





<b>CHAPTER 3 – OUR MEMBERS .....</b>	<b>30</b>
ABOUT OUR MEMBERS .....	30
MEMBER ELIGIBILITY .....	30
ENROLLMENT PROCESS.....	30
IDENTIFICATION .....	31
WELCOME KIT.....	36
MEMBER SERVICES.....	36
DISENROLLMENT PROCESS .....	36
MEMBER RIGHTS AND RESPONSIBILITIES .....	37
STATEMENT OF MEMBER’S RIGHTS AND RESPONSIBILITIES .....	37
DISCRIMINATION.....	38
<b>CHAPTER 4 – CLAIMS PAYMENT .....</b>	<b>39</b>
FILING CLAIMS FOR SERVICES RENDERED .....	39
CLAIMS ADDRESS.....	39
ELECTRONIC BILLING .....	39
CORRECT BILLING OF BOX/ITEM 32 AND 33 .....	39
HIERARCHICAL CONDITION CODES (HCC) RECONCILIATION.....	40
PAYMENT.....	40
FEE SCHEDULES .....	41
CLEAN CLAIMS.....	41
INTEREST .....	41
ADVANCED BENEFICIARY NOTICES (ABNs).....	41
MEDICARE SECONDARY PAYER (MSP).....	42
<b>CHAPTER 5 – APPEALS AND GRIEVANCES .....</b>	<b>44</b>
GRIEVANCES .....	44
APPEALS AND CLAIM DISPUTES .....	45
APPEAL REQUESTS FROM NON-CONTRACTED PROVIDERS .....	46
PROVIDER WAIVER OF LIABILITY STATEMENT .....	47
APPEAL DETERMINATION TIMEFRAME.....	47
EXPEDITED APPEALS.....	47













































## **FREQUENTLY ASKED QUESTIONS – CREDENTIALING AND RECREDENTIALING**

### **1. What activities are being delegated to the provider organization?**

ADVANTAGE delegates the following to the provider organizations:

- Primary source verification of each practitioner’s credentials no more than 180 days prior to the CC decision
- Evaluation of practitioner credentials
- Practitioner file maintenance
- Recredentialing at least every three years

If the organization sub-delegates any credentialing and recredentialing activities, there must be a mutually agreed upon document describing the responsibilities and activities to be performed by each entity, the process for evaluating the effectiveness of the sub-delegate, and remedies available if the sub-delegate does not fulfill its obligation. The document must be signed by the organization and the sub-delegate agency and be approved and retained on file at ADVANTAGE. When this occurs, ADVANTAGE will perform the on-site reviews at the entity performing the credentialing activities.

### **2. What activities are performed by ADVANTAGE Health Solutions Medicare Advantage Plans?**

ADVANTAGE performs the approval, suspension, or termination of practitioners, organizational providers, and sites of care. We maintain a current practitioner database for directories and administrative purposes. For our networks, we do a predelegation analysis and risk assessment activities. We perform annual oversight management activities, including monitoring of corrective action initiatives and ensuring that credentialing/recredentialing activities are being performed according to ADVANTAGE Health Solutions Medicare Advantage Plans and CMS Standards.

### **3. What are the standards for delegated credentialing/recredentialing activities?**

Credentialing/recredentialing documentation and provider files must be maintained for a period of at least six years from the end of the current contract period, or as required by Indiana State law. Primary source verification must be completed no earlier than 180 days prior to review by the Credentialing Committee. Credentialing activities must be completed within 180 days from receipt of the application and recredentialing activities must be completed at least every three years prior to the anniversary date.

### **4. What information does ADVANTAGE require the delegate to report?**

ADVANTAGE requires that board certifications be submitted by the delegate provider organization or independently contracted providers.

**5. How does ADVANTAGE conduct oversight of delegated credentialing functions?**

ADVANTAGE conducts a predelegation review prior to the contract being signed. We then review all delegates at least once every twelve months. The results of predelegation and annual reviews are sent to the provider organization within 60-calendar days (or within 30 calendar days, if expedited) of the date of the on-site visit. ADVANTAGE assigns due-dates (in conjunction with the delegate) and tracks all quality improvement initiatives.

**6. What happens after the predelegation site visit?**

As part of the on-site review, the auditors will indicate whether the delegate meets or does not meet each standard. Preliminary results will be summarized at the exit interview and a written report of the findings will be provided within 60 calendar days (or within 30 calendar days, if expedited) following the date of the on-site predelegation assessment.

If the predelegation review is satisfactory, a contract may be executed. If deficiencies are found, the contract may be delayed until a corrective action is completed or the contract may be executed with the understanding that corrective actions will be completed within the timeframe specified in the corrective action plan.

Delegates are asked to develop a corrective action plan within 20 working-days of request, unless the seriousness of the deficiency requires more immediate action. ADVANTAGE monitors the completion of corrective actions. All corrective actions must be completed within the timeframe specified in the corrective action plan. Generally, this will be no more than 90 calendar days from the date of the approval of the corrective action plan.

**7. How are practitioners reviewed/approved and when are they effective with ADVANTAGE Health Solutions Medicare Advantage Plans?**

The delegate performs primary source verification activities in accordance with CMS standards for each practitioner requesting entry into ADVANTAGE Health Solutions Medicare Advantage Plans. The delegate submits credentialing information for practitioners who intend to join an ADVANTAGE network and who meet the credentialing criteria set by ADVANTAGE. The following is required for each practitioner: all required data elements for each practitioner, a credentialing confirmation statement stating that the practitioners on an attached list meet the credentialing criteria set by ADVANTAGE, and a copy of the signed Authorization Release (unless the delegate utilizes an ADVANTAGE approved release form/clause).

When the delegate submits all necessary documentation, the practitioner's credentials will be reviewed at the next ADVANTAGE Credentialing Committee meeting for recommendation and approval, as well as at the next ADVANTAGE QIC meeting. The effective date for network participation is the date the practitioner's credentials are approved by the delegate's Credentialing Committee.

If the delegate reviews the practitioner's credentials and ADVANTAGE credentialing criteria are not met, the delegate may provide the entire credentialing file for review by the ADVANTAGE Credentialing and QI Committees. Delegates will be provided with a list of scheduled committee meeting dates annually. The file must be supplied at least 20 working-days prior to the ADVANTAGE Credentialing Committee meeting to allow time for file preparation.

**8. When will the practitioners be included in the ADVANTAGE Health Solutions Medicare Advantage Plans Provider Directories?**

Following approval by ADVANTAGE Health Solutions Medicare Advantage Plans, the practitioner's information will be listed in the appropriate ADVANTAGE Health Solutions Medicare Advantage Plans' online directories and claims systems. Providers will be added to the hard copy directory at the next printing.

**9. What is the process for new providers joining ADVANTAGE Health Solutions Medicare Advantage Plans?**

For network additions, the new provider will follow the specific policy and procedure for becoming a network provider.

For independent contracting a provider must contact ADVANTAGE and submit an approved application form with supporting documentation. ADVANTAGE performs the primary source verification and submits the provider for credentialing by the ADVANTAGE Health Solutions Medicare Advantage Plans Credentialing Committee using the process described above.

**10. What is included in the annual review of the delegated credentialing activities?**

CMS standards, ADVANTAGE criteria and policies and procedures will be used for the annual oversight review. ADVANTAGE Health Solutions Medicare Advantage Plans will schedule an annual oversight review of credentialing activities.

The delegate organization will forward a current practitioner list and credentialing policy and procedures to the QI Department for a desk review prior to the annual oversight review. The QI Department will randomly select 5% or 30 practitioners (whichever is greater) from the delegate's list for file audit and send the list of selected practitioners to the delegate prior to the annual oversight review. At the on-site review, the QI staff will follow-up on items that were unclear from the desk review and review practitioner files. The auditors will prepare a written report and recommendations. This information will be mailed to the delegate within 60 calendar days (expedited: 30 calendar days) of the on-site review.

**11. Is there an appeals process for practitioners not accepted by the Delegate's Credentialing Committee?**

Delegates need to maintain a practitioner appeal process consistent with the following ADVANTAGE process:

- 1) When the ADVANTAGE Credentialing Committee makes a preliminary recommendation that a practitioner be rejected or terminated, the practitioner will be given written notification of the Credentialing Committee's preliminary recommendation. The practitioner will be given the opportunity to submit written documentation or request to appear before the Credentialing Committee during a regularly scheduled meeting.
- 2) This appearance is an informal, non-adversarial, fact-gathering discussion giving the practitioner an opportunity to provide additional information to the Credentialing Committee regarding the practitioner's qualifications. This also allows the ADVANTAGE Credentialing Committee to ask the practitioner questions regarding his/her credentials or qualifications.
- 3) The practitioner may appear with legal representation or any other representation he/she so desires.
- 4) Upon request, a copy of the materials that were used by the Credentialing Committee to evaluate the practitioner's qualifications shall be forwarded to the practitioner prior to his/her appearance. Following his/her appearance, the practitioner will be notified in writing within 14 calendar days of the Credentialing Committee's final recommendation.
- 5) If the practitioner wishes to make an appearance before the Credentialing Committee, he/she must contact the QI Department within 30 calendar days of receipt of the notice that the Credentialing Committee has recommended the rejection or termination of the practitioner's participation in the ADVANTAGE Health Solutions Medicare Advantage Plans.
- 6) If the practitioner chooses not to or fails to contact the QI Department within the required 30 calendar days, the preliminary recommendation of the Credentialing Committee will be deemed a final decision.
- 7) If the practitioner is not satisfied with the final recommendation of the Credentialing Committee following his/her appearance before the Credentialing Committee, the practitioner may request an appeal before the Peer Review Appeals/Grievance Committee.

**12. Is there a second level of appeal?**

The practitioner may request an appeal from the Peer Review Appeals Committee following the final recommendation for rejection or termination. The practitioner must contact the QI Department within 30 calendar days of receipt of notice of the ADVANTAGE Credentialing Committee final recommendation to reject or terminate the practitioner from participation in ADVANTAGE.

The practitioner has the opportunity to submit documentation in writing or to appear in person and be represented by legal counsel or other adequate representation to hear all findings concerning the practitioner's practice. The practitioner shall have the right to see any records

accumulated by the QIC, the Credentialing Committee, or the Peer Review Appeals Committee concerning the practitioner's personal practice and to offer rebuttal information.

The practitioner has the right to have a record made of the proceedings; call, examine, and cross-examine witnesses; present evidence determined to be relevant by the Chairperson, regardless of its admissibility in a court of law; and submit a written statement at the close of the proceeding

Within 14 calendar days of the proceeding, the practitioner will receive the written decision from the committee including a statement of the decision. The practitioner has 30 calendar days to notify the Credentialing Committee of his/her desire to appeal the committee's final recommendation. The absence of such notification will be understood by the committee as the practitioner's acceptance of the final recommendation. The practitioner will then be given written notification of the committee's final decision.

## CHAPTER 3 – OUR MEMBERS

### ABOUT OUR MEMBERS

ADVANTAGE Health Solutions, Inc., is a locally owned and operated managed-care organization providing solutions to health care concerns in Indiana. ADVANTAGE administers enhanced Medicare benefits on behalf of its members. We are proud of our provider partnerships on a local level – providing our members with the health care products and options they need for the kind of coverage that works for them.

Members who have questions regarding their ADVANTAGE Health Solutions Medicare Advantage Plans benefits should contact Member Services at:

**Toll Free: (800) 523-7533**

**Local: (317) 573-7950**

**TDD (hearing impaired): (800)743-3333  
8:00am – 8:00pm (Monday through Friday)**

### MEMBER ELIGIBILITY

Any Medicare beneficiary who is entitled to benefits under Part A and enrolled in Part B, does not have End Stage Renal Disease (ESRD) at time of enrollment, and resides in the service area, is eligible to receive all their Medicare benefits through ADVANTAGE Health Solutions Medicare Advantage Plans. Individuals with disabilities and beneficiaries who have elected hospice coverage may also enroll in ADVANTAGE Health Solutions Medicare Advantage Plans. An eligible individual may not, however, be enrolled in any other Medicare Advantage plan and ADVANTAGE Health Solutions Medicare Advantage Plans at the same time.

### ENROLLMENT PROCESS

The enrollment process starts when the Operations Department receives an application and continues through the member confirmation call when an application is accepted. All members seeking coverage through ADVANTAGE Health Solutions Medicare Advantage Plans must complete and sign an Election Form to be enrolled. The member must agree to abide by the rules set forth by ADVANTAGE. These rules will be fully disclosed to the potential member during the election process.

An individual beneficiary is generally the only person who may execute a valid enrollment application. However, if an individual has authority under state law (e.g., legal guardian) to make health care decisions for the beneficiary, then that individual/authorized representative may execute an application for the prospective member. If an individual other than the beneficiary has completed the Election Form, that person must sign the form and indicate the relationship to the beneficiary. Proof of the individual's authority to act on behalf of the enrollee (e.g. Power of Attorney form) must be submitted with the application.

To confirm the dates for CMS Annual Open Enrollment periods, please click or copy and paste the following link into your internet browser: <http://www.cms.gov/center/openenrollment.asp>. In addition, there are other election opportunities, although they are limited, throughout the calendar year. For more information on these election opportunities, please contact Member Services at (317) 573-7950 or toll free at (800) 523-7533.

## IDENTIFICATION

Members enrolled in ADVANTAGE Health Solutions Medicare Advantage Plans will receive an ADVANTAGE ID card. It is the member's immediate proof of membership as an ADVANTAGE member. Providers should not request to see/copy the Member's Medicare Card. The ADVANTAGE card replaces the Medicare card. Members are required to show this ID card when receiving medical services covered by ADVANTAGE Health Solutions Medicare Advantage Plans.

