Ascension
Personalized Care

Clinician handbook
2023

Ascension

APC MKTG 2022-14
Revised 9/12/23

Introduction

Welcome to Ascension Personalized Care. Thank you for participating in our network of high-quality physicians, hospitals and healthcare professionals. This manual contains information on Ascension Personalized Care policies and procedures to help you as you provide services to covered Ascension Personalized Care members.

At Ascension Personalized Care, our goal is to change the way our members experience healthcare. We start by offering access to a clinically integrated network of doctors and clinicians – including hospitals, outpatient facilities, and supporting caregivers. This network is well-coordinated, so clinicians are all working together to make sure members get the best care.

We also help members navigate the complex healthcare system. Members can take advantage of Ascension's national care management team to provide the support and resources they need to take charge of their health. This approach allows them to focus on what's important – their health and their family's health. Care management services are offered to all members as part of the Plan.

Ascension
Personalized Care

Ascension Personalized Care is a **Health Benefits Plan** offered by US Health and Life Insurance Company through the health insurance exchange in Indiana, Kansas, Michigan, Tennessee and Texas.

Cigna is the **Pharmacy Benefits Manager** (PBM) that provides prescription drug coverage for Ascension Personalized Care members.

Automated Benefit Services (ABS) is the **Third-Party Administrator** (TPA) that works with clinicians and Ascension Personalized Care to pay claims within the Ascension Network.

The Ascension Care Management network is a **high-quality, clinically-integrated network** of local clinicians.

Ascension Care Management Insurance Holdings is the **utilization management vendor** for Ascension Personalized Care.

Ascension Personalized Care insurance policies are **underwritten** by US Health and Life Insurance Company.

Every member of the coordinated healthcare team above is continually working to enhance our service to you and your organization. We value your comments and feedback.

Table of contents

Introduction **2**
Overview **6**
Exclusive Provider Organization (EPO) plan 6
Ascension Personalized Care products 7
Bronze 7
Silver 8
Gold **9**
Quick reference tool **10**
Secure web portal **12**
Credentialing and recredentialing 13
Credentials Committee 14
Ongoing monitoring 14
Recredentialing 15
Practitioner right to review and correct information 15
Practitioner right to be informed of application status 15
Practitioner right to appeal adverse recredentialing determinations 16
Clinical non-discrimination 16
Member selection of primary care provider (PCP) **16**
Appointment availability **17**
Telephone arrangements 19
Training requirements 19
Ascension Personalized Care benefits **20**
Virtual care and member benefits **20**
Virtual urgent care 20
Virtual mental health and counseling service 20
Verifying member benefits, eligibiliy and cost shares **21**
Medical management **22**
Care management 22
Care Management Program 22
Utilization management 25
Medical necessity 26
Prior authorization 26
Services requiring prior authorization 26
Utilization determination timeframes 27
Timeframes for decisions 28
Standard organization determinations 29
Expedited organization determinations 29
Concurrent review 29
Retrospective review 29
Utilization review criteria 30

Clinical appeal process 32
Filing an appeal 32
Two types of appeals 32
What to expect after you file the appeal 32
Deadlines to resolve appeal 33
External Review (ER) process 33
How to request an external (independent) review (ERO) 33
Deadlines to resolve external review 33
Pharmacy 35
Pharmacy information 35
Ascension Rx 35
Pharmacy appeals 36
Healthcare 36
Emergency medical condition 36
Quality Management Program 37
Overview 37
QMPS program structure 37
Clinician involvement 37
Quality management program scope and goals 38
Patient safety and quality of care 39
Continuous Quality Improvement (CQI) model 39
Claims 40
Claim filing procedures 40
Clean claim definition 41
Upfront rejections 41
Who can file claims 41
Specific data record requirements 41
Invalid electronic claim record upfront rejections/denials 41
Acceptable forms 43
Corrected claims, requests for reconsideration or claim disputes 43
Corrected claims 44
Request for consideration 44
Claim dispute 45
Electronic funds transfer (EFT) and electronic remittance advices (ERA) 45
Risk adjustment and correct coding 46
Coding of claims/billing codes 47
Additions and terminations 47
Clincian effective date policy 48
Claim status inquiry process 49
Claim adjustments 50
Overpayment policy 50
Refund request 50
Clinician-initiated adjustments 50

Clinician reimbursement rules/sample EOB **52**
- Payment for multiple procedures 53

Code editing **53**
- Code editing and the claims adjudication cycle 53
- Claim reconsiderations related to code editing 53

Billing the member **54**
- Failure to obtain authorization 54
- No balance billing 54

Member rights and responsibilities **55**
- Member rights 55
- Member responsibilities 56

Clinician rights and responsibilities **58**
- Clinician rights 58
- Clinician responsibilities 58

Regulatory matters **60**
- Medical records 60
  - Required information 60
  - Medical records release 61
  - Compliance audits for medical record documentation 61
  - Medical records transfer for new members 62
  - Medical records audits 62
  - Access to records and audits by Ascension Personalized Care 62
  - Electronic Medical Record (EMR) access 62
- Federal and state laws governing the release of information 62
- Section 1557 of the Patient Proctection and Affordable Care Act 63
- Health Insurance Portability and Accountability Act 63
  - Privacy regulations 64
  - The Security Rule 64
  - The Breach Notification Rule 64
  - Transactions and code sets regulations 64
  - HIPAA-required code sets 65
  - HIPAA-regulated transactions 65
  - National Provider Identifier 66

Fraud, Waste and Abuse **67**
- FWA program compliance authority and responsibility 68
- False Claims Act 68

Appendix **69**
- Appendix I: Common causes for upfront claim rejections 69
- Appendix II: Common cause of claims processing delays and denials 69
- Appendix III: Instructions for supplemental information 70
- Appendix IV: Billing tips and reminders 71
- Appendix V: EDI Companion Guide overview 74
  - Claims processing 74

Accreditation **78**

Overview

Ascension Personalized Care plans are health plans providing medical and behavioral health services to members. Our health plans feature benefits that care for the whole person, including physical, mental, emotional, and spiritual health. Ascension Personalized Care is designed to achieve five main objectives:

- Access to our own Ascension network of primary care doctors and specialists, convenient locations, and options for online care and specialty prescriptions from Ascension Rx
- Plans with good coverage at a reasonable cost, that include features and benefits to connect all aspects of your health and wellness, including your emotional, mental, and spiritual health
- A customer service team who listens, respects, and helps you navigate your coverage so you can fully understand and maximize the value and benefits of your plan
- Coverage choices for the many stages of your life, allowing you and your family to get the care you need, when and where you need it
- Education and information to help you make smart, informed healthcare decisions that work for you

Exclusive Provider Organization (EPO) plan

A managed care plan where services are covered only if a patient goes to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Ascension Personalized Care takes the privacy and confidentiality of our members' health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations. The services provided by the contracted Ascension Personalized Care network clinicians are a critical component in terms of meeting the objectives above. Our goal is to reinforce the relationship between our members and their primary care physician (PCP). We want our members to benefit from their PCP having the opportunity to deliver high-quality care using contracted hospitals and specialists. PCPs are responsible for coordinating our members' health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the member about their health status, and medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

Ascension Personalized Care products

Ascension Personalized Care products are designed to allow flexibility and enhanced benefits to its members. There are three metal categories offered by Ascension Personalized Care: Bronze, Silver, and Gold. Each category reflects the amount the member and the health plan will pay.

Bronze plans offer the lowest monthly premium and the highest out-of-pocket costs.

Silver plans offer a moderate monthly premium. Out-of-pocket costs can vary but are generally lower than Bronze plans. Cost-sharing reductions available only on Silver plans for those who qualify.

Gold plans offer a higher monthly premium and the lowest out-of-pocket costs. (Gold plans may be cheaper than Silver plans in Texas due to local insurance industry regulations).

The following list of products are offered by Ascension Personalized Care:

Bronze

Ascension Personalized Care Balanced Bronze 1
Ascension Personalized Care Balanced Bronze 2
Ascension Personalized Care No-Deductible Bronze
Ascension Personalized Care Standard Expanded Bronze

	Balanced Bronze 1	Balanced Bronze 2	No Deductible Bronze	Standard Expanded Bronze
Deductible	$8,000	$9,100	$0 / $5,000 Rx	$7,500
Out-of-pocket maximum	$9,100	$9,100	$9,100	$9,000
Coinsurance	50%	0%	50%	50%
Virtual primary care provider visit	$25*	$10*	$25*	$25*
Virtual specialist care provider visit	$50*	$20*	$50*	$50*
Virtual urgent care	$64*	$30*	$64*	$64*
Primary care provider visit	$50*	$25*	$50*	$50*
Specialist visit	$100*	No charge after deductible	$100*	$100*
Emergency room visit	50% coinsurance after deductible	No charge after deductible	$1,000*	50%
Generic prescription drug coverage	$20*	$15*	$30*	$25*

*not subject to deductible

Silver
Ascension Personalized Care Low Premium Silver
Ascension Personalized Care Balanced Silver
Ascension Personalized Care No Deductible Silver
Ascension Personalized Care Standard Silver

CSR 73%
Ascension Personalized Care Low Premium Silver 73
Ascension Personalized Care Balanced Silver 73
Ascension Personalized Care No Deductible Silver 73
Ascension Personalized Care Standard Silver 73

CSR 87%
Ascension Personalized Care Low Premium Silver 87
Ascension Personalized Care Balanced Silver 87
Ascension Personalized Care No Deductible Silver 87
Ascension Personalized Care Standard Silver 87

CSR 94%
Ascension Personalized Care Low Premium Silver 94
Ascension Personalized Care Balanced Silver 94
Ascension Personalized Care No Deductible Silver 94
Ascension Personalized Care Standard Silver 94

	Low Premium Silver	Balanced Silver	No Deductible Silver	Standard Silver
Deductible	$4,000	$5,400	$0	$5,800
Out-of-pocket maximum	$8,900	$5,400	$9,100	$8,900
Coinsurance	50%	0%	40%	40%
Virtual primary care provider visit	$20*	No charge after deductible	$15*	$20*
Virtual specialist care provider visit	$40*	No charge after deductible	$30*	$40*
Virtual urgent care	$60*	No charge after deductible	$45*	$60*
Primary care provider visit	$40*	No charge after deductible	$30*	$40*
Specialist visit	$80*	No charge after deductible	$60*	$80*
Emergency room visit	50% coinsurance after deductible	No charge after deductible	$1,000*	40% coinsurance after deductible
Generic prescription drug coverage	$25*	No charge after deductible	$25*	$20*

*not subject to deductible

Gold

Ascension Personalized Care Standard Gold

	Standard Gold
Deductible	$2,000
Out-of-pocket maximum	$8,700
Coinsurance	25%
Virtual primary care provider visit	$15*
Virtual specialist care provider visit	$30*
Virtual urgent care	$60*
Primary care provider visit	$30*
Specialist visit	$60*
Emergency room visit	25% coinsurance after deductible
Generic prescription drug coverage	$15*

*not subject to deductible

Quick reference tool

The following table includes several important telephone and fax numbers available to clinicians and their office staff. When calling, it is helpful to have the following information available.

- The provider's NPI number
- The practice Tax ID Number
- The member's ID number

Department	Contact information
Eligibility/Verification	Verify eligibility by calling Ascension Personalized Care (APC) at **833-600-1311** during the hours of 8:00 a.m. to 6:00 p.m. (EST) Monday through Friday, or online at **secure.healthx.com/Provider_2022**
Authorizations	To request a prior authorization the following may be utilized: 1) Clinician Portal to view the status of an authorization: ascensionpersonalizedcare.com 2) Fax a completed Prior Authorization Form to 512-380-7507 3) Call Ascension Care Management Insurance Holdings at 844-995-1145 4) Email Ascension Care Management Insurance Holdings at shp-authorization@ascension.org For a comprehensive list of procedures with the appropriate ICD-10 or CPT codes, please refer to the **most recently published Prior Authorization Code List** posted at **ascensionpersonalizedcare.com.**
Clinician Directory	IN, KS, MI and TN: Please notify Network Services of any clinician additions, terminations or changes in status by completing the Ascension Personalized Care Clinician Network Maintenance Grid and submitting it to the Ascension Personalized Care Inbox at **acmproviders@ascension.org**. TX: All clinicians on Seton Health Plan contracts must send their additions, terminations or changes in status to **SHPProviderservices@seton.org**. If you need a copy of the Clinician Network Maintenance Grid, contact Clinician Relations at acmproviders@ascension.org or by calling the toll-free number 855-288-6747.
Labs	All services should be directed to an appropriate Ascension Personalized Care Network laboratory clinician. Please refer to the online Clinician Directory located at ascensionpersonalizedcare.com. Additionally, in-office lab services offered by Ascension Personalized Care Network clinicians will be treated as in-network services if the claims are submitted under a participating in-network Tax Identification Number (TIN). Labcorp is a participating laboratory network provider for outpatient, specialty lab and pathology testing services. For additional information please visit: APC Labcorp Flyer.

Department	Contact information
Pharmacy Benefits Manager	The Pharmacy Benefits Manager (PBM) that provides prescription drug coverage is Cigna. Cigna can be reached at **800-244-6224**.
Claims Submission/ Claims Status	**Submit paper claims to:** Ascension Personalized Care for Ascension Personalized Care, PO Box 1707, Troy, MI 48099-1707 **Submit electronic claims to: Payer ID:** 38259** ** EDI clearing houses currently contracted: Change Healthcare

Secure web portal

Ascension Personalized Care offers a robust secure web portal with functionality that will be critical to serving members and to ease administration of the Ascension Personalized Care product for clinicians. Clinician Services will be able to assist and provide education regarding this functionality. The portal can be accessed at ascensionpersonalizedcare.com

The primary resource for Ascension Personalized Care members to find clinicians also has important information for clinicians.

Go to: ascensionpersonalizedcare.com

Follow the directions on the following pages of this manual to access the Clinician Information Center.

Use the website to:

- See the list of services that require prior authorization
- See the clinician directory
- Download forms

Access requirements:

- No user ID or password required

Automated Benefit Services (ABS) clinician web portal

Go to: secure.healthx.com/Provider_2022

Use the Ascension Personalized Care Clinician Web Portal to:

- Confirm member eligibility and benefits
- Check claim status and claims history

Access requirements:

- Each person in your office who needs to access the Ascension Personalized Care clinician web portal must have a username and password.
- To obtain an Ascension Personalized Care Clinician web portal username and password, complete the application form located on the Ascension Personalized Care portal and return it to ABS. Each form allows several users to request access.
- After you log in, follow instructions on "How to Use This Site" on the left side of the screen.

