

Ascension Complete

Provider Manual Illinois



Ascension

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INTRODUCTION

Welcome to Ascension Complete AMITA (Ascension Complete). Thank you for participating in our network of high-quality physicians, hospitals and healthcare professionals.

This provider manual is to be utilized as a reference guide when servicing members who are enrolled in our Medicare Advantage program for HMO, PPO, or Dual Special Needs (D-SNP) plans.

OVERVIEW

Ascension Complete is a licensed health maintenance organization (HMO) contracted with the Centers for Medicare and Medicaid Services (CMS) to provide medical and behavioral health services to eligible members. CMS also contracts Ascension Complete to provide Part D prescription medications to members enrolled in certain health plans which include a Part D benefit.

Ascension Complete is designed to achieve four main objectives:

- Full partnership between the member, their physician, and their Ascension Complete Care Manager
- Integrated case management (medical, social, behavioral health, and pharmacy)
- Improved provider and member satisfaction
- Quality of life and health outcomes

Ascension Complete 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 Complete network providers 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.

KEY CONTACTS AND IMPORTANT PHONE NUMBERS

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

1. The provider's NPI number
2. The practice Tax ID Number
3. The member's ID number

Key Contacts and Important Phone Numbers

Ascension Complete from AMITA Health Plan	Ascension Complete AMITA P.O. Box 10420 Van Nuys, CA 91410 Website: www.ascensioncomplete.com
Provider Services	Phone: 1-833-293-5966 (TTY: 711)
Member Services	Phone: 1-833-293-5966 (TTY: 711)
Medical Management Inpatient and Outpatient Prior Authorization	Fax: 1-844-996-0202 Fax: 1-844-996-0204 Fax: 1-844-996-0206
Concurrent Review/Clinical Information	
Admission/Census Reports	
Care Management	Phone: 1-844-699-3128 (TTY:711)
Behavioral Health Outpatient Prior Authorization	Fax: 1-844-684-1679
24/7 Nurse Advice Line	Phone: 1-877-236-0230 (TTY: 711)
Interpreter Services	Phone: 1-833-603-2971 (TTY: 711)
Pharmacy Services	Prior Auth / Coverage Determinations: Phone: 1-800-867-6564
National Imaging Associates (NIA)	1-800-424-5357

	Website: RadMD.com
Envolve Vision	1-833-910-0117 Website: visionbenefits.envolvehealth.com
Envolve Dental	1-833-910-0117 Website: dental.envolvehealth.com/
Hearing Care Solutions	1-877-583-2842
American Specialty Health	1-800-972-4226
Fraud Waste and Abuse (FWA)	To report suspected fraud, waste and abuse call, 1-866-685-8664.
EDI Claims Assistance	For EDI Claim Assistance inquires, call 1-800-225-2573, ext. 6075525 Email: ediba@centene.com
Payspan	Phone: 1-877-331-7154 Email: providersupport@payspanhealth.com

MEDICARE REGULATORY REQUIREMENTS

As a Medicare contracted provider, you are required to follow applicable Medicare regulations and CMS requirements. Some of these requirements are found in your provider agreement. Others have been described throughout the body of this manual. These include, but are not limited to:

- Providers may not discriminate against Medicare members in any way based on the health status of the member.
- Providers may not discriminate against Medicare members in any way based on race, color, national origin, sex, age, or disability in accordance with subsection 92.2 of Section 1557 of the Patient Protection and Affordable Care Act.
- Providers must ensure that members have adequate access to covered health services.
- Providers may not impose cost sharing on members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow members to directly access screening mammography and influenza vaccinations.
- Providers must provide members with direct access to health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Ascension Complete will provide you with at least 60 days written notice of termination if electing to terminate our agreement without cause, or as described in your Participation Agreement if greater than 60 days.
- Providers agree to notify Ascension Complete according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operations are convenient to the member and do not discriminate against the member for any reason. Providers will ensure necessary services are available to members 24 hours a day, 7 days a week. PCPs must provide backup in case of absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Ascension Complete members without CMS and/or Ascension Complete approvals of the materials and forms.
- Services must be provided to members in a culturally competent manner, including to members with limited reading skills, limited English proficiency, members who are deaf or hard of hearing or are blind or have low vision and to members of diverse cultural and ethnic backgrounds.
- Providers will work with Ascension Complete procedures to inform our members of healthcare needs that require follow-up and provide necessary training in self-care.

- Providers will document in a prominent part of the member's medical record whether the member has executed an advance directive.
- Providers must provide services in a manner consistent with professionally recognized standards of care.
- Providers must cooperate with Ascension Complete to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare coverage.
- Providers must cooperate with Ascension Complete in notifying members of provider contract terminations.
- Providers must cooperate with the activities of any CMS-approved independent quality review or improvement organization.
- Providers must comply with any Ascension Complete medical policies, QI programs and medical management procedures.
- Providers will cooperate with Ascension Complete in disclosing quality and performance indicators to CMS.
- Providers must cooperate with Ascension Complete procedures for handling grievances, appeals, and expedited appeals.
- Providers must request prior authorization from the plan if the provider believes an item or service may not be covered for a member or could only be covered under specific conditions. If the provider does not request prior authorization, the claim may be denied, and the provider will be liable for the cost of the service. Note: if the item or service is never covered by the plan as clearly denoted in the member's Evidence of Coverage, no prior notice of denial is required, and the member may be held responsible for the full cost of the item or service.
- Providers must allow CMS or its designee access to records related to Ascension Complete services for a period of at least ten (10) years following the final date of service or termination of this agreement unless a longer period is required by applicable state or federal law.
- Provider must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
- Provider shall provide services in accordance with Ascension Complete policies: (a) for all members, for the duration of the Ascension Complete contract period with CMS, and (b) for members who are hospitalized on the date the CMS contract with Ascension Complete terminates, or, in the event of an insolvency, through the member's discharge.
- Provider shall disclose to Ascension Complete all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS.

SECURE WEB PORTAL

Ascension Complete offers a robust secure web portal with functionality that will be critical to serving members and to ease administration for the Ascension Complete product for providers. Provider Services will be able to assist and provide education regarding this functionality. The portal can be accessed at www.ascensioncomplete.com.

Functionality

All users of the secure web portal must complete a registration process. If you are already a registered user on the Ascension Complete secure web portal, a separate registration is not needed.

Once registered, providers may:

- Check eligibility
- View the specific benefits for a member
- View benefit details including member cost share amounts for medical, Pharmacy, dental, and vision services
- View demographic information for the providers associated with the registered TIN such as: office location, office hours and associated practitioners
- Update demographic information (address, office hours, etc.)
- View and print patient lists (primary care providers). This patient list will indicate the member's name, member ID number, date of birth and the product in which they are enrolled
- Submit authorizations and view the status of authorizations that have been submitted for members
- View claims and the claim status
- Submit individual claims, batch claims or batch claims via an 837 file
- View and download Explanations of Payment (EOP)
- View a member's health record including visits (physician, outpatient hospital, therapy, etc.), medications, and immunizations
- View gaps in care specific to a member including preventive care or services needed for chronic conditions
- Send secure messages to Ascension Complete staff

HIPAA Privacy

Providers 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 RE-CREDENTIALING

The credentialing and re-credentialing process exists to verify that participating practitioners and providers meet the criteria established by Ascension Complete, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with Ascension Complete AMITA in the Medicaid product, the practitioner/provider will NOT be separately credentialed for the Ascension Complete product.

Notice: In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Ascension Complete of any relevant changes to their credentialing information in a timely manner but in no event later than 10 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.
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage.
- Current controlled substance registration certificate, if applicable.
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see Ascension Complete 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, at minimum, a five-year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants.
- Signed and dated release of information form not older than 120 days; and
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable.

Ascension Complete will primary source verify the following information submitted for credentialing and re-credentialing:

- License through appropriate licensing agency.
- Board certification, residency training, and/or professional education, where applicable;

- Malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB); and
- Federal sanction activity, including Medicare/Medicaid services (OIG-Office of Inspector General, Preclusion List).

For institutional providers (hospitals and ancillary facilities), a signed, fully-completed Facility/Provider – Initial and Re-credentialing Application and all supporting documentation as identified in the application .

Once the completed application is received, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting.

Primary care practitioners cannot accept member assignments 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, termination, and direction of the credentialing procedures, including participation, denial, and termination. 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.

Re-credentialing

Ascension Complete conducts practitioner/provider re-credentialing 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/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, institutional providers, and ancillary providers previously credentialed and currently participating in the network.

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

A provider's agreement may be terminated if at any time it is determined by the Ascension Complete Credentials Committee that credentialing requirements or standards are no longer being met.

Providers Right to Review and Correct Information

All providers participating within the network have the right to review information obtained by Ascension Complete to evaluate their credentialing and/or re-credentialing 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 provider to review references, personal recommendations, or other information that is peer review protected.

Providers 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 provider 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 provider. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the provider will have the following timeframe to provide a written explanation detailing the error or the difference in information to the Credentials Committee within thirty (30) days of the initial notification.

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

Providers Right to Be Informed of Application Status

All providers who have applied to join our network have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact their Provider Relations Representative.

Providers Right to Appeal Adverse Re-credentialing Determinations

Applicants who are existing providers and who are 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 days of the date of the 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.

Provider Non-Discrimination

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

Furthermore, we do not and have never had a policy of terminating any provider who:

- Advocated on a member's behalf; or

- Filed a complaint against us; or
- Appealed a decision of ours.

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Primary Care Providers

The primary care provider (PCP) is the cornerstone of Ascension Complete's care delivery model. The PCP serves as the Medical Home for the member. The Medical Home concept addresses an approach to care in which the PCP is the primary coordinator of all care for each member and uses a holistic, patient-centered approach to treatment. The Medical Home should assist in establishing a patient-provider relationship and ultimately improve health outcomes. The PCP is responsible for providing all primary care services for Ascension Complete's members, including, but not limited to:

- Supervision, coordination, and provision of care to each assigned member.
- Initiation of referrals for medically necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health, or other referral services.
- Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral.
- Care managers will partner with the PCP not only to ensure the member receives necessary care, but also to assist with providing a Medical Home for the patient.

All PCPs may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the member's choice, Ascension Complete does not guarantee a PCP will receive a set number of patients. PCPs may contact Provider Services if they choose to change their panel size or close their panel to accept only established patients. If Ascension Complete determines that a PCP fails to maintain quality, accessible care, Ascension Complete reserves the right to cease assigning members to a PCP if necessary and re-assign members to a new PCP.

Specialist as the Primary Care Provider

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. Paper referrals are not required.

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

Specialty Care Provider

The Specialty Care Provider agrees to partner with the member's PCP and Care Manager to deliver care. Some key roles of specialty providers include:

- Rendering services requested by the PCP
- Communicating with the PCP regarding medical findings in writing

- Confirming member eligibility and benefit level prior to rendering services
- Providing a consultation report to the PCP within 60 days of the consult

Most visits to specialists do not require a prior authorization. While most specialists will require a written referral from the member's PCP, it is not required for the claim to be reimbursed by Ascension Complete. Specialists may elect to limit their practice to established patients only upon request to Provider Services.

Members may self-refer to an OB/GYN for their annual well checkup or for care related to pregnancy.

Specialty Care Physicians include, but are not limited to:

- | | |
|-----------------------------------|-----------------|
| ● Cardiology | ● Oncology |
| ● Gynecology and Related Services | ● Ophthalmology |
| ● Endocrinology | ● Orthopedics |
| ● Gastroenterology | ● Podiatry |
| ● Geriatrics | ● Pulmonology |
| ● Neurology | ● Rheumatology |
| ● Nephrology | ● Urology |

Mental Health Providers

Medicare recognizes the following practitioners who are eligible under Part B to furnish diagnostic and/or therapeutic treatment for mental, psychoneurotic, and personality disorders:

- Psychiatrist or other physicians (medical doctors [MD] and doctors of osteopathy [DO], particularly psychiatrists)
- Clinical psychologists (CP)
- Clinical social workers (CSW)
- Clinical nurse specialists (CNS)
- Nurse practitioners (NP)
- Physician assistants (PA)
- Certified nurse-midwives (CNM)
- Independently Practicing Psychologist (IPP)

Independently Practicing Psychologists (IPP) Hospitals

Hospitals are essential in delivering care to members. For this reason, Ascension Complete may contract with hospitals to provide covered services to members; however, any hospital can be used in the case of an emergency. Additionally, Ascension Complete contracts with rehabilitation facilities, ambulatory surgery

centers and other facilities needed to manage the health care of its members. Some responsibilities of hospitals include:

- Coordination of discharge planning with Ascension Complete Utilization Management staff
- Coordination of mental health /substance abuse care with the PCP and appropriate community providers
- Eligibility and benefit authorization before services are rendered
- Communication of all relevant medical information to member PCPs
- Communication of all emergent hospital admission to Ascension Complete Utilization Management staff within 48 hours of admission

Providers are encouraged to have privileges at Ascension Complete's contracted facilities or agreements with hospitalist groups to care for their members who are hospitalized. Providers should review the Provider Directory for a list of contracted hospitals and associated facilities.

Ancillary Providers

Ancillary providers cover a wide range of services including therapy and laboratory services. The following are some services provided by ancillary providers:

- Durable Medical Equipment
- Hospice Care
- Home Health
- Laboratory
- Prosthetics and Orthotics
- Radiology
- Therapy (Physical, Occupational, Speech)

Some critical areas of responsibilities for ancillary providers include:

- Obtaining member eligibility and benefit level prior to rendering services.
- Knowing limitations and/or benefit exclusions applicable to member.
- Communicating all relevant medical information to member's PCP.

PHYSICIAN INCENTIVE PROGRAMS

On an annual basis and in accordance with Federal Regulations, Ascension Complete must disclose to CMS, any physician incentive programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the physician incentive program.
- Whether services not covered by Ascension Complete are covered under any physician incentive program.
- Type of incentive arrangement (i.e., withhold, bonus, capitation).
- If an incentive arrangement involves a withhold or bonus, the percentage of the withhold or bonus.
- Amount and type of stop-loss protection.
- Patient panel size.
- Description of the pooling method, if applicable.
- For capitation arrangements, the amount of the capitation payment broken down by percentage for primary care, referral, and other services.
- The calculation of substantial financial risk (SFR).
- Whether Ascension Complete does or does not have a physician incentive program; and
- The name, address, and other contact information of the person at Ascension Complete who may be contacted with questions regarding physician incentive programs.

Physician incentive programs may not include any direct or indirect payments to providers and/or provider groups who create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers and/or provider groups at significant financial risk may not operate unless there is adequate stop-loss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk (SFR) occurs when the incentive arrangement places the provider and/or provider group at financial risk beyond the Risk Threshold. The Risk Threshold is the maximum risk if the risk is based upon the use or cost of referral services. The Risk Threshold is set at 25% and does not include amounts based solely on factors other than a provider and/or provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Partnership Manager.

First-Tier and Downstream Providers

Through written agreement, Ascension Complete may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 422.504 to First-Tier, downstream, and delegated entities. These functions and responsibilities include, but are not limited to, contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management, and provider training.

Ascension Complete oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the delegated entity's performance is inadequate. Agreements will be kept on file by Ascension Complete for reference.

MEMBER NOTIFICATIONS

Medicare providers are required in certain circumstances to provide notifications to their patients about various aspects of their care. This section outlines some of the most common, required, member notifications required by Medicare providers. For a comprehensive list of notification requirements, please review Chapter 30 (Financial Liability Protections) of the Medicare Claims Processing Manual, available on www.cms.gov.

Notice of Medicare Non-Coverage (NOMNC)

Scope

An expedited determination process is available to members in Original Medicare whose Medicare covered services are being terminated in the following settings. All members receiving services in these settings must receive a NOMNC before their services end:

- Home Health Agencies (HHAs)
- Comprehensive Outpatient Rehabilitation Services (CORFs)
- Hospice
- Skilled Nursing Facilities (SNFs)-- Includes services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e., physical therapy, occupational therapy, and speech therapy). A NOMNC must be delivered by the SNF at the end of a Part A stay or when all of Part B therapies are ending.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per §260.2. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC.

Required Delivery Timeframes

The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Detailed Explanation of Non-Coverage (DENC)

Medicare providers are responsible for the delivery of the DENC to beneficiaries who request an expedited determination by the QIO. The DENC must contain the following information:

- The facts specific to the beneficiary's discharge and provider's determination that coverage should end.
- A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered.
- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review.

The delivery must occur in person by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. A provider may also choose to deliver the DENC with the NOMNC.

Required Notification to Members for Observation Services

Scope

In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) effective August 6, 2015, contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any member who receives observation services as an outpatient for more than 24 hours. The MOON is a standardized notice to a member informing that the Member is an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status. The MOON must be delivered no later than 36 hours after observation services are initiated, or if sooner upon release. The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Notice of Hospital Discharge Appeal Rights

Hospitals must issue the **Important Message** within two calendar days of admission, obtain signature of the patient or the signature of their authorized representative, and provide a signed follow-up copy to the patient as far in advance of discharge as possible, but not more than two calendar days before discharge.

Provider-Preventable Conditions

CMS guidelines regarding Hospital Acquired Conditions, Never Events, and other Provider-Preventable Conditions (collectively, PPCs). Under Section 42 CFR 447.26 (implemented July 1, 2012), these PPCs are non-payable for Medicaid and Medicare. Additional PPCs may be added by individual states.

Never Events are defined as a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

- A different procedure altogether
- The correct procedure but on the wrong body part
- The correct procedure on the wrong patient

Hospital Acquired Conditions are additional non-payable conditions listed on the CMS website and include such events as an air embolism, falls, and catheter-associated urinary tract infection.

Healthcare providers may not bill, attempt to collect from, or accept any payment from Ascension Complete or the member for these PPCs.

MEMBER SELECTION OR ASSIGNMENT OF PCP

Ascension Complete gives members the freedom to select the healthcare provider of their choice. Services from in-network providers are covered based on contracted provisions, fee schedule, and any standard coding and claim guidelines, subject to member cost sharing or co-pays or until the maximum out-of-pocket is met. Out-of-network care is covered only in an emergency. Members are generally responsible for the full cost of care received from out-of-network providers.

The PCP to member ratio shall not exceed the following:

- Physicians 1: 2,500
- Nurse Practitioner 1: 1,250
- Physician Assistant 1: 1,250

PCPs and specialists who want to change their panel status (open, closed, existing members only) must notify Provider Services. Please note that PCPs and specialists may not refuse acceptance of new members if the panel status is open.

AMITA prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Ascension Complete members.

