available at [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy).

## Copayments

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A Provider must notify a Member if the office provides services where the Member may be billed by more than one Provider. For example, the office must inform the Member when he or she will be charged a Copayment for a Physician service and a Copayment for an ancillary service, such as radiology. If two services are billed on the same date of service, two Copayments may be required.

As required by the Patient Protection and Affordable Care Act of 2010, there is no Member cost-sharing (i.e., \$0 Copayment) for certain preventive services provided to Members. Claim Payment Policy #00.06.02: Preventive Care Services, which includes the list of applicable preventive codes, is available on NaviNet or at [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy).

The \$0 Copayment does *not* apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a Copayment. However, if the Member is experiencing a significant problem that requires a problem-focused service that could not be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, or follow-up at a shorter interval than would be normally anticipated, it would allow for cost-sharing.

When the Copayment is greater than the allowable amount, only the allowable amount should be collected from the Member. In the event the Copayment is collected and the practice subsequently determines the allowed amount is less than the Copayment, the difference between the allowable amount and the Copayment for the service must be refunded to the Member.

## Medicare-eligible Members

AmeriHealth coordinates benefits for commercial Members who are Medicare eligible, have not enrolled in Medicare Part B, and for whom Medicare would be the primary payer. If a Member is eligible to enroll in Medicare Part B but has not done so, AmeriHealth will pay as the secondary payer for services covered under an AmeriHealth HMO/PPO commercial group Benefits Program, even if the Member does not enroll for, pay applicable premiums for, maintain, claim, or receive Medicare Part B benefits. This change affects any Member who is Medicare-eligible and for whom Medicare would be the primary payer.

It is important that you routinely ask your Medicare-eligible Members to show their Medicare ID cards. If you have identified a Member who is eligible to enroll in Medicare Part B, but has not done so, you may collect the amount under “Member Responsibility” on the SOR, which includes any cost-sharing plus the amount Medicare would have paid as the primary payer.

## Clean Claims

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A Clean Claim is one that does not require further information for processing in accordance with applicable law. Incomplete and inaccurate claims will be returned as nonclean claims. Returned claims are not necessarily a denial of benefits but arise from our need for accurate and complete information.

Additionally, claims that do not have adequate information to identify the billing Provider can be neither processed nor returned.

Clean Claims (both electronic and paper-submitted) must meet the following conditions:

- The service is a Covered Service under the AmeriHealth Member's benefits plan.
- The claim is submitted with all required information on a claim form or in other instructions distributed to the Provider.
- The person to whom the service was provided was an AmeriHealth Member on the date of service.
- We do not reasonably believe the claim was submitted fraudulently.
- The claim does not require special treatment. Special treatment means unusual claim processing is required to determine whether the service is covered.

### **Clean Claims requirements**

The following information must appear correctly for a claim to be considered clean:

- Group Provider NPI\*
- performing Provider NPI
- tax ID number
- billing address
- Member's ID number (including applicable prefix and suffix) of the patient on the claim
- Member's name of the patient on the claim

*\*Be sure the Group Provider NPI is associated with the Group Tax ID number on file at AmeriHealth. Providers may use the Provider Change Form transaction on NaviNet to review current information on file at AmeriHealth.*

### **Provider NPI requirement**

For purposes of processing a claim, you must submit your registered NPI. In accordance with the reimbursement terms of your Provider Agreement, you may continue to provide your 10-digit legacy number. However, only a valid NPI will be accepted by us as the primary identifier on the claim.

The performing Provider NPI must be recorded on all claims. This is a required data element in conjunction with HIPAA compliance and other requirements. HMO, POS, and PPO claims submitted without the NPI of the Physician or other professional Provider performing the procedure or service will be rejected and returned as nonclean claims, which must be resubmitted with the necessary information.

*Note:* Taxonomy codes are used to distinguish Provider specialties when appropriate.

Further information about NPIs and how to bill using NPIs is available on our website at [www.amerihealth.com/npi](http://www.amerihealth.com/npi).

