



Provider Manual

MedCost Network

Updated January 26, 2018

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Introduction

How to Use This Manual

This procedure manual will assist your office staff in administration of MedCost programs. This manual is an extension of your MedCost agreement. You will receive advance notice via email regarding updates and revisions to this manual, and they will also be posted on our web site. You will be responsible for maintaining records of updates. As you receive updates, please insert them in your manual to ensure you have the most current information.

Whenever you have a question about any aspect of the MedCost programs, first check the appropriate section of this manual. If you don't find the answer to your question in the manual, contact MedCost. We are always willing to help. Also, please let us know if you have suggestions about improvements we can make to this manual to make it easier for you to use.

About MedCost

MedCost, LLC was established in 1983 in Winston-Salem, North Carolina. Today, MedCost services employer groups throughout the Carolinas and Virginia. MedCost offers several major health care cost management programs:

- MedCost Network - a provider network.
- MedCost Health Management - a suite of comprehensive care management programs, including inpatient review, outpatient review, case management, and prenatal.
- Ultra - a new product offering available only through MedCost Benefit Services, the benefits administration division of MedCost. MedCost Ultra is a product of the existing MedCost Network in North and South Carolina.

A provider network is a network of selected providers of health care: physicians, hospitals, home health agencies, ancillary providers, and others. MedCost is a traditional network, giving patients a financial incentive or disincentive in their benefit plan that encourages them to seek care from participating providers. Since these benefit plan differentials could significantly impact the patient's out-of-pocket cost, network utilization under the MedCost Network is very high. Patients are encouraged to use these selected providers because they receive better benefits when they do. For example, a benefit plan usually paying 80% of a covered service and requiring a \$150 calendar year deductible may pay 90% and waive the deductible when the patient seeks care from a MedCost participating provider. The plan may still reimburse for covered services if the patient is seen by a non-MedCost provider, but the patient will have more out-of-pocket expense. This gives patients *true freedom of choice* but rewards them for making cost-effective decisions. Details regarding benefit differentials should be determined by contacting the claim administrator.

A network is not an insurance plan. MedCost works with many employers and claim administrators, all of which retain their own benefit plans. **MedCost does not pay claims**, but assists in collecting information and preparing the claim for payment. Once MedCost has repriced the claim, it is routed to the appropriate claim administrator for benefit determination.

When and How to Contact MedCost

Contact us via our web site at www.medcost.com to:

- Verify that MedCost received and repriced your claims.
- Link to the claim administrator for claim status.
- Verify provider participation status.
- Request assistance with problematic claims.
- Access the physician/hospital Reference Guide.
- Get answers to frequently asked EDI questions and support for your 5010 transactions.
- Read our News page under the provider portal.
- Get highlights of current legislation.
- Get updates on provider manual or administrative changes.

Call our Customer Service Contact Center toll-free at 1-800-824-7406, Monday through Friday, from 8:30 a.m. to 5:00 p.m. (EST) to:

- Verify provider participation status.
- Request assistance on a claims repricing issue.
- Ask general administrative questions.
- Ask for EDI assistance.

Contracting

As health care costs continue to rise, employers continue to look for ways to provide coverage for employees. MedCost is encouraged as both employers and providers tell us they believe that market diversity and an array of health care options for employers are important for a future healthy market. MedCost is an important vehicle for continued market competition in Virginia and the Carolinas, working in partnership with over 70 claim administrators to deliver competitive health plans using the MedCost Network.

In working with providers, MedCost strives to set itself apart with exceptional service and a commitment to bringing parties together to resolve problem claims or relationship issues. The overall MedCost provider satisfaction rating consistently remains in the upper 90th percentile. Providers confirm that MedCost offers a higher level of service than most managed care organizations, and they do not contend with the high levels of denials, appeals, and downcoding issues that are present with some larger carriers. Our goal is to continually make MedCost program administration and our interface easy and efficient.

For MedCost to continue as a competitive option and to succeed in facilitating market diversity, we will have to demonstrate network savings levels similar to those of the large carriers with whom you contract. As a provider, you help control how big the dominant market carriers will become. For market diversity to exist, providers will have to reduce significant gaps in network savings levels. This will create a market that competes on product efficiency, ensuring a healthier market place for providers, employers, and consumers.



Your MedCost Reimbursement Schedule

The MedCost contracted allowables are designed to produce fair market rates for providers and employers and to be competitive. MedCost uses a composite of statewide and industry data and third party resources (relative value scales, etc.) when establishing a fee schedule or facility rates. Reimbursement is based on your customary charge if it does not exceed the MedCost allowable limit. MedCost evaluates fee schedules periodically against market and industry pricing.

Credentialing

The MedCost credentialing program has been accredited by URAC since 2000.

Before a provider can be added to the MedCost Network, the provider must be credentialed and approved by the MedCost Credentialing Committee. MedCost requires that all providers meet our credentialing criteria during the initial and recredentialing process, including the verification of active and approved licensure and accreditations. MedCost retains authority to make final credentialing determination regarding providers.

In our efforts to offer the best quality care for our members, MedCost is collaborating with Aperture Credentialing, LLC to provide credentialing verification services for providers included in our network.

As a MedCost participating provider, you may receive correspondence from Aperture Credentialing, LLC requesting that you update your CAQH application, re-attest to your information, or authorize MedCost as a participating plan.

Aperture Credentialing staff also may contact you directly in the event additional information is needed to complete the application process.

Any requests from Aperture Credentialing, LLC are legitimate and vital to MedCost's provider credentialing process. Your prompt response and cooperation with Aperture as our credentialing partner is much appreciated.

A provider can obtain information about the status of their credentialing application at any point during the credentialing or recredentialing process by calling the MedCost Customer Service Contact Center at 1-800-824-7406. In the event an application is incomplete, inaccurate or has conflicting information, providers will be notified and given the opportunity to provide updated information.