The front of the ADVANTAGE ID card contains:


- Member's name
- ID number
- Effective date
- Other information pertinent to coverage (e.g. co-pay)

The back of the card has additional information, including important phone numbers and claims submission details. If an ID card is lost or stolen, the member may contact the Member Services Department to receive another card at:

**Toll Free: (800) 523-7533**  
**Local: (317) 573-7950**  
**TDD (hearing impaired): (800) 743-3333**  
**8:00am – 8:00pm (Monday through Friday)**


Samples of the ADVANTAGE ID cards are depicted on the following pages.

**ADVANTAGE Medicare PPO Card Example:**

 <b>ADVANTAGE</b> <i>...rising above the service you expect™</i> <b>A Medicare Advantage PPO</b>	<Plan Name> <Plan Name continued...>
Member: <Cardholder Name> ID#: <Cardholder ID #> Policy #: <Policy #> Issuer: 80840	<b>In Network Copays:</b> Office Visit – PCP - <\$> Specialist - <\$> Urgent Care - <\$> ER - <\$>
RxBin: <#####> RxPCN: <#####> RxID: <Cardholder ID> RxGrp: <#### >	This plan does not provide prescription drug coverage. You may receive pharmacy discounts by presenting this card. <contract #> <plan #>

<b>MEMBERS:</b> Call: <# ### ### #####> TTY / TTD: <# ### ### #####> Pharmacy: <# ### ### #####> 24 Hour Nurse Line: <# ### ### #####> Routine Vision Benefits: <# ### ### #####> Routine Dental Benefits: <# ### ### #####> Some services require pre-certification. Contact ADVANTAGE Utilization Management at <# ### ###-####> for approval.	<b>PROVIDERS:</b> Claims, Benefits, and Eligibility Medical: <# ### ### #####> Dental: <# ### ### #####> Vision: <# ### ### #####> Pharmacy: <# ### ### #####> <b>Medicare limiting charges apply</b>  <b>Submit Medical Claims to:</b> Electronic Payer ID# <#####> ADVANTAGE Claims <Address> <Address> Visit us at <a href="http://advantageplan.com">advantageplan.com</a>
--	--

ADVANTAGE Medicare PPO MAPD Card Example:



**ADVANTAGE**  
*...rising above the service you expect™*  
**A Medicare Advantage PPO**

Member: <Cardholder Name>  
 ID#: <Cardholder ID #>  
 Policy #: <Policy #>  
 Issuer: 80840

RxBin: <#####>  
 RxPCN: <####>  
 RxID: <Cardholder ID>  
 RxGrp: <####>

<Plan Name>  
 <Plan Name continued...>


In Network Copays:  
 Office Visit -  
 PCP - <\$>  
 Specialist - <\$>  
 Urgent Care - <\$>  
 ER - <\$>

**Medicare<sup>Rx</sup>**  
 Prescription Drug Coverage **Rx**

<contract #> <plan #>


<p><b>MEMBERS:</b>          Call: &lt;# ### ##-####&gt;          TTY / TTD: &lt;# ### ##-####&gt;          Pharmacy: &lt;# ### ##-####&gt;          24 Hour Nurse Line:          &lt;# ### ##-####&gt;          Routine Vision Benefits:          &lt;# ### ##-####&gt;          Routine Dental Benefits:          &lt;# ### ##-####&gt;          Some services require pre-          certification. Contact          ADVANTAGE Utilization          Management at &lt;# ### ##-          ####&gt; for approval.</p>	<p><b>PROVIDERS:</b>          Claims, Benefits, and Eligibility          Medical: &lt;# ### ##-####&gt;          Dental: &lt;# ### ##-####&gt;          Vision: &lt;# ### ##-####&gt;          Pharmacy: &lt;# ### ##-####&gt;  <b>Medicare limiting charges apply</b></p> <p><b>Submit Medical Claims to:</b>          Electronic Payer          ID# &lt;#####&gt;          ADVANTAGE Claims          &lt;Address&gt;          &lt;Address&gt;          Visit us at <a href="http://advantageplan.com">advantageplan.com</a></p>
--	---

ADVANTAGE Medicare HMO Card Example:

 <p><b>ADVANTAGE</b> <i>...rising above the service you expect™</i> <b>A Medicare Advantage HMO</b></p> <p>Member: &lt;Cardholder Name&gt; ID#: &lt;Cardholder ID #&gt; Policy #: &lt;Policy #&gt; Issuer: 80840</p> <p>RxBin: &lt;#####&gt; RxPCN: &lt;####&gt; RxID: &lt;Cardholder ID&gt; RxGrp: &lt; #### &gt;</p>	<p>&lt;Plan Name&gt; &lt;Plan Name continued...&gt;</p> <p>Network: &lt;Network&gt; PCP: &lt;PCP Name&gt; PCP: &lt;PCP office phone&gt; In Network Copays: Office Visit – PCP - &lt;\$&gt; Specialist - &lt;\$&gt;</p> <p><b>Medicare<sup>Rx</sup></b> Prescription Drug Coverage</p> <p>&lt;contract #&gt; &lt;plan #&gt;</p>
---	--

<p><b>MEMBERS:</b> Call: &lt;# ### ### ####&gt; TTY / TTD: &lt;# ### ### ####&gt; Pharmacy: &lt;# ### ### ####&gt; 24 Hour Nurse Line: &lt;# ### ### ####&gt; Routine Vision Benefits: &lt;# ### ### ####&gt; Routine Dental Benefits: &lt;# ### ### ####&gt; Some services require pre-certification. Contact ADVANTAGE Utilization Management at &lt;# ### ### ####&gt; for approval.</p>	<p><b>PROVIDERS:</b> Claims, Benefits, and Eligibility Medical: &lt;# ### ### ####&gt; Dental: &lt;# ### ### ####&gt; Vision: &lt;# ### ### ####&gt; Pharmacy: &lt;# ### ### ####&gt; <b>Medicare limiting charges apply</b></p> <p><b>Submit Medical Claims to:</b> Electronic Payer ID# &lt;#####&gt; ADVANTAGE Claims &lt;Address&gt; &lt;Address&gt; Visit us at <a href="http://advantageplan.com">advantageplan.com</a></p>
---	---

**ADVANTAGE Medicare SNP Card Example:**

 <p><b>ADVANTAGE</b> <i>...rising above the service you expect™</i> <b>A Medicare Advantage HMO</b> Member: &lt;Cardholder Name&gt; ID#: &lt;Cardholder ID #&gt; Policy #: &lt;Policy #&gt; Issuer: 80840  RxBin: 012312 RxPCN: PARTD RxID: &lt;Cardholder ID&gt; RxGrp: H8822005</p>	<p>ADVANTAGE Special Needs Plan (HMO SNP)</p> <p>Network: &lt;Network&gt; PCP: &lt;PCP Name&gt; PCP: &lt;PCP office phone&gt; In Network Copays: Office Visit – PCP - 20% Specialist – 20%</p> <p><b>Medicare</b><sub>Rx</sub> Prescription Drug Coverage  H8822 005</p>
--	--

<p><b>MEMBERS:</b> Call: 1-800-523-7533 TTY / TTD: 1-800-743-3333 Pharmacy: 1-877-684-0014 24 Hour Nurse Line: 1-866-255-8052 Routine Vision Benefits: 1-800-877-7195 Routine Dental Benefits: 1-855-214-6777 Some services require pre- certification. Contact ADVANTAGE Utilization Management at 1-800-748- 2544 for approval.</p>	<p><b>PROVIDERS:</b> Claims, Benefits, and Eligibility Medical: 1-877-660-6258 Dental: 1-855-214-6777 Vision: 1-800-877-7195 Pharmacy: 1-877-684-0014 <b>Medicare limiting charges apply</b></p> <p><b>Submit Medical Claims to:</b> Electronic Payer ID# 77070 ADVANTAGE Claims P.O. Box 310 Dunmore, PA 18512 Visit us at <a href="http://advantageplan.com">advantageplan.com</a></p>
---	--

## WELCOME KIT

ADVANTAGE is committed to providing each member with clear and complete information about its Medicare Advantage Plans. One important way in which ADVANTAGE informs members about the Plan is through the preparation and mailing of a Welcome Kit to new members. ADVANTAGE mails a Welcome Kit to each new member within seven business-days of approval of the member application (based on the date received). The member's Welcome Kit includes the following materials:

- Welcome letter
- Identification card
- Provider Directory
- Evidence of Coverage
- Pharmacy Directory
- Formulary Listing

## MEMBER SERVICES

Inquiries on eligibility status for ADVANTAGE Health Solutions Medicare Advantage Plan members should be made to our Member Services Department. Member Services representatives are available Monday through Friday from 8 a.m. to 8 p.m. to answer questions and assist providers with their eligibility questions. Information regarding contacts and telephone numbers for representatives in the Member Services and other ADVANTAGE departments can be found in Chapter 7 – Contacts/Resources.

## DISENROLLMENT PROCESS

ADVANTAGE has established a consistent and timely process for handling disenrollments from the ADVANTAGE Health Solutions Medicare Advantage Plans and notifying CMS. Members are informed of the disenrollment process in the Evidence of Coverage.

Except in rare occurrences, ADVANTAGE never requests or encourages, either orally or in writing, a member to disenroll from ADVANTAGE Health Solutions Medicare Advantage Plans. All members are given a written notice of the disenrollment process and given the opportunity to clarify any issues in question prior to disenrollment. Disenrollment may occur for the following reasons:

- Voluntary disenrollment requested by the member
- Disenrollment by ADVANTAGE:
  - Optional disenrollment:
    - Plan Premiums: Plan premiums are due the 1<sup>st</sup> of each month. If plan premiums are late, we will send a letter in writing notifying the member that if they do not pay their premium within 90 days, we will end their membership in our plan. If we end their membership because they did not pay their premiums, the member will be returned to the Original Medicare Plan coverage.
    - Disruptive Behavior: The network or provider notifies ADVANTAGE that a member is not cooperating with published processes and procedures or that a member is abusive and/or disruptive. This behavior seriously impairs ADVANTAGE and its providers from furnishing services to the member or other members.

- The member provides fraudulent information or abuses his or her enrollment card.
- Required disenrollment:
  - Loss of entitlement to benefits under Parts A and B
  - Permanent move out of the geographic area for longer than 6 months
  - Incarceration
  - Death of the member
  - The Special Needs Plan (SNP) member loses special needs status
  - ADVANTAGE reduces its service area or loses its contract

If ADVANTAGE initiates a disenrollment, we will notify the member of an effective date for the disenrollment, provide information on their right to a hearing under the grievance procedure, and provide a reminder that the enrollee will continue to be eligible for services through his or her ADVANTAGE Health Solutions Medicare Advantage Plan until the effective termination date.

ADVANTAGE or CMS may choose to discontinue their Medicare Advantage contract at any time. If this were to happen, members would be notified at least 60 days in advance, and given the opportunity to move to another plan that serves their county.

## MEMBER RIGHTS AND RESPONSIBILITIES

Member rights and responsibilities are provided in the ADVANTAGE Health Solutions Medicare Advantage Plans Evidence of Coverage. The following sections outline those rights and responsibilities.

### STATEMENT OF MEMBER'S RIGHTS AND RESPONSIBILITIES

Members have the *right*:

- To have twenty-four (24) hour access to providers and receive emergency care out of network, if necessary
- To receive prompt and appropriate treatment for physical and emotional disorders and disabilities in the least restrictive environment necessary for that treatment, and remain free from unnecessary or excessive medication
- To be informed by the health care provider of information about diagnosis, treatment and prognosis in a manner that the member can understand
- To participate in decisions involving medical care. The member should receive enough information to enable them to make an informed decision before receiving any recommended treatment. The information should include the specific treatment or procedure, any medical alternatives and associated risks, regardless of cost of benefit coverage
- To receive information on early hospital discharge and follow-up care, rehabilitation and living arrangements that are available once released from the hospital
- To receive appropriate information so the member may give an informed, voluntary consent to participate in any experimental research. (Experimental and investigational procedures are not covered under the plans.)
- To refuse treatment and to be informed of the probable consequences of this action

- To have a guardian, next of kin or legally authorized person exercise rights on the members behalf if the members medical condition causes them to be incapable of understanding or exercising their rights
- To know the cost of care and treatment and to receive an explanation of financial responsibility upon request
- To have health records kept confidential except when disclosure is required by law or permitted by the member in writing. The member has the right to review their medical records with the physician after adequate notice has been given
- To receive guidance and recommendations for additional medical care when coverage ends
- To be provided with information about ADVANTAGE Health Solutions, its providers and member rights and responsibilities
- To provide opinions about ADVANTAGE Health Solutions Medicare Advantage Plans or the care provided by the health care provider and to recommend changes in policies and services by contacting Member Services
- To be informed about the Plan's grievance procedures
- To voice complaints or appeals about ADVANTAGE Health Solutions Medicare Advantage Plans or the care received and to receive a response to complaints or appeals within a reasonable amount of time
- To be treated with respect, recognition of dignity and the right to personal privacy
- To receive advice or assistance in a prompt, courteous and responsible manner

Members have the responsibility:

- To keep scheduled appointments and give adequate notice of appointment delay or cancellation
- To be considerate of other patients and to be understanding and tolerant of any delays
- To provide, whenever possible, information that the Plan and its providers need to provide care
- To communicate openly with the provider and medical staff. If member has questions or disagrees with the treatment plan, they have the responsibility to discuss concerns with the medical staff and make certain they understand the explanations and instructions
- To be honest, complete and accurate when providing information to the medical staff
- To follow the instructions and guidelines given by the medical staff and to consider the potential consequences if they do not comply
- To follow the plans and instructions for care that they have agreed upon with the providers
- To understand what medications they are taking and whether follow-up care is needed
- To obtain medically necessary specialty care
- To know how to access care in emergency, urgent and routine situations
- To express opinions, concerns, or complaints in a constructive manner to the appropriate personnel at ADVANTAGE or to the provider
- To know the benefits and exclusions of coverage
- To contact Member Services for all questions and assistance
- To treat all ADVANTAGE and provider personnel in a courteous and respectful manner

## **DISCRIMINATION**

Participating providers must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating provider is prohibited from making a distinction on the grounds of race, color, or national origin in the treatment of patients, the use of equipment and other facilities, and the assignment of personnel to provide services.