APPOINTMENT AVAILABILITY

The following standards are established regarding appointment availability:

Type of Care	Accessibility Standard
PRIMARY CARE	
Emergency	Same day or within 24 hours of member's call
Urgent care	Within 48 hours of request
Routine	Within 30 calendar days of request
SPECIALTY REFERRAL	
Emergency	Within 24 hours of referral
Urgent care	Within 2 days of referral
Routine	Within 30 days of referral
SPECIALTY CARE	
High Volume – Routine Care	Within <INSERT #> days of referral
High Volume – Urgent Care	Within <INSERT #> hours of referral
High Impact – Routine Care	Within <INSERT #> days of referral
High Impact – Urgent Care	Within <INSERT #> hours 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 request

Urgent care	Within 2 days of request
Routine	Within 21 days of request

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

The following are behavioral health appointment access guidelines:

Appointment Type	Description	Standard
Immediate	Behavioral health services provided within a time frame indicated by behavioral health condition, but no later than 6 hours from identification of need or as quickly as possible when a response within 6 hours is geographically impractical	Within 6 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 48 hours from identification of need	Within 48 hours
Care for non-life-threatening emergency		Within 6 hours
Routine – initial assessment	Appointment for initial assessment with a BHP within 10 business days of referral or request for behavioral health services	Within 10 business days of referral
Routine – first behavioral health service	Includes any medically necessary covered behavioral health service including medication management and/or additional services	Within 10 days of assessment

Follow-up routine care	Appointment for follow-up routine care at later, specified dates to evaluate patient progress and other changes that have taken place since a previous visit.	Within <INSERT #> days
Appointments for psychotropic medication		<p>The member's need for medication is assessed immediately and if clinically indicated, the member is scheduled for an appointment within a time frame that ensures:</p> <ul style="list-style-type: none"> • The member does not run out of any needed psychotropic medications; or • The member is evaluated for the need to start medications to ensure that the member does not experience a decline in their behavioral health condition.
Referrals or requests for psychotropic medications	Screening, consultation, assessment, medication management, medications, and/or lab testing services, as appropriate	Assess the urgency of the need immediately. If clinically indicated, provide an appointment with a BHP within a time frame indicated by clinical need, but no later than 30 days from the referral/initial request for services.
Non-emergency transportation		<ul style="list-style-type: none"> • 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

Providers 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 provider.
 - All calls need to be returned within 60 minutes.
- Answering machine
 - Should be on after business hours.
 - Should direct members to call another number to reach the PCP or other designated medical provider.
 - A live person should be available to answer the designated phone number; another recording is not acceptable.
- Transferred phone call
 - Calls can be transferred to another location where a live person will be able to assist and can contact the PCP or another designated medical provider.
 - All calls need to be returned within 60 minutes.

Providers are required to develop and use telephone protocol for all the following situations:

- Answering the member's telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by a member.
- Identifying and rescheduling cancelled and no-show appointments.
- Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally incapacitated.
- Scheduling continuous availability and accessibility of professional, allied and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.
- After-hours calls should be documented in a written format in either an after-hour call log or some other method and transferred to the member's medical record.

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 Complete will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program.

Training Requirements

Information on training opportunities will be posted on our website at www.ascensioncomplete.com. The following training courses are required by CMS as well as Ascension Complete:

- Annual Fraud, Waste and Abuse Training within 90 days of contracting and annually thereafter
- Annual Compliance Training within 90 days of contracting and annually thereafter
- Annual Model of Care Training within 90 days of contracting and annually thereafter
- Cultural Competency Training
- Other State Required Training

Missed Appointments and Other Charges

Ascension Complete may charge "administrative fees" to Medicare Advantage members for missed appointments with contracting providers and for not paying contracting providers required cost-sharing at the time of service.

Contracted and non-contracted providers may charge a fee for missed appointments, provided such fees apply uniformly to all Medicare and non-Medicare patients. This applies even if the Medicare Advantage Organization (MAO) itself does not charge an administrative fee for missed appointments.

ASCENSION COMPLETE BENEFITS

Ascension Complete covers all benefits through fee-for-service Medicare plus more. All services are subject to benefit coverage, limitations and exclusions as described in the applicable Ascension Complete coverage guidelines.

Access a copy of the Member's Evidence of Coverage to verify the covered services specific to each plan on the Ascension Complete portion of our website at www.ascensioncomplete.com. Please contact Provider Services at Ascension Complete Medicare HMO Phone: 1- 833-293-5966 (TTY: 711) Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP) Phone: 1- 833-293-5966 (TTY: 711) with any questions you may have regarding benefits.

The following is a partial list of services not covered under Parts A and B, however, but may be covered under a supplemental benefit:

- Acupuncture
- Hearing Aids
- Routine Foot Care
- Emergency care while traveling outside of the United States
- Routine Dental Care
- Routine Eye Care
- Custodial Care

Special Supplemental Benefits for the Chronically Ill (SSBCI) – Provider Attestation Website

Our health plan provides Special Supplemental Benefits for Chronically Ill (SSBCI) to our highest-risk members who meet specific criteria for eligibility based on CMS guidelines.

To determine eligibility, our members are required to schedule an office visit with their provider for evaluation. As part of that visit, we ask that you:

1. Evaluate your patient against the required criteria below. All criteria must be met and the completed attestation form must be received before the patient will receive access to benefits.
 - a. Criteria include:
 - a. **A need for intensive Care Management**
 1. Patient has had 2 or more inpatient admissions in the last 60 days, OR patient has had 3 or more emergency room visits in the last 60 days
 - b. **A high risk for hospitalization**

1. Patient must be at high risk for unplanned hospitalization (inpatient and/or emergency room visits) in the next 60 days.
- c. **Currently diagnosed with one or more qualifying chronic conditions**
 1. Patient must have an active diagnosis for one or more of the qualifying co-morbid and medically complex conditions. The condition must be life threatening or significantly limit the overall health or function of your patient.
 2. Submit an attestation form (via the website linked on our public forms page) indicating if your patient currently meets the criteria.
 3. Submit a claim containing the appropriate ICD-10 codes from this office visit indicating a member has been diagnosed with one or more qualifying chronic conditions.

After we receive and validate all criteria are met, we will send an approval *or* denial letter to the member to let them know if they meet the criteria and how to activate the member benefits.

VERIFYING MEMBER BENEFITS, ELIGIBILITY, AND COST SHARES

A member's eligibility status may change at any time. Therefore, all providers should verify eligibility, benefits, and cost sharing prior to each scheduled appointment. Providers should also request members to present their Ascension Complete ID card, along with additional proof of identification such as a photo ID (if applicable) at each encounter. If there are any discrepancies between the member's ID card and/or your eligibility report, please contact Provider Services at Ascension Complete Medicare HMO 1- 833-293-5966 (TTY: 711) or Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP) 1- 833-293-5966 (TTY: 711).

Member Identification Card

Below is a sample member identification card.

Front

Ascension Complete		AMITA Health Reward (HMO) CMS #: H7399-001 Effective: MM/DD/YYYY	
MEMBER INFORMATION Name: [First MI Last Name] Member ID#: [XXXXXXXX-XX] Issuer ID: (80840) 9151014609		PHARMACY INFORMATION  Prescription Drug Coverage RX CLAIMS PROCESSOR <CVS Caremark®> RXBIN: 004336 RXPCN: MEDDADV RXGRP: RX8921	
PROVIDER INFORMATION PCP Name: [Last, First Name] PCP Phone: [X-XXX-XXX-XXXX] PCP Office Visit: \$X			

Back

FOR MEMBERS Member Services: 1-833-293-5966 (TTY: 711) Website: AscensionComplete.com Clinical Care Line*: 1-833-981-0915 (TTY: 711) Virtual Care*: AscensionOnlineCare.org		FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).	
FOR PROVIDERS Medical eligibility & Prior Auth: 1-833-293-5966 Pharmacy Prior Auth: 1-800-867-6564 For help: (Pharmacy use only) 1-888-865-6567 Enroll Dental with United Concordia National Medicare Advantage Network*: 1-833-910-0117 Enroll Vision*: 1-833-910-0117 <small>*Please refer to your EOC for your extra covered benefits.</small>		SUBMIT PART D DRUG CLAIMS TO Ascension Complete Attn: Member Reimbursement Dept. PO Box 31577 Tampa, FL 33631-3577	
MEDICAL CLAIMS		EDI Payor ID: 68069 Ascension Complete Attn: Claims PO Box 8050 Farmington, MO 63640-8050	

Ascension Complete		AMITA Health Secure (HMO) CMS #: H7399-002 Effective: MM/DD/YYYY	
MEMBER INFORMATION Name: [First MI Last Name] Member ID#: [XXXXXXXX-XX] Issuer ID: (80840) 9151014609		PHARMACY INFORMATION  Prescription Drug Coverage RX CLAIMS PROCESSOR <CVS Caremark®> RXBIN: 004336 RXPCN: MEDDADV RXGRP: RX8921	
PROVIDER INFORMATION PCP Name: [Last, First Name] PCP Phone: [X-XXX-XXX-XXXX] PCP Office Visit: \$X			

FOR MEMBERS Member Services: 1-833-293-5966 (TTY: 711) Website: AscensionComplete.com Clinical Care Line*: 1-833-981-0915 (TTY: 711) Virtual Care*: AscensionOnlineCare.org		FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).	
FOR PROVIDERS Medical eligibility & Prior Auth: 1-833-293-5966 Pharmacy Prior Auth: 1-800-867-6564 For help: (Pharmacy use only) 1-888-865-6567 Enroll Dental with United Concordia National Medicare Advantage Network*: 1-833-910-0117 Enroll Vision*: 1-833-910-0117 <small>*Please refer to your EOC for your extra covered benefits.</small>		SUBMIT PART D DRUG CLAIMS TO Ascension Complete Attn: Member Reimbursement Dept. PO Box 31577 Tampa, FL 33631-3577	
MEDICAL CLAIMS		EDI Payor ID: 68069 Ascension Complete Attn: Claims PO Box 8050 Farmington, MO 63640-8050	

Preferred Method to Verify Benefits, Eligibility, and Cost Shares

The preferred method to verify member benefits, eligibility, and cost share information is through the Ascension Complete secure web portal found at www.ascensioncomplete.com. Using the Portal, registered providers can quickly access member status. Eligibility checks can be performed using Member ID or last name, DOB, and date of service. Information on the web portal is updated every 24 hours.

The screenshot displays the Ascension Complete secure web portal. On the left, the 'Quick Eligibility Check' section features two input fields: 'Member ID or Last Name' with the value '123456789 or Smith' and 'Birthdate' with the placeholder 'mm/dd/yyyy'. A green 'Check Eligibility' button is positioned to the right of these fields. Below this, the 'Recent Claims' section shows a yellow message box stating 'No Data Found'. On the right side, a 'Welcome' sidebar contains a 'Add a TIN to My ACCOUNT' button with a right arrow, a 'Reports' button with a right arrow, and a 'Recent Activity' section. The 'Recent Activity' section has a table with two columns: 'Date' and 'Activity'. It lists two activities: '08/16/2014 You changed your password.' and '08/16/2014 Your password expired.'

Other Methods to Verify Benefits, Eligibility and Cost Shares	
<p>24/7 Toll Free Interactive Voice Response (IVR) Line at:</p> <p>Ascension Complete Medicare HMO Phone:1-855-766-1572 (TTY: 711)</p> <p>Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP) Phone: 1-833-541-0767 (TTY: 711)</p>	<ul style="list-style-type: none"> Provider and member information can be sent through the IVR validation process, so Providers do not have to re-enter information Providers may also opt to use speech capability or touch-tone keypad prompts to enter the member ID number and the month of service to check eligibility.
<p>Provider Services at:</p> <p>Ascension Complete Medicare HMO Phone:1-855-766-1572 (TTY: 711)</p> <p>Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP)</p>	<ul style="list-style-type: none"> If a member's eligibility cannot be confirmed using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative. <p>Member ID number or last name and DOB are needed to authenticate verification.</p>

Phone: 1-833-541-0767 (TTY: 711)	
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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. Service/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.

The 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. The 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, the Care Management Program 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.

Care Management services include services that work synergistically to improve the health of patients across the health and wellness spectrum. While not an exhaustive list of programs and services, the following is rather a suite of functions designed specifically to work together to impact the health of our patients and communities:

- Keeping members Healthy through Wellness Programs
- Managing patients with Emerging Risk using Disease Management
- Providing safety across the Continuum of Care with Transitions of Care
- Managing patients with Multiple Chronic Illnesses by offering Complex Care Management

At least annually, Ascension Care Management (ACM) performs segmentation and risk stratification for the entire enrolled population into meaningful subsets for targeted interventions. In addition, this system is used on a regular basis (i.e., weekly or monthly), to identify, enroll, track and coordinate eligible members for engagement in appropriate clinical programs.

Ascension Complete will seek to complete an initial Health Risk Assessment (HRA) by phone, in person or via the member's preferred method of communication within 90 days of the member's enrollment date. The HRA will be the basis of the Care Plan and will be available for your review via the Provider Portal. Ascension Care Management teams support physicians by tracking adherence with the individual care plan (ICP), and facilitating communication between the PCP, member, managing physician, and the Care Management team.

The Care Manager also facilitates referrals and links to community Providers, such as local health departments and Division of Aging. The managing physician maintains responsibility for the member's ongoing care needs. The Ascension Complete Care Management team will contact the PCP, and/or, managing physician if the member is not following the plan of care or requires additional services.

All Ascension Complete members with identified needs are assessed for Care Management enrollment. Members with needs may be identified via HRA, clinical rounds, referrals from other Ascension Complete staff members, hospital census, and direct referral from Providers, self-referral, or referral from other Providers.

Care Management Process

Ascension Complete's Care Management process for high risk, complex, or catastrophic conditions contains the following key elements:

- Screen and identify members who potentially meet the criteria for Care Management
- Assess the member's risk factors to determine the need for Care Management
- Notify the member and their PCP of the member's enrollment in ACM program
- Develop and implement an ICP treatment plan that is inclusive of preventative services to improve quality and accommodates the specific cultural and linguistic needs of the member
- Establish with the member the ICP problems, goals and interventions to meet desired member outcomes
- Refer and assist the member in ensuring timely access to providers
- Coordinate medical, residential, social and other support services
- Monitor care/services and promote medication adherence
- Coordinate transitions of care and medication reconciliation post hospitalization
- Revise the ICP as necessary
- Referring a member to ACM: Providers are asked to contact an Ascension Complete Care Manager at 844-623-2998 to refer a member identified in need of Care Management intervention.

Interdisciplinary Care Team (ICT)

The Ascension Care Managers will coordinate the member's care with the Interdisciplinary Care Team (ICT). The ICT is generally comprised of multidisciplinary clinical and nonclinical staff chosen by the member. Our integrated care management approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. The purpose of the ICT is to coordinate the plan of care with the member. Our program is member centric with the PCP being the primary ICT point of contact for the member's treatment and medical care. Provider responsibilities include:

- Communicating with, and respond to communication from Ascension regarding the member's care plan, including accepting meeting invitations when applicable
- Maintaining copies of the ICP, ICT communications, medication reconciliation summary and transition of care notifications in the member's medical record when received
- Collaborating and actively communicating with Ascension Care Managers, members of the ICT, and members and caregivers

Inpatient Care: Care managers will coordinate with facilities to assist members with coordinating an appropriate discharge plan meeting the member's needs. Ascension will then notify the PCP of the transition of care and anticipated discharge date to ensure members receive the appropriate follow-up care.

Emergency Department (ED) Utilization: The PCP collaborates with the Care Manager for enrollment in Care Management and Disease Management Programs where opportunities are identified

Transition of Care: Managing transition of care for discharged members may include but is not limited to face to face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan.

ICT Training: All internal and external ICT members will be trained annually on the current Model of Care.

HMO Special Needs Plan (SNP) Model of Care (MOC) and Care Management

The MOC provides the basic framework under which Ascension Complete will meet the needs of our Medicare members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each member are identified and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. Your role in the Model of Care is very important. Every SNP member must have:

- Initial and annual HRA
- ICP

ICT participation and guidance in the development of the ICP and attendance at the ICT meeting is necessary to:

- Promote improved member outcomes and condition self-management
- All SNP members remain in Care Management as required by CMS

Purpose

- To improve quality, reduce costs, and improve the member experience
- Ensure members have full access to the services to which they are entitled
- Improve the coordination between the federal government and state requirements

- Develop innovative care coordination and integration models
- Eliminate financial misalignments that lead to poor quality and cost shifting

Model of Care Elements include:

- MOC 1: SNP Population
- MOC 2: Care Coordination and Care Transitions protocol
- MOC 3: Provider Network
- MOC 4: Quality Measurement

Health Risk Assessment

Ascension Complete shall seek to provide every SNP member a comprehensive HRA within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.

The HRA collects information about the member's medical, psychosocial, cognitive, and functional needs, and behavioral health history.

The HRA determines the member's level of health and functioning.

Ascension Complete, with the help of the member/designated caregiver and the member's provider(s), develops an ICP for each SNP member.

Following the HRA, all SNP members who choose to participate in the Case Management Program will:

- Participate with a care manager to develop and agree upon their ICP. This will be shared with the members of the ICT for input and finalization of the member's care plan.
- Receive regular telephonic contact with their assigned care manager to monitor progress/regression towards goals of the care plan.
- Benefit from ongoing communication between the care manager and other members of the ICT.

Individualized Care Plan

All SNP members must have an ICP which is developed in conjunction with the member/caregiver, Primary Care Physician and other members of the health care team including the ICT. The ICP includes:

- Problems, interventions and goals
- Specific services and benefits to be provided
- Measurable outcomes

Members receive monitoring, service referrals, and condition specific education. Care Manager's and PCP's work closely together with the member and their family to prepare, implement and evaluate the ICP. Ascension Complete disseminates evidence-based clinical guidelines and conducts studies to:

- Measure member outcomes
- Monitor quality of care
- Evaluate the effectiveness of the MOC

SNP members who can't be contacted by Ascension Complete or who refuse the Care Management Program will have an initial communication plan created and sent to their PCP. This plan is to obtain additional information about the member in order to individualize the member's care plan. We encourage the PCPs to discuss care management participation with their members and refer them to us at any time.

All SNP members who undergo a transition of care from one setting to any other setting may receive from Ascension Complete:

- Communication from care management
- Contact after discharge from one level of care to the next or home
- Education on transition and transition prevention

Providers will receive communication about the member's transition and any other status changes related to the member's health.

Utilization Management

The Utilization Management Program's goals are to optimize members' health status, sense of well-being, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM Program aims to ensure that provided services are a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Medical Necessity

The fact that a physician may prescribe, authorize, or direct a service does not itself make it medically necessary, as defined below .

Medical necessity determinations will be made following thorough review by Ascension Complete clinical staff using nationally recognized criteria, Medicare National and Local Coverage Determinations and evidenced based clinical policies. Medical policies are developed through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website.

Medically necessary services are health care 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 provider 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 provider or hospital

If a member may not agree with the medical necessity determination, a member can appeal the decision. Please refer to the "Grievance Process" section of the provider manual.

Utilization Review Criteria

Ascension Complete's Medical Director or other health care professional, with appropriate clinical expertise in treating the member's condition or disease, will review all potential adverse determinations and decide in accordance with currently accepted medical or health care practices, considering special circumstances of each case that may require deviation from NCD, LCD, nationally recognized criteria, or other standards mentioned above. Ascension Complete's Clinical Policies are posted at www.ascensioncomplete.com. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-833-293-5966. Providers can discuss any adverse decisions with an Ascension Complete physician or other appropriate reviewer at the time of an adverse determination. The Medical Director may be contacted by calling Ascension Complete at 1-833-293-5966 and asking for the Medical Director. An Ascension Complete Care Manager may also coordinate communication between the Medical Director and the requesting provider.

Utilization management decision making is based on appropriateness of care and service and the existence of coverage. Ascension Complete does not provide financial incentives and does not reward providers or other individuals for issuing denials of authorizations.

Utilization Determination Timeframes

Utilization management decision making is based on appropriateness of care and service and the covered benefits of the plan.

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

Level of Urgency

Type	Timeframe
Standard	Expediently as the member's health condition required, but no later than 15 calendar days after receipt of request

Standard Extension	Up to 14 additional calendar days (not to exceed 28 calendar days from receipt of original request)
Expedited	Expeditiously as the member's health condition requires, but no later than Within 72 hours after receipt of request
Expedited Extension	Add 11 days up to 14 additional calendar days (not to exceed 17 calendar days after receipt of original request)
Concurrent	As soon as medically indicated; usually within three (3) business day of request depending on the plan's policy

Standard Organization Determinations

Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 14 calendar days after we receive the request for service. 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 provider 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 provider's request. 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 Complete Medicare HMO Phone: 1-833-293-5966 (TTY: 711) Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP): 1-833-293-5966 (TTY: 711).