Providers will be notified within ten (10) business days of MedCost's Credentialing Committee decision. **A provider will not be considered a participant in the MedCost Network until the credentialing process is complete and a letter is sent to your practice indicating the provider's effective date. MedCost will not assign retro-effective dates. Claims sent to MedCost with dates of service prior to the effective date will be processed as out-of-network.**

Participating providers are recredentialed every three (3) years. Providers will be notified that recredentialing is due, or if you utilize CAQH, your information will be obtained directly from the Universal Provider Datasource® (UPD). It is extremely important that the recredentialing information is returned as soon as possible to avoid possible termination from the network. Providers are considered to be recredentialed unless otherwise notified.

Providers who have been terminated from the MedCost Network are required to repeat the credentialing process if MedCost is not notified within six (6) months of the date the provider was terminated and/or the provider's credentialing has expired.

If you are a professional provider who wants to bill for the use of a facility, you must be accredited and have entered into a separate facility agreement with us. Please see information under Facility Credentialing for details of that process.

Professional Providers

On behalf of MedCost, Aperture Credentialing, LLC is able to access CAQH for professional providers' credentialing information through the Universal Provider Datasource® (UPD). In an effort to make the process more uniform and to ease your administrative burden, CAQH will help you with your credentialing data and information collection.

With CAQH, each health care provider can submit just one standard application to a single database that is designed to meet the needs of all organizations involved in the credentialing process—and there is **no cost for submission**. Credentialing information can easily be accessed as long as you add MedCost as one of the health plans authorized to access your information. CAQH will ask you quarterly to verify the accuracy of your information on file, and you can easily update it anytime.

- **If you are registered with CAQH**, please send your CAQH ID to MedCost at credentialingapps@medcost.com. You will also need to log in to the UPD at <https://proview.caqh.org/PO> and add MedCost as one of the health plans authorized to access your information. Please be sure that you have updated your information to include all supporting documentation, including the most current Certificate of Liability Insurance.
- **If you are not registered with CAQH**, please click here <https://proview.caqh.org/PR/Registration> to register and add MedCost as one of the health plans authorized to access your information. Once you receive notification from CAQH that your application is complete, [click here to supply MedCost with your CAQH ID.](#)

If you do not have internet access, please contact the CAQH Help Desk at 888-599-1771 and request a CAQH application be sent by mail. Simply complete the paper copy and fax it back to the toll free number indicated on the application.

Facility Providers

Facilities that provide health care services include, but are not limited to: hospitals, free-standing surgical centers, office-based surgical suites, endoscopy centers, home health agencies, hospice providers and other ancillary providers.

If you are interested in participating with MedCost, you will need to submit the request through our web site section, "Interested In Becoming A MedCost Network Provider." We will review the request and if credentialing is required, we will initiate a credentialing event with Aperture Credentialing, LLC. Aperture will contact you regarding the application and the necessary documentation that is needed.

Facilities are recredentialed every three (3) years, and you will be notified that recredentialed is due. It is extremely important that the recredentialed information is returned as soon as possible to avoid possible termination from the network. Facilities are considered to be recredentialed unless otherwise notified.

For facility credentialing, an Organizational Credentialing application will be sent via fax, email, or mail to the credentialing contact for the facility. The application should be completed and returned as indicated on the request, including all required documentation.

Your Listing in the MedCost Directory

Upon completion of your credentialing with MedCost, your demographic information will be listed in our online provider directory at www.medcost.com.

Your office must notify MedCost of any changes in demographic information prior to the effective date of the change. This will ensure we are publishing the most current information and providing our participating claim administrators with updated provider demographics. You may fax written notification of these changes to (336) 970-2199 or go to our web site at www.medcost.com and complete the "Update Provider Information" form located within the provider portal.

Termination

MedCost is privileged to have a very comprehensive provider network, with low turnover through termination of agreements. However, we understand that due to unforeseen circumstances, either party to the agreement may choose to terminate the relationship. Your agreement with MedCost allows you or MedCost to terminate the agreement with or without cause if submitted in writing to the other party. Refer to your agreement for the timeframe specific to you.

There are also detailed instructions in your MedCost agreement about the continuation of care for MedCost Eligible Persons under your care at the time of termination of the agreement. This part of your agreement is in compliance with North Carolina Department of Insurance guidelines and is meant to ensure a smooth transition of patient care. MedCost believes the guidelines are an effective means of maintaining quality of care for MedCost Eligible Persons.

Continuity of Care

In order to ensure continuity of care, it is important for your office to notify MedCost in writing of changes in the provider's location prior to the date the changes occur. This will allow us sufficient time to make necessary changes in our system. If notified in advance, MedCost will make every effort to ensure continuity of care for your patients. You may fax written notification of these changes to (336) 970-2199.

Provider Accessibility and Availability

MedCost sets provider availability standards for average appointment waiting times as follows:

Primary Care:

Routine Appointments:	14 calendar days
Urgent Appointments:	Same day
Emergency Appointments:	Immediately or triage

Specialists:

Routine Appointments:	30 calendar days
Urgent Appointments:	Same day
Emergency Appointments:	Immediately or triage

Emergency Care:

Emergency care shall be available 24 hours a day, 7 days a week.

Use In-Network MedCost Providers

If you need to refer a MedCost patient to another provider for any service, please ensure that the provider is also in-network with MedCost. This is a benefit to your patients and can help potentially lower out-of-pocket costs for them. To verify MedCost contracted providers, please refer to our MedCost Provider Directory located on our web site at www.medcost.com or call our Customer Service Contact Center at 1-800-824-7406.