# CHAPTER 4 – CLAIMS PAYMENT

## FILING CLAIMS FOR SERVICES RENDERED

Claims are filed through ADVANTAGE not through Medicare. Do not use information from the patients' Medicare card. Instead, use the patients' ADVANTAGE Member ID Card.

### CLAIMS ADDRESS

ADVANTAGE Health Solutions Medicare Advantage Plans has contracted the claims administration process to TMG Health in Scranton, Pennsylvania. Their business is Medicare claims processing for clients like ADVANTAGE. TMG is connected to CMS for informational purposes and stays abreast of all memorandums, Local Medical Review Policies (LMRPs), fee updates, etc. Claims for services will be sent to this claims payment vendor whose address is listed below and is also available on the Member card.

Please address all paper claims to:

**ADVANTAGE Claims  
P.O. Box 310  
Dunmore, PA 18512  
Payer ID: 77070**

If you have questions about claims please call (888) 445-8958.

### ELECTRONIC BILLING

The ADVANTAGE Health Solutions Medicare Advantage Plans' Third Party Administrator (TPA) will process claims as closely as feasible to original Medicare. In other words, you should not have to make any dramatic changes to your current methodology or current programming in order to send claims to the TPA. The TPA is able to accept UB 04 (CMS 1450) and CMS 1500 standard forms. There are a couple minor issues that are different from original Medicare and they are listed below:

1. TMG can accept the UB 04 (CMS 1450) for outpatient procedures.
2. You must include the Federal Tax ID on the claim form or the claim will be returned.
3. You must include the Medicare Provider Number and National Provider Identifier (NPI) on the claim or the claim will be returned.
4. TMG does not use the Member's Social Security Number. Instead the ID number on the card, which is also a 9-digit number, must be entered on the claim form where you normally put the Social Security Number for original Medicare.

### CORRECT BILLING OF BOX/ITEM 32 AND 33

When billing, please advise your practitioners, sites, and/or facilities billing staff that claims should be submitted in the format below for box/item 32 and 33 on the CMS 1500 claim form.

**Instructions** – When billing, the actual site/facility/practice where the service is being performed should be placed in box/item 32 on the claim and the billing/payee/remit information should be placed in

box/item 33 on the claim. Therefore, although the site/facility/practice name and address may change from claim to claim, the billing/payee/remit name and address should remain the same for each Tax ID.

**Item 32** – Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home.

**Item 33** – Enter the provider of service/supplier's billing/payee name, address, ZIP code, and telephone number.

Providers are encouraged to visit the CMS Website for the most current and up to date information. Forms can be downloaded at: [www.cms.hhs.gov/cmsforms/downloads](http://www.cms.hhs.gov/cmsforms/downloads).

## HIERARCHICAL CONDITION CODES (HCC) RECONCILIATION

As a partner of ADVANTAGE Health Solutions in providing Medicare coverage to Hoosier seniors, our business relationship is valued. As such, ADVANTAGE feels it important to inform providers of continued efforts to better business processes and increase the quality of care. These efforts also help to keep the premiums in our Medicare Advantage Plans affordable and our plan competitive in the marketplace.

One method to achieve this is by working with the providers contracted with ADVANTAGE through your organization to ensure that claims are filed using appropriate coding standards as established by the Centers for Medicare and Medicaid Services (CMS).

Periodically, ADVANTAGE performs an analysis of claims for the previous year that indicates potential claims concerns. In order to validate this analysis, ADVANTAGE must review the medical records of those members involved.

ADVANTAGE will send out a letter listing the members. In the letter, we will request from providers a copy of the requested medical records for certain patients that were treated during that time frame. We encourage your support of these efforts. Due to impending CMS reporting deadlines, ADVANTAGE will sometimes have to contact the providers directly through mail and possibly by phone if the providers are a part of a participating Network (i.e. Pro Health, Suburban, Select, etc.)

If you have any questions regarding this process, please call our Provider Relations Department. Their phone number can be found in our “Contacts and Resources” Section at the end of this manual.

## PAYMENT

ADVANTAGE Health Solutions Medicare Advantage Plans payment methodologies will mirror Medicare payment methodologies. Any changes in traditional Medicare payments will be reflected with ADVANTAGE Health Solutions Medicare Advantage Plans payments. All updates released by Medicare will be incorporated in the ADVANTAGE Health Solutions Medicare Advantage Plans Claims Payment System.

Please see the Summary of Benefits for co-payment amounts by specific service for in-network (INN) providers. Should a claim be received by the claims payment vendor from an out-of-network (OON)

provider the claim will be processed according to traditional Medicare reimbursement schedules (80% / 20%) less co-insurance/co-payment.

ADVANTAGE Health Solutions Medicare Advantage Plans have provided a sample Remittance Advice in the Appendix section of this manual. In addition, a list of Reason/Remark Codes has also been provided. Reason/Remark Codes will be found on your Remittance Advice and will indicate to you the reason your claim paid and/or denied and any remark that is associated with that payment and/or denial.

### **FEE SCHEDULES**

Fee schedules are the same as traditional Medicare. If interested, please go to [www.cms.gov](http://www.cms.gov), and follow instructions to access fee schedules for your particular specialty or service. ADVANTAGE Health Solutions Medicare Advantage Plans will follow traditional Medicare guidelines for reimbursement methodologies, i.e. RUGS, Per Diems, DRGs, etc.

### **CLEAN CLAIMS**

ADVANTAGE Health Solutions Medicare Advantage Plans will use the CMS definition for a clean claim. (Title 42, Part 422, Subpart K, Sec. 422.500 Definitions)

#### *Definition of a Clean Claim*

(1) A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with Sec. 422.257 (d)) or particular circumstance requiring special treatment that prevents timely payment; and

(2) A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

ADVANTAGE processes claims billed by participating providers for covered services with timeliness, accuracy and member rights set forth by the Centers for Medicare and Medicaid Services (CMS) and outlined in 422.502 of the Federal Register.

Providers must submit claims to the health plan at the location listed on the Member's identification card issued by the health plan.

### **INTEREST**

On the 31<sup>st</sup> day after a claim is received and determined to be clean, interest will begin accumulating at the CMS rate of interest in effect on same day. This rate can be accessed by going to [www.cms.gov](http://www.cms.gov), and doing a site search for "Interest Rate." The interest rate will be listed in the Notice of Interest Rate for Medicare Overpayments and Underpayments.

### **ADVANCED BENEFICIARY NOTICES (ABNs)**

Advanced Beneficiary Notice (ABN) is a written notice the provider gives to a Medicare beneficiary before providing items and/or services that are expected to be denied by Medicare.

The ABN is not to be used for Medicare Advantage (Part C) enrollees or for non-Medicare patients because it is to be used solely for individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B).

*50.2.2.4 - M+C Enrollees and Non-Medicare Patients (Rev. 1, 10-01-03)*

Chapter 30 of the Medicare Claims Processing Manual – Section 50.2.2.4 provides the specific verbiage to this statement. To access Chapter 30, click or copy and paste the following link into an Internet browser: <http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf>

**MEDICARE SECONDARY PAYER (MSP)**

Secondary means that ADVANTAGE Health Solutions is only legally obligated to pay after primary payers satisfy their payment responsibilities. If the primary payer covers all expenses up to the Medicare allowable fee, the member's ADVANTAGE Health Solutions Medicare Advantage Plan has no payment obligation. If the primary payer covers part of the expenses, then ADVANTAGE may pay for the residual uncovered amounts up to the Medicare Allowable fee minus any member co-payment amount.

For dually-eligible individuals (SNP) who receive full Medicaid benefits, Medicare is their primary coverage source, and Medicaid functions as "wraparound" coverage. This means that if both Medicare and Medicaid cover a benefit or service, Medicare pays first and Medicaid may pick-up the remaining amount owed. Also, Medicaid pays for those Medicaid benefits and services that are not covered – or are limited – by Medicare.

The primary health care coverage status of each member is determined at the time of enrollment into ADVANTAGE Health Solutions Medicare Advantage Plans. ADVANTAGE is required to make no claims payment for services to the extent that Medicare is not the primary payer under the provision of Section 1862(b) of the Social Security Act.

Coordination of benefits occurs during claims adjudication to ensure payment is made for only that portion of the claim for which CMS/ADVANTAGE is responsible. ADVANTAGE actively pursues recoupment of any identified overpayment resulting from circumstances where a member has other health care coverage. ADVANTAGE provides CMS with regular updates on the primary payment status of each member enrolled in ADVANTAGE Health Solutions Medicare Advantage Plans.

ADVANTAGE Health Solutions Medicare Advantage Plans is not liable for any claims for which the member is entitled to benefits under a state or federal workers' compensation law or plan, any no-fault insurance, or any liability insurance policy or plan (including a self-insured plan). Claims for services rendered to ADVANTAGE Health Solutions Medicare Advantage Plans members, which arise from work related injuries/illnesses or auto accidents, must be filed directly with the workers' compensation or primary insurance carrier.

ADVANTAGE Health Solutions Medicare Advantage Plans shall administer Coordination of Benefits (COB) in connection with all encounters/claims and all ADVANTAGE Health Solutions Medicare Advantage Plans services according to applicable Medicare laws and regulations, including CMS instructions. ADVANTAGE Health Solutions Medicare Advantage Plans shall identify claims for which a third party may be liable and

make recoveries for those claims. All recovery activities shall be made in accordance with the Evidence of Coverage, applicable laws and CMS instructions.

The participating network designee or independently contracted provider shall notify ADVANTAGE's legal department of any pending litigation within five working days of receiving notice of the litigation. No litigation shall be commenced or settled by the Network or independent contractor unless prior written approval is obtained from ADVANTAGE. ADVANTAGE retains the right to select or approve any counsel engaged to represent its interest in any litigation.

# CHAPTER 5 – APPEALS AND GRIEVANCES

## GRIEVANCES

ADVANTAGE Health Solutions Medicare Advantage Plans' members have the right to communicate dissatisfaction with the quality of care that they receive, the timeliness of services, or decisions made by ADVANTAGE or its providers. CMS separates these into two categories: grievances and appeals.

Grievances are defined as:

Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Examples of grievances include:

- Services covered under the additional benefit package
- Long waiting times for appointments or at physician's office
- Physician behavior
- Involuntary disenrollment concerns
- Quality of care concerns
- Issues relating to premiums

All members are provided with detailed information on how to file a grievance during the enrollment process, involuntary disenrollment, and upon request. Grievances may be submitted orally or in writing by mail or fax not later than 60 calendar days after the event. Members may obtain information on how to submit a grievance by contacting the department listed below.

### **Appeals and Grievances**

Phone: 1-866-591-6737

TTY: 1-800-743-3333

Hours: 8 a.m.-5 p.m., Monday- Friday

Fax: 1-317-536-3323

Mailing: ADVANTAGE Health Solutions  
9045 River Road, Suite 200  
Indianapolis, IN 46240

Grievances are processed within 30 calendar days of receipt. A member may be eligible for an expedited grievance if ADVANTAGE extends the time frame to make an organization determination or reconsideration or refuses to grant a request for an expedited organization determination or reconsideration.

ADVANTAGE may contact a member's provider to request medical records or other information about the member's grievance. Providers are encouraged to respond as expeditiously as possible.

## APPEALS AND CLAIM DISPUTES

An appeal involves a request to reconsider an adverse prior authorization, organization determination, claim determination or a claim not paid timely.

Examples of appealable actions include:

- Service denials (e.g., coverage denials, notice of adverse determination was not issued within 24 calendar days for clean claim or within 60 calendar days for non-clean claim)
- Services denied for out-of-network
- Claims transferred by carriers or intermediaries
- Part A benefits for which "Part B only" Medicare beneficiaries pay a premium
- Claims by a enrollee regarding Medicare covered services furnished by the plan

A provider dispute is classified by the provider initiating contact with and voicing the specifics of their disagreement with the manner in which a claim was processed with the provider customer service department. Some disputes are resolved with this process. In the event that the dispute is unable to be resolved, the provider is advised to file an appeal with ADVANTAGE.

Any member or member's representative may request an appeal of a proposed or provided benefit. If the member wants someone to file the appeal for him/her, the member must provide his/her name, Medicare number, and a statement appointing an individual as his/her representative. The member is required to sign and date the statement. The member's representative must also sign and date the statement unless he/she is an attorney.

Non-contracted providers may seek a reconsidered determination for payment purposes. The provider must sign a waiver of liability agreeing to waive any right to payment from the member. Contracted providers do not have a formal appeals process in place, but can request that the claim be reviewed.

All members are provided with detailed information on the ADVANTAGE Appeal Procedure during the enrollment process and at the time of denial of payment for services or provision of services. Practitioners shall routinely notify enrollees at each patient encounter of their rights to receive a detailed notice about their services from ADVANTAGE itself. Members may request that ADVANTAGE provide a detailed notice of a practitioner's decision to deny a service in whole or in part. If ADVANTAGE decides to deny service or payment in whole or in part, it must provide the enrollee a detailed written notice of the determination. The practitioner's notification must inform enrollees of their right to receive a detailed

notice from ADVANTAGE and provide enrollees with all information necessary in order to contact ADVANTAGE. Appeals may be submitted in writing by mail or facsimile to ADVANTAGE. Members may obtain information on how to submit an appeal by calling the designated toll-free telephone line.

