

Section 7

Billing Guidelines

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Section 7

Billing Guidelines

Billing, Reimbursement, and Claims Submission

Submitting a Claim

AllWays Health Partners manages the claims processing for My Care Family. AllWays Health Partners is committed to processing clean claims within at least 45 days of receipt. The claim receipt's Julian date is embedded in the AllWays Health Partners claim number as shown on the Explanation of Payment (EOP).

A clean claim is defined as one that includes at least the following information:

- Full member name
- Member's date of birth
- Full AllWays Health Partners member identification number
- Date of service
- Valid diagnosis code(s)
- Valid procedure code(s)
- Valid place of service code(s)
- Charge information and units
- National provider identifier (NPI) group number
- NPI rendering provider number, when applicable
- Vendor name and address
- Provider's federal tax identification number

Claim Submission Guidelines

When using a billing agent or clearinghouse, providers are responsible for meeting all AllWays Health Partners claim submission requirements.

AllWays Health Partners requires the submission of all paper and electronic claims within 90 days of the date of service unless otherwise contractually agreed.

AllWays Health Partners will not accept handwritten claims or handwritten corrected claims.

AllWays Health Partners will only accept claims for services that you, your organization or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

AllWays Health Partners' claim submission guidelines are as follows:

Claim Type	Submission Format
Professional Charges	CMS-1500
Durable Medical Equipment (DME)	CMS-1500
DME Supplies, Home Infusion Services, etc.	CMS-1500
Institutional/Facility Charges	UB-04

EDI (Electronic) Claims

Claims submitted electronically are subject to the claim edits established by AllWays Health Partners. AllWays Health Partners' payer ID number is 04293. Companion Guides are available to assist providers interested in electronic claim submissions.

For questions regarding electronic claims submissions, please contact AllWays Health Partners Provider Service at 855-444-4647.

Paper Claims

Paper claims must be submitted on the proper forms within the aforementioned time frames or per specific contract arrangements. Claim forms other than those noted above cannot be accepted. AllWays Health Partners' front edits apply to both EDI and paper claim submissions.

NEW CLAIMS ONLY

Mail: AllWays Health Partners
P. O. Box 853908
Richardson, TX 75085-3908

This address is for submission of brand new paper claims only. To avoid processing delays, please do not send claims adjustment requests or any other correspondence to this address.

Address all other correspondence as shown below.

CLAIM ADJUSTMENT REQUESTS

Mail: AllWays Health Partners
Attn: Correspondence Department
399 Revolution Drive, Suite 810
Somerville, MA 02145

CLAIMS APPEAL REQUESTS

Mail: AllWays Health Partners
Attn: Appeals Department
399 Revolution Drive, Suite 810
Somerville, MA 02145

Corrected Claims

AllWays Health Partners accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC) and HIPAA EDI standards. Corrected claims must be submitted with the most recent version of the claim to be adjusted. For example: a corrected claim to the original claim (00000E00000) should include the original claim number. A second corrected claim request should include the latest version (00000E00000A1).

Electronic Submissions

To submit a corrected facility or professional claim electronically:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as either "7" (corrected claim), "5" (late charges), or "8" (void or cancel a prior claim).
- Enter the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #12234E01234, enter REF*F8*12234E01234.

Provider payment disputes that require additional documentation must be submitted on paper, using the [Request for Review Form](#).

Late Charge Billing

AllWays Health Partners accepts corrected claims to report services rendered in addition to the services described on an original claim. AllWays Health Partners will not accept separate claims containing only late charges.

AllWays Health Partners will not accept Late Charge claims from institutional (facility) providers, including but not limited to: hospitals; ambulatory surgery centers; skilled nursing facilities (SNF); hospice; home infusion agencies; or home health agencies.

Claim Adjustments/Requests for Review

Request for a review and possible adjustment of a previously processed claims (not otherwise classified as an appeal) should be submitted to the Claim Adjustment Requests mail box within 90 days of the EOP date on which the original claim was processed. All such requests should be submitted by completing a Request for Review Form and including any supporting documentation, with the exception of electronically submitted corrected claims.

Filing Limit Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 90 days of the EOP date on which the claim originally denied. Disputes received beyond 90 days will not be considered

If the initial claim submission is after the timely filing limit and the circumstances for the late submission are beyond the provider's control, the provider may submit a request for review by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit along with any supporting documentation. Documented proof of timely submission must be submitted with any request

for review and payment of a claim previously denied due to the filing limit. A completed Request for Review Form must also be sent with the request.