Provider Services

Interactive Web Site

MedCost's valuable online Claims Repricing Inquiry and Provider Claim Activity Report offers many benefits for our network of providers, including:

- **Convenience and improved customer service:** Our web-based Claims Repricing Inquiry and online Claim Activity Report provide 24/7 access to repricing information at MedCost. We have direct links from our web site to the web sites of claim administrators with online capabilities allowing access to payment status for repriced claims. With this online service, providers can reduce overhead costs, telephone charges, and increase efficiencies in their billing and collections areas.
- **HIPAA compliance:** MedCost's web-based Claims Repricing Inquiry function meets the HIPAA guidelines for security and privacy. We can assure providers that protected health information (PHI) is secure for all patients.
- **Interaction:** Providers can send MedCost information about claims that have not been successfully repriced. The "Contact Us" feature allows providers to send us patient policy information so we can correct, update, and release claims for payment consideration.
- **Web site inquiry demonstrations:** There is a brief demonstration of the MedCost Claims Repricing Inquiry application on our web site. This is an interactive demonstration of several of the pages that are included in the actual tool for medical providers.
IMPORTANT! Your Internet browser must accept cookies in order to view the demo and to request an account. Also, this web site application is best viewed using the Internet Explorer browser, version 5.0 or later.
- **Registration process:** After reviewing a demonstration of our Claims Repricing Inquiry, your office manager can register on our web site. New practices in a direct agreement with MedCost will receive their user ID and a temporary password with their executed agreement and welcome information.
- Once you access the MedCost web site applications, you can start checking the repricing of your claims via the Physician Claim Activity Report or get claim specific information with the Claims Repricing Inquiry. You will also be able to access the Reference Guide that allows you to view all employer groups who utilize the MedCost Network.

Provider Communication

MedCost is committed to assisting you with the administration of our network. We believe communication is the best way to ensure administrative ease. MedCost will keep you up-to-date on any changes regarding administration of our programs, helpful facts for ease in administration, large employer additions or terminations, and much more. You may receive communication from MedCost in various ways, including e-mail broadcast, our online Provider Claim Activity Report, web site, fax, or direct mail.

Customer Service Contact Center

The MedCost Customer Service Contact Center is available to assist you Monday through Friday, from 8:30 a.m. to 5:00 p.m. (EST).

Our toll free number is 1-800-824-7406.

Our mission is to provide you with outstanding customer service, performed in a timely manner by well-trained, highly skilled representatives operating under the absolute highest standard of quality.

Our automated attendant telephone system routes calls based on the call type and skills of the customer service representative.

Problematic Claim Status Inquiries

MedCost's Payer Service Team is available to assist you with problematic claims. MedCost defines a claim as "problematic" when (1) it has been outstanding more than 60 days from the MedCost repricing date, and (2) your efforts to resolve the issue with the claim administrator have been unsuccessful. Claims must be less than one year from the date of service. If you would like us to assist your practice or facility with research on a problematic claim, you may e-mail information to the Payer Service Team at payorserviceteam@medcost.com. Our Payer Service Team will contact the appropriate claim administrator and obtain the status of your claim. A response will be sent to you via e-mail, fax, or mail within 3-5 business days. You also may call our Customer Service Contact Center at 1-800-824-7406, Monday – Friday 8:30 a.m. – 5:00 p.m. (EST).

Provider Education

MedCost conducts educational teleconferences for network providers. Information regarding upcoming teleconferences can be found in the provider portal of our web site at www.medcost.com. You may register for an upcoming session via our web site. MedCost staff members also conduct workshops and are available to present educational sessions to your staff in your office or facility.

MedCost Reference Guide

The MedCost Reference Guide is a listing of companies accessing the MedCost Network. It provides the following information about the companies:

- Company name
- Group number
- Claim administrator name, phone number and web site (to verify coverage and eligibility)
- Group effective and termination dates
- Pre-certification vendor and phone number

You can access a copy of the MedCost Reference Guide via secure login from the provider portal on our web site.

Patient Identification

Identification Cards

The health identification card is used to identify patients who access the MedCost Network. The identification card presented by eligible patients will bear the name MedCost, American Healthcare Alliance* (AHA), or Ultra in North and South Carolina. Ultra** is a new product offering available only through MedCost Benefit Services, the benefits administration division of MedCost. MedCost Ultra is a product of the existing MedCost network in Virginia and the Carolinas.

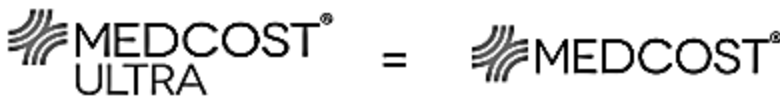
You may collect your actual charge from the patient at the time of service if the patient cannot provide proper identification showing the patient is eligible to access the MedCost Network. If the claim for the patient is processed and a fee reduction amount is indicated on the Provider Claim Activity Report, you must refund the patient accordingly.

The MedCost name will **not appear on the identification card for American Healthcare Alliance (AHA) insured. AHA is a national PPO that contracts with MedCost for network access in North Carolina and South Carolina. AHA accesses the MedCost Network exclusively in North and South Carolina.*



American
Healthcare
Alliance

***Ultra cards will show MedCost Ultra, and you need to know this equals MedCost.*



Requests for Verification of Eligibility and Benefits

MedCost does **not** maintain benefit or eligibility information for patients. Providers should contact the claim administrator indicated on the patient’s identification card for benefit and eligibility information. The claim administrator name, phone number, and web site can also be found in the MedCost Reference Guide.

MedCost recommends that providers verify benefits for all services rendered to MedCost patients. Verifying benefits allows the provider to collect any co-payment, co-insurance, deductible, etc., at the time of service.

MedCost Reference Guide

The Reference Guide is a listing of companies that access the MedCost Network and is located on the MedCost web site via secure login from the provider portal. When a patient presents an ID card reflecting MedCost, you can verify coverage and eligibility by contacting the claim administrator listed on the ID card. The Reference Guide includes the claim administrator's contact information and indicates if the group is active.

If you have any questions about any of the companies listed in the Reference Guide, please call our Customer Service Contact Center directly at 1-800-824-7406.