ADVANTAGE Health Solutions Medicare Advantage Plans providers should submit their written appeals to:

**Appeals and Grievances**

Phone: 1-866-591-6737

TTY: 1-800-743-3333

Hours: 8 a.m.-5 p.m., Monday- Friday

Fax: 1-317-536-3323

Mailing: ADVANTAGE Health Solutions

9045 River Road Suite 200

Indianapolis, IN 46240

An acknowledgement letter, confirming receipt of the appeal request, will be sent to the member within three business days of the appeal being received by ADVANTAGE Health Solutions Medicare Advantage Plans. The request should be received within 60 days of the initial claim determination. If the request is not within the 60-day filing limit, the member will be contacted by telephone and advised of the appeal filing limit. An extension can be granted if the member or his or her provider presents documentation to justify the reason for the delay in filing the appeal. Chapter 13 of the Medicare Managed Care Manual permits an extension for any of the following reasons:

- The enrollee did not personally receive the adverse organization determination notice, or he/she received it late
- The enrollee was seriously ill, which prevented a timely appeal
- There was a death or serious illness in the enrollee's immediate family
- An accident caused important records to be destroyed
- Documentation was difficult to locate within the time limits
- The enrollee had incorrect or incomplete information concerning the reconsideration process
- The enrollee lacked capacity to understand the time frame for filing a request for reconsideration.

If neither the member nor the provider documents a reason for the delay in filing, an extension will not be granted.

**APPEAL REQUESTS FROM NON-CONTRACTED PROVIDERS**

A non-contracted provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the enrollee regardless of the outcome of the appeal.

Physicians and suppliers who have executed a waiver of beneficiary liability are not required to complete the CMS-1696, Appointment of Representative, form. In this case, the physician or supplier is not representing the beneficiary, and thus does not need a written appointment of representation.

When a non-contracted provider files a request for reconsideration of a denied claim but the provider does not submit the waiver of liability documentation upon ADVANTAGE's request, the ADVANTAGE must make, and document, its reasonable efforts to secure the necessary waiver of liability form. ADVANTAGE will not undertake a review until or unless such form is obtained. The time frame for acting on a reconsideration request commences when the properly executed waiver of liability form is received. However, if ADVANTAGE does not receive the form by the conclusion of the appeal time frame, the ADVANTAGE will forward the case to the independent review entity (IRE) with a request for dismissal. ADVANTAGE must comply with the IRE's Reconsideration Process Manual section on reconsiderations that fail to meet provider-as-party requirements.

### **PROVIDER WAIVER OF LIABILITY STATEMENT**

When a non-contracted physician or provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the non-contracted physician or provider must sign a waiver of liability, i.e., the non-contracted physician or provider formally agrees to waive any right to payment from the enrollee for a service. A sample "Provider Waiver of Liability Statement Letter and Form" have been provided in the Appendix.

A quick reference has been provided for you below.

<http://www.cms.hhs.gov/manuals/downloads/mc86c13.pdf>

### **APPEAL DETERMINATION TIMEFRAME**

ADVANTAGE must make an appeal determination within 30 calendar days of receipt of the appeal for services or within 60 calendar days of receipt of an appeal for payment. If the original determination is upheld, a letter advising of such will be issued to the member.

If the decision is a completely favorable reconsideration to the member for a service, ADVANTAGE must provide or authorize the service as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the date that ADVANTAGE received the request for reconsideration.

If the decision is a completely favorable reconsideration to the member for payment, the claim must be effectuated no later than 60 calendar days after the date that ADVANTAGE received the request for reconsideration.

### **EXPEDITED APPEALS**

Any member who is dissatisfied with an organization or coverage determination may begin the 72-hour expedited appeal process by requesting an expedited reconsideration of an organization or prescription drug coverage determination.

Chapter 13 of the Medicare Managed Care Manual states:

An enrollee or any physician (regardless of whether the physician is affiliated with the Medicare health plan) may request that a Medicare health plan expedite a reconsideration of a determination, in situations where applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, including cases in which the Medicare health plan makes a less than fully favorable decision to the enrollee.

An expedited appeal may be initiated orally or in writing from the member/member's representative or provider. If the member submits a verbal request for an expedited appeal, he or she will need to submit supporting information from a physician noting the urgent need for services. A representative statement is not required from the physician. ADVANTAGE grants all physician requests for expedited appeal filed on behalf of the member. A physician may request expedited reconsideration on an enrollee's behalf without being appointed as the enrollee's authorized representative. The physician's request must indicate the possibility of serious jeopardy to the member.

If the member requests an expedited 72-hour appeal and the request is denied, the member is not required to file another request for the appeal to be processed in the standard process. Requests for an expedited appeal will be considered independently from requests for an expedited organization or coverage determination and may be granted even if the request for expedited organization determination is denied. ADVANTAGE will not process member or physician requests for an expedited appeal regarding hospital discharge if an immediate Peer Review Organization review for hospital discharge is being conducted.

ADVANTAGE will not take or threaten to take any punitive action against a physician acting on behalf or in support of a member in requesting an expedited organization determination or reconsideration.

### **LEVELS OF APPEAL**

If the outcome of an appeal is not in favor of the member, the member has the option to elevate the case to a higher level of appeal. After the initial health plan reconsideration, there are four other options for review:

- Independent review entity (IRE) reconsideration
- Office of Medicare Hearings and Appeals administrative law judge (ALJ) hearing
- Medicare Appeals Council
- Federal District Court

After an adverse decision at one level, the member will be notified about the process to appeal to a higher level of review.

## APPEALS OF ORGANIZATION DETERMINATIONS FOR DISCONTINUATION OF SERVICES

An *organization determination for discontinuation of services* is defined as any determination made by ADVANTAGE with respect to discontinuation of services when an enrollee believes that the services continue to be medically necessary. Services that fall in this category are provided by inpatient hospitals, home health agencies (HHAs), skilled nursing facilities (SNFs), and comprehensive outpatient rehabilitation facilities (CORFs). *Termination (discontinuation) of service* is defined as the discharge of an enrollee from covered provider services, or discontinuation of covered provider services, when an enrollee has been authorized by ADVANTAGE, either directly or by delegation, to receive an ongoing course of treatment from that provider. Termination includes cessation of coverage at the end of a course of treatment, regardless of whether the enrollee agrees that such services should end.

The parties that can request an organization determination are:

- The enrollee (including his or her authorized representative);
- An assignee of the enrollee (that is, a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than ADVANTAGE) determined to have an appealable interest in the proceeding.

## APPEALS OF INPATIENT HOSPITALIZATION DISCHARGES

ADVANTAGE utilization management nurses will daily review all members who are hospitalized. Nurses will contact the acute inpatient facility (hospital, long-term acute care hospital, acute inpatient rehabilitative facility) to determine the patient's status.

If the ADVANTAGE medical management team, in consultation with the hospital and the member's physicians, determines that the member should be discharged, the hospital provider will issue the Important Message from Medicare (IM) to advise the ADVANTAGE member that his or her covered services will be ending within 48 hours. If the enrollee is incompetent or otherwise incapable of receiving the notice, the notice must be delivered to the enrollee's authorized representative.

If the hospital is unable to personally deliver a notice of non-coverage to a person legally acting on behalf of an enrollee, the hospital must call the representative to advise him or her when the enrollee's services are no longer covered. The facility must explain the enrollee's appeal rights to the representative, and provide the name and telephone number of the appropriate quality improvement organization (QIO).

The date of the conversation is the date of the receipt of the notice. The hospital must confirm the telephone contact by written notice mailed on that same date, place a dated copy of the notice in the enrollee's medical file, and document the telephone contact to include:

- Name of person initiating the contact
- Name of the representative contacted

- Date and time of the contact
- Telephone number called

When direct phone contact cannot be made, the facility must send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. The hospital must place a copy of the notice in the enrollee's medical file and document the attempted telephone contact to include:

- Name of person initiating the contact
- Name of the representative you attempted to contact
- Date(s) and time(s) of the attempted contact(s)
- Telephone number(s) called

When notices are returned by the post office, with no indication of a refusal date, the enrollee's liability starts on the second working day after the provider's mailing date. The hospital should use these procedures when an enrollee has authorized an individual to act on his or her behalf, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact.

If the enrollee wishes to appeal ADVANTAGE's discharge decision that inpatient care is no longer medically necessary, he/she must request immediate QIO review of the determination in accordance with the requirements below. An enrollee will not incur any additional financial liability if all of the following occur:

- The enrollee remains in the hospital as an inpatient
- The enrollee submits the request for immediate review to the QIO
- The request is made either in writing, by telephone or fax
- The request is received by noon of the first working day after the enrollee receives written notice of ADVANTAGE's decision that the hospital stay is no longer necessary.

### **ISSUANCE OF DETAILED NOTICE OF DISCHARGE**

The Detailed Notice of Discharge (the Detailed Notice) is a standardized written notice that provides specific and detailed information to ADVANTAGE members of why their inpatient hospital services are ending. ADVANTAGE or its delegate must issue the Detailed Notice to the enrollee with a copy provided to the QIO whenever an enrollee appeals a termination decision about their inpatient hospital services.

The Detailed Notice must include:

- A specific and detailed reason why services are either no longer reasonable and necessary or otherwise no longer covered
- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee may obtain a copy of the Medicare policy from ADVANTAGE
- Any applicable ADVANTAGE policy, contract provision, or rationale upon which the discontinuation of services decision was based
- Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case

ADVANTAGE must deliver the Detailed Notice to the enrollee as soon as possible but no later than noon of the day after the QIO's notification. On the date the QIO receives the enrollee's request, the QIO will notify ADVANTAGE that the enrollee has filed a request for immediate review. ADVANTAGE must supply any information that the QIO requires to conduct its review. This must be made available by phone, fax, or in writing by the close of business of the first full working day immediately following the day the enrollee submits the request for review. In response to a request from ADVANTAGE, the hospital must also submit medical records and other pertinent information to the QIO by close of business of the first full working day immediately following the day ADVANTAGE makes its request. The QIO must solicit the view of the enrollee who requested the immediate QIO review.

The QIO must make an official determination of whether continued hospitalization is medically necessary, and notify the enrollee, the hospital, and ADVANTAGE by close of business of the first working day after it receives all necessary information from the hospital, ADVANTAGE or both.

If the enrollee fails to request an immediate QIO review in accordance with these requirements, he/she may file a request for expedited (fast track) reconsideration with ADVANTAGE. ADVANTAGE will expedite the request for an expedited reconsideration. Likewise, if the QIO receives a request for immediate QIO review beyond the noon filing deadline and forwards that request to ADVANTAGE, ADVANTAGE will expedite that request. Thus, ADVANTAGE would generally make another decision about the services within 72 hours. However, the financial liability rules governing immediate QIO review do not apply in an expedited review situation conducted by ADVANTAGE.

If the enrollee files a timely appeal for an immediate QIO review, the enrollee is entitled to automatic financial protection by ADVANTAGE. This means that if ADVANTAGE authorizes coverage of the inpatient hospital admission directly or by delegation, or this admission constitutes emergency or urgently needed care, ADVANTAGE continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the QIO notifies the enrollee of its review determination.

### **APPEALS OF DISCHARGES FROM HOME HEALTH AGENCIES, SKILLED NURSING FACILITIES, OR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES**

ADVANTAGE transitional care managers and utilization management nurses regularly review members participating in on-going care. When they identify the need to update discharge status for SNF stays, HHA services, or CORF stays, they will contact the service provider to determine patient status.

If it is determined that services are no longer medically necessary, the SNFs, HHAs, and CORFs must provide the Notice of Medicare Non-Coverage (NOMNC) to ADVANTAGE members. The NOMNC includes:

- The date that coverage of services ends
- The date that the enrollee's financial liability for continued services begins
- A description of the enrollee's right to appeal the termination of services
- Identification of the appropriate Quality Improvement Organization (QIO)

The provider is responsible for validly delivering the NOMNC on behalf of ADVANTAGE to the enrollee no later than two calendar days before the covered service ends. Valid delivery means that the enrollee must be able to sign the NOMNC to acknowledge receipt of the form. The enrollee must be able to understand that he or she may appeal the termination decision. Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus, if an enrollee is able to comprehend the notice, but either is physically unable to sign it, or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. Furthermore, if the enrollee refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the enrollee refused to sign.

If the enrollee's services are expected to be fewer than two days in duration, the provider must provide the NOMNC to the enrollee at the time of admission to the provider. If the member is in a non-residential setting and the span of time between services exceeds two days, the provider may deliver the notice at the next to last time the services are furnished. This will prevent a non-residential provider from having to make an additional trip to deliver the notice to the enrollee. A provider may deliver the notice earlier than the required two days before the covered services end if the date the coverage will end can be identified earlier.

ADVANTAGE and its providers are required to develop procedures to use when the enrollee is incompetent or incapable or receiving the notice and the provider cannot obtain the signature of the enrollee's representative through direct personal contact.

#### **ENROLLEE APPEAL TO QIO FOR DISCONTINUATION OF SERVICES FOR SNF, HHA, OR CORF**

Enrollees of Medicare Advantage (MA) plans have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their MA plan's decision that Medicare coverage of their services from a SNF, HHA, or CORF should end.

An enrollee receiving services in a SNF, HHA, or CORF that wishes to obtain an independent appeal of ADVANTAGE's determination that such care is no longer medically necessary must submit a timely request for a fast-track review to the Quality Improvement Organization (QIO) that has an agreement with ADVANTAGE. A timely request is one in which an enrollee requests an appeal from the QIO either by noon of the day following receipt of the NOMNC, or, where an enrollee receives the NOMNC more than two days prior to the date coverage is expected to end, an enrollee requests an appeal to the QIO by noon of the day before coverage ends.