Make sure your authorized user list is up to date:

- To see which individuals from your office already have usernames and passwords, or to remove a user who is no longer employed by your office, contact Ascension Personalized Care at **833-600-1311**

Disclaimer: Clinicians agree that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

Credentialing and recredentialing

The credentialing and recredentialing process exists to verify that participating practitioners and clinicians meet the criteria established by Ascension Personalized Care, as well as applicable government regulations and standards of accrediting agencies.

Ascension Personalized Care requires all clinicians be credentialed by Utilization Review Accreditation Commission (URAC) standards. In an effort to credential clinicians in a timely manner, please utilize and attest every 120 days to the Council for Affordable Quality Healthcare, Inc. (CAQH) for the clinician application.

Notice: In order to maintain a current practitioner/clinician profile, practitioners/clinicians are required to notify Ascension Personalized Care of any relevant changes to their credentialing information in a timely manner, but in no event later than 10 calendar days from the date of the change.

The following information must be on file:

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation.
- Completed ownership and control disclosure form as part of the CAQH application process.
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage that meets APC minimum coverage requirements
- Supporting documents for malpractice claims pending, settled, dismissed within the last 10 years
- Current controlled substance registration certificate, if applicable.
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see Ascension Personalized Care members, if applicable.
- Completed and signed W-9 form (initial credentialing only).
- Current Educational Commission For Foreign Medical Graduates (ECFMG) certificate, if applicable.
- Curriculum vitae listing a minimum of a five-year work history, (if work history is not completed on the application), with an explanation of gaps of employment of over six months, for initial applicants.
- Signed and dated release of information form not older than 180 days from the date of the credentialing committee meeting.
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable.

Ascension Personalized Care will primary source verify the following information submitted for credentialing and recredentialing:

- License through appropriate licensing agency.
- Board certification, or residency training, or professional education, where applicable.
- Malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB).
- Federal sanction activity, including Medicare/Medicare services (SAM, OIG-Office of Inspector General, Preclusion List).

For clinicians (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Re-credentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application. This process may take up to 90 days.

Once the signed and completed application is received, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting , but no later than 180 days.

Primary care practitioners cannot accept member assignments until they are fully credentialed. No clinician can see patients until they are fully credentialed.

Credentials Committee

The Credentials Committee, including the Medical Director or their physician designee, has the responsibility to establish and adopt necessary criteria for participation, denial, termination, and direction of the credentialing procedures. Committee meetings are held at least quarterly, and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Ongoing monitoring

Site reviews may be performed at PCP and OB/GYN clinician offices and facilities at any time for cause. The site visit to evaluate the member complaint or other precipitating event shall be conducted by appropriate personnel and may include, but not be limited to, an evaluation of any facilities or services relating to the member complaint or adverse event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices as appropriate. Within two days of receiving a member complaint, the clinical staff from the Credentialing Team or Quality Department will contact the practitioner's office or facility, notify them of the complaint and schedule an office site visit. A site review evaluates:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Appointment availability
- Adequacy of medical/treatment record keeping

The examiner will discuss the results of the review with a representative of the practitioner's office or facility. After discussion of the findings with the practitioner's office, the practitioner or facility representative will sign the medical office review tool and the examiner will file it in the practitioner or facility's file for future reference.
If the site visit score is 90% or higher, it is assumed that the problem has been corrected.

If the site visit score is lower than 90%, the examiner will point out any deficiencies with the practitioner or facility's representative and request a corrective action plan and schedule a follow up visit scheduled at six (6) months.

If the follow-up visit score is 90% or higher, it is assumed that the problem has been corrected. If the score is lower than 90%, the practitioner or facility must submit a revised corrective action plan and a final follow-up visit will be scheduled in six (6) months.

If the practitioner or facility fails to demonstrate compliance, actions outlined in *CR102 - Termination, Suspension of Network Participation* will be followed.

Recredentialing

Ascension Personalized Care conducts practitioner/clinician recredentialing at least every 36 months from the date of the initial credentialing decision and most recent re-credentialing decision. The purpose of this process is to identify any changes in the practitioner's/clinician's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/clinician's ability to perform services under the contract. This process includes all practitioners, facilities and ancillary clinicians previously credentialed and currently participating in the network.

In between credentialing cycles, Ascension Personalized Care conducts clinician performance monitoring activities on all network practitioners/clinicians. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against practitioners/clinicians in between credentialing cycles. Additionally, Ascension Personalized Care reviews monthly reports released by the state, CMS and Office of Inspector General to identify any network practitioners/clinicians who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A clinician's agreement may be terminated if at any time it is determined by the Ascension Personalized Care Credentials Committee that network participation criteria and/or URAC credentialing requirements are no longer being met.

Practitioner right to review and correct information

All practitioners participating within the network have the right to review information obtained by Ascension Personalized Care to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a clinician to review references, personal recommendations, or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the clinician believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have thirty (30) calendar days to provide a written explanation detailing the error or the difference in information to the Credentials Committee.

The Credentials Committee will then include this information as part of the credentialing or re-credentialing process.

Practitioner right to be informed of application status

All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact their Clinician Relations Representative or email AscensionCredentialing@ascension.org.

Practitioner right to appeal adverse recredentialing determinations

Applicants who are existing clinicians and who have declined continued participation due to adverse re-credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 calendar days of the adverse determination notice.

All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentials Committee at the next regularly scheduled meeting.
Ascension Personalized Care is responsible for complying with various reporting agency guidelines and State and Federal regulations to ensure that adverse actions are reported. Adverse action includes reducing, restricting, suspending, revoking, and denying clinical privileges and/or any action based on professional competence or conduct, adversely affecting clinical privileges for a period longer than 30 days. No adverse action will be reported until the provider has had an opportunity to appeal the adverse determination.

Clinical non-discrimination

We do not limit the participation of any clinician or facility in the network, and/or otherwise discriminate against any clinician or facility based solely on any characteristic protected under state or federal discrimination laws. We also do not discriminate for reimbursement or indemnification of any clinician who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification. If Ascension Personalized Care declines to include individuals or groups of clinicians in our network, we will give the affected clinicians written notice of the reason for its decision.

Furthermore, we do not and have never had a policy of terminating any clinician who:
- Advocated on behalf of a member
- Filed a complaint against us
- Appealed a decision of ours

Gag Clause Prohibition

Notwithstanding anything in this Clinician Manual or in any network agreement between the doctor or provider and APC, neither APC nor doctor or provider may restrict APC from providing doctor/provider-specific price or quality of care information to referring doctors, providers, members, or individuals eligible to become members, or from sharing plan design, plan administration, and plan financial, legal and quality improvement activities with a business associate as defined by HIPAA.

Member selection of primary care provider (PCP)

Ascension Personalized Care gives members the freedom to select the healthcare clinician of their choice. Services from in-network clinicians are covered based on contracted provisions, fee schedule, and any standard coding and claim guidelines, with exception of member cost sharing or copays, or until the maximum out-of-pocket is met.

Appointment availability

The following standards are established regarding appointment availability:

Type of care	Accessibility standard*
PRIMARY CARE	
Emergency	Within 2 days of request
Same day or within 24 hours of member's call	Routine
Urgent care	Within 21 days of request
SPECIALTY REFERRAL	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral
Routine	Within 45 days of referral
MATERNITY	
1st trimester	Within 14 days of request
2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancies	Within 3 days of identification or immediately if an emergency exists
DENTAL	
Emergency	Within 24 hours of referral
Urgent care	Within 3 days of referral

*The in-office wait time is less than 45 minutes, except when the clinician is unavailable due to an emergency.

The following are behavioral health appointment guidelines:

Appointment type	Description	Standard*
Immediate	Behavioral health services provided within a time frame indicated by behavioral health condition, but no later than 2 hours from identification of need, or as quickly as possible when a response within 2 hours is geographically impractical	Within 2 hours – may include telephonic or face-to-face interventions
Urgent	Behavioral health services provided within a time frame indicated by behavioral health condition, but no later than 24 hours from identification of need	Within 24 hours
Routine – initial assessment	Appointment for initial assessment with a behavioral health professional (BHP) within 7 days of referral or request for behavioral health services	Within 7 days of referral
Routine – first behavioral health service	Includes any medically necessary covered behavioral health service including medication management and/or additional services	Within 7 days of assessment
Non-emergency transportation		• Member must not arrive sooner than one hour before their scheduled appointment; and • Member must not have to wait for more than one hour after the conclusion of their appointment for transportation home or to another pre-arranged destination.

Telephone arrangements

Clinicians must be accessible to members 24 hours a day, seven (7) days a week.

After-hours services

- Answering services must meet language requirements
- Should be able to reach the PCP or other designated medical clinician
- All calls need to be returned within 30 minutes

Answering machine

- Should be on after business hours
- Should direct members to hang up and dial 911 in case of an emergency, and direct members to call another number to reach the PCP or other designated medical clinician
- A live person should be available to answer the designated phone number; another recording is not acceptable

Note: If after-hours urgent care or emergent care is needed, the PCP or their designee should contact the urgent care or emergency center to notify the facility.

Ascension Personalized Care will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program.

Training requirements

Information on training opportunities will be posted on MyLearning for AMG providers and ascensionpersonalizedcaretraining.com for non-AMG providers.

The training materials will contain information on the product, the plan, the ACA and more. We will continue to provide training on any updates to the plan or product. To ensure you don't miss important information from Ascension Personalized Care, verify that your contact information is up to date with us by submitting rosters regularly and including your email address.

Ascension Personalized Care benefits

All services are subject to benefits coverage, limitations and exclusions as described in the applicable Ascension Personalized Care policy and schedule of benefits.

Access a copy of the Member's Evidence of Coverage to verify the covered services specific to each plan on the Ascension Personalized Care portion of our website at ascensionpersonalizedcare.com. Please contact Clinician Services at Ascension Personalized Care with any questions you may have regarding benefits.

Verifying member benefits, eligibility and cost shares

As an Ascension Personalized Care clinician, you can contact Automated Benefit Services (ABS) to:

- Check benefits coverage
- Verify eligibility
    - Confirm primary or secondary coverage for those members who have dual medical coverage

Online: Visit **secure.healthx.com/Provider_2022**

- Log into the Ascension Personalized Care Clinician Web Portal with your Ascension Personalized Care supplied username and password

By phone: Call Ascension Personalized Care at **833-600-1311** from 8:00 a.m. to 6:00 p.m. (EST) Monday through Friday and enter the member ID number when prompted.

- Press 1 for English (other languages are available)
- Press 2 if you are a clinician
- Enter the member ID number
    - For assistance with medical eligibility, claims, billing and payment information or any other questions, press 1
- If you do not have the member's ID number, press #
    - To inquire about medical benefits/eligibility using the FaxBack system, press 1
    - To speak with a customer service representative, press 2

24/7 fax recall confirmation: 888-494-4600
Once eligibility is confirmed, you'll receive a fax including instructions on how to submit claims and a benefits schedule for the Ascension Personalized Care member's plan.

Clinicians are also responsible for confirming eligibility on the date of service and determining benefits coverage for all services provided. Except for copayments, coinsurance, deductibles or other permitted supplemental charges made in accordance with the terms of the applicable Plan, clinicians shall not bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against members or persons acting on their behalf for covered services.

Medical management

Care management

Care management is a collaborative process to assess, plan, implement, coordinate, monitor, and evaluate options and services to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. Care coordination and care management are member-centered, goal-oriented, culturally relevant, and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Care management programs are focused on providing high-quality health programs that improve the lives of patients and communities by translating mission goals into concrete programs. A care management program is dedicated to increasing the quality and value of our members' healthcare by promoting preventive care, optimizing chronic disease outcomes, as well as improving care coordination for patients and members with the most complex needs. Leveraging services across the continuum of care offered through Ascension's clinically integrated network, Ascension Care Management promotes and educates members about self-management of chronic conditions and healthy lifestyle behaviors which are key to reducing the incidence, burden and costs associated with chronic conditions. In addition, Ascension Care Management recognizes that diverse and underserved populations with chronic conditions experience health disparities and health inequities. Ascension Care Management is designed to offer comprehensive, holistic, and spiritual care for all members.

The Care Management services include those that work synergistically to improve the health of patients across the wellness spectrum. The Care Management program includes the following four areas of focus:

1. Keeping patients healthy through wellness programs.
2. Managing patients with emerging risk using disease management.
3. Providing safety across the continuum of care with transitions of care.
4. Managing patients with multiple chronic illnesses by offering complex care management.

An initial health risk assessment (HRA) will be completed by phone or in person. The HRA results help us identify members that might benefit from care management and better understand the health risks of our population. The care manager also facilitates referrals and links to community clinicians, such as local health departments and the Division of Aging. The managing physician maintains responsibility for the member's ongoing care needs. The care manager will contact the PCP, and/or, managing doctor if the member is not following the plan of care or requires additional services.

All Ascension Personalized Care members with identified needs are assessed for care management enrollment. Members with needs may be identified via clinical rounds, referrals from other Ascension Personalized Care staff members, hospital census, and direct referral from clinicians, self-referral or referral from other clinicians.

Care Management Program

Ascension's national complete Care Management Program will establish one consistent population health solution and ambulatory care management model in all ministry markets, which assists Ascension patients in achieving their healthcare goals while lowering costs and enhancing the clinician experience.

The care management process includes member engagement related to the completion of health risk screenings and assessments, quality improvement, risk adjustment, support engagement in the enhanced disease management program and complex care management.

Care management activities for all health Plan members include but are not limited to the following industry-standard activities and best practices:

- Health risk assessments
- Complex case management
- Enhanced disease management
- Transitions of care management
- Interdisciplinary team meetings with primary care providers

Core goals of care management:

- Reduction in medical expenditures for members by reducing ED and inpatient admissions and readmissions.
- Improved healthcare experience and outcomes for all members of Ascension Personalized Care.
- Prevent or delay the onset and exacerbation of chronic conditions by addressing gaps in standards of care, improving biometric outcomes, and increasing Ascension Personalized Care patient satisfaction.
- Address barriers to standards of care compliance and improve Ascension Personalized Care patient self-management.
- Improved utilization of care management and/or Ascension Personalized Care Networks.
- Enhanced clinician experience.