For paper claim submissions, the following are considered acceptable proof of timely submission:

- A copy of the computerized printout of the Patient Account Ledger indicating the claim was billed to AllWays Health Partners, with the submission date circled in black or blue ink.
- Copy of Explanation of Benefits (EOB) from the primary insurer that shows timely submission (90 days) from the date carrier processed the claim.
- Proof of follow-up with the member for lack of insurance information, such as proof that the member or another carrier had been billed, if the member did not identify him/herself as a My Care Family member at the time of service.

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted through a clearinghouse: A copy of the transmission report and rejection report showing the claim did not reject at the clearinghouse, and the claim was accepted for processing by AllWays Health Partners within the time limit.
- For claims submitted directly to AllWays Health Partners: The corresponding report showing the claim did not reject at AllWays Health Partners and was accepted for processing by AllWays Health Partners within the time limit.
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim.

A copy of the Patient Account Ledger is not acceptable documentation for EDI claims except when the patient did not identify him/herself as a My Care Family patient at the time of service.

The following are not considered to be valid proof of timely submission:

- Copy of original claim form
- Copy of transmission report without matching

rejection/error reports (EDI)

- An AllWays Health Partners rejection report or a report from the provider's clearinghouse without patient detail.
- A computerized printout of the Patient Account ledger stating "billed carrier"
- A computerized printout of the Patient Account ledger stating another carrier was billed in error, where AllWays Health Partners is the primary carrier via the New England Healthcare Exchange Network
- Hand-written Patient Account Ledger
- Verbal requests

Behavioral Health Services Claims

My Care Family's Behavioral Health benefit is administered through Optum. Claims, appeals, and adjustment requests for behavioral health specific services must be submitted to Optum directly.

Billing for Professional Services, Durable Medical Equipment, and Supplies

Professional charges, as well as DME and supplies must be billed on a CMS-1500 claim form and include all pertinent and/or required information. Missing, incomplete, or invalid information can result in claim denials.

In addition, the group and the rendering clinician's NPI numbers are required on most professional claim submissions. Claims submitted without a valid number are subject to rejection by My Care Family.

Billing for Inpatient and Outpatient Facility Services

Institutional charges must be billed on a UB-04 claim form and include all pertinent and/or required information. Where appropriate, valid ICD-10, revenue (REV), CPT-4 and/or HCPCS, and standard three-digit type of bill codes are required on institutional claims.

AllWays Health Partners requires the facility's NPI on all institutional claim submissions. Claims submitted without valid numbers are subject to rejection by AllWays Health Partners.

Room Charges

AllWays Health Partners covers only the semi-private room rate unless a private room is pre-authorized. When not pre-authorized, the semi-private room rate will be applied to all private room charges during claim adjudication.

Itemization

Itemization of inpatient charges is required upon request with each day of service separately reported.

Please refer to AllWays Health Partners' UB-04 Claim Form Completion Guidelines for more information on required fields.

Coordination of Benefits (COB) Guidelines

COB is the process to determine how medical, dental, and other health care services will be paid when a person is covered under more than one insurer. Providers are required to notify AllWays Health Partners when other coverage is identified.

Providers are responsible for verifying eligibility at the point of service, which includes possible Medicare coverage. This is particularly important given Medicare's 12-month filing limit and the significant reductions to allowed exceptions. Please note that an EOP from another insurer no longer qualifies as one of the exceptions.

The order of benefit determination is the term used for establishing the primary versus secondary insurer or carrier. The primary carrier must pay its portion of the claim first before billing the secondary carrier for review and potential payment of the balance up to its benefit or policy limits.

When a patient enrolls with My Care Family, AllWays Health Partners is *always* the payer of last resort. All payments for covered My Care Family

services rendered are considered as payment in full.

Services and charges must be billed on an appropriate claim form and submitted to AllWays Health Partners within 90 days of receipt of the Explanation of Payment (EOP) or remittance advice from the primary insurance carrier.

Third-Party Liability Claims

When a My Care Family member is involved in an automobile accident, providers should notify AllWays Health Partners directly by calling the Third-Party Liability Department at 617-772-5729 and making the proper notation on submitted claims. An AllWays Health Partners representative can assist with the process of determining which carrier should be billed for services. Providers should use a TPL Indicator Form for reporting other insurance information discovered during patient encounters for all My Care Family members. These forms are available to providers by calling Provider Service.