An enrollee will not incur financial liability if the QIO reverses ADVANTAGE's discontinuation of services decision, or if the enrollee stops receiving care no later than the effective date inserted on the enrollee's NOMNC. The enrollee will likely incur at least one day of financial liability if the QIO upholds ADVANTAGE's decision, and the enrollee continues to receive services until the day after the effective date inserted on the NOMNC.

## **ISSUANCE OF DETAILED EXPLANATION OF NON-COVERAGE**

The Detailed Explanation of Non-Coverage (DENC) is a standardized written notice that provides specific and detailed information to ADVANTAGE members of why their SNF, HHA, or CORF services are ending. ADVANTAGE (or its delegate) must issue the DENC to the enrollee (with a copy provided to the QIO) whenever an enrollee appeals a termination decision about their SNF, HHA, or CORF services. The DENC includes:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered
- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee may obtain a copy of the Medicare policy from ADVANTAGE
- Any applicable ADVANTAGE policy, contract provision, or rationale upon which the discontinuation of services decision was based
- Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case

ADVANTAGE must issue the DENC to enrollees and provide a copy to the QIO no later than the close of business of the day of the QIO's notification to ADVANTAGE that the enrollee requested an appeal, or the day before the effective date coverage ends, whichever is later. Because the QIO needs the DENC in order to conduct its review, ADVANTAGE must ensure that the QIO has the DENC timely. Providers should cooperate with ADVANTAGE requests for assistance in getting needed information. Based on the expedited timeframes, the QIO decision should take place by close of business of the day coverage is to end.

If ADVANTAGE's decision to discontinue services is upheld by the QIO, the ADVANTAGE transitional care manager will coordinate with the facility to assure that the member has services in place to transition to his or her discharge location as soon as possible. If ADVANTAGE's decision to discontinue services is not upheld by the QIO, the transitional care manager will proceed with the weekly concurrent review process. This will require a new NOMNC when the patient's services are discontinued in the future.

## **IMPORTANCE OF TIMING/NEED FOR FLEXIBILITY**

Although the regulations and accompanying CMS instructions do not require action until two days before the planned termination of covered services, ADVANTAGE emphasizes that it is generally in everyone's best interest for ADVANTAGE and its providers to work together to deliver the advance termination notice to enrollees as soon as the provider knows when ADVANTAGE will terminate coverage. Doing so will allow the patient more time to determine if they wish to appeal and may permit more time for providers and ADVANTAGE to furnish any needed records.

In some cases, CMS recognizes that permitting flexibility in the timing of notice delivery may result in an early, and possibly premature, enrollee request for a QIO review. In these situations, the QIO will immediately notify ADVANTAGE of the appeal request but all parties will need to exercise judgment in determining when it makes sense for the ADVANTAGE and/or the provider to furnish any needed medical

records or other documentation to the QIO. Although ADVANTAGE should provide the enrollee (and the QIO) with a DENC as soon as it learns of the appeal request, it may be appropriate to delay providing the enrollee's medical records until shortly before the planned coverage termination, when the record is presumably complete enough to permit an informed QIO determination. Keep in mind that the overall deadline for record provision remains close of business of the day before the planned termination.

ADVANTAGE strongly encourages providers to structure their notice delivery and discharge patterns to make the new process work as smoothly as possible. For example, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate financial liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance, facilitating a faster, simpler discharge. ADVANTAGE Transitional Case Managers can assist members and facilities with this transition.

## **FAQ- DISCONTINUATION OF SERVICES**

### **1. What do the SNF, HHA, and CORF notification requirements mean for providers?**

The NOMNC is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS has developed a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider. The NOMNC essentially includes only two variable fields (i.e., patient name and last day of coverage) that the provider must fill in.

### **2. When should the NOMNC be delivered?**

Based on ADVANTAGE's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two days before the end of coverage. If services are expected to be fewer than two days, the NOMNC should be delivered upon admission. If there is more than a two-day span between services (e.g., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. ADVANTAGE encourages providers to work with ADVANTAGE Medical Management staff so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

## **MORE INFORMATION**

Further information on this process, including the required notices and related instructions can be found on the CMS website at <https://www.cms.gov/MMCAG/>. (Also, the regulations are at 42 CFR 422.624, 422.626, and 489.27, and Chapter 13 of the Medicare Managed Care Manual includes information on the process.)

# CHAPTER 6 – MEDICAL MANAGEMENT

## PRIOR AUTHORIZATIONS/ ORGANIZATION DETERMINATIONS

Various services require authorization from ADVANTAGE. This process is called prior authorization or a pre-service organization determination.

42 C.F.R. 422.566 defines organization determination as: any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgent care services
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Prior Authorization Is Required For The Following Services:

- Inpatient Hospitalization
- Inpatient Psych Hospitalization
- Skilled Nursing Facility
- Comprehensive Outpatient Rehabilitation Facility
- Partial Hospitalization - 23 hour observation stays
- Home Health Care
- Occupational, Physical and Speech Therapy
- Mental Health & Psychiatric Services
- Ambulatory Surgery Center Procedures
- Outpatient Mental Health
- Outpatient Substance Abuse
- Cardiac Rehab
- Outpatient Durable Medical Equipment >\$500
- Renal Dialysis
- Polysomnography (Sleep Study)
- Outpatient Chemotherapy and Radiation Therapy

### STANDARD REQUEST FOR SERVICE

The parties that can request an organization determination are:

- The enrollee (including his or her authorized representative);
- An assignee of the enrollee (that is, a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);
- The legal representative of a deceased enrollee's estate; or
- Any other provider or entity (other than the Medicare health plan) determined to have an appealable interest in the proceeding.

These parties can request an organization determination by calling ADVANTAGE prior authorization line, fax or letter.

**Prior Authorization Line**

**Phone: (800) 748-2544**

**Fax: (888) 657-7693**

**Community Health Network HMO Enrollees**

**Phone: (800) 344-8672**

**Fax: (317) 621-7984**

**Address: 8180 Clearvista Parkway**

**Suite 240**

**Indianapolis, IN 46256**

Enrollees can request a standard determination or, when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy, an expedited determination. ADVANTAGE has 14 days to process a standard determination and 72 hours to process an expedited determination. If ADVANTAGE approves the service, it provides verbal notification to the provider and the member if he or she initiated the request.

ADVANTAGE (or its delegate) may extend the determination timeframe by up to 14 calendar days if the enrollee requests or if ADVANTAGE justifies a need for additional information. ADVANTAGE (or its delegate) must document how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny).

ADVANTAGE (or its delegate) must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

### **ADVERSE DETERMINATIONS**

If ADVANTAGE (or its delegate) decides to deny a service in whole or in part, the plan must give the enrollee a written Notice of Denial of Medical Coverage (NDMC). Written notice must clearly state:

- The service denied
- The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any
- Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566(b)(3))
- For service denials, a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process
- The beneficiary's right to submit additional evidence in writing or in person.

Failure to provide the enrollee with timely notice of an organization determination constitutes an adverse organization determination and may be appealed.

### **EXPEDITED REQUEST FOR SERVICE**

An enrollee or a physician (regardless of whether the physician is affiliated) may request that ADVANTAGE (or its delegate) expedite an organization determination involving situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. (This does not include requests for payment.) The enrollee or a physician must submit an oral or written request directly to ADVANTAGE (or its delegate).

ADVANTAGE (or its delegate) must promptly decide whether to expedite a determination, based on the following requirements:

- For a request made by an enrollee, ADVANTAGE (or its delegate) must provide an expedited determination if it determines that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
- For a request made or supported by a physician, ADVANTAGE (or its delegate) must provide an expedited determination if the physician indicates that making a standard determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

If ADVANTAGE (or its delegate) denies a request for expedited determination, it will automatically transfer the request to the standard timeframe and make the determination with the 14-day timeframe, which begins the day ADVANTAGE (or its delegate) received the request for expedited determination. The enrollee has the right to file a grievance if he or she disagrees with the decision not to expedite. His or her notification letter contains instructions about the grievance process and its timeframes.

If ADVANTAGE (or its delegate) grants a request for expedited determination, it must make its determination and notify the enrollee (and the physician involved, as appropriate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

ADVANTAGE (or its delegate) may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information. ADVANTAGE (or its delegate) must document how the delay is in the interest of the enrollee. When ADVANTAGE grants itself an extension to the deadline, it must notify the enrollee, in writing, of the reasons for the delay, and inform the enrollee of the right to file a grievance if he or she disagrees with the Medicare health plan's decision to grant an extension. After the extension, ADVANTAGE (or its delegate) must notify the enrollee of the decision as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

ADVANTAGE (or its delegate) must request the necessary information from a non-contracted provider within 24 hours of the initial request for an expedited organization determination. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary

information to assist ADVANTAGE (or its delegate) to meet the deadline. Regardless of whether the Medicare health plan must request information from non-contracted providers, ADVANTAGE (or its delegate) is responsible for meeting the same time frame and notice requirements as it does with its own providers.

ADVANTAGE or its delegate will first notify the enrollee of its expedited determination orally. It will then mail written confirmation to the enrollee within two working days of the oral notification. If the determination is not completely favorable to the enrollee, the notice will provide:

- The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any
- Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf
- A description of both the standard and expedited reconsideration processes which includes the conditions for obtaining an expedited reconsideration, and the other elements of the appeals process
- The beneficiary's right to submit additional evidence in writing or in person.

If ADVANTAGE (or its delegate) fails to provide the enrollee with timely notice of an expedited organization determination, the failure constitutes an adverse organization determination and may be appealed

Please call (888) 445-8958 for more information.

## **BEHAVIORAL HEALTH**

Midwest Behavioral Health Network (MBHN) is the triage/case manager for the behavioral health component of ADVANTAGE Health Solutions Medicare Advantage Plans. MBHN offers a fully-credentialed, preferred provider network of hospitals, outpatient facilities, psychiatrists, psychologists, therapists and social workers.

Before making an appointment with a behavioral health provider, members should contact MBHN at (800) 223-6246. TTY/TDD users dial 711. A representative of Midwest Behavioral Health will assist the member in making a decision about what type of behavioral health practitioner is right for them. MBHN offers 24-hour availability for members and a Quality Improvement Program to monitor performance and satisfaction.

All mental health services require prior authorization. To request a behavioral health prior authorization, please contact (800) 748-6246.

To access the Midwest Behavioral Health Network Provider Directory, you may click or copy and paste the following link into your Internet browser: <http://www.newavenuesonline.com/provider/directory>

## **CARE COORDINATION**

ADVANTAGE continually strives to coordinate the provision of comprehensive holistic care to its enrollees. Coordination of care among behavioral health and medical providers is critical in the reduction of service duplication and improvement of health outcomes.

## **CARE MANAGEMENT**

At ADVANTAGE Health Solutions, our goal is to ensure that our members have access to the types of programs that will help them improve their outcomes. This includes services that go beyond traditional Medicare coverage.

Our Care-ADVANTAGE® programs help members get the necessary services, to reduce many of their worries, take charge of their care and navigate the health care system. We have a care team available to address health concerns, provide education about medical conditions and medications, and assist members in talking with their doctors. These services are available to our members at no additional cost.

## **HEALTH COACHING**

Our health coaches include nurses, nurse practitioners, social workers, pharmacists and health educators who focus on health concerns that are common to older populations:

- Fall risks
- Urinary incontinence
- Physical inactivity
- Dementia
- Depression
- Medication complications
- Under-nutrition

Once we identify a potential risk from the above list, we work with members and their providers to assist in development of a care plan to address the risk. For information about our Care Management services please call our ADVANTAGE Member Services at 1-800-523-7533; Monday through Friday from 8 a.m. to 8 p.m. TTY/TDD users should call 1-800-743-3333.

## **TRANSITIONAL CARE COORDINATION**

We offer services to help members return to an active lifestyle following a stay in the hospital or skilled nursing facility.

After a hospital or skilled nursing facility stay, our nurses:

- Help review changes in medications
- Work with members to schedule visits with their doctors
- Give education on how to watch for changes in health
- Get members started on keeping a personal health record
- Connect members and families with additional support
- Work with members and families to help improve home safety

## **CASE MANAGEMENT**

Our Case Managers provide services to members with complex medical and care needs to address concerns with coordinating care and arranging services. Together the member, Case Manager and providers identify ways for achieving better health outcomes for the member.

For more information about Case Management services, members and providers can call our ADVANTAGE Member Services at 1-800-523-7533; Monday through Friday from 8 a.m. to 8 p.m. TTY/TDD users should call 1-800-743-3333.

## **MEDICATION THERAPY MANAGEMENT**

Our Medication Therapy Management Program (MTMP) puts our members in contact with our pharmacists and nurses to ensure they are getting the maximum benefit from their prescription drugs or medications.

### **Who can participate in MTMP?**

Members who have three (3) or more of the following chronic conditions can be selected for MTMP:

- Alzheimer's
- Arthritis
- Asthma
- Bipolar Disorder
- Chronic Heart Failure
- Depression
- Diabetes
- Heart Disease
- Osteoporosis
- Schizophrenia

Additionally, members who are taking more than eight medications and have higher cost medications can also participate in MTMP.

### **How is a member enrolled in the MTMP program?**

On a quarterly basis, members are identified by prescription records and are enrolled in MTMP if they meet the program criteria, and agree to join.

### **Does a member have to participate in the MTMP program?**

No. Participation is voluntary. Members who meet the MTMP criteria have the right to decide if they want to participate.

### **What will MTMP consist of?**

MTMP looks closely at the medications used by members and checks for possible interactions between different medications. Our pharmacists and nurses then reach members by telephone or mail.

### **How do I get more information about MTMP?**

To learn more about MTMP or prescription drug coverage, please contact ADVANTAGE Member Services at 1-800-523-7533, Monday through Friday from 8 a.m. to 8 p.m. TTY/TDD users should call 1-800-743-3333.