Claims Filing

Timely Filing

Providers should submit claims to MedCost as quickly as possible after services are rendered—the faster you file the claim, the faster you will receive payment for services. Some self-funded plans have timely filing limits that can affect whether a claim is payable if filed after a designated timeframe. Some reinsurance contracts will not reimburse for claims that fall outside the contract period. For these reasons, it is important to file claims promptly.

MedCost advises that claims should be submitted to MedCost within 90 days from the date of service; however North Carolina General Statute 58-3-225, “Prompt Payment Under Health Benefit Plans,” allows 180 days for claims filing for fully-insured plans. For South Carolina Providers, Section 38-59-200 of the ‘South Carolina Health Care Financial Recovery and Protection Act’ extends this time period to 120 days after the date of the provision of care for fully-insured plans.

Please note that most MedCost customers are self-funded and not impacted by this legislation. MedCost will not reprice a claim greater than two (2) years from the date of service.

Should your office need to refile a claim to MedCost to correct a previously repriced claim (such as a retrospective audit), please do so in writing within twelve (12) months of the repricing date. Failure to refile promptly may result in denials by the claim administrator based upon the plan’s timely filing limitations. If you receive denials on these claims due to untimely filing, please be advised that the patient should not be penalized.

Assignment and Claims Routing

As a MedCost participating provider, you have agreed to accept assignment and file claims for all services rendered to MedCost eligible patients.

MedCost encourages you to file claims to us electronically—typically, the electronic claims interface reduces payment turnaround cycles by 5-10 working days. Refer to section “Filing Your Claims Electronically” for detailed information about electronic claims filing.

Should you need to file your claims in paper format, submit them to MedCost at the following address:

MedCost
P. O. Box 25307
Winston-Salem, NC 27114-5307

Filing Claims for Services Rendered

MedCost scans paper claims into our system using imaging technology. This technology reduces data entry and improves our service to you. To make this technology as effective as possible, please follow these claims filing guidelines:

- File all claims in the appropriate current electronic format or on the current CMS approved paper version.
- If filing on paper, make sure your claims are typed or computer-generated and that the print is dark and legible.
- Do not staple items to your claims unless absolutely necessary.

Required Filing Elements for UB-04 Claims

- Be sure to complete policy number (Block 62A) and employer name (Block 61A or 65A). MedCost is unable to reprice your claim without this vital information.
- If your patient has other insurance information, be sure to complete the SSN or alternate member ID (Block 60B), policy number (Block 62B), and employer name (Block 61A or 62A).
- Include the appropriate ICDcode(s) and the Type of Bill code in Block 4 (inpatient or outpatient). This information is needed to accurately reprice your claim.

Itemized Bills

Many claim administrators require an itemized bill on large claims before payment can be released. MedCost suggests that you include an itemized bill with any claim for \$10,000 or more to avoid time delays that result from pended claims. If you file electronically, you will need to submit the I-Bill along with the UB-04 form on paper.

Inpatient Additional or Late Charges

If a hospital agreement is based on a per diem arrangement, additional or late charges need to be billed on a claim form indicating the appropriate type of bill and total charges for the entire length of stay. If the hospital does not submit late charges this way, the additional or late charges will be reduced to zero. If the hospital includes late charges on a UB-04 form that includes total charges for the entire length of stay, it will be processed as a corrected claim.

Interim Billing

Hospitals with a per diem or case rate arrangement are not allowed to interim bill. Charges for the entire length of stay must be submitted on one UB-04 to ensure accurate repricing.

OP UB-04 Claims Requiring CPT and HCPCS Codes

For claims received on or after January 15, 2017, MedCost will require hospital and ambulatory surgical center services to be filed with the appropriate CPT and HCPCS codes. Claims for outpatient services require CPT and HCPCS codes at the line level of the UB-04 and must be billed with **both revenue codes and appropriate CPT or HCPCS codes** when applicable codes exist. If multiple CPT or HCPCS codes are necessary to reflect multiple, distinct or independent services matching a single revenue code, claims should be coded to repeat that revenue code as necessary.

Required Filing Elements for CMS 1500

Complete the claim form according to the following instructions:

- 1) Bill your practice's usual charge for the service(s) rendered.
- 2) Be sure that all services are correctly coded according to the most current edition of the CPT, ICD, HCPCS, and ASA manuals.
- 3) Be sure to complete policy number (Block 11) and employer name (Block 11b). MedCost is unable to reprice your claim without this vital information.
- 4) Facility providers billing on CMS 1500 forms should file claims with modifier SG with the facility name, not the professional provider's name. Facility charges should be billed separately from any other professional charges.

Filing Your Claims Electronically

MedCost receives electronic claims via a clearinghouse. We strongly encourage providers to file claims electronically to take advantage of the numerous benefits of electronic filing, which include:

- Enhanced claim accuracy due to electronic edits.
- Rejection/confirmation reports provided by software vendors to track claim routing.
- Reduction in time and cost associated with mail preparation.
- EDI claims can be reproduced and released by our Customer Service Contact Center if a claim status inquiry or request for additional information is received.
- Potential eligibility for electronic routing to one of the connected claim administrators after claim is repriced by MedCost.
- EDI filing support services offered by MedCost.
- Reduction in accounts receivable due to increased efficiencies for submitters and receivers.

Filing claims electronically to MedCost is simple and quick to set up. If you would like to begin submitting claims to MedCost electronically, please call our Customer Service Contact Center at 1-800-824-7406. If your practice has EDI capabilities for electronic filing, please contact your practice software vendor to ensure MedCost specific edits are correctly set up. Our requirements for electronic filing are:

MedCost payer ID number is 56162.

Loop 2010BB
Segment NM109
Data element 67

Group number:

Loop 2000B
Segment SBR03
Data element 127

Please note the following fields are not edits, but their presence assists us with policy/provider validation:

Group name

Loop 2000B
 Segment SBR04
 Data element 93

Group Name should only be submitted when there is no value for Loop 2000B SBR03 (Group Number). Passing both constitutes a broken situational validation rule in 5010.