Ascension Care Management Team will:

- Develop and provide members with educational materials relevant to their conditions in compliance with CMS requirements around language, literacy, and format.
- Collaborate with the Plan to develop and execute on any member-facing initiatives that impact quality and Health Benefit Ratio (HBR) results.
- Maintain a case management system that utilizes evidence-based guidelines or algorithms to guide case managers through assessment and ongoing management of members/clinicians.
- Annual member/clinician survey conducted to evaluate experience with the care management process, and analyzes feedback to identify opportunities to improve experience with the care management program.
- Design, develop, and execute disease management programs to address condition-specific needs of the member population.
- Develop and provide members with educational materials relevant to their conditions.
- Design, develop, and execute enhanced disease management programs based on the needs of the member population.
- Develop and provide members with educational materials relevant to their conditions in compliance with regulatory requirements around language, literacy, and format.

- Employ a multidisciplinary care management team approach, including nurses, social workers, health promoters and health coaches, for the management of Ascension Personalized Care members.
- Care management will target populations at increased risk of hospital admission, readmission, inadequate or poorly coordinated care. Care management addresses an individual member's clinical and non-clinical needs and then works to remove barriers to care that are often found in the ambulatory care setting, as well as across the continuum of care. Operationally, this is achieved by a standardized model of care which leverages a care team of clinical and non-clinical staff to provide both episodic and complex care management.
- Transitional care management is designed to support a member's successful transition of care after an acute episode of care (ER visit, OBS status, SNF discharge, or inpatient admission). Once a member is identified, they are provided with care management services to ensure a plan of care is developed and fulfilled following the acute episode of care.
- Complex care management of high-risk members focuses on those who are likely to benefit from targeted, proactive, relationship-based care management. Service delivery is standardized through evidence-based care paths, which are driven by clinically validated assessment tools. Complex care management is delivered through standardized care paths, including coaching of those with diabetes, CHF, CAD, COPD, asthma, anxiety, depression, dementia, high-risk pregnancy, cancer, or in need of palliative care.
- Care management support services include:
    - Understanding new diagnosis, disease management coaching, and behavioral healthcare management.
    - Understanding how and when to access the proper level of care.
    - Benefits and billing navigation.
    - Connection to a primary care provider and assistance with appointments.
    - Assisting with transitions back home from the ER, hospital, and/or skilled nursing facility.
    - Removal of barriers to care: transportation, food insecurity, etc.
    - Facilitating access to special programs: COPD management services, palliative care, transportation resources, etc.
    - Conducting home visits and safety checks when appropriate.
    - Help understanding medications and conducting medication reconciliations.
    - Providing health coaching to improve self-management and develop/maintain healthy behaviors.

Ascension Personalized Care's care management process contains the following key elements:

- Screening and identifying members who potentially meet the criteria for care management.
- Assessing the member's risk factors to determine the need for care management.
- Notifying the member and their PCP (as assigned) of the member's enrollment in Ascension Personalized Care's Care Management program.
- Developing and implementing an Individual Care Plan (ICP) treatment plan that accommodates the specific cultural and linguistic needs of the member.
- Establishing with the member the ICP problems, goals and interventions to meet desired member outcomes.
- Referring and assisting the member in ensuring timely access to clinicians.
- Coordinating medical, residential, social and other support services.
- Monitoring care/services.
- Revising the ICP as necessary.
- Provide transition of care support for members who need alternative levels of care (includes post- discharge follow-up outreach).
- Referring a member to Ascension Personalized Care Care Management: Clinicians are asked to contact an Ascension Personalized Care care manager to refer a member identified in need of care management intervention.

Milestones required by the Care Management Program:
Annually, Ascension's Care Management Program leaders evaluate the impact of the care management strategy and programs through the measurement of relevant clinical, utilization and experience measures. Ascension's Care Management Program will complete an annual assessment which includes a review of activities, programs and resources. The analysis of the data is used to determine if changes are required to care management programs, activities, or resources, and to evaluate the extent to which these programs facilitate access and connection to community resources that address member needs outside the scope of health plan benefits. Modifications to care management program design and resources are made based on these findings. The annual assessment drives the care management planning and strategy for program activity and resource modifications. The local care management leaders and teams are provided milestones to assess the effectiveness of services. The Markets are provided data and feedback on milestones on a quarterly basis.

Utilization management

Ascension Care Management Insurance Holdings's (ACMIH) Utilization Management (UM) Program is designed to manage the use of healthcare resources and to maximize the effectiveness and quality of the care provided to its members. Its goal is to promote appropriate, safe and consistent utilization management decision-making. The program includes pre-service, concurrent and post-service review components. Program activities are completed in a manner that is consistent with the applicable policies, procedures, and standards of the state and federal regulatory agencies.

ACMIH affirms that its utilization decisions about care and service are based solely on their appropriateness in relation to each member's specific medical condition. ACMIH does not reward clinicians, practitioners, clinical staff who perform utilization reviews, or other individuals issuing denials of authorization, service or care. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve benefits coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Medical necessity

The fact that a physician may prescribe, authorize, or direct a service does not itself make it medically necessary or a covered benefit under the contract.

Medically necessary services are healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine. These include services which are:

- Appropriate and consistent with the diagnosis of the treating clinician and the omission of which could adversely affect the eligible member's medical condition.
- Compatible with the standards of acceptable medical practice in the community.
- Provided in a safe, appropriate, and cost-effective setting, given the nature of the diagnosis and severity of the symptoms.
- Not provided solely for the convenience of the member or the convenience of the healthcare clinician or hospital.

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the "Clinical Appeal Process" section of the clinician manual.

Prior authorization

Prior authorization requires that the clinician or practitioner make a formal medical necessity determination request to Ascension Personalized Care prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for only those procedures/services for which the quality of care or financial impact can be favorably influenced by medical necessity or appropriateness review, such as non-emergent inpatient admissions, all out-of-network services, and certain outpatient services, ancillary services, and specialty injectable as described on the prior authorization list.

Prior authorization is not required for emergency services or urgent care services.

Services requiring prior authorization

To see a list of services that require prior authorization please visit the Ascension Personalized Care website at ascensionpersonalizedcare.com. Failure to obtain the required prior authorization or precertification may result in a denied claim or reduction in payment. We will suspend the need for prior authorization requests during an emergency/ disaster where clinicians are unable to reach Ascension Personalized Care for an extended period and, when acting in good faith, clinicians need to deliver services to our members.

Note: All out-of-network services require prior authorization, excluding emergency room services and urgent care.

Prior authorization requests may be called to Ascension Personalized Care at 844-995-1145. Prior authorization requests may be faxed to 512-380-7507. The fax authorization form can be found on our website at ascensionpersonalizedcare.com.

The requesting or rendering clinician must provide the following information to request authorization (regardless of the method utilized):

- Member's name, date of birth and ID number.
- Provider's NPI number, taxonomy code, name and telephone number.
- Facility name, if the request is for an inpatient admission or outpatient facility services.
- Clinician location, if the request is for an ambulatory or office procedure.

- The procedure code(s). **Note:** If the procedure codes submitted at the time of authorization differ from the services actually performed, it is recommended that within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 844-995-1145 to update the authorization. Otherwise, this may result in claim denials.
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed).
- Admission date or proposed surgery date, if the request is for a surgical procedure.
- Discharge plans.

Utilization determination timeframes

Utilization management decision-making is based on appropriateness of care and service. Ascension Personalized Care does not reward clinicians or other individuals for issuing denials of authorization.

Authorization decisions are made as expeditiously as possible. Ascension Personalized Care utilizes the specific timeframes listed below. In some cases, it may be necessary to extend the timeframe below. You will be notified if an extension is necessary. Please contact Ascension Personalized Care if you would like a copy of the policy for utilization management timeframes.

Timeframes for decisions

Pre-certification determinations are made according to the URAC time standards.

Note: Where state or federal time standards differ from URAC, the more stringent time standard is applicable.

Timeframes for decisions						
Type of request	**URAC**	**Indiana**	**Kansas**	**Michigan**	**Tennessee**	**Texas**
Prospective urgent	Within 72 hours of receipt of request	As soon as possible but not later than second working day after the date of request	Within 72 hours of receipt of request	Within 24 hours of receipt of request	Within 72 hours of receipt of request	Within 72 hours of receipt of request
Prospective nonurgent	Within 15 calendar days of receipt of request	Not later than second working day after the date of request	Within 15 calendar days of receipt of request	Within 15 calendar days of receipt of request	Within two business days and receipt of all necessary information	Within three working days Acquired brain injury: no later than three business days; notification via direct telephone contact
Prospective nonurgent (extension)	Additional 15 calendar days of receipt of request	Additional 15 calendar days of receipt of request	Additional 15 calendar days of receipt of request	Additional 15 calendar days of receipt of request	Additional 15 calendar days of receipt of request	Additional 14 calendar days
Concurrent review urgent	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Within 24 hours of receipt of request	Concurrent: URAC Post Stabilization: Within one hour of request (includes concurrent review of prescription drugs or IV infusions)
Retrospective	Within 30 calendar days of receipt of request	Within 30 calendar days of receipt of request	Within 30 calendar days of receipt of request	Within 30 calendar days of receipt of request	Within 30 calendar days of receipt of request	Within 30 calendar days of receipt of request
Retrospective (extension)	Additional 15 calendar days with extension	Additional 15 calendar days with extension	Additional 15 calendar days with extension	Additional 15 calendar days with extension	Additional 15 calendar days with extension	Additional 15 calendar days with extension

Standard organization determinations

Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 15 calendar days after we receive the request for service. Please note that when state or federal time standards differ, the more stringent time standard is applied. An extension may be granted for 14 additional calendar days if the member requests an extension, or if we justify the need for additional information and documents that the delay is in the best interest of the member.

Expedited organization determinations

Expedited organization determinations are made when the member or their clinician believes that waiting for a decision under the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the member or clinician's request. Please note that when state or federal time standards differ, the more stringent time standard is applied. An extension may be granted for 14 additional calendar days if the member requests an extension, or if we justify a need for additional information and document how the delay is in the best interest of the member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited urgent requests must be called to Ascension Personalized Care phone at 844-995-1145.

Concurrent review

Concurrent review is defined as any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. Decisions are made as expeditiously as the member's health condition requires, generally within one business day of receipt. Please note that when state or federal time standards differ, the more stringent time standard is applied.

Retrospective review

A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews which Ascension Personalized Care may perform:

- Retrospective review initiated by Ascension Personalized Care. Requires periodic documentation including, but not limited to, the medical record, UB and/or itemized bill to complete an audit of the clinician-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to Ascension Personalized Care to support accurate coding and claims submission.

Retrospective review initiated by clinicians. Ascension Personalized Care will review post-service requests for authorization of inpatient admissions or outpatient services if the request is received within 90 calendar days of the date of service, and either of the following extenuating circumstances are met:

- Unable to know the situation-The clinician and/or facility is unable to identify from which health plan to request an authorization. The member is not able to tell the clinician about their insurance coverage, or the clinician verified different insurance coverage prior to rendering services.
- Not enough time situations-The member requires immediate medical services and the clinician is unable to anticipate the need for a pre-authorization immediately before or while performing a service.
- A member is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the member's needs at the time of service. Ascension Personalized Care will also identify quality issues, utilization issues and the rationale behind failure to follow Ascension Personalized Care's prior authorization/pre-certification guidelines. If Ascension Personalized Care is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to 14 calendar days of the post-service request.

Utilization review criteria

Ascension Care Management Insurance Holdings (ACMIH) utilizes nationally recognized standards of care for evidence-based medical policies and clinical utilization management guidelines for medical management coverage decisions. Medical policies are developed through periodic review of generally accepted standards of medical practice, and updated at least on an annual basis. The criteria provide a system for screening proposed medical care based on member-specific best medical care practices and rule-based systems, to match appropriate services to member needs based upon clinical appropriateness.

Federal and state law as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state acts or CMS requirements will supersede both Ascension Care Management Insurance Holdings medical policy and InterQual care criteria. Medical technology is constantly evolving, and ACMIH reserves the right to review and periodically update medical policy and utilization management criteria.