Concurrent Review

Concurrent review is defined as any review for an extension of a previously approved, ongoing course of treatment over a period 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 72 hours of receipt.

Retrospective Review

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

Retrospective review initiated by Ascension Complete

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

Retrospective review initiated by Providers

Ascension Complete will review post-service requests for authorization of inpatient admissions or outpatient services only if, at the time of treatment, the Member was not eligible, but became eligible with Ascension Complete retroactively or in cases of emergency treatment and the payer is not known at the time of service. Ascension Complete will give a written notification to the requesting Provider and Member within 30 calendar days of receipt of a request for a UM determination. If Ascension Complete is unable to decide 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.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Ascension Complete is using National Imaging Associates (NIA) to provide prior authorization services and utilization management. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scan

Key Provisions

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach NIA and obtain authorization, please call 1-800-424-5357 and follow the prompt for radiology authorizations or fax request to 1-800-424-5357 NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Ascension Complete in collaboration with NIA Magellan, is launching a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend

an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, NIA Magellan addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

NIA Magellan has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from the NIA Cardiac Advisory Board and other experts. The guidelines are transparent and available throughout their programs. NIA Magellan also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

How the Program Works

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- Multigated Acquisition Scan (MUGA Scan)
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through NIA Magellan:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach NIA and obtain authorization, please call 1-800-424-5357 and follow the prompt for radiology and cardiac authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging providers to ensure the highest technical and professional standards

PRIOR AUTHORIZATION

Prior authorization requires that the provider or practitioner make a formal medical necessity determination request to Ascension Complete prior to the service being rendered. Members may submit a request for organization determination. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage 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 but not by way of limitation 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.

For members enrolled in a PPO plan, authorization is not required for nonparticipating providers and facilities, however, services on the medical necessity/authorization required list must be covered services within the benefit plan and considered medically necessary for the plan to pay a portion of the out-of-network claim.

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 Complete website at www.ascensioncomplete.com and use the Pre-Screen Tool or call the Authorization Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. We will suspend the need for prior authorization requests during an emergency/disaster where providers are unable to reach Ascension Complete for an extended period and when, acting in good faith, providers need to deliver services to our members. Ascension Complete does not reward providers, practitioners, employees who perform utilization reviews, or other individuals for 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 benefit coverage. Ascension Complete affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Note: All out-of-network services require prior authorization excluding emergency room services, urgent care when the PCP is not available, and out of area dialysis.

Submitting Prior Authorization Requests

The preferred method for submitting authorization requests is through the Secure Web Portal at www.ascensioncomplete.com. The provider must be a registered user on the Secure Web Portal. (If a provider is already registered for the Secure Web Portal for one of our other products, that registration will grant the provider access to Ascension Complete). If the provider is not already a registered user on the Secure Web

Portal and needs assistance or training on submitting prior authorizations, the provider should contact Provider Relations.

Prior authorization requests may be called to Ascension Complete at Medicare (HMO) 1-833-293-5966 or Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP) Phone: 1-833-293-5966 (TTY: 711).

Prior authorization requests may be faxed to 1-844-996-0202. The fax authorization form can be found on our website at www.ascensioncomplete.com.

Timeframes for Prior Authorization Requests and Notifications

Service Type	Timeframe
Elective/scheduled admissions	Required five (5) business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification requested within (1) business day

The requesting or rendering provider 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
- Provider 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 performed, it is recommended that within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-833-293-5966 (TTY: 711) or 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

PHARMACY

Pharmacy coverage for Ascension Complete members varies based on the plan benefits. Information regarding the member's pharmacy coverage can be found via our secure online Provider Portal. Additional resources available on the website include the Ascension Complete formulary, Pharmacy Benefit Manager Provider Manual, and Coverage Determination (Part D Prior Authorization /Exception) form.

The formulary is a list of covered drugs selected by Ascension Complete in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary includes:

- Covered drugs, including restrictions and limitations.
- Information on prior authorization, quantity limits, step therapy and generic substitution.
- How prescribing providers can request an exception.
- Transition supplies and level of care changes.

Annually and at least quarterly, the Ascension Complete formulary is approved by the Pharmacy and Therapeutics Committee (P&T). Participants include practicing pharmacists and physicians from various specialties. The Ascension Complete formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness as part of a quality treatment program. The Centers for Medicare and Medicaid Services (CMS) must also approve of the drugs included in the Ascension Complete formulary. 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.

The formulary is updated monthly and is available to view or download on our website at www.ascensioncomplete.com. Providers may also call Provider Services at [insert phone number] for a printed copy of the pharmaceutical management procedures and updates by mail, fax, or email.

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, Ascension Complete provides support for the following:

- Temporary supply of prescription drugs according to plan rules
- Utilization Management (including Prior Authorization Requirements)
- Exceptions and Appeals
- Locating a nearby pharmacy
- Information about formulary changes
- Out-of-Network Coverage

Pharmacy Transition Policy

Under certain circumstances and following CMS requirements, Ascension Complete can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, members must meet the requirements below:

- The drug the member has been taking is no longer on the Ascension Complete formulary or the drug is now restricted in some way
- The member must be in one of the situations described below:
 - For members who are new or who were in the plan last year: We will cover a temporary supply of the member's drug during the first 90 days of their membership in the plan if they were new and during the first 90 days of the calendar 2020 Evidence of Coverage for Ascension Complete Medicare (HMO) 107 Chapter 5. Using the plan's coverage for Part D prescription drugs year if the member was in the plan last year. This temporary supply will be for a maximum of a 30-day supply. If the prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
 - For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away: We will cover one 31-day supply of a particular drug, or less if the prescription is written for fewer days. This is in addition to the above temporary supply situation.
 - For current members of the plan who are moving from a long-term care (LTC) facility, or a hospital stay to home and need a transition supply right away: We will cover one 30-day supply, or less if the prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 30-day supply of medication).
 - For current members of the plan who are moving from home, or a hospital stay to a long-term care (LTC) facility and need a transition supply right away: We will cover one 31-day supply, or less if the prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 31-day supply of medication).

Pharmacy Prior Authorization Requirements

Ascension Complete has a team of doctors and pharmacists to create tools to help provide quality coverage to Ascension Complete members. The tools include, but are not limited to prior authorization criteria, clinical edits and quantity limits. Some examples include:

Age Limits: Some drugs require a prior authorization if the member's age does not meet the manufacturer, FDA, or clinical recommendations.

Quantity Limits: For certain drugs, Ascension Complete limits the amount of the drug we will cover per prescription or for a defined period.

Prior Authorization: Ascension Complete requires prior authorization for certain drugs. (Prior Authorization may be required for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through our exceptions process.) This means that approval will be required before a prescription can be filled. If approval is not obtained, Ascension Complete may not cover the drug.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give the generic version, unless the brand-name drug was requested. If the brand-name drug is not on the formulary, an exception request may be required for coverage. If the brand-name drug is approved, the member may be responsible for a higher co-pay.

Ascension Complete can make an exception to our coverage rules, please refer to the Comprehensive Formulary. When requesting a utilization restriction exception, submit a supporting statement along with a completed Request for Medicare Prescription Drug Coverage Determination form which can be found at www.ascensioncomplete.com. To ensure your patient receives prompt service, use the Medicare specific Ascension Complete form and fax it to the number identified on the form. Generally, Ascension Complete will decide within 72 hours of getting the supporting statement. Providers can request an expedited (fast) exception if the member's health could be seriously harmed by waiting up to 72 hours for a decision. If the request to expedite is granted, Ascension Complete will provide decide no later than 24 hours after receiving the prescriber's or prescribing doctor's supporting statement.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Ascension Complete network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider only upon receiving a prior authorization from the Ascension Complete Utilization Management Department.

Health Care

Members may see a network provider, who is contracted with Ascension Complete to provide health care 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 health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Ascension Complete'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.

ENCOUNTERS AND CLAIMS

Encounter Reporting

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for services provided to an Ascension Complete member. For example, if you are the PCP for an Ascension Complete Member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero-dollar amounts. It is mandatory that your office submits encounter data. Ascension Complete utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by CMS. Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP. Providers are required to submit either an encounter or a claim for each service that you render to an Ascension Complete Member.

CLAIMS

In general, Ascension Complete follows the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Ascension Complete is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials on the explanation of payment if not submitted correctly. **Claims will be rejected or denied if not submitted correctly.**

Verification Procedures

All claims filed with Ascension Complete are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form (02/12), CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted on our Secure Provider Portal, individually or batch.
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.
- Claims must contain the CLIA number when CLIA waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- DME claims require a referring provider.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
 - Date of Service
 - Provider Type and/or provider specialty billing
 - Age and/or sex for the date of service billed
 - Bill type
 - All Diagnosis Codes are to their highest number of digits available.
- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
 - F2 – International Unit
 - GR – Gram
 - ME – Milligram
 - ML – Milliliter

- UN - Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.
- For a CMS 1500 Claim Form, this criterion looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
- All Inpatient Claims require an Admission Date in addition to an Admission Diagnosis. CMS 1500 Claim form if Location (Place of Service) is 21, 51 or 61 the Admit Date is required.
- All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
 - N - No
 - U - Unknown
 - W - Not Applicable
 - Y - Yes
- Member is eligible for services under Ascension Complete during the time period in which services were provided.
- Services were provided by a participating provider, or if provided by an “out-of-network” provider, authorization has been received to provide services to the eligible member. (Excludes services by an “out-of-network” provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.)
- An authorization has been given for services that require prior authorization by Ascension Complete.
- Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member’s contract on the date of service and prior authorization processes were followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

Clean Claim Definition

A clean claim is a claim that does not require external investigation or development to obtain information not available on the claim form or on record in www.ascensioncomplete.com's systems in order to adjudicate the claim. Clean claims must be filed within the timely filing period.

Non-Clean Claim Definition

Any claim that does not meet the definition of a clean claim is considered a non-clean claim. Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Upfront Rejections vs. Denials

Upfront Rejection

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 is 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 provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial

If all edits pass and the claim is accepted, it will then be entered into the system for processing. **A DENIAL** is defined as a claim that has passed edits and is entered into the system, however, has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below with explanations in Appendix II.

Timely Filing

Participating providers must submit first time claims within 180 days of the date of service. Claims received outside of this timeframe will be denied for untimely submission.

Who Can File Claims?

All providers who have rendered services for Ascension Complete members can file claims. It is important that providers ensure Ascension Complete has accurate and complete billing information on file. Please confirm with the Provider Services department or Provider 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 providers notify Ascension Complete 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 provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Electronic Claims Submission

Providers are encouraged to submit clean claims and encounter data electronically. Ascension Complete can receive an ANSI X12N 5010 837 professional, institutional transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice and deliver it securely to providers electronically or in paper format, dependent on provider preference. For more information on electronic claims and encounter data filing and the clearinghouses Ascension Complete has partnered with, contact:

Ascension Complete
c/o Centene EDI Department
1-800-225-2573, ext. 6075525
or
by email at: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Ascension Complete can receive coordination of benefits (COB) or secondary claims electronically. Ascension Complete follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

The Ascension Complete Payer ID is 68069. For a list of clearinghouses that we currently work with, please visit our website at www.ascensioncomplete.com.

Specific Data Record Requirements

Claims transmitted electronically must contain all 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.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Ascension Complete, all EDI claims must first be forwarded to one of Ascension Complete's clearinghouses. This can be completed via a direct submission to a clearinghouse, or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan specific requirements. Claims not meeting the requirements are immediately rejected

and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Ascension Complete. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Ascension Complete and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Ascension Complete by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back daily to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims; these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Ascension Complete.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor Customer Service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to Ascension Complete 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 Complete. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in 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 our EDI BA Support at 1-800-225-2573 Ext. 6075525, or via e-mail at EDIBA@centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

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 e.g., custom DME, prosthetics. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review (e.g., complicated, or unusual procedure). NOTE: Provider is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity e.g., oxygen, motorized wheelchairs.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Submitting claims through clearinghouses: Ascension Complete Payer ID number for all clearinghouses: <ul style="list-style-type: none"> ● Medical - 68069 ● Behavioral Health - 68068 	Availity is our primary clearinghouse, which provides an extensive network of connectivity. Providers may use their preferred clearinghouse as Availity maintains active connections with many clearinghouses.
General EDI Questions	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com
Claims Transmission Report Questions	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?)	Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com

Remittance Advice Questions	Contact Provider Services or the Secure Provider Portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes	Notify Provider Service in writing (W9).

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 Provider Services that the provider is set up in the Ascension Complete system prior to submitting EDI claims.
4. You will receive two (2) 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 Complete, and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Ascension Complete. ALWAYS review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit.
5. All claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Ascension Complete has made it easy and convenient to submit claims directly to Ascension Complete on the Secure Provider Portal at www.ascensioncomplete.com.

You must request access to our secure site by registering for a username and password. If you have technical support questions, please contact Provider Services.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Detailed instructions for submitting via Secure Web Portal are also stored on our website; you must login to the secure site for access to this manual.

Paper Claim Submission

The mailing address for first time claim submissions, corrected claims, and requests for reconsideration is:

Ascension Complete
Attn: Claims
P.O. Box 3060
Farmington, MO 63640-3822

Ascension Complete encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available in the Appendix section of this Manual. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claim's office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected. If a paper claim has been rejected, provider should correct the error and resubmit the paper claim as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

The mailing address for Part D vaccine claims administered in a provider's office is:

Part D Claims
P.O. Box 419069
Rancho Cordova, CA 95741-9069

Acceptable Forms

Ascension Complete 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 provider. This includes black and white forms, as well as form with handwriting.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Ascension Complete does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman fonts, 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 provider. 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 Provider 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 provider.
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 of 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 provider or that the "out-of-network" provider has received authorization to provide services to the eligible member.

7. Ensure an authorization has been given for services that require prior authorization by Ascension Complete.

Claims missing the necessary requirements are not considered “clean claims” and will be returned to providers 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 90 days from the date of explanation of payment or denial is issued. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 90 days corrected claim filing limit 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 provider, or damage or destruction of the provider’s business office or records by a natural disaster, mechanical, administrative delays, or errors by Ascension Complete or the Federal and/or State regulatory body.

The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all the following conditions are met:

- The provider’s records document that the member refused or was physically unable to provide their ID Card or information
- The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered
- The provider has not filed a claim for this member prior to the filing of the claim under review

Below are relevant definitions:

- **Corrected claim** – A provider is submitting a correction to the original claim
- **Request for Reconsideration** – Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
- **Claim Dispute** – Provider disagrees with the outcome of the Request for Reconsideration

Corrected Claims

All requests for corrected claims must be received within 90 calendar days from the date of explanation of payment or denial is issued. Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the secure Provider Portal - Follow the instructions on the portal for submitting a correction.
- Submit a corrected claim electronically via a Clearinghouse

- 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 Complete
Attn: Corrected Claims
P.O. BOX 3060
Farmington, MO 63640-3822

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 cancelled) 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 provider about a disagreement with the way a claim was processed. All requests for reconsideration must be received within 90 calendar days from the date of explanation of payment or denial is issued. 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. Form - Providers may utilize the Request for Reconsideration form found on our website (preferred method).
2. Phone call to Provider Services - This method may be utilized for requests for reconsideration that do not require submission of supporting or additional information. An example of this would be when a provider may believe a particular service should be reimbursed at a particular rate, but the payment amount did not reflect that rate.
3. Written Letter - Providers 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's name, member ID number, date of service, total charges, provider 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 cancelled) 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 Complete
Attn: Request for Reconsideration
PO BOX 3060
Farmington, MO 63640-3822

Claim Dispute

A claim dispute should be used only when a provider 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 Complete
Attn: Claim Dispute
PO BOX 4000
Farmington, MO 63640-4400

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

Ascension Complete 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 Transfers (EFT) and Electronic Remittance Advices (ERA)

Ascension Complete partners with specific vendors to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment. Providers can enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact Provider Services.

Benefits include:

- **Elimination of paper checks** - all deposits transmitted via EFT to the designated bank account
 - Convenient payments & retrieval of remittance information
 - Electronic remittance advices 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 advices 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 advices quickly** – You can associate electronic payments with electronic remittance advices 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 provider home page on our website at www.ascensioncomplete.com. If further assistance is needed, please contact our Provider Services department at Ascension Complete Medicare HMO Phone 1-833-293-5966 (TTY: 711) or Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP) 1-833-293-5966 (TTY: 711).

RISK ADJUSTMENT AND CORRECT CODING

Risk adjustment is critical requirement defined in CFR42 (Section 42 of the Code of Federal Regulations) and the Medicare Modernization Act, that will help ensure the long-term success of the Medicare Advantage program. Accurate calculation of risk adjustment requires accuracy, documentation completeness, and specificity in diagnostic coding. Providers should always document and code according to CMS regulations and follow all applicable coding guidelines CPT, DSM-IV, and HCPCS code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity using the 4th and 5th digits, when applicable and defensible through chart audits and medical assessments.
- Code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment, or management.
- 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 provider manual.
- Alert Ascension Complete of any erroneous data submitted and follow Ascension Complete's policies to correct errors as set forth in your contract or this provider manual.
- Provide ongoing training to your staff regarding appropriate use of ICD coding for reporting diagnoses.

Coding Of Claims/ Billing Codes

Ascension Complete requires claims to be submitted using codes from the current version of ICD-10-CM, ASA, DRG, CPT, and HCPCS Level II for the date the service was 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:

- Code billed is missing, invalid, or deleted at the time of services
- Code inappropriate for the age or sex of the member
- Diagnosis code missing the 4th and 5th digit as appropriate
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on 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 Complete.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. A separate claim needs to be submitted for the mother, and their newborn.

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code / modifier combinations.

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 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.

For more information regarding billing codes, coding, and code auditing/editing, please contact Ascension Complete Provider Services.

CODE EDITING

Ascension Complete 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 provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier, and place of service codes against correct coding guidelines. While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, Ascension Complete 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 Complete may have policies that differ from generally accepted coding principles. Accordingly, exceptions to general coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

Ascension Complete 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.

CPT and HCPCS Coding Structure

The Healthcare Common Procedure Coding System (HCPCS) is a set of health care procedure codes based on the American Medical Association's (AMA) Current Procedural Terminology (CPT). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding.

1. **Level I HCPCS Codes (CPT):** This code set is maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are updated (added, revised, and deleted) on an annual basis.
2. **Level II HCPCS Codes:** The Level II set of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, and prosthetics, etc.). The Level II set is an alphanumeric coding system which is maintained by CMS. These codes are updated on an annual basis.
3. **Miscellaneous/Unlisted Codes:** These codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous or unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claim submission. If records are not received, the provider will receive a denial indicating that medical records are required. The medical documentation should clearly define the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a qualified medical professional will review the medical records to determine if there was a more specific code(s) to accurately describe the service or procedure rendered. Clinical validation also includes identifying and reviewing other procedures and services billed on the claim that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services

that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. **Temporary National Codes:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.
5. **Modifiers:** Modifiers are used to indicate additional information about the HCPCS, or CPT code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -25 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD-10)

ICD-10 is an alphanumeric system used by providers to classify diagnoses and symptoms. These codes consist of three to seven digits, which allows for a high level of specificity in coding a wide range of health problems.

Revenue Codes

These 4-digit numeric codes are utilized by institutional providers to represent services, procedures, and/or supplies provided in a hospital or facility setting. Claims submitted with revenue codes should indicate a corresponding procedure code.