Rendering provider’s name and credentials:

	Last Name	Segment NM103	Data element 1035
Loop	Qualification Degree	Segment NM107	Data element 1039
2310B	First Name	Segment NM104	Data element 1036
	Middle Initial	Segment NM105	Data element 1037
	Professional Rendering Provider NPI Number	Segment NM109 where NM108 = xx	Data element 67
	Institutional Rendering Provider NPI Number	Segment NM109 where NM108 = xx	Data element 67

Loop 2310B (Rendering Provider) should only be submitted when the Rendering Provider information is different than Loop 2010AA (Billing Provider) information.

Valid patient date of birth:

If patient equals subscriber: 2010BA, DMG02,1251 (ccyymmdd)

If patient is not subscriber: 2010CA, DMG02, 1251

We do recommend you notify us after your initial EDI transmission so we can verify receipt and ensure your claims were received correctly. Please feel free to call a member of our Customer Service Contact Center at 1-800-824-7406 with any questions regarding electronic filing to MedCost.

Additional Claim Filing Reminders

MedCost follows coding guidelines as defined by the current Uniform Billing, ICD-10, and CPT manuals when repricing claims. We accept the American Medical Association's (AMA) guidelines that state the code(s) reported/billed "accurately identifies the service performed". In addition, MedCost also requires compliance with the HIPAA standardized code sets and thus only considers valid and current ICD-10 (or its successor), CPT-4, and HCPCS codes with their appropriate modifiers. We also agree with AMA's statement in their introduction to the CPT-4 manual, that, "inclusion or exclusion of a procedure does not imply any health insurance coverage or entitlement to reimbursement." Services that are inappropriately billed, unbundled or subject to a reduction, should not be billed to the patient.

CMS guidelines may also be used as a guide for filing claims. Please follow these guidelines to avoid problems with claims repricing and payment. Improper coding may result in incorrect repricing, and/or payment delays. Services may also be denied by our payer partners based on the payment policies defined for correct coding.

Our payer partners adjudicate claims based on an employer group's plan design.

Filing Tips

Quick Tips to Ensure Successful Electronic Filing to MedCost

We have identified various reasons an electronic claim may reject at your clearinghouse/vendor level or result in the claim being converted to paper and mailed to MedCost. To assist in ensuring your electronic claims are successfully received at MedCost, please review the following tips:

- **Routinely review your rejection/confirmation report.**
Your vendor should provide a report which confirms receipt of your claim transmissions and flags rejections. It is vital that you routinely receive and review this report. If you are not receiving this report, please contact your vendor.
- **Confirm our MedCost payer ID – 56162.**
Ensure all MedCost accounts are flagged for electronic routing to MedCost with our payer ID of 56162. Please do not use MedCost Benefit Services (TPA) payer ID of 56205 as this will direct your electronic claim to our claim administrator and create an unnecessary delay.
- **Verify whether your vendor requires a CPID/payer routing number for MedCost claims (other than 56162).**
Some vendors require a unique payer ID number developed by the vendor for routing purposes. Please check with your vendor to determine if they have any requirements apart from the MedCost payer ID of 56162.
- **Ensure your carrier file for MedCost is set up to transmit claims electronically.**
Some vendors/clearinghouses have carrier files. If your system contains multiple MedCost accounts, please ensure each is coded for electronic transmission to our payer ID of 56162.
-

- **Confirm your claim contains a group number.**
MedCost has an edit in place with our vendor, which requires submitters to file a policy number in 2000B, SBR03, 127. In order to reprice your electronic claim, we must be able to identify the group. If this segment is blank, your claim will be rejected. Please do not file Self, Unknown, Individual, None, 123456789, or all zeros as this will result in a reject by your vendor.
- **Ensure your claim contains complete diagnosis codes.**
Diagnosis codes not carried out to the 5th digit can result in a reject or claim received on paper at MedCost.
- **Certify your claim contains a valid patient date of birth.**
If the patient is the subscriber please ensure you have entered a valid date of birth (ccyyymmdd) in 2010BA, DMG02, 1251. If the patient is not the subscriber, please ensure you have entered a valid date of birth in 2010CA, DMG02, 1251.
- **Ensure your claim contains a valid 9-digit SSN/alternate member ID.**
The insured's 9-digit SSN or alternate member ID should be entered in 2010BA, NM109, 67. Please do not submit the patient's group number, group name or patient relationship code in this segment. Please do not file a SSN with greater than or less than 9 digits. This can result in a reject at the payer level when MedCost sends your electronic claim on to the payer on your behalf.

Some Major Differences with Filing 5010 Compared To 4010

- **Billing Provider Address**
Loop 2010AA – N301 or N302 – The billing address can no longer contain a post office box or lock box. It must only contain the physical address associated with the NPI subpart listed in Loop 2010AA – NM109. If you wish to file a post office box or lock box for claims correspondence and/or payment, the address must be submitted in Loop 2010AB (Pay-To Address Name).
- **Subscriber Definition Change**
Loop 2000B (Subscriber) versus Loop 2000C (Patient) – If dependents have a unique member number, the dependent must be filed as the Subscriber (Loop 2000B) in 5010.
- **Patient Status Code**
Loop 2300 – CL103 – This is specific to Institutional claims only. Patient Status Code was only required when filing inpatient claims in 4010, but is required for all claims (Inpatient and Outpatient) in 5010.

MedCost’s Handling of Your Claim

How MedCost Collects Information and Adjusts Claims

When MedCost receives a claim electronically, the information on the claim is uploaded into the MedCost claims system. If a claim is received on paper, all information on the claim is scanned or manually entered into the MedCost claims system. Each participating provider’s negotiated contracted rates are stored in MedCost’s database. When the claim is entered into our system, your contracted rates are displayed, and the claim is repriced based upon contracted arrangements. The claim is then forwarded within two business days to the appropriate claim administrator electronically or on paper with a MedCost Claim Review Form indicating the contracted rate.