## **DISEASE MANAGEMENT**

Care-ADVANTAGE® offers Disease Management programs for members who are dealing with long-term conditions. Members work with our Health Educators to set personal goals and learn ways to manage their chronic conditions.

Our Disease Management programs include the following conditions:

- Asthma
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Diabetes or High Blood Sugar
- Hypertension or High Blood Pressure
- Migraine Headaches
- Chronic obstructive pulmonary disease (COPD)

For more information about our Disease Management programs, call us at 1-877-901-2237 ext 2922, Monday through Friday 8 a.m. to 5 p.m. and speak to our Disease Management Coordinator.

# CHAPTER 7 – CONTACTS / RESOURCES

## PROVIDERS

### Provider Relations

(888) 445-8958

### Mailing Address

ADVANTAGE Health Solutions  
Medicare Advantage Plans  
9045 River Road, Suite 200  
Indianapolis, IN 46240

### Claims Submission

ADVANTAGE Claims  
PO Box 310  
Dunmore, PA 18512  
(888) 445-8958  
Electronic Payor ID #: 77070  
Claims Status: (888) 445-8958

### Prior Authorization

General: (800) 748-2544  
Behavioral Health: (866) 468-8257  
Community Health Network HMO Only: (800)  
344-8672 or (317) 621-7565

### Grievances & Appeals Written

#### Correspondence

Medicare Advantage Provider Appeals  
ADVANTAGE Health Solutions, Inc.  
9045 River Road, Suite 200  
Indianapolis, IN 46240  
(317) 573-6218 FAX

### Midwest Behavioral Health

(888) 525-2929

### VSP (Vision Plan)

(800) 877-7195

### Translation Plus Interpreter Services

(888) 338-5514.

## MEMBERS

### Member Services

Local: (317) 573-7950

Toll Free: (800) 523-7533

TDD: (800) 743-3333

8:00 a.m. - 8:00 p.m. Monday through Friday

Email:

[PreferredPlusMbrSrvcs@advantageplan.com](mailto:PreferredPlusMbrSrvcs@advantageplan.com)

Visit <http://www.advantageplan.com/advppo/>

for additional information such as:

- Benefit Grid
- Formulary
- Summary of Benefits
- Evidence of Coverage

# APPENDICES

Provider Notification Form

Remittance Advice

Provider waiver of liability statement letter and form sample

Reason/Remark Codes

The following is a sample Provider Notification Form



### Provider Relations Provider Notification Fax Form Part 1

Print, complete, and fax forms to ADVANTAGE Health Solutions Provider Relations Department. Please fill out this form as well as the other two parts to the Notification Fax Form and fax the completed forms to ADVANTAGE Health Solutions, Provider Relations 317-663-1895.

Prepared By  Date

Change Category

Change Comment

Type of Change  Add Office Address  Billing Address  Fax Number  Fee Schedule  
 Tax ID Number  Telephone Number  Name Change  New Office Address

### Provider Information

Effective Date

Provider Type

Provider NPI

Last Name

First Name

Middle Name

Suffix

Gender

Date of Birth

Ethnicity

Medicare ID

Medicaid ID

Provider Email

Practice Web

### Practice Information

Practice Name

Address 1

Address 2

City

State

County

Zip

Phone

Fax

Office Manager

Office Email

Group IHCP Number

Group Medicare ID

Group NPI

### Office Hours

Mon   -to-

Tue   -to-

Wed   -to-

Thu   -to-

Fri   -to-

Sat   -to-

Sun   -to-

Handicap Accessible

OB Services

GYN Services

Age Restrictions

Accepting Patients

Include Provider in ADVANTAGE Printed Directory

## Billing Information

Billing Location is the same as Practice Location?

Tax ID	<input type="text"/>
Billing Name	<input type="text"/>
Billing Address 1	<input type="text"/>
Billing Address 2	<input type="text"/>
Billing City	<input type="text"/>
Billing State	<input type="text"/>
Billing County	<input type="text"/>
Billing Zip	<input type="text"/>
Billing Phone	<input type="text"/>
Billing Fax	<input type="text"/>

## Credentialing Information

CAQH	<input type="text"/>
Provider Education	<input type="text"/>
Provider Internship	<input type="text"/>
Provider Residency	<input type="text"/>

### Malpractice Coverage

Malpractice Coverage	<input type="text"/>
Insurance Carrier	<input type="text"/>
Amount	<input type="text"/>
Eff Date	<input type="text"/>
Exp Date	<input type="text"/>

### Licenses

State	<input type="text"/>
License Number	<input type="text"/>
Eff Date (mm/dd/yyyy)	<input type="text"/>
Exp Date	<input type="text"/>
DEA	<input type="text"/>
CSR#	<input type="text"/>

## Board Certifications (If more than 3 certs, enter in Comments below)

Board Cert Name	<input type="text"/>
If Certification is not listed, please enter here: <input type="text"/>	
Eff Date	<input type="text"/>
Exp Date	<input type="text"/>
Cert #	<input type="text"/>

Board Cert Name	<input type="text"/>
If Certification is not listed, please enter here: <input type="text"/>	
Eff Date	<input type="text"/>
Exp Date	<input type="text"/>
Cert #	<input type="text"/>

Board Cert Name	<input type="text"/>
If Certification is not listed, please enter here: <input type="text"/>	
Eff Date	<input type="text"/>
Exp Date	<input type="text"/>
Cert #	<input type="text"/>

## Additional Comments

<input type="text"/>
----------------------

Print, complete, and fax forms to ADVANTAGE Health Solutions Provider Relations Department. Please fill out this form as well as the other two parts to the Notification Fax Form and fax the completed forms to ADVANTAGE Health Solutions, Provider Relations 317-663-1895.

Print, complete, and fax forms to ADVANTAGE Health Solutions Provider Relations Department. Please fill out this form as well as the other two parts to the Notification Fax Form and fax the completed forms to ADVANTAGE Health Solutions, Provider Relations 317-663-1895.

### Specialty

ALLERGY & IMMUNOLOGY AMBULATORY CARE AMBULATORY SURGICAL CENTER ANESTHESIOLOGY CARDIAC SURGERY CARDIOLOGY CHIROPRACTIC COLORECTAL SURGERY DERMATOLOGY DURABLE MEDICAL EQUIPMENT EMERGENCY MEDICINE ENDOCRINOLOGY FAMILY PRACTICE GASTROENTEROLOGY GENERAL SURGERY GERIATRIC MEDICINE GYNECOLOGICAL & ONCOLOGY GYNECOLOGY HAND SURGERY HEMATOLOGY & ONCOLOGY HOME HEALTH HOME HEALTH/HOME INFUSION HOSPICE & PALLIATIVE CARE HOSPITAL (ACUTE CARE FACILITY) INFECTIOUS DISEASE INFUSION THERAPY INTERNAL MEDICINE MATERNAL & FETAL MEDICINE MAXILLOFACIAL SURGERY MEDICAL ONCOLOGY NEONATOLOGY NEPHROLOGY NEUROLOGY NEUROPSYCHIATRY NEUROSURGERY NUCLEAR MEDICINE NURSE PRACTITIONER OBSTETRICS & GYNECOLOGY OPHTHALMOLOGY OPHTHAMOLOGY OPHTHAMOLOGY OPTOMETRY ORTHOPEDIC SURGERY OSTEOPATHIC MANIPULATIVE THERAPY OTHER OTOLARYNGOLOGY PATHOLOGY & LABORATORY PATHOLOGY AND LAB PEDIATRIC MEDICINE PHARMACY PHYSICAL MEDICINE & REHABILITATION PHYSICIAN ASSISTANT PLASTIC & RECONSTRUCTIVE SURGERY PODIATRY PSYCHIATRY PULMONARY DISEASE RADIATION ONCOLOGY RADIOLOGY RECOVERY FACILITY RHEUMATOLOGY SPEECH THERAPY TRANSPLANT SURGERY TRAUMA SURGERY URGENT CARE UROLOGY VASCULAR SURGERY
--

### Language

Arabic Armenian Basque Chinese Croatian English Filipino French German Greek Gujarati Hebrew Hindi Hungarian Italian Japanese Korean Lithuanian Persian Polish Portuguese Pumdabi Punjabi Romanian Russian Sign Somali Spanish Szech Tagalog Tamil Telugu Thai Urdu Vietnamese Yoruba Bengali Bulgarian Cantonese Czech Farsi Guarani Indian(east) Marathi Nigerian Turkish Ukranian
--

### Degree

ANP APN APRN-BC ARNP ATC AUD BCBA BSN CCRN CFNP CNM CNP CNS CPNP CRNA CST DC DDS DNS DO DPM DPT ED ED D EMT FACC FACP FNP HSPP LCSW LMFT LMHC LMSP MBBS MD MSN MSNA MSW NP OD OT OTR PA PA-C PHD PMH PSHY PSYD PT PTA RN RNP RPT RT WHNP
--

## Provider Notification Fax Form Part 3 - Hospital Privileges

Print, complete, and fax forms to ADVANTAGE Health Solutions Provider Relations Department. Please fill out this form as well as the other two parts to the Notification Fax Form and fax the completed forms to ADVANTAGE Health Solutions, Provider Relations 317-663-1895.

Adams Memorial Hospital  
 Ball Memorial Hospital Inc  
 Bedford Regional Medical Center  
 Blackford Community Hospital  
 Bloomington Hospital  
 Bloomington Hospital Of Orange County Inc  
 Bloomington Meadows Hospital  
 Bluffton Regional Medical Center  
 Cameron Memorial Community Hospital Inc  
 Clarian Arnett Hospital  
 Clarian Health Partners Inc dba Methodist IU Riley  
 Clarian North Medical Center  
 Clarian West Medical Center  
 Clark Memorial Hospital  
 Columbus Regional Hospital  
 Community Hospital  
 Community Hospital Of Anderson  
 Community Hospital Of Bremen Inc  
 Community Hospital South  
 Community Hospitals Of Indiana Inc East/North  
 Daviess Community Hospital  
 Deaconess Cross Pointe Center LLC  
 Deaconess Hospital Inc  
 Dearborn County Hospital  
 Decatur County Memorial Hospital  
 Dekalb Memorial Hospital Inc  
 Doctors Hospital  
 Dukes Memorial Hospital  
 Dupont Hospital LLC  
 Elkhart General Hospital  
 Fairbanks Hospital  
 Fayette Memorial Hospital Association Inc  
 Floyd Memorial Hospital And Health Services  
 Franciscan Physicians Hospital  
 Franciscan St Francis Health - Beech Grove  
 Franciscan St Francis Health - Indianapolis  
 Gibson General Hospital  
 Good Samaritan Hospital  
 Goshen General Hospital  
 Grant General Hospital  
 Greene County General Hospital  
 Hancock Regional Hospital  
 Harrison County Hospital  
 Healthsouth Deaconess Rehabilitation Hospital  
 Healthsouth Hospital Of Terre Haute  
 Heartland Memorial Hospital LLC  
 Hendricks Regional Health  
 Henry County Memorial Hospital  
 Hind General Hospital LLC  
 Howard Regional Health System  
 Howard Regional Health System West Campus Sp  
 Indiana Heart Hospital, The  
 Indiana Orthopaedic Hospital  
 Jasper County Hospital  
 Jay County Hospital  
 Jennings Hospital  
 Johnson Memorial Hospital  
 Kindred Hospital Indianapolis  
 Kindred Hospital Indianapolis South  
 King's Daughters Hospital And Health Services  
 Kosciusko Community Hospital  
 Lafayette Home Hospital  
 Laporte Hospital And Health Services  
 Logansport Memorial Hospital  
 Luthern Hospital Of Indiana  
 Major Hospital  
 Margaret Mary Community Hospital Inc  
 Marion General  
 Memorial Hospital  
 Memorial Hospital And Health Care Center  
 Memorial Hospital Of South Bend  
 Methodist Hospitals Inc  
 Morgan Hospital And Medical Center  
 Our Lady Of Peace Hospital  
 Parkview Hospital  
 Parkview Huntington Hospital  
 Parkview Lagrange Hospital  
 Parkview Noble Hospital  
 Parkview Whitley Hospital  
 Perry County Memorial Hospital  
 Porter Memorial  
 Pulaski Memorial Hospital  
 Putnam County Hospital  
 Regency Hospital Of Northwest Indiana LLC  
 Rehabilitation Hospital Of Fort Wayne  
 Rehabilitation Hospital Of Indiana  
 Reid Hospital And Health Care Services  
 Renaissance Specialty Hospital Of Central Indiana  
 Riverside Hospital Corporation  
 Riverview Hospital  
 Rush Memorial Hospital

Schneck Medical Center  
 Scott County Memorial Hospital  
 Select Specialty Hospital Beech Grove  
 Select Specialty Hospital Bloomington Inc  
 Select Specialty Hospital Evansville  
 Select Specialty Hospital Fort Wayne  
 Select Specialty Hospital Indianapolis  
 Select Specialty Hospital Northwest Indiana  
 Southern Indiana Rehabilitation Hospital  
 St Anthony Medical Center Of Crown Point  
 St Anthony Memorial Health Centers  
 St Catherine Hospital Inc  
 St Catherine Regional Hospital  
 St Clare Medical Center  
 St Elizabeth Ann Seton Hospital Of Carmel  
 St Elizabeth Ann Seton Hospital Of Indianapolis  
 St Elizabeth Hospital Central  
 St Elizabeth Hospital East  
 St Frands Hospital And Health Centers Mooresville  
 St John's Health System  
 St Joseph Hospital And Health Center Inc  
 St Joseph Hospital Inc  
 St Joseph Regional Medical Center Mishawaka Ca  
 St Joseph's Hospital Of Huntingburg Inc  
 St Joseph's Regional Medical Center Plymouth Ca  
 St Joseph's Regional Medical Center South Bend O  
 St Margaret Mercy Healthcare Centers North Cam  
 St Margaret Mercy Healthcare Centers South Cam  
 St Mary Medical Center Inc  
 St Mary's Medical Center Of Evansville Inc  
 St Mary's Warrick Hospital Inc  
 St Vincent Carmel Hospital Inc  
 St Vincent Clay Hospital Inc  
 St Vincent Dunn Hospital  
 St Vincent Frankfort Hospital Inc  
 St Vincent Heart Center  
 St Vincent Hospital And Health Services Inc  
 St Vincent Jennings Hospital Inc  
 St Vincent Mercy Hospital Inc  
 St Vincent Pediatric Rehabilitation Center Inc  
 St Vincent Randolph Hospital Inc  
 St Vincent Salem Hospital  
 St Vincent Seton Specialty Hospital  
 St Vincent Williamsport Hospital Inc  
 Starke Memorial Hospital  
 Sullivan County Community Hospital  
 Terre Haute Regional Hospital  
 Tipton Hospital  
 Union Hospital Inc  
 Wabash County Hospital  
 Wabash Valley Hospital Inc  
 Wellstone Regional Hospital  
 West Central Community Hospital  
 Westview Hospital  
 White County Memorial Hospital  
 Wishard Memorial Hospital  
 Witham Health Services  
 Women's Hospital  
 Woodlawn Hospital

**REMITTANCE ADVICE EXAMPLE**



**Provider Remittance Advice**

ADVANTAGE Medicare Solutions, Inc. is a Medicare Advantage PPO plan. Claims from all providers (both in and out of network) are processed at the Medicare allowable rate. ADVANTAGE Medicare Solutions, Inc. Members should not be billed for amounts over the Medicare allowable rate. If you have any questions regarding this Remittance, please contact us at 888-445-8958.