### **Member ID numbers on ID cards**

To better protect Member identity and privacy, we use a unique Member ID number for external communications to Members, including on all Member ID cards. To facilitate claims processing, be sure to include the complete Member ID number as it appears on the Member's ID card.

The Member ID number consists of a 3-position alpha prefix, an 8-position ID number, and a 2-position suffix that defines a Member of the family unit. For AmeriHealth PPO, AmeriHealth Traditional Medical, and CMM Members, it is especially important that you include alpha prefix when submitting claims. For

HMO and POS Members, the laboratory indicator (e.g., A, H, L, M, N, T, or Q) located on the front of HMO and POS ID cards should not be included in the Member's ID number.

AmeriHealth rejects claims not billed with the complete Member ID number and patient date of birth. For timely and accurate claim payment, the full Member ID must be billed as it appears on the Member ID card.

### ***Place-of-service codes***

Participating Providers are required to use the most current place-of-service codes on professional claims to specify the entity where service(s) was rendered. The most frequently submitted place-of-service codes are listed in the following table. Always consult with your vendor or practice management system contact to discuss payer-specific changes to your system.

Place-of-service code	Place-of-service name
11	Office
12	Home
21	Inpatient
22	Outpatient
23	Emergency department/room — hospital
24	Ambulatory surgical center
31	Skilled nursing facility
32	Nursing facility
41	Ambulance — land
42	Ambulance — air or water
65	End-stage renal disease treatment facility
81	Independent lab

## **Submitting claims**

Visit our website at [www.amerhealth.com/edi](http://www.amerhealth.com/edi) for information on claims submission and billing and tools related to these activities. This site makes it easy to find important claims-related information and provides access to electronic billing guidelines, HIPAA Companion Guides, payer ID grids, and claim form requirements.

Claims submission addresses can be found in the *General Information* section of this manual.

### **CMS-1500 claim submitters**

All paper claims received must be submitted on the CMS-1500 (08/05) form. Paper claims submitted on forms CMS-1500 (12/90) and UB-92 will be rejected. A sample CMS-1500 (08/05) claim form is included in the *Claims Submission Toolkit for Proper Electronic and Paper Claims Submissions* document, available at [www.amerhealth.com/npi](http://www.amerhealth.com/npi).

If you submit claims using the HCFA-1500 claim form, you will continue to receive the Rejected Claim Report for notification of rejected claims. The error description on the Rejected Claim Report will aid you in correcting and resending claims to ensure an expedited remittance.

## Electronic claims submitters

If you submit claims electronically, you will continue to receive the unsolicited 277 (U277) for notification of both rejected and accepted claims. The error description on the U277 will aid you in correcting and resending files to ensure an expedited remittance.

For more information, refer to *Claims resolution* on [page 6.15](#). You can also refer to [www.amerihealth.com/ediforms](http://www.amerihealth.com/ediforms) or contact your Network Coordinator for more information.

### ***Clearinghouse options for electronic claims submission***

Your software vendor may be contractually obligated to use a specific third-party clearinghouse vendor for electronic submissions. That clearinghouse can assist you with testing to ensure that your electronic claims submissions are seamless. Many clearinghouse options are available. For a list of clearinghouse vendors, visit [www.amerihealth.com/edi](http://www.amerihealth.com/edi).

Clearinghouses may update their submission rules from time to time. Always contact your clearinghouse for confirmation of up-to-date, specific submission requirements.

If you are interested in submitting electronic claims and have existing practice management software, contact your vendor as they will more than likely have an existing clearinghouse vendor that connects to our gateway. Otherwise, you can reference the list of clearinghouse vendors on our website that have a connection or can connect directly to our gateway.

### ***Submitting Coordination of Benefits information electronically***

Providers may submit Coordination of Benefits (COB) information electronically for professional services using the 837P and 837I formats. For instructions on how to bill electronically, visit [www.amerihealth.com/ediforms](http://www.amerihealth.com/ediforms).