Edit Sources

The claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, current research, etc.

The following sources are utilized in determining correct coding guidelines for the software:

- Centers for Medicare & Medicaid Services (including National Correct Coding Initiative (NCCI) Policy Manual and Claims Processing Manual guidelines as well as current PTP and MUE tables)
- American Medical Association (CPT, HCPCS, and ICD-10 guidelines and publications including CPT manual, AMA website, CPT Assistant, CPT Insider's View, etc.)
- Public domain specialty provider associations (such as American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons, American College of Obstetricians and Gynecologists, etc.).
- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals)

- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, MLN Matters and Provider Transmittals
- Health Plan policies and provider contract considerations
- In addition to nationally recognized coding guidelines, the software has flexibility to allow business rules that are unique to the needs of individual product lines

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/provider 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/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

Deny: Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions

Replace and Pay: Code editing recommends denial of a service line, and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing, as the original billing remains on the claim.

Code Editing Principles

The below principles do not represent an all-inclusive list of the available code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling

PTP Practitioner and Hospital Edits

CMS has designated certain combinations of codes that are generally not separately reimbursable on the same date of service. These are known as Procedure-to-Procedure (PTP) and/or Column I/Column II edits. Within the PTP edit category, there are Practitioner edits (applicable to claims submitted by physicians, non-physician

practitioners, and ambulatory surgical centers) and Hospital edits (applicable to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, speech-language pathology, and comprehensive outpatient rehabilitation facilities).

The procedure code listed in column I is the most comprehensive code; reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component to the successful outcome of the column I code.

While these code pairs should not be billed together under most circumstances, there are circumstances when an NCCI-associated modifier may be appended to the column II code to indicate a significant and separately identifiable or distinct service. When these modifiers are used, prepay clinical validation will be performed to ensure that services are reported appropriately. For more information on the PTP edits, please visit www.cms.gov.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

An MUE is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, nature of the service/procedure, nature of the analyte, equipment prescribing information and clinical judgment. Not all HCPCS/CPT codes have an MUE limit.

Code Bundling Rules Not Sourced to CMS NCCI Edit Tables

Many specialties medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with “MMM”

Global periods for maternity services are classified as “MMM” when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

Identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered bundled into the inpatient admission and therefore are not separately reimbursable.

Multiple Code Rebundling

Analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. Some codes are allowed a limited number of times on a single date of service, over a given period or during a member’s lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period or during a member’s lifetime. A frequency edit is applied by code editing software when the procedure code is billed more than these guidelines.

Duplicate Edits

The code editing software evaluates prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software also looks across different providers to determine if another provider was paid for the same procedure, for the same

member on the same date of service. Finally, the software analyzes multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician billing for office visits for the same member on the same date of service.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services, or technologies can be paid by Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

Evaluates claims billed with a co-surgeon or team surgeon that normally do not require a co-surgeon/team surgeon. CMS guidelines define whether an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co- or team surgeon.

Add-on and Base Code Edits

Analyzes claims in which an add-on CPT code was billed without the primary service CPT code. Additionally, add-on codes are denied if the primary service code was denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

Analyzes claims in which modifier -50 has been billed, but the same procedure code is submitted on a different service line on the same date of service without modifier -50. This rule is highly customized, as many health plans allow this type of billing.

Replacement Edits

Recommends that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, a provider bills more than one outpatient consultation code for the same member in the member's history. The software will deny the office consultation code and replace it with the appropriate evaluation and management service, established patient or subsequent hospital care code. Another example of the edit's function is when a provider has billed a new patient evaluation and management

code within three years of a previous new patient visit. The edit will replace the second submission with the appropriate established patient visit. A crosswalk is used to determine the appropriate code to add.

Missing Modifier Edits

Analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

Identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of postoperative follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- **Procedure code invalid:** Evaluates claims for invalid procedure and revenue or diagnosis codes
- **Deleted Codes:** Evaluates claims for procedure codes which have been deleted
- **Modifier to procedure code validation:** Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers such as -24, -25, -26, -57, -58 and -59.
- **Age:** Identifies procedures inconsistent with member's age
- **Gender Procedure:** Identifies procedures inconsistent with member's gender
- **Gender Diagnosis:** Identifies diagnosis codes inconsistent with member's gender
- **Incomplete/invalid diagnosis codes:** Identifies incomplete or invalid diagnosis codes

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Ascension Complete's clinical validation services is the review of modifiers -25, -59, and X(EPSU). Within the CMS NCCI PTP edit tables, some code pairs allow an NCCI-associated modifier to be appended when the correct coding modifier indicator is "1". Furthermore, public domain specialty organization edits may also be considered for override when billed with these modifiers. When these

modifiers are billed, the provider's documentation should support a separately reimbursable service. Some examples of separately identifiable services include a different session, site or organ system, surgery, incision/excision, lesion, or separate injury. Ascension Complete's clinical validation team uses the information on the prospective claim and claims history to determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifiers -59 and X(EPSU)

The NCCI (National Correct Coding Initiative) states that the primary purpose of modifier -59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate for separate reimbursement under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers routinely assign modifier -59 or X(EPSU) when billing a combination of codes that will result in a denial due to unbundling. Modifier -59 is commonly misused as related to the portion of the definition that allows its use to describe "different procedure or surgery". NCCI guidelines state that providers should not use modifier -59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier -59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

Ascension Complete uses the following guidelines to determine if modifier -59 or X(EPSU) was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated.
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier -25

Both CPT and CMS specify that by using modifier -25, the provider is indicating that a “significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service”. Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra-, and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Ascension Complete uses the following guidelines to determine whether modifier -25 was used appropriately. If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- The E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient’s condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member’s need for additional services.
- To avoid incorrect denials, providers should assign all applicable diagnosis codes that support additional E/M services.

Claim Reconsiderations Related to Code Editing

Claims appeals resulting from claim editing are handled per the provider 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.

To request claim reconsideration, documentation (medical records) must be submitted 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

Viewing Claims Coding Edits

Code Auditing Tool

A web-based code editing reference tool designed to “mirror” how code editing products evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on the Secure Provider Portal. The tool can be accessed in the Claims Module by clicking “Claim Editing Tool” in the Secure Provider Portal.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
- Proactively determine the appropriate code/code combination representing the service to ensure accurate billing

The tool reviews the codes entered to determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a “what if” or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate

The code editing assistant can be accessed from the Secure Provider Portal.

Disclaimer: This tool is used to apply coding logic only. It will not consider individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Automated Clinical Payment Policy Edits

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system. Once adopted by the health plan, these policies are posted on the health plan’s Secure Provider Portal.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.xxx in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.xxx in the reference number of the policy.

Most clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (EX) code is applied to the service line billed with the disallowed procedure. This EX-code can be viewed on the provider’s explanation of payment.

- xE: Procedure Code is disallowed with this Diagnosis Code(s) Per Plan Policy.

Examples

Policy Name	Clinical Policy Number	Description
Diagnosis of Vaginitis	CP.MP.97	To define medical necessity criteria for the diagnostic evaluation of vaginitis in members ≥ 13 years of age
Urodynamic Testing	CP.MP.98	To define medical necessity criteria for commonly used urodynamic studies
Bevacizumab (Avastin)	CP.PHAR.93	To ensure patients follow selection criteria for Avastin use.

Some clinical payment policy edits may also occur as the result of a single code denial for a service that is not supported by medical necessity. When this occurs, the following explanation (ex) code is applied to the service line billed with the disallowed procedure. This ex-code can be viewed on the provider's explanation of payment.

- xP: Service is denied according to a payment or coverage policy

Policy Name	Clinical Policy Number	Description
Fractional Exhaled Nitric Oxide	CP.MP.103	To clarify that testing for fractionated exhaled nitric oxide (FeNO) is investigational for diagnosing and guiding the treatment of asthma, as there is insufficient evidence proving it more than or as effective as existing standards of care.

Clinical Payment Policy Appeals

Clinical payment policy denials may be appealed based on medical necessity. Providers who disagree with a claim denial based on a clinical payment policy, and who believe that the service rendered was medically necessary and clinically appropriate, may submit a written reconsideration request for the claim denial using the provider claim reconsideration/appeal/dispute or other appropriate process as defined in the health plan's provider manual. The appeal should include information such as:

- 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.

THIRD PARTY LIABILITY

Third party liability refers to any other third-party including, but not limited to, health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, self-funded, commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If third party liability coverage is determined after services are rendered, Ascension Complete will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

BILLING THE MEMBER

Failure to Obtain Authorization

Providers may NOT bill members for services when the provider fails to obtain an authorization and the claim is denied by Ascension Complete.

No Balance Billing

Providers may not seek payment from Ascension Complete members for the difference between the billed charges and the contracted rate paid by Ascension Complete.

Non-Covered Services

Contracted providers may only bill Ascension Complete members for non-covered services if:

- A request for prior authorization was denied by the plan and the member received a written Notice of Denial of Medical Coverage (form CMS 10003-NDMCP) in advance of receiving the service; or
- The member's Evidence of Coverage clearly states the item or service is never covered by the plan.

Note: the member is not obligated to pay for the service if it is later found that the service was covered by Ascension Complete at the time it was provided, even if Ascension Complete did not pay the provider for the service because the provider did not comply with Ascension Complete requirements.

Qualified Medicare Beneficiaries (QMB) Billing

Ascension Complete from www.ascensioncomplete.com works to ensure that the Medicare members are never inappropriately held financially liable for the care they receive.

Billing of Qualified Medicare Beneficiaries (QMBs) Is Prohibited by Federal Law

Medicare providers and suppliers may not bill Ascension Complete members enrolled in the QMB program for Medicare cost-sharing. Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice.

Providers and suppliers may also verify a patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

MEMBER RIGHTS AND RESPONSIBILITIES

The following description of Member Rights and Responsibilities may not be an exhaustive list.

Member Rights

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

1. To participate with providers in making decisions about their health care. 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.
2. 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.
3. To receive the benefits for which the member has coverage.
4. To be treated with respect and dignity.
5. To privacy of their personal health information, consistent with state and federal laws, and Ascension Complete policies.
6. To receive information or make recommendations, including changes, about Ascension Complete's organization and services, the Ascension Complete network of providers, and member rights and responsibilities.
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit 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 provider 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 provider will ask for the member's approval for treatment unless there is an emergency and the member's life, and health are in danger.
8. To make recommendations regarding the Ascension Complete member's rights, responsibilities, and policies.
9. To voice complaints or appeals about: Ascension Complete, any benefit or coverage decisions Ascension Complete makes, Ascension Complete coverage, or the care provided.

10. 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 provider(s) of the medical consequences.
11. To see their medical records.
12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Ascension Complete rules and guidelines. Ascension Complete will notify members at least [insert timeframe] 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.
13. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion.
16. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.
17. To receive information in a different format in compliance with the Americans with Disabilities Act if the member has a disability.
18. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care physician or other provider. The primary care physician or other provider must discuss different treatment plans with the member. The member must make the final decision.
19. To select a primary care physician within the network. The member has the right to change their primary care physician or request information on network providers close to their home or work.
20. 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.
21. To have access to an interpreter when the member does not speak or understand the language of the area.

22. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.
23. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. 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 Complete contract in its entirety.
2. To treat all health care 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 provider, so they understand the care they are receiving.
4. To review and understand the information they receive about Ascension Complete. The member needs to know the proper use of covered services.
5. To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
6. To know the name of their assigned primary care physician. The member should establish a relationship with their primary care physician. The member may change their primary care physician verbally or in writing by contacting the Ascension Complete Member Services Department.
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 health care providers in developing mutually agreed upon treatment goals to the degree possible.
9. To supply, to the extent possible, information that Ascension Complete and/or their providers need in order to provide care.

10. To follow the treatment plans and instructions for care that they have agreed on with their health care providers.
11. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care physician 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 benefit 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 physician.
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 Complete coverage, the member must provide this information to Ascension Complete.
15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

PROVIDER RIGHTS AND RESPONSIBILITIES

The following description of Provider Rights and Responsibilities may not be an exhaustive list.

Provider Rights

1. To be treated by their patients, who are Ascension Complete 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 Complete 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 providers to act as partners in members' treatment plans.
5. To expect members to follow their health care 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 Complete 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 Complete quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
9. To contact Provider Services with any questions, comments, or problems.
10. To collaborate with other health care professionals who are involved in the care of members.
11. To not be excluded, penalized, or terminated from participating with Ascension Complete for having developed or accumulated a substantial number of patients in Ascension Complete with high-cost medical conditions.
12. To collect member cost shares at the time of the service.

Provider Responsibilities

Providers 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 forego 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 based on 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 provider'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 restriction 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 benefit 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, if 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 health care services appropriately.

15. To follow all state and federal laws and regulations related to patient care and rights.
16. To participate in Ascension Complete data collection initiatives, such as HEDIS® and other contractual or regulatory programs.
17. To review clinical practice guidelines distributed by Ascension Complete.
18. To comply with the Ascension Complete Medical Management program as outlined herein.
19. To disclose overpayments or improper payments to Ascension Complete.
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
21. To obtain and report to Ascension Complete information regarding other insurance coverage the member has or may have.
22. To give Ascension Complete timely, written notice if provider is leaving/closing a practice.
23. To contact Ascension Complete 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 based on the provider's moral or religious beliefs or other similar grounds.
27. To provide hours of operation to Ascension Complete members which are no less than those offered to other Medicare patients.

Interference with Health Care Professionals' Advice

Ascension Complete has a responsibility to uphold the prohibition against interference with health care professionals' advice. We may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an Ascension Complete member:

- The member's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

For more information, please visit the Medicare Managed Care Manual. This information is currently located in Section Interference with Health Care Professionals' Advice to Enrollees Prohibited (Rev. 24, 06-06-03).

CULTURAL COMPETENCY

Ascension Complete views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Ascension Complete is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every enrollee regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care.

As part of Ascension Complete's Cultural Competency Program, providers must:

- Inform members of their right to access free, quality medical interpreters and signers, accessible transportation, and TDD/TTY services.
- Facilitate member access to Cultural and Linguistic Services, including Informing members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services.
 - To support informing members of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance for the top 15 languages as identified by the ACA 1557 and include at least one tagline in 18-point font.
- Document member requests for language services and/or refusal of professional language services in the medical record.
- Participate in cultural competency education and training at least annually.
- Provide medical care with consideration of the members' primary language, race, ethnicity, and culture.

- Ensure that office staff routinely interacting with members have been given the opportunity, and have participated in, cultural competency training.
- Ensure that treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on health care.
- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public facility, or be subjected to discrimination by any such facility.

Ascension Complete considers this mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member covered services, or availability of a facility.
- Providing an Ascension Complete member covered services that are different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

Ascension Complete provides Cultural Competency cultural competency training, located on the provider portal, to meet annual cultural competency training requirements. Providers can participate in training opportunities administered by the State, nationally recognized organizations, or training provided by other organizations. For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at: <https://cccm.thinkculturalhealth.hhs.gov/>
- Think Cultural Health's website includes classes, guides and tools to assist you in providing culturally competent care. The website is: <http://www.thinkculturalhealth.hhs.gov/>
- The Agency for Healthcare Research and Quality website, which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at <https://www.ahrq.gov/health-literacy/improve/precautions/toolkit.html>.

The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) website at

<https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy>. Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.

Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition against national Origin Discriminations, the President's Executive Order 131166, section 1557 of the Patient Protection and Affordable care Act, Ascension Complete AMITA and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to Ascension Complete members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if cultural and linguistic needs are not met.

Language services include:

- Telephonic interpretation
- Oral translation (reading of English material in a members preferred language)
- Face to Face non-English interpretation
- American Sign language
- Auxiliary aids including alternate formats such as large print and braille
- Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for a member, contact Ascension Complete provider services. For Face to Face and American Sign Language requests, contact Ascension Complete provider services as soon as possible, or at least 5 business days before the appointment. All providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center at: 1-833-293-5966 or TTY 711.

Restrictions Related to Interpretation or Facilitation of Communication

- Providers may not request or require an individual with limited English proficiency to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- Providers may not use an accompanying adult or minor child to interpreter or facilitate communication

Exceptions to these expectations include:

- In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.
- Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the

accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.

Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

PROVIDER ACCESSIBILITY INITIATIVE

Ascension Complete is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Ascension Complete through an onsite Accessibility Site Review (ASR).

Ascension Complete expectation, as communicated through the provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Ascension Complete providers.

Americans with Disabilities Act

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity.
- Denial of the benefits of services, programs, or activities of a public entity.
- Discrimination by any such entity Ascension Complete providers must provide physical access, accommodations, and accessible equipment for members with physical or mental disabilities as required by 42 CFR Section 438.206(c)(3).

Providers are required to comply with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). Ascension Complete must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the provider is architecturally and programmatically accessible to persons with disabilities. "Physical access," also referred to as "architectural access," refers to a person with a disability's ability to access buildings, structures, and the environment. "Programmatic access" refers to a person with a

disability's ability to access goods, services, activities and equipment.

If any disability access barriers are identified, the provider agrees, in writing, to remove the barrier to make the office, facility, or services accessible to persons with disabilities within one hundred eighty (180) days after the barrier has been identified.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats, including but not limited to:
 - an in-person interpreter upon a member's request.
 - telephone, relay, or video remote interpreting 24 hours a day seven days a week; or
 - through other formats, such as real-time captioning or augmentative & alternative communication devices, that ensure effective communication.
- Provide Member-Informing Materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages and provided through a variety of other means. This may include but not be limited to:
 - oral interpretation for other languages upon request.
 - accessible formats (e.g., documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; and
 - easy-to-understand materials provided in a manner that considers different levels of health literacy.
- Provide services, programs, or activities that are readily accessible to and useable by Members with disabilities. This includes but is not limited to accessible: medical care facilities, diagnostic equipment, and examination tables & scales; and modification of policies, practices, and procedures (e.g., modify policies to permit the use of service animals or to minimize distractions and stimuli for Members with mental health or developmental disabilities).
- Inform Members of the availability of these cultural, linguistic, and disability access services at no cost to Members on brochures, newsletters, outreach and marketing materials, other materials that are routinely disseminated to Members, and at Member orientation sessions and sites where Members receive covered services.
- Ascension Complete and participating providers shall also facilitate access to these services and document a request and/or refusal of services in the health plan and the provider's member data system.

Call your Provider Relations Representative at 1-833-293-5966 (TDD/TTY: 711) for more information.

Important Points to Remember: Word Choice

Avoid words with negative connotations like "handicapped", "afflicted", "crippled", "victim", "sufferer", etc. Do not refer to individuals by their disability. A person is not a condition.

Emphasize “Person First” Terminology	
Handicapped	A PERSON with a disability.
Deaf	A PERSON who is deaf.
Mute	A PERSON without speech.
Confined/Wheelchair-Bound	A PERSON who uses a wheelchair.

If you happen to not have a disability currently in your life, that DOES NOT make you “normal” or “able-bodied”. It makes you “non-disabled”.

Call your Provider Relations Representative at 1-833-293-5966 for more information.

The term "disability" means, with respect to an individual. Disability is any substantial limitation of one or more of a person’s daily life activities and may be present from birth or may occur during a person’s lifetime. Any individual meeting any of these conditions is an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of members with disabilities to receive the same quality of care as other persons.