MedCost Claims Adjustment Policies

The following claims adjustment policies are part of the claims repricing process and may impact the amount allowed by MedCost. Any disallowed amounts will appear on your Provider Claim Activity Report and should be adjusted off the patient’s account. **Please Note:** *These are the MedCost claims adjustment policies that may affect repricing. Each claim administrator may have similar policies and procedures that may affect the payment based on the benefit plan.*

Modifiers that Affect MedCost Repricing

There are a few modifiers that affect MedCost repricing. Some may allow repricing for an individual detail line that would not normally be allowed, based on the MedCost adjustment policies. Others may reduce the allowable amount based on factors such as multiple procedures. The MedCost allowable may be affected when the following modifiers are added to the CPT codes. Please file modifiers that affect repricing in the first position.

Modifier	Effect on MedCost Repricing
24	Allows unrelated evaluation and management services by the same physician during a postoperative period.
25	Allows significant, separately identifiable evaluation and management service by the same provider on the same day as other procedures.
26	If no allowable has been established reduces the MedCost allowable to 40% of the global allowable.
TC	If no allowable has been established reduces the MedCost allowable to 60% of the global allowable.
50	Reduces the MedCost allowable to 150% of the global allowable.
51	Reduces the MedCost allowable to 50% of the global allowable.
57	Allows the evaluation and management service when billed on the same day as a non-starred surgical service.
80	Reduces the MedCost allowable to 20% of the global.
81/AS	Reduces the MedCost allowable to 14% of the global.
82/AS	Reduces the MedCost allowable to 14% of the global.

There are many other modifiers listed in the Current Procedural Terminology (CPT) and ASA Manuals, and some may affect the actual payment received from the claim administrators. Please ensure you are filing according to the most current coding guidelines.

Payment appeals associated with the application of modifiers other than those listed above or in your MedCost agreement should be directed to the claim administrator for review.

- **Adjustment for Bilateral Surgical Procedures:**

Claims for bilateral procedures should be filed with one procedure code appended with a modifier 50. Modifier –50 designates the performance of a bilateral procedure. Charges for bilateral procedures (modifier -50) will be approved at 150% of the MedCost allowable fee for that procedure unless your contract states otherwise. MedCost follows CPT guidelines with respect to bilateral surgeries.

MedCost will not accept claims for bilateral services billed on two detail lines. MedCost will return any claim with bilateral charges filed as two services on two lines back to your office and request that you refile them as one procedure appended with a Modifier-50 on one detail line.

- **Adjustment for Multiple Surgical Procedures:**

Charges for secondary or subsequent surgical procedures (modifier -51) will be approved at 50% of the MedCost allowable fee for that procedure unless your contract states otherwise. MedCost will consider the highest billed procedure as primary unless your contract states otherwise.

- **Charges for Hospital Admission and Daily Care When a Surgical Procedure Is Performed during the Same Admission:**

When a surgical procedure is performed during a hospital admission, no charges for hospital admission, daily management, or hospital discharge of the patient can be approved for the provider who performed the procedure or for his partners. MedCost follows CMS guidelines to make this determination. MedCost does allow for a new patient visit and a procedure to be performed on the same day. If that new patient care occurs in an inpatient setting, please provide documentation that you are providing services for a new patient. Without this documentation, MedCost will assume you are providing care for an established patient and will not allow the charge. Charges made for daily consultation by providers in other specialties may be approved if they are necessary because of the patient's medical condition.

- **Global Charges for Surgical Procedures:**

Charges for surgical procedures are considered global and include pre- and post-operative care. MedCost uses standard follow-up days in evaluating out-of-hospital postoperative charges.

- **Emergency Room Visit Charges:**

Emergency Room visit charges will not be approved when a hospital admission charge is made by the same provider with the same date of service on the claim.

- **Charges for Separate, Identifiable Services on the Same Day:**
If your practice must bill for two evaluation and management services on the same date of service because you provided separate, identifiable services to a patient, you must include modifier 25 on your claim. MedCost relies on the presence of modifier 25 to determine when separate, identifiable services have been rendered. Without it, we will only allow one office visit per day.
- **Charges for Professional Component Only:**
If no allowable has been established, Modifier 26 reduces the MedCost allowable to 40% of the global allowable.
- **Charges for Technical Component Only:**
If no allowable has been established, Modifier TC reduces the MedCost allowable to 60% of the global allowable.
- **Adjustment for Charges Made by an Assistant Surgeon:**
Charges for assistant surgeons are not allowed unless the presence of an assistant surgeon is necessary due to the complexity of the procedure or the condition of the patient. To assure accurate repricing, MedCost requests that all providers file assistant surgeon charges with the full surgeon rate, applying the 80, 81, 82, or AS modifiers. MedCost will determine the allowable based on the policy and procedures in place for the modifier and provider of service billed. **Please note:** *The claim administrator makes payment consideration for assistant surgeon charges based on the plan design.*
- **Charges for Medically Unnecessary Services:**
Charges for procedures or services which, based on repricing guidelines, are unnecessary will be reduced to zero. Providers may not balance bill for the services that are deemed unnecessary. (Example: MedCost would deem charges for assistant surgeons medically unnecessary based on Medicare guidelines. If operative notes are required, the payer would request that information from the provider for review.
- **Limitation on In-Hospital Daily Visits:**
For medical (i.e., non-surgical) admissions, charges for only one hospital visit per day by the attending provider (or his covering provider) will be allowed. Charges by another specialist for daily consultation will be approved if warranted by the patient's medical condition.
- **Multiple Evaluation and Management Codes Billed on the Same Day:**
MedCost will reduce the lesser charge(s) to zero for claims billed with two or more E&M codes on the same day when filed without the appropriate modifier. In addition, a hospital discharge and subsequent care cannot be billed on the same day.
- **Allergen Immunotherapy**
CPT codes 95115-95199 include professional services necessary for allergen immunotherapy. Office visit codes may be used in addition to allergen immunotherapy **IF** other identifiable services are provided at that time. If an office visit is billed in the absence of other identifiable services, MedCost will reduce the charges to zero.