Providers may obtain a copy of the Health Plan's provider dispute and appeals policies and procedures upon request. In the event a provider wishes to appeal our decision they must sign a Waiver of Liability Statement which states the provider waives any right to collect payment from the enrollee for which payment has been denied. "I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600."

Servicing Provider Name: John Doe (000000000000)

Payee Name: The John Doe Group (000000000000)

Servicing Provider NPI: 0000000000

**Patient and Services Information**

<b>Account Number</b> 00000000		<b>Subscriber #</b> 000000000		Advantage Preferred Plus								
<b>Patient Name</b> Smith, Jane		<b>Claim Id</b> 000000000000										
Dates of Service	Proc/Rev Code	Amount Billed	Amount Allowed	Adjusted	Primary Payor Pmt	Patient Responsibility				Interest Owed	Plan Payment	Remarks
						Co Pay	Co Ins	Ded Amt	Non Cvr'd			
mmddyy	mmddyy	00000000	00.00	00.00	0.00	00.00	0.00	0.00	0.00	--	00.00	
mmddyy	mmddyy	00000000	00.00	0.00	0.00	0.00	0.00	0.00	0.00	--	0.00	000
<b>Claim totals for:</b> 11359001400		000.00	000.00	0.00	0.00	00.00	0.00	0.00	0.00	0.00	00.00	

**Current Payment Amount:** \$00.00  
**Prior Paid Amount:** \$0.00  
**Net Payment Amount:** \$00.00

## PROVIDER WAIVER OF LIABILITY STATEMENT LETTER AND FORM SAMPLE

Date

Name

Address

Patient:

Member ID:

Date of Service (DOS):

Claim #:

Appeal #:

Issue:

Dear:

We are in receipt of your request to appeal the claim indicated above. At this time our office cannot accept the provider appeal as submitted.

Pursuant to the Centers for Medicare & Medicaid Services (CMS), Chapter 13 Medicare Managed Care Manual, Section 70.1 – ‘Who May Request Reconsideration’ specifically states:

“When a non-contracted physician or provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the non-contracted physician or provider must sign a waiver of liability, i.e., the non-contracted physician or provider formally agrees to waive any right to payment from the enrollee for a service.”

We have included a waiver of liability for you to complete so we can properly process your appeal. According to CMS guidance the waiver of liability must be submitted to our organization within 60 days after the claim was denied.

If you have any questions about this notice, you may contact us directly. To call locally, dial 816-6737 or toll free at 1-866-591-6737. If you are hearing impaired, please call the TTY/TDD line at 1-800-743-3333 to discuss.

Sincerely,

**ADVANTAGE Health Solutions**

Enclosure: Waiver of Liability Statement

H5508\_H8822\_LTR\_90\_09

Approved Date 6/23/09

**WAIVER OF LIABILITY STATEMENT**

\_\_\_\_\_  
Medicare/HIC Number

\_\_\_\_\_  
Enrollee's Name

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Dates of Service

\_\_\_\_\_  
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the afore mentioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Health Solutions Medicare Advantage Plans Provider Remittance Notice Remark Codes and Descriptions

Old Remark Code	New Remark Code	Description
	00H	Charges are being paid in Per Diem Rate
	01h	Provider not part of this TAX-ID
	01H	Provider not part of this TAX-ID
801	01Y	Diagnosis code submitted lacks specificity. You are required to code to the highest level of specificity.
	02h	Rendering Provider not affiliated with Billing Group
	02H	Rendering Provider not affiliated with Billing Group
802	02Y	Deny - Sanction Provider
693	03h	Total charges do not equal billed amount. Please resubmit corrected bill.
793	03H	Total charges do not equal billed amount. Please resubmit corrected bill.
	03Y	Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances.
	04h	Requested information was not provided or was insufficient/incomplete.
	04H	Requested information was not provided or was insufficient/incomplete.
	04Y	Services deemed cosmetic are not covered.
684	05h	Diagnosis code submitted lacks specificity. You are required to code to the highest level of specificity.
784	05H	Diagnosis code submitted lacks specificity. You are required to code to the highest level of specificity.
	05Y	Please resubmit claim with certificate of medical necessity
	06h	Plan paid. Bill any secondary insurance
	06H	Plan paid. Bill any secondary insurance
	07h	The oncology demonstration program does not apply to Medicare beneficiaries in Medicare Advantage plans.
	07H	The oncology demonstration program does not apply to Medicare beneficiaries in Medicare Advantage plans.
675	08h	Revenue code and Procedure code do not match
665	08h	The procedure code/bill type is inconsistent with the place of service
775	08H	Revenue code and Procedure code do not match
765	08H	The procedure code/bill type is inconsistent with the place of service
	09h	Payment has already been made for same/similar procedure
	09H	Payment has already been made for same/similar procedure
738	0H1	Please submit claim to the primary insurance carrier
638	0h1	Please submit claim to the primary insurance carrier

Old Remark Code	New Remark Code	Description
809	0H2	Unit value was not reported on the claim. Please resubmit corrected claim.
808	0h2	Unit value was not reported on the claim. Please resubmit corrected claim.
807	0H3	Refund/returned check applied here
806	0h3	Refund/returned check applied here
811	0H4	Reversal/Adjustment
810	0h4	Reversal/Adjustment
544	0M1	Miscellaneous non Medicare and non-Plan Services
444	0m1	Miscellaneous non Medicare and non-Plan Services
545	0M2	Benefit limit has been reached
445	0m2	Benefit limit has been reached
	10h	Patient/Insured health identification number and name do not match
	10H	Patient/Insured health identification number and name do not match
821	11H	Please submit a valid admission source code
674	12h	Payment denied/reduced for absence of precertification/authorization
774	12H	Payment denied/reduced for absence of precertification/authorization
	13H	Please resubmit claim with the National Provider Identifier (NPI)
600	14H	RAP claim not on file, Final Bill received only
700	14H	RAP claim not on file, Final Bill received only
799	15H	Please resubmit claim on UB-04 claim form
	16H	Please resubmit on the CMS 1500 (08-05)
	17h	Payment Dispute Decision - Denied, dispute request submitted beyond time limit.
	17H	Payment Dispute Decision - Denied, dispute request submitted beyond time limit.
	18h	Claim Payment Dispute Decision - Denied, original claim paid correctly
	18H	Claim Payment Dispute Decision - Denied, original claim paid correctly
812	19h	Claim denied. Required documentation was not submitted
813	19H	Claim denied. Required documentation was not submitted
	1AA	5% PSA Bonus Applied to Payment
	1CE	Diagnosis is valid for procedure preformed
794	1GD	Please resubmit claim with the National Provider Identifier (NPI)
	2AA	10% HPSA Bonus Applied to Payment
	2CE	Place of service is valid for procedure preformed
	3AA	15% PSA and HPSA Bonuses Applied to Payment
	f01	Capitated Service
	F01	Capitated Service
	f02	Claim Payment Dispute Decision- Approved, claim adjusted
	F02	Claim Payment Dispute Decision- Approved, claim adjusted
800	h00	Payment has been included in the payment made on the first line
601	h01	Age invalid for diagnosis submitted

Old Remark Code	New Remark Code	Description
701	H01	Age invalid for diagnosis submitted
61A	h02	Drug amount discarded/not given to any patient
71A	H02	Drug amount discarded/not given to any patient
603	h03	Charges have been paid to another provider
703	H03	Charges have been paid to another provider
604	h04	Charges included in physician's surgery fee
704	H04	Charges included in physician's surgery fee
605	h05	Charges previously considered
705	H05	Charges previously considered
606	h06	Claim adjusted per corrected bill
706	H06	Claim adjusted per corrected bill
607	h07	Conflicting information on the hospital claim was submitted Please resubmit corrected claim
707	H07	Conflicting information on the hospital claim was submitted Please resubmit corrected claim
608	h08	Date of service does not fall within the statement date. Please resubmit corrected claim
708	H08	Date of service does not fall within the statement date. Please resubmit corrected claim
609	h09	Exceeds timely filing requirements
709	H09	Exceeds timely filing requirements
610	h10	Invalid address in field 32, please resubmit corrected claim
710	H10	Invalid address in field 32, please resubmit corrected claim
611	h11	Invalid dates of service, please resubmit corrected claim
711	H11	Invalid dates of service, please resubmit corrected claim
612	h12	Invalid procedure/modifier submitted. Please resubmit corrected claim
671	h12	Payment adjusted because the procedure modifier was invalid on the date of service
677	h12	Payment adjusted because this procedure code and modifier were invalid on the date of service
664	h12	The procedure code is inconsistent with the modifier used or a required modifier is missing
692	h12	The procedure/modifier submitted is not recognized by Medicare
712	H12	Invalid procedure/modifier submitted. Please resubmit corrected claim
771	H12	Payment adjusted because the procedure modifier was invalid on the date of service
777	H12	Payment adjusted because this procedure code and modifier were invalid on the date of service
764	H12	The procedure code is inconsistent with the modifier used or a required modifier is missing
792	H12	The procedure/modifier submitted is not recognized by Medicare
613	h13	Member name on claim does not match our records
713	H13	Member name on claim does not match our records
614	h14	Missing/invalid bill type. Please resubmit corrected claim.
714	H14	Missing/invalid bill type. Please resubmit corrected claim.
615	h15	Missing/incomplete/invalid DRG code. Please resubmit corrected claim.

Old Remark Code	New Remark Code	Description
689	h15	Missing/incomplete/invalid DRG code
715	H15	Missing/incomplete/invalid DRG code. Please resubmit corrected claim.
789	H15	Missing/incomplete/invalid DRG code
616	h16	Missing/invalid ICD9 diagnosis code(s) Please resubmit corrected claim
716	H16	Missing/invalid ICD9 diagnosis code(s) Please resubmit corrected claim
682	h17	Missing/incomplete/invalid place of service
617	h17	Missing/incomplete/invalid place of service. Please resubmit corrected claim.
666	h17	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service
782	H17	Missing/incomplete/invalid place of service
717	H17	Missing/incomplete/invalid place of service. Please resubmit corrected claim.
766	H17	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service
618	h18	Missing/incomplete/invalid procedure code(s). Please resubmit corrected claim
681	h18	Missing/incomplete/invalid procedure code(s)
670	h18	Payment adjusted because this procedure code was invalid on the date of service
718	H18	Missing/incomplete/invalid procedure code(s). Please resubmit corrected claim
781	H18	Missing/incomplete/invalid procedure code(s)
770	H18	Payment adjusted because this procedure code was invalid on the date of service
619	h19	Missing/incomplete/invalid revenue code(s). Please resubmit corrected claim.
719	H19	Missing/incomplete/invalid revenue code(s). Please resubmit corrected claim.
620	h20	Missing/invalid RUG category. Please resubmit corrected claim.
720	H20	Missing/invalid RUG category. Please resubmit corrected claim.
621	h21	Missing/incomplete/invalid taxpayer identification number (TIN). Please resubmit corrected claim.
721	H21	Missing/incomplete/invalid taxpayer identification number (TIN). Please resubmit corrected claim.
622	h22	No information was submitted on the hospital claim. Please resubmit corrected claim
722	H22	No information was submitted on the hospital claim. Please resubmit corrected claim
623	h23	Please provide a description of services rendered
723	H23	Please provide a description of services rendered
624	h24	Please rebill under correct provider
724	H24	Please rebill under correct provider
625	h25	Please resubmit a legible EOB from the primary insurance carrier
725	H25	Please resubmit a legible EOB from the primary insurance carrier
626	h26	Please resubmit claim according to Medicare billing guidelines
726	H26	Please resubmit claim according to Medicare billing guidelines
627	h27	Please resubmit claim completing field 31
727	H27	Please resubmit claim completing field 31