Common Methods to Ensure Equal Communication and Access to Information

- Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded other members
 - Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location
- Provision for a presence of sign language interpreters to enable full communication with deaf or hard of hearing members who use sign language
- Provision for making auditory information (e.g., automated messages) available via alternative means
 - Written communication or secure web-based methods may be used as possible substitutes
- Provision for communicating with deaf or hard of hearing members by telephone
 - Use of telephone relay services (TRS), video relay services (VRS), a TDD, or use of secure electronic means

Policies for Scheduling and Waiting

- Policies that allow scheduling additional time for the duration of appointments for members with disabilities who may require it

- Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
- Policies to enable members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival
 - Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious
- Policies to allow flexibility in appointment times for members who use paratransit
 - Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability
- Policies to enable compliance with federal law that guarantees access to provider offices for people with disabilities who use service animals
 - Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Conducting the Examination

- Training of healthcare providers in operation of accessible equipment
- Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral

- Current or potential members including people with disabilities should only be referred to another provider for established medical reasons or specialized expertise.
 - Referral results in a delay of treatment and subjects members to additional time, expense, and reduces member choice of providers.
- Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which members are referred.
 - Members may be unable to comply with medical referrals if referred location is not accessible and/or not prepared to provide the recommended service

General Requirements

General prohibitions against discrimination. Except as may be otherwise provided by applicable law, the following prohibitions against discrimination binding upon public entities also apply to Providers:

- No qualified individual with a disability shall, because of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, because of disability.
- Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service.
- Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded to others.
- Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others.
- Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others.
- Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates because of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program.
- Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards.
- Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Ascension Complete, or opportunity enjoyed by others receiving the aid, benefit, or service.
- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
 - That have the effect of subjecting qualified individuals with disabilities to discrimination because of disability; or
 - That have the purpose or effect of defeating; or
 - substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
 - That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control and are agencies of the same State.
- A public entity may not, in determining the site or location of a facility, make selections:

- That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
 - That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination because of disability.
- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination because of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination because of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination because of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
- Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.
- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

MEMBER GRIEVANCES AND APPEALS

Grievances

Members must follow the grievance process as listed below when a member is dissatisfied with any aspect of the operations, activities, or behavior of Ascension Complete, or its providers, or a delegated entity of Ascension Complete. Grievances may include, but are not limited to:

- An enrollee's involuntary disenrollment by the plan.
- Member believes they were misdiagnosed.
- Member believes treatment was not appropriate.
- Member believes they received, or did not receive, care that adversely impacted or had the potential to adversely impact their health.
- A change in premiums or cost sharing arrangements from one contract year to the next. Lack of quality of the care received.
- Plan benefit design.
- Difficulty contacting Ascension Complete via phone.
- Problems with the appeals process.
- Ascension Complete's decision not to expedite a coverage or appeal request.
- General dissatisfaction about a co-payment amount, but not a dispute about the amount the enrollee paid or is billed.
- General issue about a drug not being on the formulary or listed as an excluded drug.
- Calculation of True Out-of-Pocket (TrOOP) costs.
- Interpersonal aspects of care.

Members or their representative may submit a grievance verbally, in writing, via phone, mail, facsimile, or in person but must do so within 60 calendar days after the event. If the grievance meets the necessary criteria, a resolution is delivered to the member as expeditiously as the member's case requires, based on health status, but no later than 24 hours for expedited grievances and 30 calendar days for standard grievances. Extensions of up to 14 calendar days can be granted for standard grievances if the enrollee requests the extension or if Ascension Complete justifies the need for additional information and the delay is in the best interest of the member.

Appeals

Members or their representatives may file a formal appeal if they are dissatisfied with a medical care or drug coverage decision made by Ascension Complete. Appeals must be submitted within 60 days of the decision. Expedited reconsiderations/redeterminations will be made on medical care or drug coverage not yet received if standard deadlines could cause serious harm to the member's health. Standard appeals must be made in writing to the address below. Expedited appeals may also be made in writing or verbally by calling Member Services. Members may request an appeal via the secure web portal if available.

Member Grievance and Appeals Address

Written grievances and appeals must be mailed or faxed to:

Ascension Complete

Attn: Medicare Grievances and Authorization Appeals (Medicare Operations)

7700 Forsyth Blvd

St. Louis, MO 63105

FAX: 1-844-273-2671

For process or status questions, members or their representatives can contact Member Services at Ascension Complete Medicare HMO Phone: 1-833-293-5966 (TTY: 711) Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP): 1-833-293-5966 (TTY: 711).

PROVIDER COMPLAINT AND APPEALS PROCESS

Ascension Complete Complaint

A Complaint is a verbal or written expression by a provider which indicates dissatisfaction with Ascension Complete's policies, procedure, or any aspect of Ascension Complete's functions. Ascension Complete logs and tracks all complaints/grievances whether received verbally or in writing. A provider has 30 calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint. After a complete review of the complaint/grievance, Ascension Complete shall provide a written notice to the provider within 30 calendar days from the received date of Ascension Complete's decision. If the complaint is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint.

Providers who wish to file a verbal or written complaint or appeal can do so by the following:

Verbal contact the Provider Services at HMO: 1-833-293-5966 (TTY: 711) or HMO SNP: 1-833-293-5966 (TTY: 711).

To file a written complaint:

**Ascension Complete
Attn: Complaints Dept.
P.O. Box 10420
Van Nuys, CA 91410**

To file a written appeal:

**Ascension Complete
Attn: Appeals
7700 Forsyth Blvd
St Louis, MO 63105**

Authorization and Coverage Appeals

An Appeal is the mechanism which allows providers the right to appeal actions of Ascension Complete such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Ascension Complete. A provider has 60 calendar days from Ascension Complete's notice of action to file the appeal. Ascension Complete shall acknowledge receipt of each appeal within 10 business days after receiving an appeal. Ascension Complete shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Ascension Complete receives the appeal. Ascension Complete may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Ascension Complete

demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Ascension Complete shall provide written notice to the member for the delay.

Expedited appeals may be filed with Ascension Complete if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Ascension Complete may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Ascension Complete provides satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

An Appeal is the channel which allows providers the right to have the actions of Ascension Complete re-examined. Examples of appeals include but are not limited to, the denial of a prior authorization; if the provider disagrees with any rule, policy or procedure or decision made by Ascension Complete. A provider has 60 calendar days from Ascension Complete's notice of action to file the appeal. Ascension Complete shall acknowledge receipt within 10 business days after receiving an appeal. Ascension Complete shall review each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires. The notice shall not exceed 30 calendar days from the date Ascension Complete receives the appeal. Ascension Complete may extend the timeframe for resolution of the appeal up to 14 calendar days if: 1.) the member requests the extension or 2.) Ascension Complete demonstrates that there is need for additional information and the delay is in the member's best interest. For any extension not requested by the member, Ascension Complete shall provide written notice to the member for the delay.

Expedited appeals may be filed with Ascension Complete if the member's provider determines that the time expended for a standard resolution could seriously jeopardize the member's life or health. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals as defined herein.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal. Ascension Complete may extend this timeframe by up to an additional 14 calendar days if 1.) the member requests the extension or 2.) if Ascension Complete provides satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

QUALITY IMPROVEMENT

Overview

Ascension Complete's Quality Improvement (QI) Program is comprehensive, systematic and continuous. It applies to all Member demographic groups, care settings, and types of services afforded to Medicare Advantage Members, including the Dual Special Needs Plan membership. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include, but are not limited to:

- Utilization management
- Population Health Management (including Care Management/Disease Management/Chronic Care Improvement Program, Preventive and Clinical Health and Model of Care)
- Coordination/Continuity of Care
- Cultural Competency
- Credentialing and Peer Review
- Patient Safety and Quality of Care
- Appeals, Grievances and Complaints
- Member Experience and Retention
- Provider Experience
- Components of operational service (including customer service/claims, etc.)
- Contractual, regulatory and accreditation reporting requirements
- Behavioral Health Services
- Clinical Indicators and initiatives (including HEDIS®, HOS, and Star ratings)
- Member Record Review
- Delegation
- Pharmacy and Therapeutics
- Network Adequacy and Accessibility®
- Confidentiality and Ethics

The QI Program reflects a continuous quality improvement (CQI) philosophy and mode of action. The QI Program Description, the QI Work Plan, and the Annual Medicare and SNP Quality Improvement Program Evaluation describe CQI processes and are approved by the applicable committees. The Organization uses the CQI methodology to improve and accomplish identified goals and processes. The QI Program Description defines program structure, accountabilities, scope, responsibilities, and available resources. The Organization uses the Plan-Do-Study-Act (PDSA) method of CQI throughout the organization where multiple indicators of quality of care and service are reviewed and analyzed against benchmarks of quality clinical care, evidence-based medicine, and service delivery. When variations are noted, root cause analysis, action plans, and remeasurement occur to ensure progress toward established goals.

The strategy of PDSA incorporates the continuous tracking and trending of quality indicators to ensure that outcomes are measured, and goals attained. Quality of care interventions and outcomes are monitored through nationally recognized quality standards such as HEDIS® performance measures and CAHPS® surveys, while also utilizing current knowledge and clinical experience to monitor external quality review studies, periodic medical record reviews, clinical management, and quality initiatives. Previously identified Issues Action Plans are issued annually based on market and corporate performance with each measure within the Work Plan

The annual QI Work Plan identifies specific activities and initiatives carried out by the Plan and the performance measures for analysis throughout the year. Work Plan activities align with contractual, accreditation, and regulatory requirements and identify measurements to accomplish goals.

The Annual QI Program Evaluation describes the level of success achieved in realizing set clinical and service performance goals through quantitative and qualitative analysis and trending as appropriate. The Program Evaluation describes the overall effectiveness of the QI Program by including:

- A description of ongoing and completed QI activities and initiatives
- Trended clinical care and service performance measures as well as the desired outcomes and progress toward achieving goals
- An analysis and evaluation of the effectiveness of the QI Program and its progress toward influencing the quality of clinical care and service
- A description of any barriers to accomplishing quality clinical care or achieving desired outcomes
- Current opportunities for improvement with recommendations for interventions.
- Regular follow-up on action items identified in the Quality Improvement Committee (QIC) meeting forum

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Practitioner Involvement

Network Practitioners and Providers are contractually required to cooperate with all Quality Improvement (QI) activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in the <health plan's> QI programs. Practitioner and Provider contracts, or a contract addendum, also require that Practitioners and Providers allow <health plan> the use of their performance data for quality improvement activities.

Key Program Functions, Activities, and Initiatives

Ascension Complete continually assesses data and information to improve the level of care provided to its members. Some of the areas addressed by various programs and initiatives include:

- Network Access/availability monitoring
- Appeals/concerns/complaints/grievances
- Member experience
- Provider experience
- Behavioral health services
- Utilization management
- Cultural competency
- Model of Care
- Patient safety and quality of care
- Continuity and coordination of care
- Delegation
- Clinical indicators and initiatives (HEDIS®, HOS, Star ratings)

- Credentialing and Peer Review
- Pharmacy and therapeutics
- Preventive and clinical health guidelines
- Medical record review
- Delegation oversight
- Cultural competency
- Population health management (including disease and case management, chronic care improvement program, preventive and clinical health, and model of care)
- Components of operational service (customer service/claims, etc.)
- Confidentiality, ethics, regulatory and/or accreditation reporting requirements

Access/Availability Monitoring

Ascension Complete monitors geographic access through the production of GeoAccess reports and maps. Reports are generated using the specific access standards per regulatory agencies and accrediting bodies to ensure compliance and that the needs of all Members are met.

Ascension Complete monitors the timeliness of access to care within its Provider networks via appointment accessibility and after-hours telephone surveys per requirements outlined by regulatory agencies, contractual requirements and accrediting bodies. Ascension Complete requires that all network Providers, both first tier and downstream Providers, offer hours of operation that are no less than the hours of operation offered to commercial and fee-for-service patients.

GeoAccess maps and accessibility reports are developed and reviewed for targeted lines of business that adhere to regulatory agencies, accrediting bodies and company requirements. On

at least a semi-annual basis, Ascension Complete completes GeoAccess analysis to evaluate compliance to geographic access standards and act as appropriate. Results of the reports are reported into the appropriate committees.

In addition, average speed of answer, hold times, and call abandonment rates are monitored on an ongoing basis to ensure adequate access to Ascension Complete personnel for Members and Providers. Access and availability are also monitored on an annual basis via the Member satisfaction survey. Network availability data is reported to the QIC on a semiannual basis.

Appeals/Concerns/Complaints/Grievances

The Health Plan provides an appeal process includes both standard and expedited reviews and provides objective resolution for members and Providers who submit a request for review of an adverse determination. The mission of the Appeals Department is to support the organization's reconsideration process and compliance through the review of all requests for additional review of service and claim denials, as well as provide a mechanism for approval and/or payment for overturned decisions. The Appeals Department establishes and maintains procedures for reviewing all appeals made by enrollees, Providers on behalf of enrollees, appointed representatives, or Providers. In accordance with federal and state laws, an external appeal mechanism may also be available when the Plan makes an adverse decision. Appeals activities are reported to the Customer Service Quality Improvement Workgroup (CSQIW), Utilization Management Advisory Committee (UMAC), and Quality Improvement Committee (QIC). If a trend of medical necessity or benefit coverage overturns is identified, an in-depth review of the decision process will be initiated, and an intervention plan implemented as appropriate. In addition, monthly metrics regarding reasons for the appeal and the reasons for the overturn are presented to stakeholders with appeals volume and overturn rates by top

Providers (by volume). Appeals trends are monitored and reviewed through ad-hoc workgroups relating to utilization management, claims, processing errors, and configuration.

Within the Appeals Department, goals are:

- Resolve 95% of appeals within compliance and/or accreditation time frames
- Improve quality of data to facilitate reporting, tracking and trending, and analysis
- Achieve acceptable scores on accreditation, and internal and external audits
- Reduce the volume of appeals
- Improve compliance and efficiency through automation whenever possible

Members and Providers are encouraged to contact the Plan to report issues. Concerns may be reported via telephone, the company website, or in writing. A thorough review is conducted on all expressions of dissatisfaction received from our members or authorized representatives on behalf of the Members. Concerns are carefully analyzed and completely resolved; the best interests of the Member are always considered in accordance with Ascension Complete's coverage and service requirements.

Issues are documented in a common database to enable appropriate classification, timely investigation, and accurate reporting of issues to the appropriate Quality committee. Trended data is reviewed on a periodic basis to determine if a need for further action exists, be it Plan, practitioner, or Provider-focused. This data, any identified trends or problem areas, and mitigation strategies to eliminate top reasons for dissatisfaction are reported through UMAC and QIC on a quarterly basis.

Ascension Complete uses information regarding Member experiences to measure Member satisfaction with their healthcare. Sources of data used to evaluate experience include the annual Consumer Assessment of Health Providers and Systems (CAHPS) survey, the annual Experience of Care and Behavioral Health Outcomes (ECHO®), grievances, and appeals.

Member Experience

The Member experience data collected through the CAHPS survey addresses leading indicators of Member satisfaction including Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Care Coordination, Rating of Drug Plan, Getting Needed Prescription Drugs, Flu Vaccination, Pneumonia Vaccination, How Well Doctors Communicate, Rating of Healthcare Quality, and Rating of Health Plan. Ascension Complete identifies opportunities for improvement based on the information collected through the CAHPS survey, the BH ECHO® survey, appeals, and grievances.

Ascension Complete contracts with a NCQA-certified survey vendor to conduct the CAHPS survey on an annual basis, using NCQA-required survey techniques and specifications required by NCQA and CMS. CAHPS results are presented to the QIC and in turn given to the UMAC for review by the external providers.

Member retention analysis and reporting is also a part of the Member experience evaluation process. The Member Loyalty and Retention Department strives for excellent Member satisfaction and uses voluntary disenrollment performance as the basis for monitoring success and performing root cause analyses for continual improvement of Member satisfaction.

Please refer to Medicare Stars Rating for additional information regarding CAHPS.

Provider Experience

An ongoing analysis of Provider complaints is conducted to evaluate Provider satisfaction. Also, the Provider network is formally surveyed by a certified vendor on an annual basis to assess Provider satisfaction with the Plan. Results are analyzed and an action plan is developed and implemented to address the areas identified as needing improvement. The results and action plan are presented to the QIC and then sent to the UMAC for approval and recommendations

Behavioral Health Services

Behavioral health is integrated in the overall care model. The goals and objectives of the behavioral health activities are congruent with the Population Health Solutions health model and are incorporated into the overall care management model program description.

Special populations such as serious and persistent mental illness (SPMI) adults may require additional services and attention, which may lead to the development of special arrangements and procedures with our Provider network to arrange for and provide certain services including:

- Coordination of services for Members after discharge from state and private facilities to integrate them back into community. This includes coordination to implement or access services with network behavioral health Providers or Community Mental Health Clinics (CMHCs).
- Targeted care management by community mental health Providers for adults in the community with a severe and persistent mental illness.

The goals of the Behavioral Health Program mirror those of the Utilization and Care Management programs. The program is intended to decrease fragmentation of healthcare service delivery; facilitate appropriate utilization of available resources; and optimize Member outcomes through education, care coordination and advocacy services for the compromised populations served. It is a collaborative process using a multidisciplinary, Member-centered model that integrates the delivery of care and services across the care continuum. It supports the Institute for Healthcare Improvement's Triple Aim objectives, which include:

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of populations; and
- Reducing the per capita cost of healthcare.

Utilization Management

Utilization Management (UM) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring and evaluating the utilization of healthcare services. The UM program is a multidisciplinary, comprehensive approach and process to manage resource allocation. The UM process influences systematic monitoring of Medical Necessity and quality and maximizes the cost effectiveness of the care and service provided to Members. Integral factors in the UM process include:

- Consideration of individual Member clinical needs, including those identified with special healthcare needs, cultural characteristics, safety and preferences
- An available and accessible care delivery system
- A diverse network of qualified Providers

- Clinically sound, evidence-based medical/behavioral health necessity decision-making tools that promote the consistent, efficient and effective use of resources.
- Available and applicable plan benefits
- Communication to the Primary Care Practitioner on file when a member has a planned or unplanned admission and discharge to an inpatient or subacute level of care.

The scope of the UM program includes an overview of policies, procedures and operation processes related to the delivery of medical care, behavioral healthcare, dental care, and pharmaceutical management, including services and physicians who influence the provision of healthcare. This includes the evaluation of Medical Necessity and the efficient use of medical services, procedures facilities, specialty care, inpatient and outpatient care, home care, skilled nursing services, ancillary services and pharmaceutical services. To help in the coordination of care, Ascension Complete encourages PCPs, treating Providers and facilities to share and review updated Member records during planned and unplanned admissions upon discharge to another level of care to include treatments performed, medications, test results, and the treatment plan.

The UM program processes include components of prior authorization as well as prospective, concurrent, and retrospective review activities, each of which are designed to provide for an evaluation of healthcare and services based on the Member's coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to Providers of care. Neither Ascension Complete nor the plans reward its practitioners, Providers, or associates who perform utilization reviews, including those of the delegated entities, for denials. No entity or associate is compensated or otherwise given incentives to encourage denials. Utilization denials (adverse determinations) are based on lack of medical necessity or lack of covered benefits. As part of the UM Program performance measurement data regarding frequency of selected procedures, and Behavioral Health readmissions and admissions are all monitored and reported to QIC or the appropriate sub-committee.

The multidisciplinary staff and practitioners employed by Ascension Complete conduct UM activities within their legal scope of practice as identified by licensure standards.