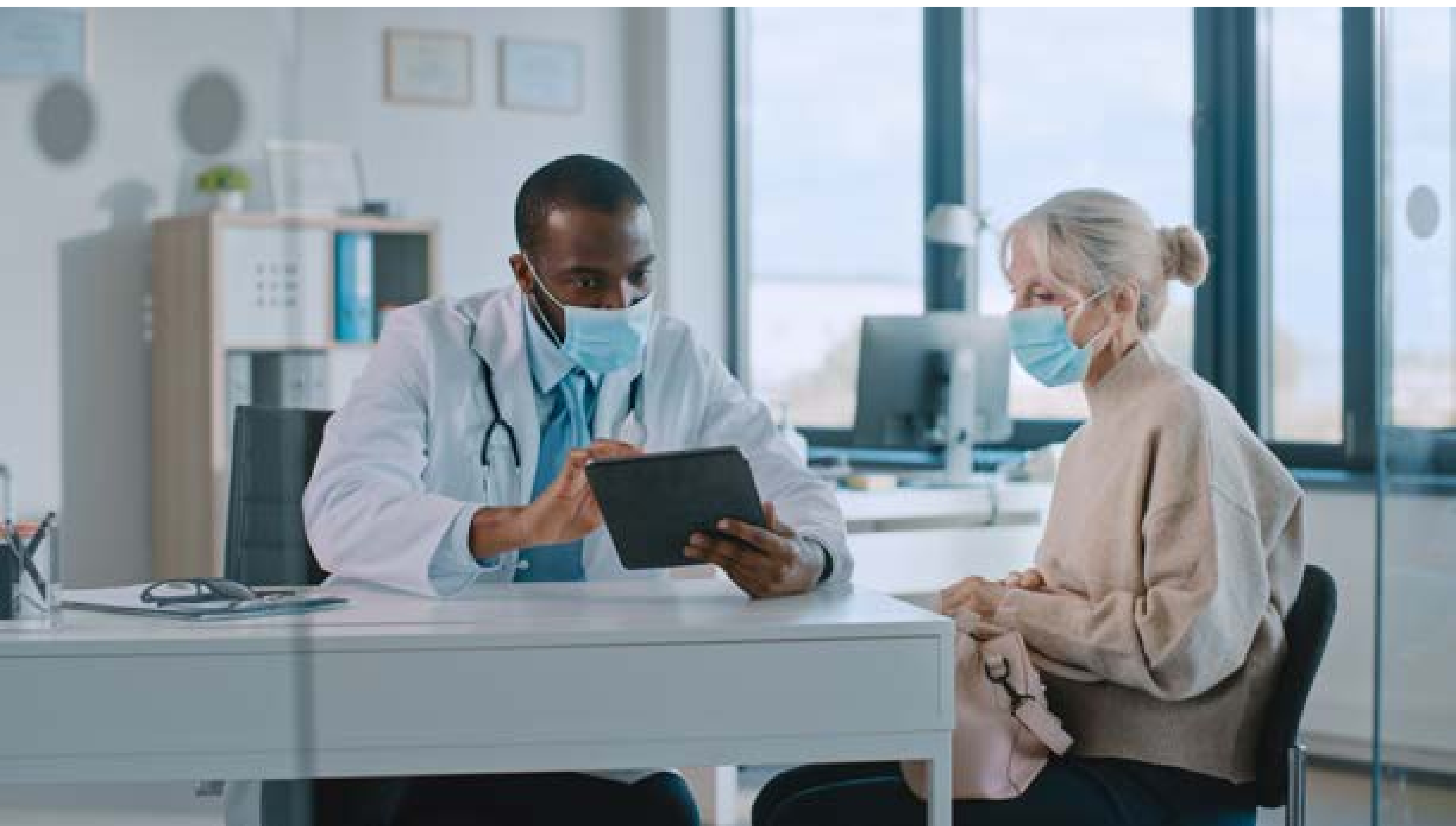
Criteria	Application
InterQual Acute – Adult and Pediatrics	• Inpatient admissions • Continued stay and discharge readiness
InterQual Imaging	• Imaging studies and X-rays
InterQual Procedures – adult and pediatrics	• Surgery and invasive procedures
InterQual adult and geriatric psychiatry criteria	• Inpatient admissions • Continued stay and discharge readiness
InterQual child and adolescent criteria	• Inpatient admissions • Continued stay and discharge readiness
InterQual substance use disorders and dual diagnosis criteria	• Inpatient admissions • Continued stay and discharge readiness
InterQual Inpatient rehabilitation criteria	• Inpatient admissions acute rehabilitation • Continued stay and discharge readiness • Skilled nursing facility admissions
Specialty RX Non-Oncology Specialty RX Oncology	• Specialty medications
Durable medical equipment (DME)/prosthetics and orthotics: CMS Medicare Clinical Coverage Guidelines	• Durable medical equipment • Prosthetics and orthotics

Ascension Personalized Care's Medical Director or other healthcare professional, with appropriate clinical expertise in treating the member's condition or disease, will review all potential adverse determinations and make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from nationally recognized criteria, or other standards mentioned above. Utilization management decision-making is based on appropriateness of care and service and the existence of coverage. Ascension Personalized Care does not provide financial incentives and does not reward clinicians or other individuals for issuing denials of authorizations.

Ascension Personalized Care's Clinical Policies are posted at ascensionpersonalizedcare.com. Clinicians may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 844-995-1145. Clinicians have the opportunity to discuss any adverse decisions with an Ascension Personalized Care doctor or other appropriate reviewer at the time of an adverse determination. The Medical Director may be contacted by calling Ascension Personalized Care at 844-995-1145 and asking for the Medical Director. An Ascension Personalized Care care manager may also coordinate communication between the Medical Director and the requesting clinician.

When the determination is made, notification is sent as follows:

- If the request is approved, ACMIH sends a written notification to the member. Clinicians can look up the status of the request via e-referral.
- If the request is denied, ACMIH sends a letter to the member and the primary care provider and to other doctors and practitioners, as appropriate, explaining the reason(s) for the denial along with instructions for filing an appeal.
- ACMIH's Medical Director provides an opportunity for the clinician of record to review the case prior to issuing a denial. The purpose of the peer-to-peer discussion is to exchange information about the clinical nuances of the member's medical condition and the medical necessity of the requested service. The Medical Director may be contacted by calling Ascension Personalized Care at 844-995-1145 and asking for the Medical Director. An Ascension Personalized Care care manager may also coordinate communication between the Medical Director and the requesting clinician.



Clinical appeal process

Filing an appeal

In cases where an authorization request is denied, the enrollee, or someone acting on the enrollee's behalf, and the clinician of record have the right to appeal an adverse determination (denial) orally or in writing. The appeal will be handled through a structured appeals process. A licensed practitioner not involved in the initial coverage decision will review the appeal. The reviewing practitioner is in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment, as well as treating similar complications of those conditions.

The appealing party must send us the appeal no later **than 180 calendar days after the date of the letter.**

- **Written appeal:** To submit a written appeal, mail, fax or email the written appeal to the following address, fax number or email address:

  Ascension Care Management Insurance Holdings Medical Management
  Attention: Appeal Department
  1345 Philomena St., Suite 305
  Austin, TX 78723
  Fax: 512-380-7507
  Email: SHP-Authorization@ascension.org

- **Oral appeal:** To file an oral appeal, call the following toll-free number: 1-844-995-1145.

Two types of appeals

- **Standard appeal:** Is an appeal for care other than a condition or type of service that qualifies for an expedited appeal.
- **Expedited appeal:** An expedited appeal is available for emergency care, life-threatening conditions, prevention of serious harm, and hospitalized enrollees. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits. An expedited appeal is also available for a denied step therapy protocol exception request.

What to expect after you file the appeal

Within five working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form, but we encourage its return because the form will help us resolve the appeal.

Enrollees/members can look at their medical records, the guidelines, and other information that we used to make our decision. Upon request we'll send this information for free.

If the appeal is about a medical issue, the enrollee's doctor may talk to the licensed practitioner who will be reviewing the appeal.

Deadlines to resolve appeal

Our deadlines to resolve the appeal and send a written decision to the enrollee, or someone acting on the enrollee's behalf, and the doctor of record are:

- **Standard appeal:** 30 calendar days of receipt of the appeal.
- **Expedited appeal:** The shorter of one working day from the date we receive all information necessary to complete the appeal, or 48 hours from when we receive the appeal. We may provide the determination by telephone or electronic transmission but will provide a written determination within the shorter of three working days of the initial telephonic or electronic notification, or 72 hours from when we received your request. Please note that when state or federal time standards differ, the more stringent time standard is applied.
- **Retrospective (claim) Appeal:** 30 calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed 15 days.

External Review (ER) process

If we deny the appeal, the enrollee, someone acting on the enrollee's behalf or the doctor of record have the right to request a review by an external reviewer within 120 days of getting the appeal decision. The external reviewer does not have an affiliation with the health plan, healthcare doctors, or the Utilization Review Agent.

How to request an external (independent) review (ERO)

To request an external review, the enrollee, someone acting on the enrollee's behalf, or the doctor of record will complete the enclosed external review request form and mail, fax or email it to the following address, fax number or email address:

Ascension Care Management Insurance Holdings Medical Management
Attention: Appeal Department
1345 Philomena St., Suite 305
Austin, TX 78723
Fax: 512-380-7507
Email: SHP-Authorization@ascension.org

If the enrollee, enrollee's representative, or doctor of record believes that waiting for an external review will seriously jeopardize the enrollee's life or health, or their ability to attain, maintain, or regain maximum function, the enrollee, enrollee's representative, or doctor of record may request for an expedited external review by completing the expedited review section of the external review request form. The treating doctor must submit documentation stating that a delay would seriously jeopardize the life or health of the enrollee, or would jeopardize the enrollee's ability to regain maximum function.

Deadlines to resolve external review

Our deadlines to resolve the external review request and send a written decision to the enrollee or someone acting on the enrollee's behalf and the doctor of record are:

- **Standard (non-urgent) review:** Written notice of the final external review decision as **expeditiously as possible and no later than 45 days** after the external review organization receives the request for the external review. The enrollee, or person acting on behalf of the enrollee and doctor of record will receive review determinations in writing from us. Please note that when state or federal time standards differ, the more stringent time standard is applied.
- **Expedited review:** Notice of the final external review decision as **expeditiously as the medical circumstances require and within 48 hours** of the external review organization receipt of the request for the external review. We may initially provide the final external review decision orally to the enrollee, or person acting on behalf of the enrollee and doctor of record, but it must be followed up in writing within 48 hours. Please note that when state or federal time standards differ, the more stringent time standard is applied.

Exceptions to the above external review process:

Kansas Members:

Process:

1. You, or your authorized representative, can ask for an external review within 4 months of getting the appeal resolution letter. The request must be written. When the request is made by your provider, acting on your behalf, you or your legally authorized representative must send written authorization. The written request must be sent to:

Kansas Insurance Commissioner Kansas Insurance Department 420 SW 9th Street
Topeka, KS 66612
(785) 296-3071 or (800) 432-2484

Michigan Members:

Process:

1. You, or your authorized representative must complete the Michigan Health Care Request for External Review and send the form to the Michigan Department of Insurance and Financial Services. Your doctor can find the form here: https://www.michigan.gov/documents/difs/FIS_2326_600931_7.pdf. The **request must be submitted within 127 days** after you receive our final adverse determination.
2. If we said the service is experimental and/or investigational, your doctor has to complete the Treating Provider Certification for Experimental/Investigational Denials form and send it in with your request. Your doctor can find the form here: https://www.michigan.gov/documents/difs/FIS_2326_600931_7.pdf
3. You, or your authorized representative may contact the Michigan Department of Insurance and Financial Services (DIFS) as follows:

    DIFS - Office of Research, Rules, and Appeals - Appeals Section
    Phone: 877-999-6442
    Fax: 517-284-8838
    Email: DIFS-HealthAppeal@michigan.gov
    Or visit: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Pharmacy

Cigna is the Pharmacy Benefit Manager (PBM) for the Ascension Personalized Care plan. Cigna will send each member a pharmacy ID card. This Cigna pharmacy ID card must be used for coverage when filling prescriptions, and can only be used for prescription benefits. Ascension Personalized Care medical ID cards cannot be used to fill a prescription.

Pharmacy coverage for members varies based on the plan benefits. Information regarding the member's pharmacy coverage can be found via the secure online Clinician Portal. Additional resources available on the website include formulary, coverage position, ability to submit a prior authorization, and more.

The formulary is a list of covered drugs selected by the plan in consultation with a team of healthcare clinicians, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary includes:

- Which drugs are covered, tier status, including restrictions and limitations.
- Information on prior authorization, quantity limits, step therapy and generic substitution.
- How prescribing doctors can request an exception.

At least quarterly, the plan's formulary is approved by the Cigna's Pharmacy & Therapeutics (P & T) Committee. P & T Committee participants include practicing pharmacists and physicians from various specialties. The formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness as part of a quality treatment program. Positive changes to the formulary are made monthly, while negative changes are made at least twice a year. If a physician feels that a certain medication merits addition to the list, a request can be submitted to the plan, along with supporting clinical data for review by the committee.

Please note: Per state requirements, the Texas formulary will only be updated annually.

The formulary is available to view or download on our website. Clinicians may also call Clinician Services for a printed copy of the formulary.

We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. In addition, the plan provides support for the following:

- Utilization management (including prior authorization requirements)
- Exceptions and appeals
- Locating a nearby pharmacy
- Information about formulary changes

Pharmacy information

Important pharmacy information can be located on cignaforhcp.cigna.com. This includes:

- Formulary
- Coverage position
- Submit prior authorization, and more

Ascension Rx

Referring patients to Ascension Rx for specialty medications is an easy process and will be fully supported by a specialty pharmacist.

- Pharmacy operating hours are Monday through Friday, 9:00 a.m. to 5:00 p.m. EST; however, there is a pharmacist on call 24/7.
- Electronically send prescriptions to Ascension Rx specialty pharmacy or fax to: 855-394-7057.
- If you are an Ascension Medical Group provider, please request prescriptions to be sent to Ascension Rx specialty pharmacy and choose Ascension Rx - Specialty #1303 via the EHR.

Ascension Rx specialty pharmacy address:
30055 Northwestern Highway
Suite 225
Farmington Hills, MI 48334

For more information, please call 855-292-1427.

If you do not have access to an Ascension Rx specialty pharmacy or a local Ascension Rx pharmacy, please refer your Ascension Personalized Care member to Accredo, a Cigna specialty pharmacy at 866-759-1557.

Pharmacy appeals

Cigna's National Appeals Policy consists of a single-level internal appeals process for resolving disputes regarding pre/post-service medical necessity denials of covered benefits, as well as post-service benefits coverage denials. If an issue cannot be quickly resolved prior to appeal, a formal internal appeals process can be initiated in writing, usually up to 180 calendar days from the date of last determination.

In each case, Cigna may be entitled to a one-time extension of not more than 15 days. Expedited appeals are conducted within 72 hours of receipt of the appeal.

Reviewers making appeal determinations are selected to assure that neither they nor their managers were involved in the prior decision.

To submit an appeal with Cigna:

- Standard appeals fax number: 877-815-4827
- Expedited appeals fax number: 860-731-3452
- Mail: Attn: Appeal Coordinator
  P.O. Box 188011
  Chattanooga, TN 37422

Online form at: https://www.cigna.com/static/www-cigna-com/docs/appeal.pdf

Healthcare

Members may see a network doctor, who is contracted with Ascension Personalized Care to provide healthcare services directly, without prior authorization for:

- Medically necessary maternity care
- Covered reproductive health services
- Preventive care (well care) and general examinations
- Gynecological care
- Follow-up visits for the above services
- Emergency care

If the member's healthcare doctor diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Ascension Personalized Care's prior authorization requirements.

Emergency medical condition

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant member, the health of the member or their unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Quality Management Program

Overview

The Quality Management (QM) Program is a coordinated and comprehensive program designed to monitor, assess and improve the quality and appropriateness of care and services provided to members/covered persons with coverage within Ascension Personalized Care. This is accomplished by creating an infrastructure and set of business processes to make the achievement of high quality outcomes and service an integral part of the way Ascension Personalized Care does business.