When AllWays Health Partners is the secondary carrier, all claims must be submitted with a copy of the primary carrier's EOP, remittance advice, or denial letter.

Workers Compensation (WC) Claims

When a My Care Family patient is injured on the job, the employer's workers compensation carrier should be billed directly for the services. Only upon denial from the workers compensation carrier will AllWays Health Partners consider additional claims.

Reconciling AllWays Health Partners' Explanation of Payment (EOP)

Each EOP claim line reflects the specific service codes billed to AllWays Health Partners. Denied claim lines will have corresponding "Remarks" explaining the reason for the denial.

A claim line can be denied for many reasons, including but not limited to:

- The payment submitted is included in the allowance for another service/procedure.
- The service code submitted is not within the AllWays Health Partners contract.
- The member was not effective for some or all dates of service (i.e., AllWays Health Partners was billed for five days but the member was effective for only three of those days).
- The time limit for filing the claim has expired.
- A required authorization is required and not on file.

Providers with questions or concerns on the disposition of a denied claim should first validate that all reasons for the claim denial have been considered before re-submitting to AllWays Health Partners.

Providers are strongly encouraged to reconcile the EOP timely or at least within 90 days of receipt. Requests for adjustments or corrections received beyond the 90-day adjustment request filing limit cannot be considered for reprocessing.

To assist in reconciling, AllWays Health Partners offers instant access to PDF versions of current and historical EOP copies on our secure provider portal, allwaysprovider.org. To enroll in the provider portal, simply follow the easy registration instructions, or consult with your site's appointed user administrator.

Provider Reimbursement

Reimbursement for services rendered must be treated as payment in full. Providers may not seek or accept payment from a My Care Family patient for any covered service rendered. In addition, providers may not have any claim against or seek payment from MassHealth for any My Care Family covered service rendered to a My Care Family patient. Providers should look solely to AllWays Health Partners for payment with respect to My Care Family covered services rendered.

Furthermore, a provider may not maintain any action at law or in equity against any member or MassHealth to collect any sums that are owed to the provider by AllWays Health Partners for any reason, up to and including AllWays Health Partners' failure to pay, insolvency, or otherwise breach of the terms and conditions of the AllWays Health Partners Provider Agreement.

In the event that a non-medically necessary or non-My Care Family covered service is provided in place of a covered service, the provider may not seek reimbursement from the member unless documentation is provided indicating the provider explained the liability of payment for the non-medically necessary or non-My Care Family covered service to the member prior to services being rendered. Documentation must indicate that the member both understood and agreed to accept liability for payment at the time of service.

Serious Reportable Events/Occurrences

A serious reportable event (SRE) is an event that occurs on the premises of a provider's site that results in an adverse patient outcome, is identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Potential SREs or quality of care (QOC) occurrences may be identified by members, providers, or My Care Family staff and may come into AllWays Health Partners through Customer Service or any other department. The duty to report a SRE is the responsibility of the individual facility or provider. The facility or provider must document their findings; and provide a copy of the report to both the MA Department of Public Health (DPH) and to the AllWays Health Partners Director of Quality Management and Improvement within the required time frame.

Issues of concern may also be found through claims data or when medical record audits are performed by AllWays Health Partners. Claims data are reviewed on a quarterly basis to identify possible SREs. Any problems identified include both acts of commission and omission, deficiencies in the clinical quality of care, inappropriate behavior during the utilization management process, and any instances of provider impairment documented to be a result of substance abuse or behavioral health issues. All contracted providers must participate in and comply with programs implemented by the Commonwealth of Massachusetts through its agencies, such as, but not limited to the Executive Office of Health and Human Services (EOHHS), to identify, report, analyze and prevent SREs, and to notify AllWays Health Partners of any SRE.

AllWays Health Partners reviews and promptly responds within 30 days to actual or potential QOC occurrences. The provider will have within seven days to report SREs. AllWays Health Partners uses the National Quality Forum's (NQF)

definition of SREs (referred to as "never events") and the NQF's current listing of "never events."

AllWays Health Partners does not reimburse services associated with SREs, "never events," and/or provider preventable conditions.