Submitting COB information electronically eliminates the need for paper claims submission. Claims submitted electronically are processed faster and have a significantly higher “first-pass” adjudication rate. This means faster payment to you.

For questions concerning electronic billing, call the eBusiness Help Desk at [215-241-2305](tel:215-241-2305) or contact your Network Coordinator.

## Claims preprocessing

Claims preprocessing is an initiative that allows NaviNet to validate claim data that is critical for claims processing and payment, prior to AmeriHealth receiving the claim. We incorporated the HIPAA-compliant 837P transactions into the existing Claim Preprocessing System (CPPS) for AmeriHealth HMO, AmeriHealth POS (referred), AmeriHealth PPO, and AmeriHealth CMM claims.

The benefits of claims preprocessing:

- increased accuracy of claims processing and payment;
- avoidance of payment delays due to missing or inaccurate data;
- error reports that, when appropriate, provide data needed for error correction.

Types of claims preprocessed:

- all electronically submitted HMO, POS (referred), PPO, or CMM claims in the ANSI X-12 HIPAA-compliant 5010A1 format with a 95044, 93688, or 60061 NAIC code;
- all HMO and POS (referred) claims billed via CMS-1500 claim forms.



If you are having problems with claims rejecting, refer to *Electronic claims submitters* on [page 6.13](#). This information will help you to submit claims successfully.

## Claims resolution

The *Claims Preprocessing Edits Claims Resolution* document highlights rules that are applied to claims and advises on how to remedy rejected claims for resubmission of a Clean Claim. This document is available at [www.amerihealth.com/ediforms](http://www.amerihealth.com/ediforms) and is updated periodically to reflect new error codes and claims resolution instructions. It is intended to provide guidance on current billing submission errors we have encountered.

When referencing the document, keep in mind the following:

- *Column A* contains the CPPS error code and the general description of why the claim was rejected for paper and electronic claims submissions.
- *Column B* contains the error description reported on the U277 in data element STC12 for electronic claims and the rejected claims report for paper claims submissions.
- *Column C* contains U277 HIPAA Status and HIPAA Category codes for electronic claims submissions only.
- *Column D* contains the claims resolution instructions for 837P Loop/Data elements for electronic claims submissions only.
- *Column E* (on HIPAA 4010 version only) contains the claims resolution instructions for 837P Loop/Data elements for electronic claims submissions only.
- *Column F* contains the claims resolution instructions for error resolutions for electronic claims submissions.

Note the following:

- Providers should continue to submit claims according to our guidelines.
- Provider claims will continue to be validated against the existing business rules.
- If a HIPAA 837P 4010 transaction or paper claim has been submitted and rejected, you will need to use the 4010 version of the *Claims Preprocessing Edits Claims Resolution* document (10/2012).

## Submission of claims adjustments

When submitting adjustment requests electronically to your Network Coordinator or our Adjustment Department using Microsoft® files (e.g., Excel® or Access®), please submit the following fields:

- |                                             |                           |
|---------------------------------------------|---------------------------|
| ▪ AmeriHealth claim ID number               | ▪ modifier                |
| ▪ Member ID number                          | ▪ modifier                |
| ▪ date of service from/to                   | ▪ revenue code            |
| ▪ procedure/service code                    | ▪ units billed            |
| ▪ Member first and last name                | ▪ charged (billed) amount |
| ▪ Subscriber ID number                      | ▪ allowed amount          |
| ▪ vendor (billing) Provider name and number | ▪ payment amount          |
| ▪ performing Provider name and number       | ▪ expected amount         |
| ▪ modifier                                  |                           |



By submitting your adjustment requests with the fields listed, we will be able to improve the turnaround time and maintain a higher level of service while processing the claim.