- **Filing Claims With Non-Credentialed Providers:**

Claims for services rendered by non-credentialed providers listed below should be filed under the overseeing medical doctor's name in block 31 on the HCFA or EDI equivalent. The overseeing medical doctor must be a participating provider in the MedCost Network. You should also include the overseeing medical doctor's assigned NPI on the claim:

- RN – Registered Nurse
- CST – Certified Surgical Tech
- RD, LDN – Registered/Licensed Dietician
- MCC – Maternity Care Coordinator
- MSN – Master of Science in Nursing
- LPN – Licensed Practical Nurse
- MA LPA – Licensed Psychologist Assistant
- MA CCCA – Audiologist
- PTA – Physical Therapy Assistant
- OTA – Occupational Therapy Assistant

Claims not filed in this manner may be returned for a corrected bill.

- **Physician Assistant (PA) and Nurse Practitioner (NP) Reimbursement**

Services rendered by a PA or NP should be identifiable on a claim by filing under one of these two options:

- You may submit a request to credential your Physician Assistant(s) or Nurse Practitioner(s). A request can be submitted through the provider portal of our web site at www.medcost.com.
- File all Physician Assistant or Nurse Practitioner claims under the supervising MD's name and assigned NPI. The supervising MD must be a participating provider in the MedCost Network.

- **Filing Claims For Anesthesia Services**

When filing anesthesia services, MedCost requires that you file using the appropriate ASA (American Society of Anesthesiology) codes. We further require that you file the total minutes for anesthesia services versus the actual number of units. MedCost will calculate the units based on the total time reported. For electronic claims, the total minutes should be filed in Loop 2400, SV104 Segment, with the preceding qualifier of MJ in the SV103 segment.

Per ASA guidelines, when multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code with the highest base unit value should be reported. The time reported should be the combined total for all procedures. Add-on anesthesia codes are an exception to this policy. Add-on codes are listed in addition to the primary procedure.

MedCost does not recognize physical status modifiers. We will not recognize qualifying circumstance codes (99100, 99116, 99135, and 99140). If these codes are filed on a claim, they will be reduced to \$0, and the patient cannot be billed for these services. This is consistent with industry guidelines as well as our current policy on physical status modifiers.

- **Filing Claims for Locum Tenens**

MedCost recognizes claims for locum tenens in circumstances where a participating provider has a locum tenen covering for a period of time no greater than 60 days. After 60 days has lapsed, the locum tenen must either be credentialed or no longer submit claims to MedCost. Claims should be submitted to MedCost under the participating provider's name and tax ID for whom the locum tenen is covering; and include the modifier Q6 to indicate the use of a locum tenen. It is important for the participating provider to confirm that the locum tenen has the applicable licensure, malpractice insurance coverage, and any other specific requirements needed to treat patients.

Provider Claim Activity Report

How MedCost Notifies Providers of Adjusted Claims

MedCost provides an online Provider Claim Activity Report that shows the MedCost fee adjustments. The Claim Activity Report allows you to run a detailed report for all claims processed under your facility or practice for any date range up to 31 days. You may either run the report for all claims processed or for a specific patient. This report shows you exactly how much to write off of the patient's account. The report includes:

Patient name
Repricing date
Patient ID
Date of service
Specific procedures billed
Billed amount
Allowed amount
Fee reduction
Claim Administrator
Claim Administrator phone #

This report also contains information about the claims MedCost **could not reprice** during the specified date range. There are a number of reasons that MedCost may not be able to reprice a claim you file to us. Some examples of those reasons are:

- Policy number or group name missing
- Diagnosis code missing or invalid
- CPT code inappropriate, missing, or invalid
- Date of service is prior to the policy's participation or after the policy's termination.

It is your responsibility to log into the MedCost web site and download your Provider Claim Activity Report.

Claims Repricing Errors or Disputes

MedCost makes every attempt to reprice claims accurately and per contract terms. Stringent system testing and audit processes are conducted when new or revised contract terms are implemented, but we do advise providers to review repricing amounts on their Provider Claim Activity Report to assure repricing is per current contract terms.

If a repricing discrepancy is noticed, please notify us as soon as possible. If a claim dispute is not made within 12 months of the MedCost repricing date, the provider has agreed to accept the negotiated amount and no repricing or payment adjustment will be made.

Billing and Collection

Collection of Co-payment and Co-insurance

MedCost recommends the collection of co-payment or co-insurance amounts at the time of service. You may collect co-insurance amounts based on your actual charge. You should credit the patient's account or refund the patient accordingly if a fee reduction amount is indicated on the online Provider Claim Activity Report.

You may collect your actual charge at the time of service when patients cannot identify themselves as MedCost patients. You also may collect your actual charge at the time of service if the patient cannot provide proof that the calendar year deductible has been met. As above, you should credit the patient's account or refund the patient accordingly if a fee reduction amount is indicated on the online Provider Claim Activity Report.

Collection Turnaround Time

As a network provider, you are entitled to collect 100% of the MedCost allowable amount for services rendered. Reimbursement will come from two sources: the claim administrator for the employer and/or the patient. Network providers should receive payment or denial from the patient's plan administrator within 30 days from the MedCost repricing date. The patient is responsible for the difference between the payment issued by the claim administrator and the MedCost allowable amount. Network providers may bill the patient up to the MedCost allowable amount if payment has not been received 30 days from the MedCost repricing date.

For claims where payment or denial* has not been received within 90 days from the date MedCost repriced the claim, you may request to rescind the MedCost negotiated discount. Payment liability for the claim administrator and/or the patient should then be based on actual charges. **You may submit your request to rescind the discount in writing via fax (336-970-2100), e-mail to payorserviceteam@medcost.com, or mail to:**

Attention: Payer Service Team
PO Box 25347
Winston-Salem, NC 27114-5347

Claims are not eligible for rescinding the discount if either of the following applies:

- Claim administrator does not show receipt of claim.
- Request for rescind is not received within 12 months of the MedCost repricing date.