QMPS program structure

The Ascension Personalized Care Board of Directors (BOD) has the ultimate oversight for the care and service provided to members. The BOD oversees the QM Program and has established various committees and ad-hoc committees to monitor and support the QM Program.

The Quality Management and Patient Safety Committee (QMPSC) is a senior management committee with physician representation that is directly accountable for the QM Program to the BOD. The purpose (at a minimum) of the QMPSC is to:

- Enhance and improve quality of care;
- Promote patient safety for all members;
- Provide oversight and direction regarding policies, procedures, and protocols for member care and services; and,
- Offer guidelines based on recommendations for appropriateness of care and services

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the QMPS, Clinical Care (UM/CM/PH), and Credentialing and Recredentialing programs.

Clinician involvement

Clinician involvement at various levels of the process and feedback is highly encouraged through clinician representation. Ascension Personalized Care promotes primary care clinicians, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QMPSC, Credentials Committee, and select ad-hoc committees.

Quality management program scope and goals

The QM Program is comprehensive, ongoing, and includes effective mechanisms to identify, monitor, evaluate, and resolve issues that impact the accessibility, availability, continuity, and quality of care and service provided to our members. The scope of the QM Program includes a wide range of activities including process and outcomes of clinical care, behavioral health, ancillary services, pharmacy services, vendor services, member services and satisfaction, patient safety and efficient use of resources. The QM Program Description and Work Plan are reviewed and updated at least annually. A copy of the QM Program Description is available to clinicians upon request.

The QM Program activities are categorized by the following: access, quality of care and service, clinical quality, member and provider experience, continuity and coordination, qualified providers, patient safety, compliance and communication.

The QM Program monitors the availability, accessibility, continuity and quality of care and services on an ongoing basis using the established following goals:

1. Maintain a High Quality Network: Monitor the quality of care and services provided by participating providers, practitioners and independently contracted delegates to Ascension Personalized Care.
2. Delivery of Care for Persons with Complex Healthcare Needs: Ensure the delivery and coordination of care of members with complex health needs through case management, complex case management, and effective coordination with services
3. Promote Population Health Management: Act on opportunities for improvement of the health status of members through the development and implementation of population health programs addressing health and wellness promotion, preventive health education, behavioral healthcare, and disease and case management programs.
4. Ensure Patient Safety: Maximize the safety and quality of health care delivered to members through the continuous quality improvement process.
5. Provide the Ultimate Member and Provider Experience: Maintain a high level of member and provider experience with the services provided by Ascension Personalized Care.
6. Achieve and Sustain Regulatory and Compliance Goals: Maintain compliance with local, state and federal regulatory requirements and accreditation standards (e.g, URAC).

Activities and outcomes of the QM Program may be communicated to both members and or clinicians through avenues such as the member newsletter, the clinician newsletter and the Ascension Personalized Care website.

Patient safety and quality of care

The role of Ascension Personalized Care in improving patient safety involves fostering a supportive environment to assist practitioners and providers in maintaining a safe practice. Ascension Personalized Care's commitment to patient safety include but is not limited to the following:

- Distributing information to members, practitioners, and providers which improves knowledge regarding clinical safety as it relates to self-care;
- Focusing on improving patient safety in existing QI Activities; and,
- Distributing information to members, practitioners, and other providers which facilitate informed decisions.

Ascension Personalized Care collaborates with network clinicians and providers to improve the safety of clinical care. These activities may include but are not limited to:

- Conducting initiatives to improve continuity and coordination of care between practitioners/providers;
- Providing performance data to members and practitioners/providers;
- Investigating potential Quality of Care (QOC) concerns; and,
- Encouraging the use of electronic health record systems (EHR) and e-prescribing.

Potential Quality of Care (QOC) concerns may be referred by Ascension Personalized Care associates (including UM, CM, member services, and or compliant coordinators), network clinicians, facilities or ancillary providers, members or member representatives, Medical Directors, or the BOD. Potential QOC concerns require investigation of the situation in order to make a determination of severity and the need for corrective action up to and including review by the Peer Review Committee and or Credentialing Committee. These concerns are tracked and monitored for trends in occurrence, regardless of the outcome or severity level.

Continuous Quality Improvement (CQI) model

Selection of CQI Initiatives begins using the Continuous Quality Improvement (CQI) principles of performance evaluation, determining if efforts require new or continued projects, then prioritizing based on criteria. Often, CQI initiatives are selected based on problems, issues, and trends supported by reliable and comparable data. All QI projects are developed with consideration of Ascension Personalized Care values and goals.
The Plan/Do/Study/Act model is Ascension Personalized Care's overall framework for continuous process improvement. Targeted interventions with the greatest potential for improving health outcomes or service standards are designed using cross-functional teams and clinician input (as appropriate).

Claims

Claim filing procedures

How to file a claim for professional services

Please note the changes to timely filing deadlines for out-of-network doctors effective September 1, 2023.

Ascension Network doctors should submit claims as follows:

What	When	Where	How
All claims	**In-network:** Claims must be received by Ascension Personalized Care within 180 days from the date of service. Claims received outside of this timeframe will be denied for untimely submission. **Out-of-network - Indiana, Kansas, Tennessee and Texas:** Claims must be received by Ascension Personalized Care within 95 days from the date of service. Claims received outside of this timeframe will be denied for untimely submission. - Effective September 1, 2023 **Out-of-network - Michigan:** Claims must be received by Ascension Personalized Care within 60 days from the date of service. Claims received outside of this timeframe will be denied for untimely submission. - Effective September 1, 2023	Submit electronic claims to one of the vendors below.**	Electronic Claims: Submit under Payer ID 38259**

****EDI clearinghouses currently contracted:** Change Healthcare

To avoid rejected claims, please include the following:

- Member ID number
- Patient's name
- Patient's birthdate and sex
- Insured's group number
- Indication of auto/employment/emergency-related condition (when applicable)
- Pre-certification number — include referral or precertification when applicable
- Name of referring doctor. If the patient self-referred, type "self"
- Diagnosis code (ICD-10-CM)
- Date of service
- Procedure code (CPT/HCPCS when applicable, with appropriate modifiers)
- Billed charges
- Number of units
- Total charges
- Provider Tax ID Number
- Provider NPI Number
- Provider's billing address and phone number
- Include NDC number (when applicable)

Ascension Personalized Care will return claims missing any of the above information to the doctor for completion.

Ascension Personalized Care has the ability to receive direct electronic ANSI X12 EDI transmissions via our direct portal established through our Change HealthCare. The process can be initiated by submitting an email to Ascension Personalized Care at edisupport@abs-tpa.com, with the information below. Once the information is received, we will have a representative contact you and begin the implementation process.
The information we would need to provision is: Submitter name ISA06 (sender ID) – usually tax ID Contact name Contact email Contact phone Transfer method (manual or SFTP) For those doctors not set up electronically, Change HealthCare also makes available an online data entry system that allows doctors the ability to enter and submit claims. Information on this process is available upon request.

Clean claim definition

"Clean claim" means a claim that has no defect, impropriety, lack of any required substantiating documentation — including the substantiating documentation needed to meet the requirements for encounter data — or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Upfront rejections

An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located in the Appendix of this manual. A list of common upfront rejections can be located in Appendix I of this manual. Upfront rejections will not enter our claims adjudication system, so there will be no explanation of payment (EOP) for these claims. The doctor will receive a letter or a rejection report if the claim was submitted electronically.

Who can file claims

All clinicians who have rendered services for Ascension Personalized Care members can file claims. It is important that clinicians ensure Ascension Personalized Care has accurate and complete billing information on file. Please confirm with the Clinician Services department or Clinician Partnership Manager that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Group National Provider Identifier (NPI) (if applicable)
- Tax Identification Number (TIN)
- Taxonomy code (This is a required field when submitting a claim)
- Physical location address (as noted on current W-9 form)
- Billing name and address (as noted on current W-9 form)

We recommend that clinicians notify Ascension Personalized Care 60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end-of-the-year 1099 IRS form will be mailed, a new W-9 form will be required. Changes to a clinician's TIN and/or address are not acceptable when conveyed via a claim form.

Specific data record requirements

Claims transmitted electronically must contain all of the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements.

Invalid electronic claim record upfront rejections/denials

All claim records sent to Ascension Personalized Care must first pass the clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Ascension Personalized Care. In these cases, the claim must be corrected and resubmitted within the required filing deadline, as previously mentioned in the Timely Filing section of this manual. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to 833-600-1311.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

Specific electronic edit requirements – 5010 information
Institutional claims – 837Iv5010 Edits
Professional claims – 837Pv5010 Edits

Corrected EDI claims
CLM05-3 required 7 or 8
IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned
Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76)

Exclusions
The following inpatient and outpatient claim types are excluded from EDI submission options and must be filed on paper:

- Claim records requiring supportive documentation or attachments, i.e. consent forms. (Note: COB claims can be filed electronically).
- Medical records to support billing miscellaneous codes.
- Claims for services that are reimbursed based on purchase price, i.e., custom DME, prosthetics. The clinician is required to submit the invoice with the claim.
- Claims for services requiring clinical review, i.e. complicated or unusual procedure. A clinician is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity, i.e., oxygen, motorized wheelchairs.

Important steps to a successful submission of EDI claims:

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse regarding what data records are required.
3. Verify with Clinician Services that the clinician is set up in the Ascension Personalized Care system prior to submitting EDI claims.
4. You will receive two reports from the clearinghouse. **Always** review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Ascension Personalized Care, and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Ascension Personalized Care. ALWAYS review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit.
5. **Most importantly,** all claims must be submitted with clinicians identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Acceptable forms

Ascension Personalized Care only accepts the original red and white CMS 1500 (02/12) and CMS 1450 (UB-04) paper claims forms. Other claim form types will be upfront rejected and returned to the clinician. This includes black and white forms, as well as forms with handwriting.

Professional clinicians and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Ascension Personalized Care does not supply claim forms to clinicians. Clinicians should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten and nonstandard forms will be upfront rejected and returned to the clinician. To reduce document handling time, do not use highlights, italics, bold text or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact Clinician Services.

Important steps to successful submission of paper claims:

1. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. **Note:** Non-red and handwritten claim forms will be rejected back to the clinician.
2. Ensure all diagnosis codes, procedure codes, modifier, location (place of service), type of bill, type of admission, and source of admission codes are valid for the date of service.
3. Ensure all diagnosis and procedure codes are appropriate for the age and sex of the member.
4. Ensure all diagnosis codes are coded to their highest number of digits available.
5. Ensure member is eligible for services during the time period in which services were provided.
6. Ensure that services were provided by a participating clinician or that the “out-of-network” clinician has received authorization prior to providing services to the eligible member.
7. Ensure an authorization has been given for services that require prior authorization by Ascension Personalized Care.

Claims missing the necessary requirements are not considered “clean claims” and will be returned to clinicians with a written notice describing the reason for return.

Corrected claims, requests for reconsideration or claim disputes

All requests for corrected claims, reconsiderations or claim disputes must be received within 180 calendar days from the original claim filing date. Prior processing will be upheld for corrected claims or clinician claim requests for reconsideration or disputes received outside of 180 days from the original claim filing date, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operation of the clinician, or damage or destruction of the clinician’s business office or records by a natural disaster, mechanical, administrative delays or errors by Ascension Personalized Care or the federal and/or state regulatory body.
- The member was eligible; however the clinician was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
    - The clinician’s records document that the member refused or was physically unable to provide their ID card or information.
    - The clinician can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered.
    - The clinician has not filed a claim for this member prior to the filing of the claim under review.

Below are relevant definitions:

- Corrected claim – A clinician is submitting a correction to the original claim.
- Request for reconsideration – Clinician disagrees with the original claim outcome (payment amount, denial reason, etc.).
- Claim dispute – Clinician disagrees with the outcome of the request for reconsideration.

Corrected claims

All requests for corrected claims must be received within 180 calendar days from the original claim filing date. Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim electronically via Change Healthcare (Payer ID: 38259)
    - Institutional claims (UB): Field CLM05-3=7 and Ref*8 = original claim number
    - Professional claims (CMS): Field CLM05-3=7 and REF*8 = original claim number
- Submit a corrected paper claim to:

Ascension Personalized Care
PO Box 1707
Troy, MI 48099-1707

- The original claim number must be typed in field 22 (CMS 1500) and in field 64 (UB-04) with the corresponding frequency codes (7 = replacement or corrected; 8 = voided or canceled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form
- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected

Request for reconsideration

A request for reconsideration is a communication from the clinician about a disagreement with the manner in which a claim was processed. All requests for reconsideration must be received within 180 days from the original claim filing date. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit or authorization denial, medical records must accompany the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. Written Letter — Clinicians may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information which includes, at a minimum, the member name, member ID number, date of service, total charges, clinician name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a UB-04 form. The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or canceled) in field 22 of the CMS 1500 and in field 4 of the UB-04 form

Requests for reconsideration and any applicable attachments must be mailed to:

Ascension Personalized Care
PO Box 1707
Troy, MI 48099-1707

Claim dispute

A claim dispute should be used only when a clinician has received an unsatisfactory response to a request for reconsideration.

A claim dispute must be submitted on a claim dispute form found on our website. The claim dispute form must be completed in its entirety. The completed claim dispute form may be mailed to:

Ascension Personalized Care
PO Box 1707
Troy, MI 48099-1707

If the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the clinician will receive a revised explanation of payment (EOP). If the original decision is upheld, the clinician will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Ascension Personalized Care shall process, and finalize all corrected claims, requests for reconsideration and disputed claims to a paid or denied status in accordance with law and regulation.

Electronic funds transfer (EFT) and electronic remittance advices (ERA)

Ascension Personalized Care partners with specific vendors to provide an innovative web-based solution for electronic funds transfers (EFTs) and electronic remittance advice (ERAs). Clinicians are able to enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact Clinician Services.

Benefits include:

- Elimination of paper checks — All deposits transmitted via EFT to the designated bank account.
- Convenient payments and retrieval of remittance information.
- Electronic remittance advice presented online.
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System.
- Reduce accounting expenses – Electronic remittance advice can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improve cash flow – Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts — You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advice quickly – You can associate electronic payments with electronic remittance advice quickly and easily.
- Manage multiple payers – Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.