To administer this policy, AllWays Health Partners recognizes but is not limited to the SREs identified by the National Quality Forum, HealthyMass, and the CMS Medicare Hospital-Acquired Conditions (Present on Admission Indicator) reporting.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and providers performing the billable procedure(s) during which an "event" occurred.

AllWays Health Partners will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another provider.

Prov Name Patient Account#				Member Number / Name		Prov NPI#		Prov NHP# Claim Number			DRG
1	12/16/2016	12/16/2016	0250	1	\$0.37	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 DENIED
2	12/16/2016	12/16/2016	73590 0320	1	\$240.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 DENIED
3	12/16/2016	12/16/2016	99284 0450	1	\$1,321.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00 DENIED
Totals:					\$1,561.37	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Remarks: Claim denied as patient cannot be identified as our insured.											

On this example of an EOP section above, all claim lines were denied, with corresponding explanations below.

Billing for Missed Appointments

My Care Family considers a missed appointment as factored into the overhead cost of providing services and not a distinct reimbursable service. In recognition of this, provider fee schedules are designed to cover this cost, keeping the member from incurring additional costs.

My Care Family expects that the practice and its providers will cooperate and participate with My Care Family in programs focused on improving member appointment attendance.

Providers must not:

- Bill members for missed appointments.
- Refuse to provide services to members due to missed appointments.
- Refuse to provide services to members because the member has an outstanding balance owed to the practice from a time prior to the patient becoming a My Care Family member.

Audits

AllWays Health Partners' audit process ensures accuracy of charges and consistency with plan policies, provider agreements, and applicable nationally recognized medical claims reimbursement and administration policies. AllWays Health Partners auditing specialists, possessing thorough knowledge of medical procedures, terminology, and procedural coding, will perform the audits, review findings, and respond to provider questions or concerns.

Audits may be conducted on claims paid during the current year or two prior AllWays Health Partners fiscal (calendar) years and up to six years when investigating possible cases of fraud or abuse. AllWays Health Partners policies, including but not limited to medical policies, claims administration policies, and provider payment guidelines, will apply to all reimbursement and claims matters. In any matter where AllWays Health Partners does not maintain a specific

policy or guideline, AllWays Health Partners adopts and follows the national standards and policies relating to procedural coding, medical claims administration, and reimbursement, which are recognized by government payers such as the Centers for Medicare and Medicaid Services (CMS), national health insurance carrier organizations, local coverage determinations (LCDs), and the American Medical Association (AMA).

Pursuant to the AllWays Health Partners Provider Agreement, AllWays Health Partners has the right to inspect, review, and make copies of medical records. All requests for medical record review are made in writing. The inspection of medical records is conducted in compliance with the provider's standard policies governing such processes and that are applied uniformly to all payers.

Provider notification includes the audit parameters and corresponding medical records. The number of selected medical records is determined based on generally accepted statistical sampling methodology, rules, and techniques recognized in the field of statistical probability. Should additional areas of questions be identified, AllWays Health Partners reserves the right, at its election, to expand the scope of any audit, and perform extrapolation of audit results to the defined audit population. If extrapolation methodology is selected, the process shall be performed in accordance with generally accepted sampling principles as outlined above. AllWays Health Partners strictly adheres to state and federal requirements regarding confidentiality of patient medical records. A separate consent form will be provided when required by law.

When an initial review of a provider's medical records is required, AllWays Health Partners' provider audit process includes written 30-days' prior notification. For on-site audits, the provider must arrange a suitable work area, and make available to the auditor the medical records, including but not limited to pharmacy profile and corresponding fee book when applicable. The fee

book should be an electronic file (Excel or similar program) unless another format has been agreed upon.

When additional records or documentation are necessary to complete the audit, the auditor will submit a written request for information to the provider's representative identifying the necessary documents to complete the audit, specifying a reasonable time period within which the provider will supply the requested documents.

Unless otherwise contractually agreed upon, AllWays Health Partners does not reimburse for audit-related administrative fees incurred by a provider.