Population Health Management

Population Health Management (PHM) allows for the assessment of the characteristics and needs of the entire membership with the goal of determining actionable categories for appropriate intervention. The results of the assessment and stratification of Members allow the Plan to develop its strategy to improve the quality of life of its members. The population assessment is conducted annually by collecting, stratifying, and integrating various data sets

and programs to assess Member's needs across the entire membership. The population assessment is used to:

- Assess the characteristics and needs of its member population including social determinants of health factors
- Identify and assess sub-populations
- Assess the needs of child and adolescent Members
- Assess the needs of Members with disabilities
- Assess the needs of Members with serious and persistent mental illness (SPMI)
- Stratify Members into one of the following focus areas:
 - Keeping Members Healthy

- Managing Members with Emerging Risk
 - Patient Safety or Outcomes Across Settings
 - Managing Multiple Chronic Illnesses
- Review and update PHM activities to address Member needs in each of the focus areas
 - Review and update PHM resources to address Member needs in each of the focus areas
 - Review community resources for integration into program offerings to address Member needs for each of the focus areas
 - Identify and address Members' social determinants of health in each of the focus areas

Annually, the Plan:

- Completes a Population Assessment
- Uses the Population Assessment to update the Population Health Strategy
- Measures the effectiveness of its PHM programs for each focus area

The population assessments for each market are presented to the Quality Improvement Committee QIC on, at least, an annual basis.

Care Management

The mission of the Care Management department is to educate Members and coordinate timely, cost-effective, evidence based, integrated services for the individual health needs of Members to promote positive clinical outcomes. Integrated program components include complex care management, disease management, behavioral health management and transitional care management. Care Management uses multiple data sets to identify and treat high-risk Members. The department employs a multidisciplinary population health model to approach outlying Members from a variety of perspectives.

Care Management monitors the participation rate of Members being managed, the Members' satisfaction with Care Management, Members' utilization of services, readmission rates, admission rates and high-volume service utilization. Care Management also reviews continuity of care between the Member's behavioral healthcare services and their medical care services,

for those Members who are receiving both. Care Management data is reported to UMAC and QIC on a quarterly basis.

Model of Care

Ascension Complete identifies, supports, and engages our most vulnerable Members at any point in their healthcare continuum to help them achieve an improved health status. Ascension Complete provides services in a member-centric fashion. Ascension Complete's objectives for serving Members with complex and special needs include, but are not limited to:

- Completing an annual population assessment to identify the needs of the population and subpopulations, so Care Management processes and resources can be updated to address Member needs
- Promoting preventive health services and the management of chronic diseases through disease management programs that encourage the use of services to decrease future morbidity and mortality in Members

- Conducting of comprehensive assessments that identify Member needs and barriers to care
- Coordinating transitions of care for Members with complex and special needs to assist in navigating the complex healthcare system and accessing Provider, public and private community-based resources
- Improving access to primary and specialty care for Members with complex health conditions so they receive appropriate services
- Consulting with appropriate specialized healthcare personnel when needed such as medical directors, pharmacists, social workers and behavioral health professionals, etc.
- Ensuring that Members' socioeconomic barriers are addressed

Effectiveness of the Model of Care Program is evaluated through the identification of objective, measurable, and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes are analyzed, opportunities are identified, interventions are implemented for goal attainment, and reports are generated for ongoing monitoring. Data collection follows protocols established in approved policies and/or program designs. Data sources include administrative data such as claims, survey data, medical record documentation, or a combination of sources. There is a documented systematic step sequence for administrative data collection. Standardized tools are developed for utilization with any manual data collection such as extraction of data from medical records. Statistically valid sampling techniques are used as appropriate.

Ascension Complete has established performance outcomes for the SNP plans to evaluate and measure the quality of care, quality outcomes, service, and access for Members. For each metric, benchmarks have been established based on evidenced-based medicine found in current literature, standards, and guidelines. Root cause analysis is conducted, and interventions identified for each indicator that falls below the desired value. The analysis, process improvement plan, implementation of interventions, and improvements are reported to the QIC for review, feedback, and approval.

Patient Safety

The QI Program places emphasis on patient safety. The goals for incorporation of patient safety into the QI Program are to:

- Prevent harm to Members in healthcare delivery
- Develop organization-wide standards, definitions, processes, and norms
- Promote evidence-based policies and practices
- Disseminate training and re-training of case management/utilization management (both medical and behavioral health) in identifying and reporting potential quality of care issues
- Encourage all associates/Providers to report potential quality of care issues
- Strengthen efforts in providing safer and sustainable healthcare systems
- Reduce Member instances of potential quality of care issues which put patient safety at risk

In focusing on patient safety, the Plan aims to:

- Inform Members and Providers regarding Ascension Complete's patient safety initiatives
- Encourage the practitioner and Provider community to adopt processes to improve safe clinical practices
- Motivate Members to be participants in the delivery of their own safe healthcare

- Communicate patient safety best practices
- Develop clear policies, sound organizational leadership, and meaningful data to drive safety improvements

The scope of the Patient Safety/Quality of Care (QOC) plan encompasses review of medical, behavioral health, pharmaceutical care, and administrative issues in Provider and Member interactions. All Member demographic groups, care settings, and types of services are included in patient safety activities. The sources of data used to monitor aspects of patient safety include, but are not limited to:

- Practitioner-to-practitioner communication
- Office site visit review results
- Medical record review findings
- Clinical Practice Guideline compliance
- Potential QOC (PQOC) tracking/trending
- Concurrent review during the Utilization Management process
- Identification of potential trends in underutilization and overutilization
- Case and Disease Management Program participation
- Pharmaceutical management practices
- Member communication
- Provider/practitioner actions to improve patient safety

The Patient Safety Work Group was established to serve as a proactive, interactive team consisting of Quality Improvement Specialists/Nurse Reviewers from all markets. The group's aim is to build cohesiveness in the PQOC process from identification and investigation to action taken and reporting. The group meets monthly, and action plans and minutes are generated and reviewed by the physician champion and the QIC for approval.

Continuity and Coordination of Care

Ascension Complete, in accordance with federal and state regulations, ensures that its members' care is directed and coordinated by a Primary Care Physician (PCP). The company also complies with CMS requirements, applicable federal and state regulations, and state-specific Medicaid contracts regarding partnership with Ascension Complete's Providers in coordinating appropriate services for Members requiring continuity and coordination of care. NCQA requires that accredited organizations monitor and act, as necessary, to improve continuity and coordination of care across the healthcare network. Ascension Complete refers to these standards as Medicare Continuity and Coordination of Care standards. These standards guide the organization in utilizing information at its disposal to facilitate coordination of care and collaboration between medical and behavioral healthcare Providers across its care delivery system.

The Plan's activities encourage the PCP relationship to serve as the Member's Provider "home." This strategy promotes one Provider having comprehensive knowledge of the Member's healthcare needs, whether it is disease or preventive care in nature. Through contractual language and program components, PCPs are educated regarding their responsibilities.

With increased coordination of care, healthcare interventions can be more consistent with an individual's overall physical and/or behavioral health, and there become fewer opportunities for negative medication interactions, side effects, complications, and polypharmacy. Attention to continuity and coordination of care

promotes patient-centered care, improves a member's overall physical and mental well-being, decreases hospitalizations, and ensures appropriate and smooth transitions of care. Effective coordination of care is dependent upon clear and timely communication among PCPs, specialists, behavioral health practitioners, and facilities. Effective communication allows for better decision-making regarding treatment interventions, decreases the potential for fragmentation of treatment, and improves Member health outcomes.

Coordination of care is a continual quality process that requires ongoing monitoring and evaluation of the delivery of high-quality, high-value, patient-centered care to Members.

Ascension Complete uses a variety of mechanisms to monitor continuity and coordination of care. In addition, Ascension Complete works collaboratively with medical and behavioral health practitioners to monitor and improve coordination between medical and behavioral healthcare. The metrics chosen to identify areas that contribute to continuity and coordination of care include, but are not limited to:

Specific Area Monitored	Description of Monitor	Frequency
Movement between practitioners	HEDIS® – Comprehensive Diabetes Care – Retinal Eye Exam (CDC)	Annual
Movement between practitioners	HEDIS®- UOP- Use of Opioids Multiple Prescribers, Multiple Pharmacies	Annual
Movement between settings	HEDIS® FMC- Follow Up after Emergency department Visit for People with High-Risk Multiple Chronic Conditions.	Annual
Movement between settings	HEDIS® – Medication Reconciliation Post-Discharge (MRP)	Annual
Exchange of Information	Provider Satisfaction Survey – Receipt of Feedback/Reports from Behavioral Health Clinicians for Mutual Patients	Annual
Appropriate Diagnosis, Treatment, and Referral of Behavioral Disorders Commonly Seen in Primary Care	HEDIS® – Antidepressant Medication Management – Acute Phase (AMM)	Annual
Appropriate Use of Psychotropic Medications	HEDIS® – Potentially Harmful Drug-Disease Interactions in the Elderly – Dementia + Prescription of Antiemetics, Antipsychotics, Benzodiazepines, Tricyclic Antidepressants, H2 Receptor Antagonists, Nonbenzodiazepine Hypnotics, or Anticholinergic Agents (DDE)	Annual
Management of Treatment Access and Follow-Up for Enrollees with Coexisting Disorders	HEDIS® – Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Annual
Primary or Secondary Preventive Behavioral Healthcare Program Implementation	Depression Screening for Members with a Chronic Health Condition	Annual
Special Needs of Members with Severe and Persistent Mental Illness	HEDIS® – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	Annual

The Medicare Continuity and Coordination of Care Steering Committee is comprised of medical directors from medical and behavioral health arenas and corporate leadership from Quality, Utilization Management, Care Management, and Population Health Solutions. The Steering Committee reviews and analyzes data and guides

the Medicare Continuity and Coordination of Care Work Group in identifying barriers to adequate continuity and coordination of care and markets that have successfully implemented interventions to overcome such barriers.

The mission of the Medicare Continuity and Coordination of Care Steering Committee and Work Group is to ensure that Ascension Complete continues to serve Members by establishing high quality programs and processes that enable proper coordination of care between medical and behavioral health Providers. The vision of the group is to establish and maintain a position as a leader in government-sponsored healthcare programs through organizational collaboration with primary care and behavioral health practitioners to improve coordination of integrated healthcare. The work group encourages the monitoring of Member experience to ensure desired health outcomes for our members.

Practice Guidelines

Ascension Complete, whenever possible, adopts preventive and clinical practice guidelines (CPG) from recognized sources, for the provision of acute, chronic and behavioral health services relevant to the populations served. Guidelines will be presented to the Quality Improvement and Utilization Management Committee (QIUMC) for appropriate physician review and adoption. Guidelines will be updated at least every two years or upon significant new scientific evidence or changes in national standards.

Ascension Complete adopts clinical practice guidelines for at least two non-preventive acute or chronic medical conditions. Ascension Complete also adopts at least two behavioral health conditions (preventive or non-preventive) relevant to the population. At least two of the adopted CPGs directly correspond with two disease management programs offered by Ascension Complete. Guidelines will be based on health needs of population and/or opportunities for improvement as identified through the QAPI program.

Clinical Practice guidelines (CPG) may include, but are not limited to:

- Asthma Guidelines
- Diabetes Care Guidelines
- Sickle Cell Guidelines
- Ascension Complete also adopts applicable preventive health guidelines. Preventive health guidelines may include, but are not limited to:
 - Adult Preventive Health Guidelines
 - Immunization Guidelines

Copies of these guidelines are available on our website at www.ascensioncomplete.com

All guidelines are reviewed annually for updating and/or when new scientific evidence or national standards are published.

Ascension Complete's QAPI program assures that Practice Guidelines meet the following:

- Adopted guidelines are approved by Ascension Complete's QIC bi-annually
- Adopted guidelines are evidence-based and include preventive health services
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than bi-annually.
- Guidelines are disseminated to Providers in a timely manner via the following appropriate communication settings:
 - Provider orientations and other group sessions
 - Provider e-newsletters
 - Online via the HEDIS® Resource Page
 - Online via the Provider Portal
 - Targeted mailings
- Guidelines are posted on Ascension Complete's website or paper copies are available upon request by contacting Ascension Complete's QI Department.

Patient Safety and Quality of Care

Patient Safety is a key focus of the Ascension Complete QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Ascension Complete employees (including utilization management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting and analyses. Potential quality of care issues requires investigation of the factors surrounding the event in order to decide of their severity and need for corrective action up to and including review by the Peer Review Committee and/or the Credentials Committee as appropriate. Potential quality of care issues received in the QI Department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The Ascension Complete QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established

standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Ascension Complete to monitor improvement over time.

Annually, Ascension Complete develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Ascension Complete communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Ascension Complete website.

At any time, Ascension Complete providers may request additional information and paper copies on the health plan programs including a description of the QAPI Program and a report on Ascension Complete's progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

Additionally, Ascension Complete develops and implements chronic care improvement programs and quality improvement projects required by CMS. Ascension Complete encourages all providers to participate in these initiatives.

Office Site Surveys

Ascension Complete conducts site visits to the provider's office to investigate member complaints related to physical accessibility, physical appearance and adequacy of exam room and waiting room space. Site visits can also be conducted as part of the credentialing process, or as part of standard audits to ensure standards are being met. Standards are determined based on NCQA guidelines, State and Federal regulations. Site visits conducted by Ascension Complete Representatives may include:

- Staff information, including CPR certification
- Access for the disabled
- Licensure
- Office policies/general information verifying that a confidentiality policy is in place and maintained
- Cultural competency training
- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Scheduling/appointment availability, including office protocols/policies (Access, Office Hours, Wait Time, Preventive Health Appointment)
- Availability of emergency equipment, including in-stock unexpired emergency medications
- Clinical lab (CLIA) standards

- Medication administration/dispensing/storage of drug samples and prescription pads; and
- Adequacy of medical records keeping practices.

At the conclusion of an office site survey, the results will be reviewed with you or a designated Member of your staff. You may make a copy of the survey for your records. If there are deficiencies, you may be asked to submit a corrective action plan.

MEDICARE STAR RATINGS

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

The ratings are posted on the CMS consumer website, www.medicare.gov, to help beneficiaries when choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize providers for demonstrating an increase in performance measures over a defined period.

CMS's Star Rating Program is based on measures in 9 different domains

Part C

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long-term) conditions
3. Member experience with the health plan
4. Member complaints, problems getting services and improvement in the health plan's performance
5. Health plan customer service

Part D

1. Drug Plan Customer Service
2. Member Complaints and Changes in the Drug Plan's Performance
3. Member Experience with the Drug Plan
4. Drug Safety and Accuracy of Drug Pricing

How Can Providers Help to Improve Star Ratings?

Continue to encourage patients to obtain preventive screenings annually or as recommended including but not limited to:

- Breast and/or Colon Cancer Screening
- Annual Flu Vaccine
- Adult BMI Assessment

Continue to monitor and assess the health and well-being of patients with known chronic conditions including but not limited to:

- Diabetes Care
- Retinal Eye Exam

- Kidney Disease Monitoring (via urine protein testing or ACE/ARB therapy)
- Routine monitoring to ensure HbA1c control (<9)
- Ensure members remain adherent to their diabetic medications and receive necessary statin therapy
- Controlling High Blood Pressure (<140/90)
- Ensure members remain adherent to their hypertension medications (RAS antagonists)
- Statin Therapy for patients with cardiovascular disease
- Ensure members remain adherent to their cholesterol medications (statin therapy)
- Timely Osteoporosis Management for women who have had a fracture through one of the following (within six months of the fracture)
 - Bone mineral density test
 - Medication therapy to treat osteoporosis
- Rheumatoid Arthritis Management through anti-rheumatic medication therapy
- Continue to talk to your patients and document interventions regarding topics such as:
 - improving or maintaining their mental and physical health
 - issues with bladder control and fall prevention
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes and properly document medical charts for all members.
- Review the gap in care files listing members with open gaps which is available on our secure portal.
- Follow up with patients within 14 days post hospitalization; complete post hospitalization medication reconciliation; and
- Identify opportunities for you or your office to have an impact on member gaps in care.

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). CMS utilizes HEDIS® rates to evaluate the effectiveness of a managed care plan's ability to demonstrate an improvement in preventive health outreach to its members.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS® rates are becoming more and more important, not only to the health plan, but to the individual provider.

HEDIS® Rate Calculations

HEDIS® rates are calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include Breast Cancer Screening (routine mammography) and use of Disease Modifying Anti-Rheumatic Drugs for Members with Rheumatoid Arthritis, Osteoporosis Management in Women Who Had a Fracture, Access to PCP Services, and Utilization of Acute and Mental Health Services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT II, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS® measures typically requiring medical record review include:

- Adult BMI Assessment.
- Comprehensive Diabetes Care (screenings and results including HbA1c.
- Nephropathy.
- Dilated retinal eye exams, and blood pressures).
- Colorectal Cancer Screening (colonoscopy, sigmoidoscopy, FOBT, CT, Colonography, or FIT-DNA test).
- Medication Review Post Hospitalization and Controlling Blood Pressure (blood pressure results <140/90 for members with high blood pressure).

Who conducts Medical Record Reviews (MRR) for HEDIS®?

Ascension Complete may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS® MRR on its behalf. Medical record review audits for HEDIS® can occur anytime throughout the year but are usually conducted March through May each year. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Ascension Complete that allows them to collect PHI on our behalf.

How can Providers improve their HEDIS® scores?

- Understand the specifications established for each HEDIS® measure.
- Submit claims and encounter data for every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Ascension Complete. Claims and encounter data is the most efficient way to report HEDIS®.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS® rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record documentation of each member service and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS® measures such as diabetes, eye exam, and blood pressure.

- If you have any questions, comments, or concerns related to the annual HEDIS® project or the medical record reviews, please contact the Quality Improvement Department.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of the Star rating system. It is a standardized survey administered annually to members by CMS certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well practitioners and the plan is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the Star rating program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the member received an annual flu vaccine
- Whether members perceive they are getting needed care, tests, or treatment needed including specialist appointments and prescriptions
- Whether the member's personal doctor's office followed up to give the member test results
- Appointment availability and appointment wait times
- Whether the member's personal doctor is informed and up to date on care received from specialist

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in the Medicare Star rating program. The goal of the Medicare HOS is to gather data to help target quality improvement. The HOS assesses practitioners and Medicare Advantage Organization's (MAO) ability to maintain or improve the physical and mental health of its Medicare members over time. Ascension Complete HOS questions that may reflect on the service of providers includes:

- Whether the member perceives their physical or
- Mental health is maintained or improving

Look for opportunities to discuss and address concerns regarding the following:

- Mobility: Address potential needs for assistive devices
- Physical Activity: Discuss starting, increasing, or maintaining patients' level of physical activity
- Mental Health: Address social interactions and other behavioral health needs that may require further follow-up if provider has discussed fall risks and bladder control with the member by considering the following:
 - Fall Risk Prevention: Educate patients on fall risk prevention by addressing any needs for assistive devices and reviewing any potential high-risk medications that could increase their fall risk
 - Bladder Control: Assess the need for bladder control education and potential treatment

REGULATORY MATTERS

Medical Records

Ascension Complete requires all providers (physician, hospital, and ancillary) to maintain sound medical record keeping practices that are consistent with Ascension Complete's medical records guidelines. Ascension Complete 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's name and be accessible. To ensure the member's privacy, medical records should be kept in a secure location. Ascension Complete requires providers 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 provider.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider 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 provider. 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. Providers 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 provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- 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 chart for adults.

- Evidence that preventive screening and services are offered in accordance with Ascension Complete practice guidelines.
- 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 under- or over utilization 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 primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers 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 release 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 Complete may audit record-keeping practices and individual member medical records in conjunction with ongoing Quality Improvement Program activities, utilizing the standards listed above. Providers 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 Complete's Quality Improvement Committee (QIC) for recommendations.

