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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® web portal, our secure Provider portal that expedites processing and payment.

The NaviNet® web portal

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 the systems used by AmeriHealth, NaviNet enables you to submit and receive information electronically with increased speed, efficiency, and accuracy.

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

Clear Claim Connection™

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*.

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.

Billing/reimbursement requirements

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 Transaction Standard Companion Guides available at *www.amerihealth.com/ediforms*.

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 Loop 2400 data element SV101-1 – Description.

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/manufacturer; 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.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

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* 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* for more information about ICD-10, including a Frequently Asked Questions document.

Billing guidelines

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

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
- 99218
- 99219
- 99220
- 99234
- 99235
- 99236

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® 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*.

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*.

Clean Claims

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 non-clean 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 a valid NPI as the primary identifier on the claim. In addition, 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, PPO, and EPO 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 and are required on all claims.

Further information about NPIs and how to bill using NPIs is available on our website at *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. The Member ID number consists of a 3-character alpha prefix, an 8-position ID number, and a 2-position suffix that defines a Member of the family unit.

To facilitate claims processing, be sure to include the complete Member ID number as it appears on the Member's ID card. 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.

For AmeriHealth PPO, AmeriHealth New Jersey EPO, AmeriHealth Traditional Medical, and CMM Members, it is especially important that you also include the 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.

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.amerihealth.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 Transaction Standard Companion Guides, payer ID grids, and claim form requirements.

CMS-1500 claim submitters

All paper claims received must be submitted on a CMS-1500 claim form. A sample CMS-1500 claim form is included in the *Claims Submission Toolkit for Proper Electronic and Paper Claims Submissions* document, available at *www.amerihealth.com/providers/claims_and_billing/claim_requirements.html*.

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 claim 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 the *Claims resolution* section in this manual. You can also refer to *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.

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 the gateway AmeriHealth uses to process EDI transactions, which is managed and operated by Highmark, Inc. (Highmark).

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*.

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.

If you have questions about electronic claims submission, please contact Highmark EDI Operations at 1-800-992-0246.

Claims preprocessing

Claims preprocessing validates 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, AmeriHealth New Jersey EPO, 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, EPO, 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 the CMS-1500 claim form.

If you are having problems with claims rejecting, refer to the *Electronic claim submitters* section in this manual. 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* 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 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.

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

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 Investigation

Professional Providers can access the Claim Investigation transactions on NaviNet by selecting *Claim Inquiry and Maintenance* from the Plan Transactions menu. Providers must first locate the claim through

the Claim Status Inquiry transaction. Then providers can link to Claim Investigation. 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 18 months prior to the current date.

The Claim Investigation Inquiry transaction is also available for Providers to review the status of submitted adjustment requests.

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

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 log on to NaviNet, select *Claim Inquiry and Maintenance* from the Plan Transactions menu, and then *Claims Status Inquiry.* Once the claim is accessed, you can link to Claim Investigation 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.

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.

Provider claims inquiry

The Provider claims review process will consider HMO, POS, PPO, and EPO 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, then select *Claim Status Inquiry* to locate the claim, and then you can link to *Claims Investigation*.

- Complete a *Provider Claim Inquiry Form*, available at *www.amerihealth.com/providerforms.* Follow the instructions for submission on the form, and be sure to include the SOR.

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.