General Claims Audits

General post payment claims audits are conducted to identify the accuracy of charges and the consistency of claims reimbursement with My Care Family's policies, Provider Agreements, Payment Guidelines, and applicable nationally recognized medical claims reimbursement and administration policies, including but not limited to: CPT, MassHealth, and CMS guidelines. Audits include, but are not limited to:

- Billing for services at a higher level than provided
- Billing for services not documented and not provided
- Incorrect coding, including unbundling component service codes, modifier usage, units of service, and duplicate payments
- Historical claim audits to include the global surgical period for codes submitted on the current claim
- Medical necessity based on My Care Family and/or CMS guidelines as applicable to the member benefit plan

For claim overpayments greater than \$500, the provider is notified in writing from AllWays Health Partners 30 or more days prior to the retraction of any monies identifying claim discrepancies totaling over \$500 per vendor that have been

identified by AllWays Health Partners' post-payment audit resulting in claim adjustments. All adjustments are processed against future payments. Unless otherwise instructed, providers should not issue a refund to AllWays Health Partners for overpayments identified by AllWays Health Partners. (However, this does not alter the Provider's obligation under federal or state law to report and return any overpayments.)

If the provider disagrees with the adjustments, a letter of appeal or a completed AllWays Health Partners Provider Audit Appeal Form may be submitted to AllWays Health Partners' Appeals department within 90 days of receipt (or 30 days if requesting an extension), along with comprehensive documentation to support the dispute of relevant charges. AllWays Health Partners will review the appeal and, when appropriate, consult with AllWays Health Partners clinicians or subject matter experts in the areas under consideration. To the extent that the provider fails to submit evidence of why the adjustment is being disputed, the provider will be notified of AllWays Health Partners' inability to thoroughly review the appeal request. The provider can resubmit (provided this occurs within the 90 days EOP window) and the appeal's receipt date will be consistent with the date AllWays Health Partners received the additional documentation.

AllWays Health Partners will review the appeal and, when appropriate, consult with clinicians or subject matter experts in the areas under consideration. The appeal determination will be final and if the determination is favorable to the provider, the claims in question will be adjusted accordingly within 10 calendar days of the final determination notification.

External Hospital Audits

Audits are conducted at a mutually convenient time and cancellations by either party require written 15 days advance notice. In the event that an audit is cancelled, the audit must be rescheduled within 45 days of the originally

scheduled date. AllWays Health Partners' audits involving inpatient and outpatient claims also include an exit interview to review and discuss the findings.

Documented unbilled services are charges for documented services that were detailed and billed for on the original audited claim but not billed to the full extent of the actual services provided. These charges will be considered for payment only when an accounting of the services is presented at the time of the on-site audit review for verification and acceptance during the on-site audit review. In addition, the charges must be submitted on an AllWays Health Partners accepted claim form. The accepted charges will be adjusted (netted out) against the unsupported charges at the conclusion of the audit.

If there is a question of medical necessity or level of care, the hospital designee will coordinate dissemination and review of the findings with hospital staff and present a rebuttal position prior to the exit interview or within the 30-day appeal period.

At the conclusion of the audit, if the hospital designee agrees with the findings, the auditor will provide a dated copy of the signed and final Discrepancy Report. Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and will reflect accordingly in subsequent EOPs. Alternative arrangements for payment to AllWays Health Partners must be made in writing and signed by all parties.

Physician and Ancillary Audits

Physician and ancillary provider audits may consist of both off-site and on-site audits, with the audit of designated medical records conducted at either AllWays Health Partners or the vendor's office, when applicable. The determination of an off-site and/or on-site audit will be made by AllWays Health Partners.

Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and

will reflect accordingly in subsequent EOPs. Alternative arrangements for payment to AllWays Health Partners must be made in writing and signed by all parties.

Hold Harmless Provision

Providers contractually agree that in no event, including, but not limited to, non-payment by AllWays Health Partners, AllWays Health Partners' insolvency, or breach of the Provider Agreement, should a provider or any of its medical personnel bill, charge, collect a deposit from, or have any recourse against any My Care Family member or person, other than AllWays Health Partners, acting on their behalf for services provided. The provider must not solicit or require from any member or in any other way payment of any additional fee as a condition for receiving care. Providers must look solely to AllWays Health Partners for payment with respect to covered services rendered to all My Care Family members.

This provision does not prohibit collection of supplemental charges or copayments on AllWays Health Partners' behalf made in accordance with the terms of the applicable Subscriber Group Agreement between AllWays Health Partners and the member.

Payment Guidelines

AllWays Health Partners' payment guidelines are designed to help with claim submissions by promoting accurate coding and by clarifying coverage. AllWays Health Partners' payment guidelines are found at allwaysprovider.org.