For more information, please visit our clinician home page on our website at ascensionpersonalizedcare.com. If further assistance is needed, please contact our Clinician Services department at Ascension Personalized Care Phone: 833-600-1311

Risk adjustment and correct coding

Risk adjustment is critical and a requirement to report defined in HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes (Section 1343). Section 1343 of the ACA established a permanent risk adjustment program in which states collect charges from health insurance issuers that enroll lower-than-average risk populations and provide payments to health insurance issuers that enroll higher-than-average-risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to avoid higher-risk enrollees. Accurate calculation of risk adjustment requires accuracy, documentation completeness, and specificity in diagnostic coding. Clinicians should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines CPT, DSM-IV, and HCPCs code sets. Clinicians should note the following guidelines:

- Code all diagnoses to the highest level of specificity, making sure they are defensible through chart audits and medical assessments.
- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment, or management. Documentation for any listed diagnosis must include "MEAT" (M)onitoring, (E) valuation, (A)ssessment, or (T)reatment. Only one of the criteria is required, not all.
- Ensure that medical record documentation is clear, concise, consistent, complete and legible, and meets CMS signature guidelines (each encounter must stand alone).
- Submit claims and encounter information according to the requirements specified in your contract or this clinician manual.
- Alert Ascension Personalized Care of any erroneous data submitted and follow Ascension Personalized Care's policies to correct errors as set forth in your contract or this clinician manual.
- Provide ongoing training to your staff regarding appropriate use of ICD-10-CM coding for reporting diagnoses.
- Medical records created and maintained by providers must correspond to and support the hospital inpatient, outpatient, and physician diagnoses submitted by the provider to us. In addition, regulations require that providers submit samples of medical records for validation of risk-adjustment data and the diagnoses reported to CMS, as required by CMS. Therefore, providers must give access to and maintain medical records in accordance with Medicare and state laws, rules, and regulations.

Coding of claims/billing codes

Ascension Personalized Care requires claims to be submitted using codes from the current version of ICD-10-CM, ICD-10-PCS and CPT/HCPCS (including Level II), along with NDCs for the date services were rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Diagnosis or procedure code billed is missing, invalid, or deleted at the time of service.
- Diagnosis or procedure code inappropriate for the age or sex of the member.
- Diagnosis code missing.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as a primary diagnosis code.
- Procedure code billed is inappropriate for the location or specialty billed.
- Procedure code billed is a part of a more comprehensive code billed on the same date of service.

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims, or at the request of Ascension Personalized Care.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. A mother and a newborn each require a separate claim to be submitted.

Services from rural health clinics (RHC) and federally qualified health centers (FQHC) for covered RHC/FQHC services furnished to members should also be billed with the appropriate CPT code/modifier combinations and diagnosis codes to the highest level of specificity, based on the patient condition.

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated which are not the reason for visit today and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Additions and terminations

IN, KS, MI and TN: Please notify Ascension Personalized Care Network Services of any clinician additions, terminations or changes in status by completing the Clinician Network Maintenance Grid and submitting it to Ascension Personalized Care at acmproviders@ascension.org. See the Clinician Effective Date Policy below for detailed information on the processing time of clinician data as it relates to effective dates.

TX: All clinicians on Seton Health Plan contracts must send their additions, terminations or changes in status to SHPProviderservices@seton.org.

If you need a copy of the Clinician Network Maintenance Grid, contact Network Services at acmproviders@ascension.org or by calling the toll-free number, 855-288-6747.

Interested in becoming an Ascension Network clinician? Email acmproviders@ascension.org for details and requirements.

Clinician effective date policy

This policy provides the guidelines for submitting Ascension Care Management Network credentialed clinician rosters (additions, terminations and changes) for inclusion in the Ascension Care Management Network.

It is preferable to receive the submission of new clinician data the month before the desired effective date of the clinician in the Ascension Care Management Network.

Any clinician additions, terminations or changes submitted in the current month will be implemented effective the 1st of the following month.

Example: Clinician update received on June 20. The clinician update will be effective July 1.

Note: If data submission is received by the 15th, but the information provided is incomplete or inaccurate, then Ascension Personalized Care will process it the 1st of the month, following receipt of correct and complete data.

Claim status inquiry process

You may inquire about payment of claims either online or by phone, fax, or mail. You may make online inquiries 10 days after the claim was electronically submitted or submit other inquiries 30 days after the claim was submitted.

You can request a six-month history of claims submitted to Ascension Personalized Care by fax recall. Call **833-600-1311**. Follow the prompt; enter your contract number, tax ID number, and fax number.

When	How	What's needed?	When can a response be expected?
10 days after filing electronic claim	Online: **secure.healthx.com/ provider_22**	Use your Ascension Personalized CareClinician Web Portal login.	Immediate
30 days after filing the claim	By phone: **833-600-1311**	A copy of the outstanding claim for reference. Please limit calls to 3 claims	Immediate
	By fax recall: **888-494-4600**	Follow prompts; enter contract number, tax ID number and fax number.	Within 2-3 minutes, a return fax will detail the 6-month claims history for your tax id number.
	By mail: **Ascension Personalized Care PO Box 1707 Troy, MI 48099-1707**	An original claim form stamped "status inquiry" in red ink in the upper right hand corner.	Within 21 days from receipt of the inquiry.

Ascension Personalized Care is committed to resolving all payment inquiries in an efficient manner. If you are unable to resolve a payment inquiry after 30 days from the initial request, please contact the Ascension Personalized Care Customer Service Supervisor. Provide documentation of the original request so Ascension Personalized Care can address the service delay. You can expect resolution within 10 business days.

Please have the following information available when calling the Customer Service Supervisor:

Type of inquiry	Information required
Written	• Copy of the status inquiry claim
Phone	• Date of the original inquiry • Name of the assisting Ascension Personalized Care service representative • Status of the claim at the time of the call • Expected outcome

Claim adjustments

The Plan is allowed to **recoup payments** made to facilities and clinicians when the payment has been made in error. Overpayments may be identified by **ABS, the clinician, and/or the member (claimant).**

A claim may be overpaid for several reasons, including, but are not limited to, the following:

- Claim was paid incorrectly, as per clinician's network contract.
- Clinician canceled the charge for any reason.
- COB - Credit or duplicate payment received by clinician.
- "Not our patient" – Payment received by clinician who did not render services.
- Medicare eligible or Workers Compensation payment already made.
- Third-party liability determined.

Overpayment policy

In accordance with Clinician Relations/Operations, it is the policy of Ascension Personalized Care and Automated Benefit Services (ABS) to follow the time limitations listed below when requesting overpayment dollars from clinicians.

- **Adjustment/notification date for recovery will be limited to 12 months** from date of payment,unless identified through a medical record audit, in which case adjustment/notification date for recovery will be limited to 18 months from the date the clinician is notified of an audit (as these audits would be initiated prior to the payment of the claim).
- **Fraud and abuse:** Adjustment/notification date for recovery time period will be the statute of limitations of the state where the services are performed.

Refund request

When an overpayment is identified by ABS, a refund request is sent to the clinician (payee) explaining the reason for the request. If a response is not received from the payee, two follow-up letters are sent.

- If a telephone or written response is not received, or **if the amount of the overpayment is not returned within 120 days** of the follow-up letter date, Ascension Personalized Care will refer the file to an overpayment recovery service vendor contracted by ABS.

Clinician-initiated adjustments

Ascension Personalized Care will consider payment adjustments to processed claims if:

- The original claim was submitted with incorrect information.
- Payment was made to the incorrect clinician.
- Payment was made at the incorrect contracted amount.
- Payment was not made due to a processing error.
- Coordination of benefits was calculated incorrectly.
- Clinician received a duplicate payment.

What's needed?	How to submit	Timeframe to submit	Timeframe to process
1. Copy of EOB 2. Reason for request 3. Supporting documentation 4. Copy of original claim 5. (if applicable)	**By phone:** Call 833-600-1311 for assistance to handle processing errors. **Written (Mail to ABS):** Fill out the request form and attach the required data.	Submit requests for adjustments within 180 days from the date the claim was processed.	Ascension Personalized Care will process adjustment requests within 30 days after receiving all necessary information. Clinicians will receive a final copy of the adjustment request when completed.

Please have the following information available when calling ABS:

Type of original inquiry	Information required
Written	• Copy of the status inquiry claim
Phone	• Date of the original inquiry • Name of the assisting Ascension Personalized Care service representative • Status of the claim at the time of the call • Expected outcome

Clinician reimbursement rules/sample EOB

Automated Benefit Services (ABS) processes claims received from Ascension Personalized Care clinicians. If you submit a claim with all required information, Ascension Personalized Care will process your claim within 30 calendar days of receipt. An Explanation of Benefits (EOB) will accompany payment for each service billed.
Here's a sample of an Ascension Network EOB and check:

Ascension Personalized Care uses various vendors to review all claims for unbundling, upcoding and other billing anomalies. This review significantly reduces payment errors and identifies savings that reduce overall healthcare costs.

Payment for multiple procedures

Ascension Personalized Care follows CMS guidelines to pay for multiple surgical procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day.

Ascension Personalized Care pays for multiple surgeries by ranking from the highest contracted amount to the lowest contract amount. When the same physician performs more than one surgical service in the same session, the allowed amount is 100% for the surgical code with the highest contracted amount. For subsequent surgical codes, the allowed amount is 50% of the contracted amount.

Code editing

Ascension Personalized Care uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. The software detects and documents coding errors on clinician claims prior to payment by analyzing diagnosis, procedure, modifier and place of service codes against correct coding guidelines. While code auditing software is a useful tool to ensure clinician compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, Ascension Personalized Care uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. Ascension Personalized Care may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to ascensionpersonalizedcare.com policies and to facilitate accurate claims reimbursement.

Ascension Personalized Care may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with correct coding guidelines.

Code editing and the claims adjudication cycle

Code editing is the final step in the claims adjudication process. Once a claim has completed all previous adjudication steps (such as benefits and member/clinician eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim, as well as previously paid claims found in the member/clinician history.

Claim reconsiderations related to code editing

Claims appeals resulting from claim editing are handled per the clinician claims dispute process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

If you disagree with a code edit and request claim reconsideration, you must submit documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code edit will be upheld.

The reconsideration may include this type of information:

- Statement of why the service is medically necessary.
- Medical evidence which supports the proposed treatment.
- How the proposed treatment will prevent illness or disability.
- How the proposed treatment will alleviate physical, mental or developmental effects of the patient's illness.
- How the proposed treatment will assist the patient to maintain functional capacity.
- A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
- How the recommended service has been successful in other patients.

Billing the member

Failure to obtain authorization

Clinicians may **not** bill members for services when the clinician fails to obtain an authorization and the claim is denied by Ascension Personalized Care.

No balance billing

Clinicians may not seek payment from Ascension Personalized Care members for the difference between the billed charges and the contracted rate paid by Ascension Personalized Care.

Member rights and responsibilities

Member rights

Clinicians must comply with the rights of members as set forth below:

- To participate with clinicians in making decisions about their healthcare. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options.
- To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.
- To receive the benefits for which the member has coverage.
- To be treated with respect and dignity.
- To the privacy of their personal health information, consistent with state and federal laws, and Ascension Personalized Care policies.
- To receive information or make recommendations, including changes, about Ascension Personalized Care's organization and services, the Ascension Personalized Care network of clinicians, and member rights and responsibilities.
- To candidly discuss with their clinicians appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefits coverage. This includes information from the member's primary care physician about what might be wrong (to the level known), treatment and any known likely results. The clinician must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The clinician will ask for the member's approval for treatment unless there is an emergency and the member's life and health are in serious danger.
- To make recommendations regarding the Ascension Personalized Care member's rights, responsibilities and policies.
- To voice complaints or appeals about: Ascension Personalized Care, any benefits or coverage decisions Ascension Personalized Care makes, Ascension Personalized Care coverage, or the care provided.
- To participate with practitioners in making decisions about their care and the right to refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by the clinician(s) of the medical consequences.
- To see their medical records.
- To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, clinicians, advance directive information, referrals and authorizations, benefits denials, member rights and responsibilities, and other Ascension Personalized Care rules and guidelines. Ascension Personalized Care will notify members before the effective date of the modifications. Such notices shall include the following:
- Any changes in clinical review criteria.
- A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.
- To have access to a current list of network clinicians. Additionally, a member may access information on network clinicians' education, training, and practice.
- To select a health plan or switch health plans, within the guidelines, without any threats or harassment.

- To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin or religion.
- To access medically necessary urgent and emergency services 24 hours a day and seven days a week.
- To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability.
- To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the clinician's instructions are not followed. The member should discuss all concerns about treatment with their primary care physician or other clinician. The primary care physician or other clinician must discuss different treatment plans with the member. The member must make the final decision.
- To select a primary care provider within the network. The member has the right to change their primary care provider or request information on network clinicians close to their home or work. Members are not required to select a primary care provider.
- To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care physician.
- To have access to an interpreter when the member does not speak or understand the language of the area.
- To a second opinion by a network physician, at no cost to the member, if the member believes that the network clinician is not authorizing the requested care, or if the member wants more information about their treatment.
- To execute an advance directive for healthcare decisions. An advance directive will assist the primary care provider and other clinicians to understand the member's wishes about the member's healthcare. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:
    - Living will
    - Health Care power of attorney
    - "Do not resuscitate" orders

Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

Member responsibilities

1. To read their Ascension Personalized Care contract in its entirety.
2. To treat all healthcare professionals and staff with courtesy and respect.
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their clinician so they understand the care they are receiving.
4. To review and understand the information they receive about Ascension Personalized Care. The member needs to know the proper use of covered services.
5. To show their ID card and keep scheduled appointments with their clinician, and call the clinician's office during office hours whenever possible if the member has a delay or cancellation.
6. The member should establish a relationship with a primary care provider. The member may change their primary care provider at any time.
7. To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it.
8. To understand their health problems and participate, along with their healthcare clinicians, in developing mutually agreed upon treatment goals to the degree possible.