Old Remark Code	New Remark Code	Description
628	h28	Please resubmit claim completing field 32
728	H28	Please resubmit claim completing field 32
629	h29	Please resubmit claim on CMS 1500 form
729	H29	Please resubmit claim on CMS 1500 form
630	h30	Please resubmit claim on UB04 form
730	H30	Please resubmit claim on UB04 form
631	h31	Please resubmit claim with field 24 information.
731	H31	Please resubmit claim with field 24 information.
632	h32	Please resubmit claim with the Medicare provider number
732	H32	Please resubmit claim with the Medicare provider number
633	h33	Please resubmit itemized bill including provider full name and address
733	H33	Please resubmit itemized bill including provider full name and address
634	h34	Please submit a copy of the emergency room report
734	H34	Please submit a copy of the emergency room report
635	h35	Please submit a copy of the operative report
735	H35	Please submit a copy of the operative report
636	h36	Please submit a copy of the pathology report
736	H36	Please submit a copy of the pathology report
637	h37	Please submit claim to the primary insurance carrier
737	H37	Please submit claim to the primary insurance carrier
660	h38	Please submit to member's VA insurance
760	H38	Please submit to member's VA insurance
639	h39	Please submit claim to the worker's compensation carrier
739	H39	Please submit claim to the worker's compensation carrier
640	h40	Please submit daily itemization
740	H40	Please submit daily itemization
641	h41	Please submit medical records
741	H41	Please submit medical records
642	h42	Previously billed using conflicting modifier Please resubmit corrected claim
742	H42	Previously billed using conflicting modifier Please resubmit corrected claim
643	h43	Procedure not payable when performed in this setting
743	H43	Procedure not payable when performed in this setting
644	h44	Redundant charge or service, payment included in primary procedure
744	H44	Redundant charge or service, payment included in primary procedure
645	h45	Refund/returned check applied here
745	H45	Refund/returned check applied here
646	h46	Reversal/Adjustment
746	H46	Reversal/Adjustment

Old Remark Code	New Remark Code	Description
60J	h47	Member enrolled in Hospice - Submit to Medicare
647	h47	Services covered under hospice
70J	H47	Member enrolled in Hospice - Submit to Medicare
747	H47	Services covered under hospice
648	h48	Unit value billed does not correspond to procedure code submitted
748	H48	Unit value billed does not correspond to procedure code submitted
649	h49	Unit value was not reported on the claim. Please resubmit corrected claim.
749	H49	Unit value was not reported on the claim. Please resubmit corrected claim.
678	h50	Not otherwise classified or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure
650	h50	Unlisted procedure-please submit medical/operative report
778	H50	Not otherwise classified or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure
750	H50	Unlisted procedure-please submit medical/operative report
679	h51	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider
651	h51	UPIN omitted. Please resubmit corrected claim
779	H51	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider
751	H51	UPIN omitted. Please resubmit corrected claim
652	h52	Procedure code is incidental to another Procedure
752	H52	Procedure code is incidental to another Procedure
653	h53	Missing/Invalid CPT/HCPCS Code
753	H53	Missing/Invalid CPT/HCPCS Code
654	h54	Principal procedure dates reported do not fall within statement dates. Please resubmit corrected claim
754	H54	Principal procedure dates reported do not fall within statement dates. Please resubmit corrected claim
655	h55	These are non-covered services because this is not deemed a "medical necessity" by the payer.
755	H55	These are non-covered services because this is not deemed a "medical necessity" by the payer.
656	h56	Provider not covered for service
756	H56	Provider not covered for service
657	h57	Please resubmit claim with valid HIPPS or MSA number.
757	H57	Please resubmit claim with valid HIPPS or MSA number.
	h58	Please resubmit claim with certificate of medical necessity
	H58	Please resubmit claim with certificate of medical necessity
60D	h59	Fifth digit of HIPPS does not correspond to RAP
70D	H59	Fifth digit of HIPPS does not correspond to RAP
	h60	Charges submitted to pharmacy for consideration

Old Remark Code	New Remark Code	Description
	H60	Charges submitted to pharmacy for consideration
696	h61	Missing/Invalid value in item 19
796	H61	Missing/Invalid value in item 19
697	h62	Missing/Invalid Value Code
797	H62	Missing/Invalid Value Code
698	h63	Information supplied does not support this service.
798	H63	Information supplied does not support this service.
	h64	Zero Payment RAP. Claim payment will be made on final claim
	H64	Zero Payment RAP. Claim payment will be made on final claim
60A	h65	Supplying/dispensing fee denied as drug was not submitted on claim
70A	H65	Supplying/dispensing fee denied as drug was not submitted on claim
60B	h66	Please resubmit claim completing Box 33
658	h66	Please resubmit valid information in field 33.
70B	H66	Please resubmit claim completing Box 33
758	H66	Please resubmit valid information in field 33.
699	h67	CMG code required. Please resubmit claim with this information
803	H67	CMG code required. Please resubmit claim with this information
60C	h68	POA indicator required. Please resubmit claim with this information
70C	H68	POA indicator required. Please resubmit claim with this information
61B	h69	Discharge Status Missing. Please resubmit claim with this information.
71B	H69	Discharge Status Missing. Please resubmit claim with this information.
61C	h70	Billing exceeds rental months covered or approved for this item
71C	H70	Billing exceeds rental months covered or approved for this item
61D	h71	Not covered more than once in a 12 month period
71D	H71	Not covered more than once in a 12 month period
804	h72	Unlisted procedure code was billed when there is a specific procedure code for this procedure/service.
805	H72	Unlisted procedure code was billed when there is a specific procedure code for this procedure/service.
60E	h73	Missing/incomplete/invalid operate date
70E	H73	Missing/incomplete/invalid operate date
60F	h74	Missing pick up zip/value codes, please resubmit corrected claim
70F	H74	Missing pick up zip/value codes, please resubmit corrected claim
60G	h75	Invalid/incomplete/missing information from field 24E
70G	H75	Invalid/incomplete/missing information from field 24E
60H	h76	Member name and/or date of birth submitted do not match our records
70H	H76	Member name and/or date of birth submitted do not match our records
60I	h77	Sales tax/S&H charge is included in the approved amount for this item
70I	H77	Sales tax/S&H charge is included in the approved amount for this item

Old Remark Code	New Remark Code	Description
	h78	Please resubmit claim using Medicare consultation code
	H78	Please resubmit claim using Medicare consultation code
	h79	Missing/Incorrect provider name or credentials in field 31
	H79	Missing/Incorrect provider name or credentials in field 31
669	h80	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
769	H80	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
	h81	Payment denied due to lack of proof of delivery documentation
	H81	Payment denied due to lack of proof of delivery documentation
	h82	Payment denied. Rental modifier missing or invalid for this capped rental item
	H82	Payment denied. Rental modifier missing or invalid for this capped rental item
	h83	Payment denied. Missing or invalid capped rental modifier and certificate of delivery for this capped rental item
	H83	Payment denied. Missing or invalid capped rental modifier and certificate of delivery for this capped rental item
683	h84	Missing/incomplete/invalid HCPCS modifier.
783	H84	Missing/incomplete/invalid HCPCS modifier.
	h85	Missing Accreditation to perform Office Based Surgery
	H85	Missing Accreditation to perform Office Based Surgery
686	h86	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD).
786	H86	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD).
687	h87	Add-on code cannot be billed by itself
787	H87	Add-on code cannot be billed by itself
814	h88	Qualifying procedure is required for payment of this service
815	H88	Qualifying procedure is required for payment of this service
	h89	Charges included in original DRG payment
	H89	Charges included in original DRG payment
673	h90	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay
773	H90	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay
668	h91	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already
691	h91	Separately billed services have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
768	H91	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already
791	H91	Separately billed services have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Old Remark Code	New Remark Code	Description
688	h92	Missing/incomplete/invalid anesthesia time/units
788	H92	Missing/incomplete/invalid anesthesia time/units
	h93	Missing/incomplete/invalid days or units of service
	H93	Missing/incomplete/invalid days or units of service
685	h94	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents
785	H94	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents
	h95	Claim requires E Code
	H95	Claim requires E Code
662	h96	Payment for related services provided within 3 days is included in reimbursement for related inpatient admission.
762	H96	Payment for related services provided within 3 days is included in reimbursement for related inpatient admission.
661	h97	This diagnosis is not valid with this procedure
443	h97	This procedure is not covered with the submitted diagnosis
761	H97	This diagnosis is not valid with this procedure
543	H97	This procedure is not covered with the submitted diagnosis
663	h98	Procedure code invalid for Medicare Advantage Plan. Member not liable.
763	H98	Procedure code invalid for Medicare Advantage Plan. Member not liable.
659	h99	Provider type not recognized by plan
759	H99	Provider type not recognized by plan
695	hAA	Please resubmit claim to ProHealth/Adv Medicare, PO Box 50407, Indianapolis, IN 46250
	HAA	Please resubmit claim to ProHealth/Adv Medicare, PO Box 50407, Indianapolis, IN 46250
401	m01	Non ambulance transport
501	M01	Non ambulance transport
402	m02	Ambulance not covered
502	M02	Ambulance not covered
403	m03	Chiro not covered
503	M03	Chiro not covered
404	m04	Services deemed cosmetic are not covered.
504	M04	Services deemed cosmetic are not covered.
405	m05	Dental services not covered
505	M05	Dental services not covered
406	m06	Non DME
506	M06	Non DME
407	m07	DME not authorized
507	M07	DME not authorized
408	m08	Member not eligible

Old Remark Code	New Remark Code	Description
508	M08	Member not eligible
409	m09	Home health member not homebound
509	M09	Home health member not homebound
410	m10	Home health does not meet skilled guidelines
510	M10	Home health does not meet skilled guidelines
431	m11	Non-covered charge(s)
411	m11	Miscellaneous non Medicare and non Plan services
531	M11	Non-covered charge(s)
511	M11	Miscellaneous non Medicare and non Plan services
412	m12	Personal comfort items are not covered
512	M12	Personal comfort items are not covered
413	m13	Over the counter rx not covered
513	M13	Over the counter rx not covered
414	m14	Routine foot care is not covered
514	M14	Routine foot care is not covered
415	m15	Inpatient psychiatric benefit maximum reached
515	M15	Inpatient psychiatric benefit maximum reached
416	m16	Shoe orthotics are not covered
516	M16	Shoe orthotics are not covered
417	m17	SNF maximum benefit period
517	M17	SNF maximum benefit period
418	m18	SNF custodial care
518	M18	SNF custodial care
419	m19	Benefit limit has been reached
519	M19	Benefit limit has been reached
442	m20	Provider not covered for service
542	M20	Provider not covered for service
	m21	Services rendered by a provider who does not accept Medicare Assignment
	M21	Services rendered by a provider who does not accept Medicare Assignment
	m22	Inpatient foreign travel maximum of 60 days met
	M22	Inpatient foreign travel maximum of 60 days met
429	m23	Payment denied/reduced for absence of precertification/authorization.
529	M23	Payment denied/reduced for absence of precertification/authorization.
	m24	Date of service exceeds authorized dates of service
	M24	Date of service exceeds authorized dates of service
420	m25	Service is not a covered benefit under Medicare advantage plans.
520	M25	Service is not a covered benefit under Medicare advantage plans
426	m26	Expenses incurred prior to coverage

Old Remark Code	New Remark Code	Description
526	M26	Expenses incurred prior to coverage
427	m27	Expenses incurred after coverage terminated
527	M27	Expenses incurred after coverage terminated
428	m28	Claim denied as patient cannot be identified as our insured
528	M28	Claim denied as patient cannot be identified as our insured
422	m29	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished
440	m29	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished
441	m29	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished
540	m29	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished
541	m29	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished
522	M29	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished
430	m30	Charges do not meet qualifications for emergent/urgent care
530	M30	Charges do not meet qualifications for emergent/urgent care
	m31	The First 3 pints of blood used in each year are not covered
	M31	The First 3 pints of blood used in each year are not covered
432	m32	Payment is denied when performed/billed by this type of provider
532	M32	Payment is denied when performed/billed by this type of provider
433	m33	Payment is adjusted when performed/billed by a provider of this specialty
533	M33	Payment is adjusted when performed/billed by a provider of this specialty
434	m34	The prescribing/ordering provider is not eligible to prescribe/order the services billed
534	M34	The prescribing/ordering provider is not eligible to prescribe/order the services billed
435	m35	The rendering provider is not eligible to perform the service billed
535	M35	The rendering provider is not eligible to perform the service billed
436	m36	Missing/incomplete/invalid level of subluxation
536	M36	Missing/incomplete/invalid level of subluxation
437	m37	The patient is liable for charges as you informed the patient before service was furnished that we would not pay, and patient agreed to pay
537	M37	The patient is liable for charges as you informed the patient before service was furnished that we would not pay, and patient agreed to pay
438	m38	Please resubmit claim with certificate of medical necessity
538	M38	Please resubmit claim with certificate of medical necessity
421	m39	Re-submit with paid receipt
521	M39	Re-submit with paid receipt

Old Remark Code	New Remark Code	Description
105	MXP	Manual Price Override
602	N/A	Billing error
676	N/A	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying
667	N/A	Procedure code was incorrect. This payment reflects the correct code
680	N/A	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with
690	N/A	This procedure code was added/changed because it more accurately describes the services rendered
702	N/A	Billing error
776	N/A	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying
767	N/A	Procedure code was incorrect. This payment reflects the correct code.
780	N/A	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with
790	N/A	This procedure code was added/changed because it more accurately describes the services rendered
902	R02	TRC 702 Plan ID
903	R03	TRC 703 Plan ID
905	R05	TRC 705 Plan ID
906	R06	TRC 706 Plan ID/Region
909	R09	TRC 709 Plan ID
910	R10	TRC 710 Plan ID
911	R11	TRC 711 Plan ID
912	R12	TRC 712 Plan ID
	R13	TRC 713 Plan ID
920	R20	TRC 709 old effective date
921	R21	TRC 710 old term date
922	R22	TRC 712 old term date
	R24	TRC 223 Code
795	X05	Please resubmit claim to ProHealth/Adv Medicare, PO Box 50407, Indianapolis, IN 46250