### Claim INFO transactions

The Claim INFO transactions are now available on NaviNet to professional Providers:

- **Claim INFO Adjustment Submission.** This transaction allows Providers to submit claim adjustments through NaviNet for claims in a paid or denied status. Claims data is available for up to two years prior to the current date.
- **Claim INFO Adjustment Inquiry.** This transaction enables Providers to review the status of submitted requests.

Both transactions can be accessed by selecting *Claim Inquiry and Maintenance* from the Plan Transactions menu. For assistance with these or any other transactions offered through NaviNet, Providers can view the User Guides under Customer Support, or they can contact NaviNet Customer Care at 1-888-482-8057.

### Statement of Remittance

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The Statement of Remittance (SOR) contains detailed claims information for the payment of claims, claims adjustments, and claims interest payments to Providers. Providers can view their SOR in the following ways:

- **Paper SOR.** A paper SOR is mailed to your address with each remittance.
- **835 SOR.** An 835 SOR is a standardized EDI file format that can be transmitted to Providers if requested. It is also known as an ERA (electronic remittance advice).
- **Online SOR.** You can use the Online SOR Inquiry transaction on NaviNet to view all remittances issued to Providers in your group. SOR information can be viewed for a 13-month rolling calendar. Online SORs have several advantages: You can search for specific SORs by patient account number, statement date, or statement number; obtain greater detail within individual remittances; and easily obtain each claim's summary and line-level detail.

Access to the Online SOR Inquiry transaction is controlled by your designated Security Officer. Once permission to register for online SORs is granted for a particular user, that individual can use the transaction by selecting *ePayment* from the Plan Transactions menu, then *Online SOR Inquiry*.

### Overpayments

If you identify an erroneous overpayment when reviewing your SOR and reconciling it against a Member account, please do one of the following:

- **NaviNet-enabled Providers.** Select *Claim Inquiry and Maintenance* from the Plan Transactions menu, and then *Claim INFO Adjustment Submission* to request a claim retraction through the claims adjudication process. Through this preferred and expedited process, credits and/or retractions will automatically appear on a future SOR.
- **If you are not NaviNet-enabled.** If you are not yet NaviNet-enabled, complete an *Overpayment/Refund Form*, available at [www.amerihealth.com/providerforms](http://www.amerihealth.com/providerforms), and submit it using the instructions on the form. Include a copy of the SOR and overpayment with your submission so we can quickly identify it and accurately credit your account. You can also call Customer Service.

Occasionally we identify erroneous overpayments, in which case you will receive instructions either in a letter highlighting the specific overpayment or listed on your A/R statement. Follow the specific instructions noted in the letter and/or statement.

## Fee schedule inquiry

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Fee schedule rates are available to all Participating Professional Providers via the Fee Schedule Inquiry transaction on NaviNet. The fee schedule allowed amounts will reflect your specific contract rates for your written contractual Agreement with AmeriHealth.

The Fee Schedule Inquiry transaction provides online access to allowed amounts for contractual procedures prior to claims and benefits settlement, but it does not provide the actual payment that a Provider may receive for a specific submitted claim. In addition, it does not include rates for capitated services or for special contracting agreements.

To access this tool through NaviNet, select *Claim Inquiry and Maintenance* from the Plan Transactions menu, and then select *Fee Schedule Inquiry*.

## Provider claims inquiry

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The Provider claims review process will consider HMO, POS, and PPO claims payment issues concerning the application and correction of coding, claims logic, and other general issues related to claims processing norms. Claims data is available for up to two years prior to the current date.

You can initiate the Provider claims review process in one of the following ways:

- For claims that are in the paid or denied status, use NaviNet. Select *Claim Inquiry and Maintenance* from the Plan Transactions menu, and then *Claim INFO Adjustment Submission*.
- Complete a *Provider Claim Inquiry Form*, available at [www.amerihealth.com/providerforms](http://www.amerihealth.com/providerforms). Follow the instructions for submission on the form, and be sure to include the SOR.
- Contact Customer Service.

Whichever method you choose, be sure to clearly identify the claims issue and be prepared to provide any supporting documentation to help explain your position.