9. To supply, to the extent possible, information that Ascension Personalized Care and/or their clinicians need in order to provide care.
10. To follow the treatment plans and instructions for care that they have agreed on with their healthcare clinicians.
11. To understand their health problems and tell their healthcare clinicians if they do not understand their treatment plan or what is expected of them. The member should work with their primary care provider to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision.
12. To follow all health benefits plan guidelines, provisions, policies and procedures.
13. To use any emergency room only when they think they have a medical emergency. For all other care, the member should call their primary care provider.
14. To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Ascension Personalized Care coverage, the member must provide this information to Ascension Personalized Care.
15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

Clinician rights and responsibilities

Clinician rights

1. To be treated by their patients, who are Ascension Personalized Care members, and other healthcare workers with dignity and respect.
2. To receive accurate and complete information and medical histories for members' care.
3. To have their patients, who are Ascension Personalized Care members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
4. To expect other network clinicians to act as partners in members' treatment plans.
5. To expect members to follow their healthcare instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Ascension Personalized Care and/or a member.
7. To file a grievance on behalf of a member, with the member's consent.
8. To have access to information about Ascension Personalized Care quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
9. To contact Clinician Services with any questions, comments, or problems.
10. To collaborate with other healthcare professionals who are involved in the care of members.
11. To not be excluded, penalized, or terminated from participating with Ascension Personalized Care for having developed or accumulated a substantial number of patients in Ascension Personalized Care with high-cost medical conditions.
12. To collect member cost shares at the time of the service.

Clinician responsibilities

Clinicians must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information regarding the nature of treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered.
    - Be informed of risks and consequences associated with each treatment option or choosing to forgo treatment as well as the benefits of such treatment options.
2. To treat members with fairness, dignity, and respect.
3. To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high-cost care.
4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the clinician's practice and scope of service.
6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
7. To allow members to request restrictions on the use and disclosure of their personal health information.

8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
9. To provide clear and complete information to members — in a language they can understand — about their health condition and treatment, regardless of cost or benefits coverage, and allow member participation in the decision-making process.
10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
12. To respect members' advance directives and include these documents in their medical record.
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
14. To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
15. To follow all state and federal laws and regulations related to patient care and rights.
16. To participate in Ascension Personalized Care data collection initiatives, such as healthcare effectiveness data and information set (HEDIS) and other contractual or regulatory programs.
17. To review clinical practice guidelines distributed by Ascension Personalized Care.
18. To comply with the Ascension Personalized Care Medical Management program as outlined herein.
19. To disclose overpayments or improper payments to Ascension Personalized Care.
20. To provide members, upon request, with information regarding the clinician's professional qualifications, such as specialty, education, residency, and board certification status.
21. To obtain and report to Ascension Personalized Care information regarding other insurance coverage the member has or may have.
22. To give Ascension Personalized Care timely, written notice if the clinician is leaving/closing a practice.
23. To contact Ascension Personalized Care to verify member eligibility and benefits, if appropriate.
24. To invite member participation in understanding any medical or behavioral health problems that the member may have, and to develop mutually agreed upon treatment goals, to the extent possible.
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
26. To object to providing relevant or medically necessary services on the basis of the clinician's moral or religious beliefs or other similar grounds.
27. To provide hours of operation to Ascension Personalized Care members which are no less than those offered to other patients.

Regulatory matters

Medical records

Ascension Personalized Care requires all clinicians (doctor, hospital and ancillary) to maintain sound medical record keeping practices that are consistent with Ascension Personalized Care's medical records guidelines. Ascension Personalized Care requires that records be maintained in compliance with all HIPAA regulations and other federal and state laws. Records must be kept in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review. Whether using paper or electronic record keeping systems, medical records need to be identifiable by the patient name and be accessible. To ensure the member's privacy, medical records should be kept in a secure location. Ascension Personalized Care requires clinicians to maintain all records for members for at least 10 years after the final date of service, unless a longer period is required by applicable state or federal law. Medical records must be accessible at the site of the member's PCP or other clinician.

Required information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: clinician notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. X-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care physician or clinician. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Clinicians must maintain complete medical records for members in accordance with the standards set forth below:

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the clinician rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list, and all past and current diagnoses are noted.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record. If no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in a chart for adults.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant members, or infant risk assessment for newborns.

- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- There is review of underutilization or overutilization of consultants.
- If a consultation is requested, there's a note from the consultant in the record.
- Consultation, laboratory and image reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans. All entries should be initialed by the rendering clinician and or primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary clinicians are documented, including follow up of outcomes and summaries of treatment rendered elsewhere, including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 12 years and over, appropriate notations concerning use of tobacco, alcohol and substance use. (For members seen three or more times, substance abuse history should be queried.)
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Medical records release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

All releases of specific clinical or medical records for substance use disorders must meet federal guidelines at 42 CFR part 2 and any applicable state laws.

Compliance audits for medical record documentation

Ascension Personalized Care may audit record-keeping practices and individual member medical records in conjunction with ongoing Quality Improvement Program activities, utilizing the standards listed above. Clinicians scoring less than 80% on medical record audits may be placed under a corrective action plan, subject to additional medical record reviews, or referred to Ascension Personalized Care's Quality Management and Patient Safety Committee (QMPSC) for recommendations.

Ascension Personalized Care encourages clinicians to request medical records that document care previously provided to members that are new to their panel. This will assist in assuring the member receives continuous care, as well as helping determine the most appropriate course of treatment for the patient.

Medical records transfer for new members

All clinicians are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Ascension Personalized Care members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous clinicians, then this should also be noted in the medical record.

Medical records audits

Ascension Personalized Care will conduct random medical record audits as part of its Quality Management Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Ascension Personalized Care will provide written notice prior to conducting a medical record review.

Access to records and audits by Ascension Personalized Care

Subject only to applicable state and federal confidentiality or privacy laws, clinician shall permit Ascension Personalized Care or its designated representative access to clinician's records, at clinician's place of business in this state during normal business hours, or remote access of such records, in order to audit, inspect, review, perform chart reviews, and duplicate such records. If the audit needs to be performed on site, Ascension Personalized Care or its designated representative will provide at least 30 business days prior written notice to request access to records for the purpose of an on-site audit. The audit shall be scheduled at mutually agreed upon times, but not more than 60 days following such written notice.

Electronic Medical Record (EMR) access

Clinicians will grant Ascension Personalized Care access to clinicians' electronic medical record (EMR) system in order to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to Ascension Personalized Care for this access.

Federal and state laws governing the release of information

The release of certain information is governed by a myriad of federal and/or state laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and clinicians, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the state level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA — Please visit the Centers for Medicare & Medicaid Services (CMS) website at: cms.hhs.gov and then select "Regulations and Guidance" and "HIPAA – General Information."
- Part 2 regulations — Please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: samhsa.gov.
- State laws — consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted clinicians within the Ascension Personalized Care network are independently obligated to know, understand and comply with these laws.

Ascension Personalized Care takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Ascension Personalized Care Compliance Officer by phone at 833-600-1311 or by email at ascensionpersonalizedcare.com with any questions about our privacy practices.

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS.
- Any health program or activity that HHS itself administers.
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

For more information please visit.hhs.gov/civil-rights/for-individuals/section-1557/index.html

Health Insurance Portability and Accountablity Act

To improve the efficiency and effectiveness of the healthcare system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for electronic healthcare transactions and code sets, unique health identifiers and security, as well as federal privacy protections for individually identifiable health information. The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare and Medicaid Services (CMS), and include:

- Transactions and code sets standards
- Employer identifier standard
- National Provider Identifier standard

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules. A summary of the HIPAA Administrative Simplification Rules can be found at CMS.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/.

Privacy regulations

The Privacy rules regulate who has access to a member's personally identifiable health information (PHI) whether in written, verbal or electronic form. In addition, this regulation affords individuals the right to keep their PHI confidential, and in some instances, from being disclosed.

In compliance with the privacy regulations, Ascension Personalized Care has provided each Ascension Personalized Care member with a privacy notice, which describes how Ascension Personalized Care can use or share a member's health records and how the member can get access to the information. In addition, the Member Privacy Notice informs the member of their healthcare privacy rights and explains how these rights can be exercised. Copies of Ascension Personalized Care's Member Privacy Notices can be found at ascensionpersonalizedcare.com.

1. As a clinician, if you have any questions about Ascension Personalized Care's privacy practices, contact the Ascension Personalized Care Compliance Officer at 833-600-1311.
2. Members should be directed to Ascension Personalized Care's Member Services department with any questions about the privacy regulations. Member Services can be reached at Ascension Personalized Care Phone, 833-600-1311.

The Security Rule

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by Ascension Personalized Care. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of electronic protected health information. The Security Rule is located at 45 CFR Part 160, and Subparts A and C of Part 164.

The Breach Notification Rule

On January 25, 2013, the Office for Civil Rights (OCR) of the United States Department of Health and Human Services (HHS) published in the Federal Register a final omnibus rule that revises certain rules promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These revised rules were issued pursuant to changes enacted by Congress in the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Nondiscrimination (GINA) Act of 2008. Effective March 23, 2013, the Final Rule implements section 13402 of the HITECH Act by requiring various notifications following a breach of unsecured protected health information.

The Final Rule eliminates the significant risk of harm standard from the Interim Rule for determining whether a breach has occurred. Covered entities and business associates must ensure compliance with regulatory definitions relating to breach notifications.

Transactions and code sets regulations

Transactions are activities involving the transfer of healthcare information for specific purposes. Under HIPAA, if Ascension Personalized Care or a healthcare clinician engages in one of the identified transactions, they must comply with the standard for it, which includes using a standard code set to identify diagnoses and procedures. The Standards for Electronic Transactions and Code Sets, published August 17, 2000, and since modified, adopted standards for several transactions, including claims and encounter information, payment and claims status. Any healthcare clinician who conducts a standard transaction also must comply with the Privacy Rule.

Version 5010 refers to the revised set of HIPAA electronic transaction standards adopted to replace the current standards. Every standard has been updated, including claims, eligibility and referral authorizations.

All HIPAA-covered entities must be using version 5010 as of January 1, 2012. Any electronic transaction for which a standard has been adopted must have been submitted using version 5010 on or after January 1, 2012.

HIPAA-required code sets

The HIPAA Code Sets regulation requires that all codes utilized in electronic transactions are standardized, utilizing national standard coding. Only national standard codes can be used for electronic claims and/or authorization of services. Nationally recognized code sets include:

1. Health Care Common Procedure Coding System (HCPCS) — This code set, established by the CMS, primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes, which can be purchased from the American Medical Association (AMA) at 1-800-621-8335.
2. Current Procedure Terminology (CPT) codes- The CPT codes are used to describe medical procedures, and this code set is maintained by the American Medical Association. For more information on the CPT codes, please contact the AMA.
3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 and 2 (diagnosis codes) — These are maintained by the National Center for Health Statistics and Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).
4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) — Those are maintained by CMS.
5. International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM- This is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 and 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, Volume 3, and two parts:
    - Part 1: ICD-10-CM for diagnosis coding. ICD-10-CM is for use in all U.S. Healthcare settings. Diagnosis coding under ICD-10-CM uses three to seven digits instead of the three to five digits used with ICD-9-CM, but the format of the code sets is similar.
    - Part 2: ICD-10-PCS for inpatient procedure coding. ICD-10-PCS is for use in U.S. Inpatient hospital settings only. ICD-10-PCS uses seven alphanumeric digits instead of the three or four numeric digits used under ICD-9-CM procedure coding. National Drug Code (NDC). The NDC is a code that identifies the vendor (manufacturer), product and package size of all medications recognized by the Federal Drug Administration (FDA). To access the complete NDC code set, see fda.gov/Drugs/InformationOnDrugs/ucm142438.htm.

HIPAA-regulated transactions

Below are the 10 electronic standardized transactions that are mandated by the HIPAA legislation:

1. Transaction name
2. HIPAA transaction number
3. Claims and encounters
4. Enrollment and disenrollment
5. Health plan eligibility solicitations and response
6. Payment and remittance advice
7. Premium payment
8. Claim status solicitation and response
9. Coordination of benefits
10. Referral and authorization

Though it is a standard operating process, Ascension Personalized Care does not currently utilize all standard transaction sets. Functionality equivalent to that which is offered by these transaction sets is made available to Ascension Personalized Care's members and clinicians via various alternative capabilities such as online tools. Ascension Personalized Care currently offers an alternative through the Secure Clinician Portal, for the following transactions:

- ASC X12 270 Eligibility Status Inquiry
- ASC X12 271 Eligibility Status Response
- ASC X12 276 Claim Status Inquiry
- ASC X12 277 Claim Status Response
- ASC X12 278 Referral Certification and Response

For more information on conducting these transactions electronically, contact Ascension Personalized Care at **888-492-6811.**

National Provider Identifier

The National Provider Identifier (NPI) is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare clinicians. Covered healthcare clinicians and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare clinicians, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy clinician identifiers in all electronic HIPAA standards transactions. However, some LTSS clinicians are considered "Atypical Clinicians" because they render non-health or non-medical services to Ascension Personalized Care members. These clinicians bill using their Atypical ID (LTSS #) in the Non-NPI Provider ID field of the claim form.

As outlined in the federal regulation, covered clinicians must also share their NPI with other clinicians, health plans, clearinghouses and any entity that may need it for billing purposes.

Please contact the Ascension Personalized Care Compliance Officer by phone at 833-600-1311 or in writing (refer to address below) with any questions about our privacy practices.

Ascension Personalized Care
Attn: Compliance Officer
PO Box 1707
Troy, MI 48099-1707

Fraud, Waste and Abuse

Ascension Personalized Care takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Fraud, Waste and Abuse (FWA) program that complies with the federal and state laws. Ascension Personalized Care operates a Fraud, Waste and Abuse unit. Ascension Personalized Care routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Claims section and Billing the Member section of this manual. The Ascension Personalized Care Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against clinicians who commit fraud, waste and/or abuse. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity.
- More stringent utilization review.
- Recoupment of previously paid monies.
- Termination of clinician agreement or other contractual arrangement.
- Civil and/or criminal prosecution.
- Any other remedies available to rectify.

Some of the most common FWA practices include:

- Unbundling of codes.
- Up-coding services.
- Add-on codes billed without primary procedure code.
- Diagnosis and/or procedure code not consistent with the member's age/gender.
- Use of exclusion codes.
- Excessive use of units.
- Misuse of benefits.
- Claims for services not rendered.
- If you suspect or witness a clinician inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Ascension Personalized Care takes all reports of potential fraud, waste and abuse very seriously and investigates all reported issues.