Ascension Complete encourages providers 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 PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Ascension Complete 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 providers, then this should also be noted in the medical record.

Medical Records Audits

Ascension Complete will conduct random medical record audits as part of its QAPI 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 Complete will provide written notice prior to conducting a medical record review.

Access to Records and Audits by Ascension Complete from AMITA

Subject only to applicable state and federal confidentiality or privacy laws, provider will permit Ascension Complete from AMITA or its designated representative access to provider's records, at provider's place of business in this state during normal business hours, or remote access of such records, to audit, inspect, review, perform chart reviews, and duplicate such records. If the audit needs to be performed on site, Ascension Complete from AMITA or its designated representative will provide at least thirty (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 sixty (60) days following such written notice.

Electronic Medical Record (EMR) Access

Providers will grant Ascension Complete from AMITA access to providers Electronic Medical Record (EMR) system 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 Complete from AMITA 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 providers, 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: www.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: www.samhsa.gov
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Ascension Complete network are independently obligated to know, understand and comply with these laws.

Ascension Complete 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 Complete Compliance Officer by phone at 1-866-595-8133 or in writing (refer to address below) with any questions about our privacy practices.

Ascension Complete from AMITA

Attn: Compliance Officer

P.O. Box 10420

Van Nuys, CA 91410

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 based on 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 www.hhs.gov/civil-rights.

Health Insurance Portability and Accountability 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 www.CMS.gov/Regulations-and-Guidance.

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 Complete has provided each Ascension Complete member with a privacy notice, which describes how Ascension Complete 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 Complete's Member Privacy Notices can be found at www.ascensioncomplete.com.

1. As a provider, if you have any questions about Ascension Complete's privacy practices, contact the Ascension Complete Compliance Officer at 1-866-685-8664.
2. Members should be directed to Ascension Complete's Member Services department with any questions about the privacy regulations. Member Services can be reached at Ascension Complete Medicare HMO Phone 1-833-293-5966 or Ascension Complete Dual Medicare (HMO DSNP) & Ascension Complete Dual Medicare Essentials (HMO DSNP) 1-833-293-5966.

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 Complete. 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 Complete or a healthcare provider 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 was published August 17, 2000, and since modified, adopted standards for several transactions, including claims and encounter information, payment and claims status. Any healthcare provider that 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. Health care settings. Diagnosis coding under ICD-10-CM uses three (3) to seven (7) digits instead of the three (3) to five (5) 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 (7) alphanumeric digits instead of the three (3) or four (4) 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 www.fda.gov.

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 standard operating process, Ascension Complete does not currently utilize all standard transaction sets. Functionality equivalent to that which is offered by these transaction sets is made available to Ascension Complete's members and providers via various alternative capabilities such as online tools.

Ascension Complete currently offers an alternative through the Secure Provider 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 the EDI Department at 1-800-225-2573, ext. 6075525 or by email at EDIBA@centene.com.

National Provider Identifier

The National Provider Identifier (NPI) is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers 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 providers such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in all electronic HIPAA standards transactions. However, some LTSS providers are considered “Atypical Providers” because they render non-health or non-medical services to Ascension Complete members. These providers bill using their Atypical ID (LTSS #) in the Non-NPI Provider ID field of the claim form.

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

Please contact the Ascension Complete Compliance Officer by phone at 1-866-595-8133 or in writing (refer to address below) with any questions about our privacy practices.

Ascension Complete from AMITA

Attn: Compliance Officer

P.O. Box 10420

Van Nuys, CA 91410

FRAUD WASTE AND ABUSE

Ascension Complete 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 Complete, in conjunction with its parent company, Centene, operates a Fraud, Waste and Abuse unit. Ascension Complete 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 Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers 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 provider 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 CPT
- 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 provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Ascension Complete takes all reports of potential Fraud, Waste and Abuse very seriously and investigates all reported issues.

OIG/GSA Exclusion and CMS Preclusion List – As a provider in our Medicare network, 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

Providers' implementation of Fraud, Waste, and Abuse safeguards to identify excluded providers and entities.

Medicare payment may not be made for items or services furnished or prescribed by a precluded or excluded provider or entity. Plans shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, 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 Complete 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, temporary employee, volunteer, consultant, governing body member, or FDR, and monthly thereafter. If anyone is identified, providers are required to notify Ascension Complete immediately so that if needed Ascension Complete can take appropriate action. Providers may contact the Ascension Complete Compliance Officer at 1-866-685-8664.

FWA Program Compliance Authority and Responsibility

The Ascension Complete Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Ascension Complete is committed to identifying, investigating, sanctioning, and prosecuting suspected Fraud, Waste and Abuse.

The Ascension Complete provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

To report suspected Fraud, Waste and Abuse call, 1-866-685-8664.

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 www.cms.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 Provider 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.
- CPT/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.

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: Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

EX Code	Definition
OB	ADJUST: CLAIM TO BE REPROCESSED CORRECTED UNDER NEW CLAIM NUMBER
OI	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER
1D	DENY: DISCHARGE STATUS INVALID FOR TYPE OF BILL
52	DENY - PAYMENT INCLUDED IN ALLOWANCE FOR ANOTHER PROCEDURE
57	DENY - AUTHORIZATION LIMITATION EXCEEDED
64	DENY - PROCEDURE INCONSISTENT WITH DIAGNOSIS
65	DENY-MISSING OR INVALID INFORMATION
71	DENY-MEMBER NOT ELIGIBLE ON DATE OF SERVICE
76	DENY - MAXIMUM BENEFIT HAS BEEN PAID
78	DENY: INVALID OR MISSING PLACE OF SERVICE LOCATION
82	DENY-NON-COVERED SERVICES
83	DENY - DUPLICATE OF PREVIOUS SUBMITTED CLAIM
A1	APC - OCE LINE-ITEM REJECTION
A2	APC - OCE LINE-ITEM DENIAL
A4	APC - OCE CLAIM LEVEL RETURN TO PROVIDER (RTP)
A5	APC - OCE CLAIM LEVEL REJECTION
AN	DENY - SERVICE DENIED FOR NO AUTHORIZATION ON FILE
BT	DENY: TYPE OF BILL INVALID
C5	DENY: CODE REPLACED BASED ON CODE AUDITING
dh	DENY - NON-EMERGENCY OUT OF AREA SERVICES ARE NOT COVERED

DZ	DENY: RESUBMIT WITH CORRECTED COUNT
EB	DENIED BY MEDICAL SERVICES
EC	DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
Es	INVALID OR MISSING REQUIRED ESRD OR HHA \CLAIMS DATA
FT	INVALID FORM TYPE FOR PROCEDURE(S) SUBMITTED
Hn	HHA GROUPER INVALID OR NO TREATMENT AUTHORIZATION CODE PROVIDED
Jq	ORIGINAL CHECK NOT CASHED-PAY TO/ADDRESS VERIFICATION NEEDED
MR	MODIFIER REQUIRED FOR PROCEDURE
NN	MODIFIER NOT REQUIRED FOR THIS PROCEDURE
NV	DENY: PLEASE RESUBMIT WITH INVOICE FOR SERVICES RENDERED
PM	DENY - INVALID PROCEDURE MODIFIER COMBINATION SUBMITTED
QR	DENY: ADJUSTMENT WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT
S9	DENY - CODE BILLED IS NOT COVERED FOR PROVIDER TYPE
TF	DENY - FILING LIMIT EXCEEDED
x2	SERVICE(S) OR SUPPLIES DURING GLOBAL SURGICAL PERIOD
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
ya	DENY: DENIED AFTER REVIEW OF PATIENT S CLAIM HISTORY
ye	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
YO	DENY: ADD ON CODE BILLED WITHOUT PRIMARY PROCEDURE
ZW	AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS

Appendix IV: 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 dollars 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

ERROR ID	ERROR_DESC
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag

29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc

55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006; OR Invalid DOS
75	Invalid Unit
76	Original claim number required
77	INVALID CLAIM TYPE
81	Invalid Unit; Invalid Prv
83	Invalid Unit; Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
B1	Rendering and Billing NPI are not tied on state file

B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

Appendix VI: Claim Form Instructions

Billing Guide for a CMS 1500 and CMS 1450 (UB-04) Claim Form.

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided

Note: Claims with missing or invalid Required (R) field information will be rejected or denied

Completing A CMS 1500 Claim Form

Updated format (Form 1500 (02-12)) can be accepted as of January 1, 2014, and is required after October 1, 2014.

Please see the following example of a CMS 1500 form.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PATIENT AND INSURED INFORMATION										CARRIER		
<div>1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (ID# DoD) (Member ID#) (ID#)</div>										FICA <input type="checkbox"/>		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
CITY			STATE		8. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street)			CITY		
ZIP CODE			TELEPHONE (Include Area Code) ()				ZIP CODE			TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10a. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER							b. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE							b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE							c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME							e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL					15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Release to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSC/Perk Fee I. ID. QUAL J. RENDERING PROVIDER ID. #												
1										NPI		
2										NPI		
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX ID. NUMBER SSN EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? Original bills <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Field #	Field Description	Instruction or Comments	Required or Conditional
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being filed. Enter "X" in the box noted "Other"	R
1a	INSURED'S I.D. NUMBER	The 9-digit identification number on the member's I.D. Card	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8-digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's I.D. Card	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C

7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	<p>Enter the patient's complete address and telephone number including area code on the appropriate line.</p> <p>First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).</p> <p>Second line – In the designated block, enter the city and state.</p> <p>Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).</p> <p>Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.</p>	C
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a, b, c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When	R

		marked Yes, primary insurance information must then be shown in Item Number 11.	
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM DD YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier have been designated for use: Y4 Property Casualty Claim Number FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required

14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	<p>Enter the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.</p> <p>Enter the applicable qualifier to identify which date is being reported.</p> <p>431 Onset of Current Symptoms or Illness</p> <p>484 Last Menstrual Period</p>	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C

19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	Resubmission Code/Original Ref. No.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j General Information	<p>Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.</p> <p>The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number.</p> <p>Shaded boxes 24 a-g is for line-item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information</p>		

	<p>on how to complete.</p> <p>The un-shaded area of a claim line is for the entry of claim line-item detail.</p>		
24 A-G Shaded	SUPPLEMENTAL INFORMATION	<p>The shaded top portion of each service claim line is used to report supplemental information for:</p> <p>NDC</p> <p>Narrative description of unspecified codes</p> <p>Contract Rate</p> <p>For detailed instructions and qualifiers refer to Appendix IV of this guide.</p>	C
24A Unshaded	DATE(S) OF SERVICE	<p>Enter the date the service listed in field 24D was performed (MM DD YYYY). If there is only one date, enter that date in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.</p>	R
24B Unshaded	PLACE OF SERVICE	<p>Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.</p>	R
24C Unshaded	EMG	<p>Enter Y (Yes) or N (No) to indicate if the service was an emergency.</p>	Not Required
24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	<p>Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.</p> <p>Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.</p>	R

24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line-item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99). Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for ID, if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. Atypical Providers:	R

		Enter the Provider ID number.	
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number	C
27	ACCEPT ASSIGNMENT	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a member using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing when Ascension Complete is listed as secondary or tertiary. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99).	C

		Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	
30	BALANCE DUE	<p>REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer).</p> <p>Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.</p>	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	<p>If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed.</p> <p>Note: Does not exist in the electronic 837P.</p>	R
32	SERVICE FACILITY LOCATION INFORMATION	<p>REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the name and physical location. (P.O. Box numbers are not acceptable here.)</p> <p>First line – Enter the business/facility/practice name.</p> <p>Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).</p> <p>Third line – In the designated block, enter the city and state.</p> <p>Fourth line – Enter the zip code and phone number. When entering a 9-digit</p>	C

		zip code (zip+4 codes), include the hyphen.	
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). NOTE: The 9-digit zip code (zip + 4	R

		code) is a requirement for paper and EDI claim submission	
33a	GROUP BILLING NPI	<p>Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33.</p> <p>Enter the 10-character NPI ID.</p>	R
33b	GROUP BILLING OTHERS ID	<p>Enter as designated below the Billing Group taxonomy code. Typical Providers:</p> <p>Enter the Provider Taxonomy Code. Use ZZ qualifier.</p> <p>Atypical Providers:</p> <p>Enter the Provider ID number.</p>	R

Completing a UB-04 Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Ascension Complete. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.

Please refer to your provider contract with Ascension Complete or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

Below is an example of a UB-04 form

1		2		3a PAT. CNTL # b. MED. REC. #		4 TYPE OF BILL	
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		9 PATIENT ADDRESS					
b		b		c		d	
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	CONDITION CODES 22 23 24 25 26 27 28	
29 ACCT STATE		30					
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	37 OCCURRENCE CODE	38 OCCURRENCE DATE
39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT			
a		b		c		d	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1		1		1		1	
2		2		2		2	
3		3		3		3	
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PAGE ____ OF ____		CREATION DATE		TOTALS			
50 PRAYER NAME		51 HEALTH PLAN ID		52 REL. INFO		53 PRIOR PAYMENTS	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRV ID	
58 INSURED'S NAME		59 P-REL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
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798		799		800			

FIELD #	Field Description	Instruction Comments	or Required or Conditional
1	UNLABELED FIELD	<p>LINE 1: Enter the complete provider's name.</p> <p>LINE 2: Enter the complete mailing address.</p> <p>LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9-digit zip (zip +4 codes) is a requirement for paper and EDI claims.</p> <p>LINE 4: Enter the area code and phone number.</p>	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	<p>Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows:</p> <p>1st Digit – Indicating the type of facility.</p> <p>2nd Digit – Indicating the type of care.</p> <p>3rd Digit- Indicating the bill sequence (Frequency code).</p>	R

5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not used	Not Required
8a-8b	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the member's I.D. card	Not Required
		<p>8b – enter the patient's last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names.</p> <p><u>Titles:</u> (Mr., Mrs., etc.) should not be reported in this field.</p> <p><u>Prefix:</u> No space should be left after the prefix of a name (e.g., McKendrick. H)</p>	R

		<p><u>Hyphenated names:</u> Both names should be capitalized and separated by a hyphen (no space)</p> <p><u>Suffix:</u> a space should separate a last name and suffix.</p> <p>Enter the patient's complete mailing address of the patient.</p>	
9	PATIENT ADDRESS	<p>Enter the patient's complete mailing address of the patient.</p> <p>Line a: Street address</p> <p>Line b: City</p> <p>Line c: State</p> <p>Line d: Zip code</p> <p>Line e: country Code (NOT REQUIRED)</p>	<p>R</p> <p>(Except line 9e)</p>
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	<p>Enter the date of admission for inpatient claims and date of service for outpatient claims.</p> <p>Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.</p>	R

13	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14- 02:00 to 02:59 03-03:00 to 03:39 15- 03:00 to 03:59 04-04:00 to 04:59 16- 04:00 to 04:59 05-05:00:00 to 05:59 17- 05:00:00 to 05:59 06-06:00 to 06:59 18- 06:00 to 06:59 07-07:00 to 07:59 19- 07:00 to 07:59 08-08:00 to 08:59 20- 08:00 to 08:59 09-09:00 to 09:59 21- 09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions (Enter the 1-digit code indicating the of the	R

		<p>admission using the appropriate following codes:</p> <ol style="list-style-type: none"> 1. Emergency 2. Urgent 3. Elective 4. Newborn 5. Trauma 	
15	ADMISSION SOURCE	<p>Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes.</p> <p><u>For Type of admission 1, 2, 3, or 5:</u></p> <ol style="list-style-type: none"> 1. Physician Referral 2. Clinic Referral 3. Health Maintenance Referral (HMO) 4. Transfer from a hospital 5. Transfer from Skilled Nursing Facility 6. Transfer from another health care facility 7. Emergency Room 8. Court/Law Enforcement 9. Information not available <p><u>For Type of admission 4 (newborn):</u></p>	R

		1. Normal Delivery 2. Premature Delivery 3. Sick Baby 4. Extramural Birth 5. Information not available	
16	DISCHARGE HOUR	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:59 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59	C

		08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	
16	DISCHARGE HOUR	Instructions or Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:59 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59	RC

		<p>07-07:00 to 07:59 19-07:00 to 07:59</p> <p>08-08:00 to 08:59 20-08:00 to 08:59</p> <p>09-09:00 to 09:59 21-09:00 to 09:59</p> <p>10-10:00 to 10:59 22-10:00 to 10:59</p> <p>11-11:00 to 11:59 23-11:00 to 11:59</p>	
17	PATIENT STATUS	<p>REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes:</p> <p>01 Routine Discharge</p> <p>02 Discharged to another short-term general hospital</p> <p>03 Discharged to SNF</p> <p>04 Discharged to ICF</p> <p>05 Discharged to another type of institution</p> <p>06 Discharged to care of home health service Organization</p>	R

Field 17 (continued)		<p>07 Left against medical advice</p> <p>08 Discharged/transferred to home under care of a Home IV provider</p> <p>09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)</p> <p>20 Expired or did not recover</p> <p>30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)</p> <p>40 Expired at home (hospice use only)</p> <p>41 Expired in a medical facility (hospice use only)</p> <p>42 Expired—place unknown (hospice use only)</p> <p>43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital)</p> <p>50 Hospice—Home</p>	
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		<p>51 Hospice—Medical Facility</p> <p>61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed</p> <p>62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital</p> <p>63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)</p> <p>64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare</p> <p>65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital</p> <p>66 Discharged/transferred to a critical access hospital (CAH)</p>	
18-2817	<p>CONDITION STATUS</p> <p>CODESPATIENT</p>	REQUIRED when applicable. Condition codes are used to identify	CR

		<p>conditions relating to the bill that may affect payer processing.</p> <p>Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>REQUIRED for inpatient and outpatient claims.</p> <p>Enter the 2-digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes:</p> <p>01 Routine Discharge</p> <p>02 Discharged to another short-term general hospital</p> <p>03 Discharged to SNF</p> <p>04 Discharged to ICF</p> <p>05 Discharged to another type of institution</p> <p>06 Discharged to care of home health service Organization</p> <p>07 Left against medical advice</p>	
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<p>Field 17 (continued)</p>		<p>08 Discharged/transferred to home under care of a Home IV provider</p> <p>09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)</p> <p>20 Expired or did not recover</p> <p>30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)</p> <p>40 Expired at home (hospice use only)</p> <p>41 Expired in a medical facility (hospice use only)</p> <p>42 Expired—place unknown (hospice use only)</p> <p>43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital)</p> <p>50 Hospice—Home</p> <p>51 Hospice—Medical Facility</p>	
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		<p>61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed</p> <p>62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital</p> <p>63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)</p> <p>64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare</p> <p>65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital</p> <p>66 Discharged/transferred to a critical access hospital (CAH)</p>	
2918-28	ACCIDENT STATECONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing.	C

		<p>Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p>	
3029	UNLABELED FIELD ACCIDENT STATE	NOT USED	Not Required
31-34 a-b 30	OCCURRENCE CODE and OCCURENCE DATE UNLABELED FIELD	<p>Occurrence Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in</p>	C

		MMDDYYYY format. NOT USED	
a-b	31-34 OCCURRENCE CODE and OCCURRENCE DATE	<p>Instructions or</p> <p>Occurrence Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.</p>	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	<p>Occurrence Span Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered</p>	

		<p>codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.</p>	
<p>37</p> <p>35-36</p> <p>a-b</p>	<p>(UNLABELED FIELD)</p> <p>OCCURRENCE SPAN CODE and</p> <p>OCCURRENCE DATE</p>	<p>REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim. Occurrence Span Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.</p> <p>Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes).</p> <p>For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence</p>	<p>C</p>

		Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	
38 37	RESPONSIBLE PARTY NAME AND ADDRESS (UNLABELED FIELD)	REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
39-41 a-d 38	VALUE CODES and AMOUNTS RESPONSIBLE PARTY NAME AND ADDRESS	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified.	C

		<p>Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign (\$) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</p>	
<p>39-41 a-d</p>	<p>VALUE CODES CODES and AMOUNTS</p>	<p>Instructions or Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</p> <p>Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199,999.99).</p>	<p>C</p>

		Do not enter a dollar sign (\$) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e., 10.00), enter 00 in the area to the right of the vertical line.	
General Information Fields 42-47	SERVICE LINE DETAIL	<p>The following UB-04 fields – 42-47:</p> <p>Have a total of 22 service lines for claim detail information.</p> <p>Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.</p>	
42 Line 1-22 General Information Fields 42-47	REV CD SERVICE LINE DETAIL	<p>Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions.</p> <p>Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value. The following UB-04 fields – 42-47:</p> <p>Have a total of 22 service lines for claim detail information.</p> <p>Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.</p>	R

42 Line 23 42 Line 1-22	Rev CD REV CD	Enter 0001 for total charges. Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	RR
43 Line 1-2242 Line 23	DESCRIPTION Rev CD	Enter a brief description that corresponds to the revenue code entered in the service line of field 42. Enter 0001 for total charges.	RR
43 Line 23 43 Line 1-22	PAGE ___ OF ___ DESCRIPTION	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e., PAGE "1" OF "1"). (Limited to 4 pages per claim) Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	CR

43 Line 23	PAGE ____ OF ____	Instructions or Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e., PAGE “1” OF “1”). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-2244	SERVICE DATE HCPCS/RATES	REQUIRED on all outpatient claims. Enter	CC

		<p>the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims</p> <p>REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.</p>	
<p>45 Line 2345 Line 1-22</p>	<p>CREATION DATE SERVICE DATE</p>	<p>Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY). REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims</p>	<p>RC</p>

46 45 Line 23	SERVICE UNITS CREATION DATE	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed. Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	RR
47 Line 1-2246	TOTAL CHARGES SERVICE UNITS	Enter the total charge for each service line. Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	RR
47 Line 2347 Line 1-22	TOTALS TOTAL CHARGES	Enter the total charges for all service lines. Enter the total charge for each service line.	RR
48 Line 1-2247 Line 23	NON-COVERED CHARGES TOTALS	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts. Enter the total charges for all service lines.	CR
48 Line 2348 Line 1-22	TOTALS NON-COVERED CHARGES	Enter the total non-covered charges for all service lines. Enter the	CC

		non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required
50 A-C49	PAYER(UNLABELED FIELD)	<p>Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability.</p> <p>Line A refers to the primary payer; B, secondary; and C, tertiary</p> <p>Not Used</p>	RNot Required
51 A-C50 A-C	HEALTH PLAN IDENTIFICATION NUMBERPAYER	Enter the name of each Payer from which reimbursement is being sought in the order of	Not RequiredR

		<p>the Payer liability.</p> <p>Line A refers to the primary payer; B, secondary; and C, tertiary</p>	
<p>52 A-C51 A-C</p>	<p>REL INFOHEALTH PLAN IDENTIFICATION NUMBER</p>	<p>REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y'.</p>	<p>RNot Required</p>
<p>5352 A-C</p>	<p>ASG. BEN.REL INFO</p>	<p>Enter "Y" (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y'.</p>	<p>RR</p>

5453	PRIOR PAYMENTSASG. BEN.	Enter the amount received from the primary payer on the appropriate line when Ascension Complete is listed as secondary or tertiary. Enter "Y" (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	CR
5554	EST. AMOUNT DUEPRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Ascension Complete is listed as secondary or tertiary.	Not RequiredC
56 55	NATIONAL PROVIDER IDENTIFIER OR PROVIDER IDEST. AMOUNT DUE	Required: Enter providers 10-character NPI ID.	RNot Required

5756	OTHER PROVIDER INTERNATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	<p>a. Enter the numeric provider identification number.</p> <p>Enter the TPI number (non - NPI number) of the billing provider. Required: Enter providers 10-character NPI ID.</p>	RR
5857	INSURED'S NAMEOTHER PROVIDER ID	<p>b. For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial. Enter the numeric provider identification number.</p> <p>Enter the TPI number (non - NPI number) of the billing provider.</p>	RR
5958	PATIENT RELATIONSHIPINSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for	Not Required

		the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	
59	PATIENT RELATIONSHIP	c.	No t Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
6160	GROUP NAME INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	Not Required R
6261	INSURANCE GROUP NO. GROUP NAME		Not Required Not Required
6362	TREATMENT AUTHORIZATION CODES INSURANCE GROUP NO.	Enter the Prior Authorization or referral when services require pre-certification.	C Not Required

6463	DOCUMENT CONTROL NUMBER TREATMENT AUTHORIZATION CODES	<p>Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Ascension Complete Health Plan from field 50.</p> <p>Applies to claim submitted with a Type of Bill (field 4) Frequency of “7” (Replacement of Prior Claim) or Type of Bill Frequency of “8” (Void/Cancel of Prior Claim).</p> <p>* Please refer to reconsider/corrected claims section. Enter the Prior Authorization or referral when services require pre-certification.</p>	CC
6564	EMPLOYER NAME DOCUMENT CONTROL NUMBER	<p>Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Ascension Complete Health Plan from field 50.</p> <p>Applies to claim submitted with a Type of Bill (field 4) Frequency of “7” (Replacement of Prior Claim) or Type of Bill Frequency of “8” (Void/Cancel of Prior Claim).</p>	Not Required C

		* Please refer to reconsider/corrected claims section.	
6665	DX QUALIFIER NAME	VERSION EMPLOYER	Not Required Not Required
6766	PRINCIPAL CODE QUALIFIER	DIAGNOSIS VERSION	R Not Required
67	PRINCIPAL CODE	DIAGNOSIS CODE	R
67 A-Q	OTHER CODE	DIAGNOSIS CODE	C

		<p>9/10-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. "E" and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>Note: Claims with incomplete or invalid diagnosis codes will be denied.</p>	
<p>6867</p> <p>A-Q</p>	<p>PRESENT ON ADMISSION INDICATOR OTHER DIAGNOSIS CODE</p>	<p>Enter additional diagnosis or conditions that coexist at the time of admission or that develop after the admission and influence the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. "E" and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>Note: Claims with incomplete or invalid diagnosis codes will be denied.</p>	<p>RC</p>

6968	ADMITTING DIAGNOSIS CODEPRESENT ON ADMISSION INDICATOR	<p>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. "E" codes and most “V” is NOT acceptable as a primary diagnosis.</p> <p>Note: Claims with missing or invalid diagnosis codes will be denied.</p>	RR
69	ADMITTING DIAGNOSIS CODE	<p>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.</p> <p>Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. "E" codes and most “V” is NOT acceptable as a primary diagnosis.</p> <p>Note: Claims with missing or invalid</p>	R

		diagnosis codes will be denied.	
70	PATIENT REASON CODE	<p>Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry, fields 70b-70c are conditional.</p> <p>Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or “5”. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims with missing or invalid diagnosis codes will be denied.</p>	R
7170	PPS/DRG CODEPATIENT REASON CODE	<p>Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry, fields 70b-70c are conditional.</p> <p>Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or “5”. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis.</p> <p>NOTE: Claims with missing</p>	<p>Not Required</p> <p>R</p>

		or invalid diagnosis codes will be denied.	
72 a, b, c 71	EXTERNAL CAUSE CODEPPS/DRG CODE		Not Required Not Required
73 72 a, b, c	UNLABELED EXTERNAL CAUSE CODE		Not Required Not Required
7473	PRINCIPAL PROCEDURE CODE/DATE UNLABELED	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9	C

		<p>procedure code(s) that identify</p> <p>significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-9 Procedure</p> <p>Codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>	
7574 a-e	UNLABELED OTHER PROCEDURE CODE DATE	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9 procedure code(s) that identify</p> <p>significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-9 Procedure</p> <p>Codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied.</p> <p>DATE: Enter the date the</p>	Not Required C

		principal procedure was performed (MMDDYY).	
7675	ATTENDING PHYSICIANUNLABLED	<p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>OB – State License #.</p> <p>1G – Provider UPIN.</p> <p>G2 – Provider Commercial #.</p> <p>B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician's last name.</p> <p>FIRST: Enter the attending physician's first name.</p>	RNot Required
76	ATTENDING PHYSICIAN	<p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID</p>	R

		<p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>OB – State License #.</p> <p>1G – Provider UPIN.</p> <p>G2 – Provider Commercial #.</p> <p>B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician's last name.</p> <p>FIRST: Enter the attending physician's first name.</p>	
77	OPERATING PHYSICIAN	<p>REQUIRED when a surgical procedure is performed.</p> <p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>OB – State License #.</p> <p>1G – Provider UPIN.</p>	C

		<p>G2 – Provider Commercial #.</p> <p>B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician's last name.</p> <p>FIRST: Enter the attending physician's first name.</p>	
78 & 7977	OTHER PHYSICIANOPERATING PHYSICIAN	<p>Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care.</p> <p>(Blank Field): Enter one of the following Provider Type Qualifiers:</p> <p>DN – Referring Provider</p> <p>ZZ – Other Operating MD</p> <p>82 – Rendering Provider</p> <p>NPI: Enter the other physician 10-character NPI ID.</p> <p>QUAL: Enter one of the</p>	CC

		<p>following qualifier and ID number:</p> <p>OB - State license number</p> <p>1G - Provider UPIN number</p> <p>G2 - Provider commercial number</p> <p>REQUIRED when a surgical procedure is performed.</p> <p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>OB – State License #.</p> <p>1G – Provider UPIN.</p> <p>G2 – Provider Commercial #.</p> <p>B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician’s last name.</p> <p>FIRST: Enter the attending physician’s first name.</p>	
80	REMARKS	Enter the Provider Type qualifier, NPI, and	Not Required

78 & 79	OTHER PHYSICIAN	<p>name of the physician in charge of the patient care.</p> <p>(Blank Field): Enter one of the following Provider Type Qualifiers:</p> <p>DN – Referring Provider</p> <p>ZZ – Other Operating MD</p> <p>82 – Rendering Provider</p> <p>NPI: Enter the other physician 10-character NPI ID.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>OB - State license number</p> <p>1G - Provider UPIN number</p> <p>G2 - Provider commercial number</p>	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider.	R

		Use B3 qualifier.	
8281	Attending Physician CC	Enter name or 7-digit Provider number of ordering physician A: Taxonomy of billing provider. Use B3 qualifier.	RR
82	Attending Physician	Enter name or 7-digit Provider number of ordering physician	R

Appendix VII: Billing Tips and Reminders

Adult Day Health Care

- 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 is limited to 13xs-14x range
- Late charge claims are not allowed. Only replacement claims. Claims with late charges will be denied being resubmitted.
- Claims spanning two calendar years will be required to be submitted by the provider 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: Providers 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

- Providers must utilize correct coding for Maternity Services.
- Services provided to members prior to their Ascension Complete effective date should be correctly coded and submitted to the payer responsible.
- Services provided to the member on or after their Ascension Complete effective date should be correctly coded and submitted to Ascension Complete.

Modifiers

- Appropriate Use of – 25, 26, TC, 50, GN, GO, GP
- **25 Modifier** - should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of another procedure (e.g., 99381 and 99211-25. Modifier 25 is 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. Well-Child and sick visit performed on the same day by the same physician). *NOTE: 25 modifiers are not appended to non-E&M procedure codes, e.g., lab.
- **26 Modifier** – should never be appended to an office visit CPT code.

Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes. Inappropriate use may result in a claim denial/rejection.

- **TC Modifier** – used to indicate the technical component of a test or study 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 required for speech, occupational, and physical therapy

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. Providers may not bill for any reusable supplies.

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 by a different practitioner 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.

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 VIII: Reimbursement Policies

Generally, Ascension Complete follows Medicare reimbursement policies. Instances that vary from Medicare include:

Physician Rules

Calculating Anesthesia

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Certified Nurse Midwife (CNM) Rules

Payment for CNM services is made at 100% of the contracted rate.

EKG Payment

EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Physician Site of Service

Physicians will be paid at Physician rate only at the following Sites of Service: Office, Home, Assisted Living Facility, Mobile unit, walk in retail health clinic, urgent care facility, birthing center, nursing facility, SNFs, independent clinic, FQHC, Intermediate HC Facility, Resident Substance Abuse Facility, Nonresident Substance Abuse Facility, Comprehensive OP Rehab facility, ESRD Facility, State or Local Health Clinic, RHC, Indy lab, Other POS.

Endoscopic Multiple Procedure Rules

When you have two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608) - identify the primary code within the family, and then apply multiple procedure discounts to the two primary codes. Secondary codes are not paid because you consider the total payment for each set of endoscopies as one service.

When you have two related endoscopies and a third, unrelated procedure - identify the primary code in the related endoscopies. Then apply multiple procedure discounts to the unrelated code and the identified primary code. The secondary code is not paid because you consider the total payment for each set of endoscopies as one service.

Diagnostic Testing of Implants

Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Lesser Of Language

Pay Provider lesser of the Providers allowable charges or the negotiated rate

Multiple Procedure Rules for Surgery

Payment should be paid at 100%/50%/50%, starting with procedure ranked highest. Max of 3 procedures.

Procedures 4+ are subject to manual review and payment if appropriate.

Multiple Procedure Ranking Rules

If two or more multiple surgeries are of equal payment value and bill charges do not exceed the payment rate, rank them in descending dollar order billed pay based on multiple procedure discounts.

Multiple Procedure Rules for Radiology

Multiple procedure radiology codes follow Multiple Procedure discount rules: 100%/50%/50%, max three radiology codes.

Physician Assistant (PA) Payment Rules

Physician assistant services are paid at 85% of what a physician is paid under the Ascension Complete Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid 85% of what a physician is paid under the Ascension Complete Physician Fee Schedule.
- PA assistant-at-surgery services at 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Payment Rules

In general, NPs and CNSs are paid for covered services at 85% of what a physician is paid under the Ascension Complete Physician Fee Schedule.

- NP or CNS assistant-at-surgery services at 85% of what a physician is paid under the Ascension Complete Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Ascension Complete Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Surgical Physician Payment Rules

For surgeries billed with either modifiers 54, 55, 56, or 78 pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.

Incomplete Colonoscopy Rule

Incomplete colonoscopies should be billed with CPT 45378 and MOD 53. This will pay 25% of the FS rate for the incomplete procedures. The rest of the claim pays according to the FS.

Injection Services

Injection service codes must pay separately if no other physician service is paid and when not billed with office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Unpriced Codes

If the CMS/Medicare RBRVS does not contain a published fee amount, an alternate “gap fill” source is utilized to determine the fee amount. If there is no fee available on the alternate “gap fill” source, Ascension Complete will reimburse 40% of billed charges less any applicable copay, coinsurance, or deductible, unless contracted differently. Unlisted codes are subject to the code edit and audit process and will require the submission of medical records.

Rental or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Payment for Capped Rental Items during Period of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than 15 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 15 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Ascension Complete coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers new medical necessity.

If the beneficiary changes suppliers during or after the 15-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 15th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 15-month period. If the supplier changes after the 10th month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

An entire month's rent may not be paid when a patient is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Transcutaneous Electrical Nerve Stimulator (TENS)

To permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two months rental.

Appendix IX: EDI Companion Guide Overview

The Companion Guide provides Ascension Complete 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 Complete Companion Guide documents any assumptions, conventions, or

data issues that may be specific to Ascension Complete business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Ascension Complete 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 Complete. This document provides information on Ascension Complete- 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 <http://store.x12.org>.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Ascension Complete and its trading partners. Refer to the TPA for guidelines pertaining to Ascension Complete legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Ascension Complete 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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Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Ascension Complete.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1, 999). A TA1 Acknowledgment is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgment may be used to verify a successful transmission or to indicate various types of errors.

Transmission Confirmation cont.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgement

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgement

The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction Sets.

277CA Health Care Claim Acknowledgement

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Ascension Complete also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. *NOTE: The STC03 – Action Code will only be a “U” if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.*

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Ascension Complete checks five values within the ISA for redundancy:

- ISA06, ISA08, ISA09, ISA10, ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of “025” (Duplicate Interchange Control Number).

Duplicate Batch Check cont.

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Ascension Complete checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payer ID

New Trading Partners

New trading partners should access <https://sites.edifecs.com/index.jsp>, register for access, and perform the steps in the Ascension Complete trading partner program. The EDI Support Desk will contact you with additional steps necessary upon completing your registration.

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 health care claims, and the Ascension Complete 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 Complete recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

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 Complete 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 Complete 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 Complete 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 parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Ascension Complete 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 Complete will not accept more than 97 service lines per UB-04 claim.
- Ascension Complete will not accept more than 50 service lines per CMS 1500 claim.
- Ascension Complete 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 Complete 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 Complete expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Ascension Complete will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Ascension Complete EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers 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 provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers 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 Provider

Ascension Complete has no specific requirements for Referring Provider information.

Atypical Provider

Atypical providers are not always assigned an NPI number, however, if an atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e., carpenters, transportation, etc.). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop.

NOTE: If an NPI is billed in any part of the claim, it will not follow the Atypical Provider 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 Complete 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 Complete 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 Complete encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Ascension Complete offers two options for connectivity via FTP.

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

Encryption

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

Direct Submission

Ascension Complete also offers posting an 837-batch file directly on the Provider Portal website for processing.

Edits and Reports

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

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Level	Structure	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Control	Interchange		TA1
GS/GE Functional Group ST/SE Segment		HIPAA Implementation Guide violations	999 Ascension Complete Claims Audit Report (a proprietary

Detail Segments		confirmation and error report)
Detail Segments	Ascension Complete Business Edits (See audit report rejection reason codes and explanation.)	Ascension Complete Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Ascension Complete Business Edits.	277CA

277CA/Audit Report Rejection Codes

Error Code	Rejection Reason
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Provider
07	Invalid Mbr DOB & Provider
08	Invalid Mbr & Provider
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Provider not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv

Error Code	Rejection Reason
17	Invalid Diag Code
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diagnosis Code
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag Code
25	Invalid Mbr; Invalid Prv; Invalid Diag Code
26	Mbr not valid at DOS; Invalid Diag Code
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag Code
29	Provider not valid at DOS; Invalid Diag Code
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid Future Service Date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag

Error Code	Rejection Reason
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc

Error Code	Rejection Reason
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service
76	Original Claim Number Required
77	Invalid Claim Type
78	Diagnosis Pointer- Not in sequence or incorrect length
81	Invalid units of service, Invalid Prv
83	Invalid units of service, Invalid Prv, Invalid Mbr
89	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
91	Invalid Missing Taxonomy or NPI/Invalid Prov
92	Invalid Referring/Ordering NPI
93	Mbr not valid at DOS; Invalid Proc
96	GA OPR NPI Registration-State
A2	Diagnosis Pointer Invalid
A3	Service Lines- Greater than 97 Service lines submitted- Invalid
B1	Rendering and Billing NPI are not tied on State File- IN rejection

Error Code	Rejection Reason
B2	Not enrolled with MHS IN and/or State with rendering NPI/TIN on DOS. Enroll with MHS and Resubmit claim
B5	Invalid CLIA
C7	NPI Registration- State GA OPR
C9	Invalid/Missing Attending NPI
HP/H1/H2	ICD9 after end date/ICD10 sent before Eff Date/Mixed ICD versions