OIG/GSA Exclusion and CMS Preclusion List – You are required to check the exclusion lists prior to hiring or contracting and monthly thereafter as outlined below for all your staff, volunteers, temporary employees, consultants, board of directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901 Clinicians' implementation of fraud, waste, and abuse safeguards is to identify excluded clinicians and entities.

Payment may not be made for items or services furnished or prescribed by a precluded or excluded clinician or entity. Plans shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a clinician, supplier, employee or First Tier, Downstream or Related entities (FDR) precluded by CMS and/or excluded by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) or the General Services Administration (GSA). Ascension Personalized Care will review the CMS Preclusion List, the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties List (EPLS) prior to hiring or contracting of any new employee,

FWA program compliance authority and responsibility

The Ascension Personalized Care Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Ascension Personalized Care is committed to identifying, investigating, sanctioning and prosecuting suspected fraud, waste and abuse.

The Ascension Personalized Care clinician network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pretrial conferences, hearings, trials and in any other process, including investigations.

To report suspected fraud, waste and abuse call, 833-600-1311.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval.
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.
- Conspiring to commit any violation of the False Claims Act.
- Falsely certifying the type or amount of property to be used by the government.
- Certifying receipt of property on a document without completely knowing that the information is true.
- Knowingly buying government property from an unauthorized officer of the government.
- Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the government.

For more information regarding the False Claims act, please visit cms.hhs.gov.

Appendix

Appendix I: Common causes for upfront claim rejections

Common causes for upfront rejections include but are not limited to:
Unreadable Information — The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), or the font is too small.

- Member date of birth is missing
- Member name or identification number is missing
- Provider name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) number is missing
- Attending clinician information missing from Loop 2310A on institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form
- Date of service is not prior to the received date of the claim (future date of service)
- Date of service or date span is missing from required fields. Example: "Statement From" or "Service From" dates
- Type of bill is invalid
- Diagnosis code is missing, invalid, or incomplete
- Service line detail is missing
- Date of service is prior to member's effective date
- Admission type is missing (Inpatient Facility Claims – UB-04, field 14)
- Patient status is missing (Inpatient Facility Claims – UB-04, field 17)
- Occurrence code/date is missing or invalid
- Revenue code is missing or invalid
- Procedure code is missing or invalid
- A missing CLIA Number in Box 23 or a CMS 1500 for CLIA or CLIA waived service
- Incorrect form type used
- Missing National Drug Code (NDC) number

Please note: EDI HIPAA claims edits are in place. Please speak to your EDI Clearinghouse for further details.

Appendix II: Common cause of claims processing delays and denials

- Procedure or modifier codes entered are invalid or missing. This includes GN, GO, or GP modifier for therapy services
- Diagnosis code is missing the 4th or 5th digit
- DRG code is missing or invalid
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete
- Third party liability (TPL) information is missing or incomplete
- Member ID is invalid
- Place of service code is invalid
- Provider TIN and NPI do not match
- Revenue code is invalid
- Dates of service span do not match the listed days/units
- Tax Identification Number (TIN) is invalid

Appendix III: Instructions for supplemental information

(CMS- 1500 02/12) FORM, SHADED FIELD 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) Claim Form field 24-A-G:

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Code (NDC)
- CTR Contract Rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollar signs (ex. 1000.00; 123.45).

Additional Information for Reporting NDC:

When adding supplemental information for NDC, enter the information in the following order:

- Qualifier
- NDC Code
- One space
- Unit/basis of measurement qualifier
- F2- International Unit
- ME – Milligram
- UN – Unit
- GR – Gram
- ML — Milliliter
- Quantity
- The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999)
- When entering a whole number, do not use a decimal (ex. 2)
- Do not use commas
- Unspecified/Miscellaneous/Unlisted Codes

Appendix IV: Billing tips and reminders

Adult day healthcare

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 99

Ambulance

- Must be billed on a CMS 1500 Claim Form
- Appropriate modifiers must be billed with the Transportation Codes

Ambulatory surgery center (ASC)

- Ambulatory surgery centers must submit charges using the CMS 1500 Claim Form
- Must be billed in place of service 24
- Invoice must be billed with corneal transplants
- Most surgical extractions are billable only under the ASC

Anesthesia

- Bill total number of minutes in field 24G of the CMS 1500 Claim Form and must be submitted with the appropriate modifier
- Failure to bill total number of minutes may result in incorrect reimbursement or claim denial
- Appropriate modifiers must be utilized

APC billing rules

- Critical access hospitals (CAHs) are required to bill with 13x-14x codes
- Bill type for APC claims are limited to 13xs-14x range
- Late charge claims are not allowed, only replacement claims. Claims with late charges will be denied to be resubmitted.
- Claims spanning two calendar years will be required to be submitted by the clinician as one claim.
- CMS Maximum Unit Edits (MUEs) will be applied per line, per claim.
- Claim lines exceeding the MUE value will be denied.
- Observation: Clinicians are required to bill HCPCS G0378 along with the revenue code. The Observation G code will allow the case rate.
- Ambulance Claims: Need to be submitted on a CMS 1500 form. Any Ambulance claim submitted on a UB will be denied.
- Revenue codes and HCPCs codes are required for APC claims.

Comprehensive day rehab

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 61
- Acceptable modifiers

Deliveries

- Use appropriate value codes as well as birth weight when billing for delivery services.

DME/supplies/prosthetics and orthotics

- Must be billed with an appropriate modifier
- Purchase only services must be billed with modifier NU
- Rental services must be billed with modifier RR

Hearing aids

- Must be billed with the appropriate modifier LT or RT

Home health

- Must be billed on a UB 04
- Bill type must be 3XX
- Must be billed in location 12
- Both Rev and CPT codes are required
- Each visit must be billed individually on separate service line

Long-term acute care facilities (LTACs)

- Long-term acute care facilities (LTACs) must submit Functional Status Indicators on claim submissions.

Maternity services

- Clinicians must utilize correct coding for maternity services.
- Services provided to members prior to their Ascension Personalized Care effective date should be correctly coded and submitted to the payer responsible.
- Services provided to the member on or after their Ascension Personalized Care effective date should be correctly coded and submitted to Ascension Personalized Care.

Modifiers

- 25 Modifier — Indicates a significant and separately identifiable E/M service is performed by the same physician on the same day of another service or procedure (e.g., Well child visit 99381 and E/M 99213-25 or 99213-25 and 20610).
    - Subject to the code edit and audit process. Appending a modifier 25 is not a guarantee of automatic payment and may require the submission of medical records
    - Only appended to E/M procedure codes
- 26 Modifier - Indicates that the professional component of a test or study is performed using the 7XXXX(radiology) or 8XXXX (laboratory/pathology) series of CPT codes.
    - Inappropriate use may result in a claim denial/rejection
    - Never appended to an office visit CPT code
- TC Modifier – Indicates the technical component of a test or study that is performed
- 50 Modifier –Indicates a procedure performed on a bilateral anatomical site
    - Procedure must be billed on a single claim line with the 50 modifier and quantity of one
    - RT and LT modifiers or quantities greater than one should not be billed when using modifier 50
- GN, GO, GP Modifiers –Therapy modifiers that are required for speech, occupational, and physical therapy

Outpatient hospital laboratory services

- Bill Type 141 – Must be utilized when a non-inpatient or non-outpatient hospital member's specimen is submitted for analysis to the Hospital Outpatient Laboratory. The member is not physically present at the hospital.
- Bill Type 131 and Modifier L1 – Must be utilized when the hospital only provides laboratory tests to the member and the member does not also receive other hospital outpatient services during the same encounter. Must also be utilized when a hospital provides a laboratory test during the same encounter as other hospital outpatient services that are clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered is by a different practitioners than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.
- Services not billed following the above guidelines will be denied as EX code AT.

POA

- Present on Admission (POA) Indicator is required on all inpatient facility claims
    - Failure to include the POA may result in a claim denial/rejection

Rehabilitation services – inpatient services

- Functional status indicators must be submitted for inpatient Rehabilitation Services

Supplies

- Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.
- Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may not be billed separately. Clinicians may not bill for any reusable supplies.

Telemedicine

- Physicians at the distant site may bill for telemedicine services and **must** utilize the appropriate modifier to identify the service was provided via telemedicine.
    - E/M CPT plus the appropriate modifier
    - Via interactive audio and video tele-communication systems

Appendix V: EDI Companion Guide overview

The Companion Guide provides Ascension Personalized Care trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). The Ascension Personalized Care Companion Guide documents any assumptions, conventions, or data issues that may be specific to Ascension Personalized Care business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this companion guide is unique to Ascension Personalized Care and its affiliates.

This document does **not** replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Ascension Personalized Care. This document provides information on Ascension Personalized Care-specific code handling and situation handling that is within the parameters of the HIPAA Administrative Simplification rules. Readers of this companion guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here, although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at store.x12.org.

The companion guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Ascension Personalized Care and its trading partners. Refer to the TPA for guidelines pertaining to Ascension Personalized Care legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the companion guide for information on Ascension Personalized Care business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.

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Claims processing

Acknowledgements
Senders receive four types of acknowledgement transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge healthcare claims, and the Ascension Personalized Care Audit Report. At the claim level of a transaction, the only acknowledgement of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of benefits (COB) processing
To ensure the proper processing of claims requiring coordination of benefits, Ascension Personalized Care recommends that clinicians validate the patient's membership number and supplementary or primary carrier information for every claim. Please also send in any primary payments on the 837 file to facilitate payment and avoid a request for an Explanation of Benefits from the primary carrier.

Code Sets
Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and reversals
The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data format/content

Ascension Personalized Care accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD
- The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20
- Dates that include hours should use the following format: CCYYMMDDHHMM
- Use military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM
- No spaces or character delimiters should be used in presenting dates or times
- Dates that are logically invalid (e.g. 20011301) are rejected
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after the patient's service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and unit amount values

Ascension Personalized Care accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Ascension Personalized Care are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

Phone numbers

Phone numbers should be presented as contiguous number strings, without dashes or parentheses markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Ascension Personalized Care requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Ascension Personalized Care will not accept more than 97 service lines per UB-04 claim
- Ascension Personalized Care will not accept more than 50 service lines per CMS 1500 claim
- Ascension Personalized Care will only accept single digit diagnosis pointers in the SV107 of the 837P
- The Value Added Network Trace Number (2300-REF02) is limited to 30 characters

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Ascension Personalized Care sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Ascension Personalized Care expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Ascension Personalized Care will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Ascension Personalized Care EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that clinicians use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing clinician is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering clinician

When clinicians perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than Loop 2310B/NM1*82.

Referring clinician

Ascension Personalized Care has no specific requirements for Referring clinician information.

Atypical clinician

Atypical clinicians are not always assigned an NPI number, however, if an atypical clinician has been assigned an NPI, then they need to follow the same requirements as a medical clinician. An Atypical clinician which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc.).

Existing Atypical clinicians need only send the Provider Tax ID in the REF segment of the billing clinician loop. **Note**: If an NPI is billed in any part of the claim, it will not follow the Atypical Clinician Logic.

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber's card in the 2010BA element.

Claim Identifiers

Ascension Personalized Care issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. Ascension Personalized Care returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Ascension Personalized Care encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Ascension Personalized Care offers two options for connectivity via FTP.

- Method A – The trading partner will push transactions to the Ascension Personalized Care FTP server and Ascension Personalized Care will push outbound transactions to the Ascension Personalized Care FTP server.
- Method B – The trading partner will push transactions to the Ascension Personalized Care FTP server and Ascension Personalized Care will push outbound transactions to the trading partner's FTP server.

Encryption

Ascension Personalized Care offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS. (Note this method only applies with connecting to Ascension Personalized Care's Secure FTP. Ascension Personalized Care does not support retrieving files automatically via HTTPS from an external source at this time.) If PGP or SSH keys are used they will be shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

Direct submission

Ascension Personalized Care also offers posting an 837 batch file directly on the clinician portal website for processing.

Edits and reports

Incoming claims are reviewed first for HIPAA compliance and then for Ascension Personalized Care business rules requirements. The business rules that define these requirements are available as a comprehensive list in the 837 Professional Claims – Ascension Personalized Care Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Ascension Personalized Care business edit errors are returned on the Ascension Personalized Care Claims Audit Report.

Reporting

If problem data is found within the 837 Professional Claim Transaction please contact ABS at: edi-support@abs.tpa.com

Accreditation

Ascension Personalized Care has earned Marketplace Health Plan Accreditation from URAC. "Ascension Personalized Care earned a recognition of its health plan with URAC accreditation that is recognized in all 50 states and the District of Columbia. It proved compliance with rigorous standards, proving an ability to adhere to the mandates of the Affordable Care Act and compete in insurance marketplaces nationwide," said URAC President and CEO Shawn Griffin, M.D. "Ascension Personalized Care demonstrates its quality and compliance with standards that align with state and federal expectations for a more value-based delivery of care."

Indiana

Health Plan with Health Insurance Marketplace (HIM) 7.4 Accreditation
Full accreditation: Effective 1/1/22 through 1/1/25
Certificate Number: HIX-5
HIOS Issue Identifier: 35755
NAIC Company Code: 97772
NAIC Group Code: NULL

Kansas

Health Plan with Health Insurance Marketplace (HIM) 7.4 Accreditation
Full accreditation: Effective 1/1/22 through 1/1/25
Certificate Number: HIX-5
HIOS Issue Identifier: 32542
NAIC Company Code: 97772
NAIC Group Code: NULL

Michigan

Health Plan with Health Insurance Marketplace (HIM) 7.4 Accreditation
Full accreditation: Effective 1/1/22 through 1/1/25
Certificate Number: HIX000005
HIOS Issue Identifier: 58996
NAIC Company Code: 97772
NAIC Group Code: NULL

Tennessee

Health Plan with Health Insurance Marketplace (HIM) 7.4 Accreditation
Full accreditation: Effective 1/1/22 through 1/1/25
Certificate Number: HIX-5
HIOS Issue Identifier: 31663
NAIC Company Code: 97772
NAIC Group Code: NULL

Texas

Health Plan with Health Insurance Marketplace (HIM) 7.4 Accreditation
Full accreditation: Effective 1/1/22 through 1/1/25
Certificate Number: HIX-5
HIOS Issue Identifier: 57125
NAIC Company Code: 97772
NAIC Group Code: NULL

Ascension
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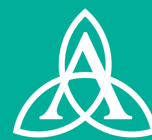

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