****Denial is any notification from MedCost or the claim administrator regarding a claim.***

Explanations of Benefits

Claims will be adjudicated by the claim administrator based on the negotiated allowable. Providers should convert patient accounts to self-pay when applicable. Amounts from co-payments, co-insurance, etc., should not remain in your MedCost accounts receivable categories. Any amount not paid up to the MedCost allowable is considered patient responsibility. Non-payment explanation of benefits should be posted and the charges converted to patient responsibility.

Non-covered Services

Providers who verify that a patient's service is non-covered by the plan may collect their actual charge at the time of service. However, you should credit the patient's account or refund the patient accordingly if a fee reduction amount is indicated on the Provider Claim Activity Report. This benefit is to provide an incentive for the patient to select a network provider even though services may not be covered by their benefit plan.

Individual Office Policies

Individual office policies (including signed patient waivers) do not supersede the MedCost contract.

Coordination of Benefits

It is the responsibility of the claim administrator to handle all coordination of benefits, including, but not limited to, cases involving workers' compensation claims, Eligible Persons covered by more than one Health Benefits Plan, and Eligible Persons who have a right to recover costs of Covered Services through subrogation (i.e., third-party insurance) or first-party insurance (i.e., automobile or medical). MedCost providers are required to file claims for all MedCost plans regardless of the order of benefit determination. Providers cannot pursue collection from the patient for more than the MedCost contractual allowance if the payment was based on the MedCost allowable.

Collection Follow-up

MedCost encourages network providers to follow up on outstanding claims instead of filing duplicate claims. You may follow up with the claim administrator directly by calling the telephone number listed on the patient's identification card, the MedCost Provider Claim Activity Report, and on the MedCost Reference Guide. Many claim administrators also have online claims follow-up; you can link to these sites directly from our web site at www.medcost.com or link from our Claims Repricing Inquiry tool.

If after following up with the claim administrator, your claim issue is still not resolved, you may ask MedCost for assistance in resolving the issue.

Serious Adverse Events (Never Events)

MedCost defines “Serious Adverse Events” as the following:

1. Surgery performed on the wrong body part.
2. Surgery performed on the wrong patient.
3. Wrong surgical procedure performed on Participant.
4. Unintended retention of a foreign object in Participant after surgery or other procedure.
5. Death or serious disability of Participant associated with a medication error (e.g. errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
6. Death or serious disability of Participant associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.
7. Artificial insemination with the wrong donor sperm or wrong egg.
8. Iatrogenic pneumothorax with venous catheterization.
9. Falls and trauma – including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock.
10. Surgical-site infections following certain orthopedic procedures.
11. Surgical-site infections following bariatric surgery for obesity.
12. Manifestations of poor glycemic control.
13. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.

There will be no payment by our payer partners for the Serious Adverse Events listed above, including payment to any professional provider that is associated with a Serious Adverse Event.

Serious Adverse Events not listed above, but defined by the Centers for Medicare and Medicaid Services (CMS), may be added upon prior written notice.

Serious Adverse Events and subsequent nonpayment may include one, if not all, of the following elements:

1. Error or event must be preventable – Provider shall not be held accountable for something that could not be reasonably prevented by Provider.
2. Error or event must be within the control of Provider – Provider shall not be held accountable for errors made by third parties, such as errors in the manufacture of drugs, devices or equipment, which occurred well before the materials reached Provider.
3. Error or event must be the direct result of a mistake made by Provider - The event must clearly and unambiguously be the result of a mistake made by Provider, procedures not followed, and not something that could otherwise occur. In no event shall a Serious Adverse Event occur as a result of health care services provided by another provider.
4. Error or event must directly result in significant harm.

The Hospital Acquired Conditions included in the listing of Never Events are as follows:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burn
 - Other Injuries
- Manifestations of Poor Glycemic Control
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):
- Surgical Site Infection Following Bariatric Surgery for Obesity
 - Laparoscopic Gastric Bypass
 - Gastroenterostomy
 - Laparoscopic Gastric Restrictive Surgery
- Surgical Site Infection Following Certain Orthopedic Procedures
 - Spine
 - Neck
 - Shoulder
 - Elbow
- Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:
 - Total Knee Replacement
 - Hip Replacement
- Iatrogenic Pneumothorax with Venous Catheterization

Source: http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

Provider shall not bill or request payment for services related to Serious Adverse Events from Payer and/or Eligible Person. In the event a bill is submitted related to a Serious Adverse Event, Provider agrees to identify those services related to the Serious Adverse Event, segregate the charges for those services to the extent feasible, and use its best efforts to make the appropriate adjustments with the Payer and/or Eligible Person as soon as possible. In the event MedCost reprises a claim that is deemed by the Payer to be a Serious Adverse Event, the Eligible Person cannot be billed. If a claim is submitted for a Never Event, providers must populate Present on Admission (POA) indicators on all acute care inpatient hospital claims for Never Events when submitting them to MedCost.

Serious Adverse Events and information pertaining to Serious Adverse Events are sensitive material and shall be treated as confidential and proprietary information, whether in specific or aggregate form.

Utilization Management

As a MedCost provider, you have agreed to comply with utilization review requirements. MedCost recommends that patients not be charged for the completion of forms associated with utilization review.

NOTE: For many companies who participate with MedCost, review is performed by MedCost Health Management; **however**, there are companies whose utilization management is performed by the claim administrator or alternate utilization review organization.

MedCost Health Management Phone Number: 1-800-722-2157

Other UR firms: The patient's ID card will identify the appropriate UR organization and telephone number to call. You also can locate the UR organization and telephone number for a particular employer group on the MedCost Reference Guide.

MedCost offers certifications via our web portal 24/7. Providers will get an automatic certification about 80% of the time for inpatient procedures. All scans can be initiated online and clinical may be submitted to optimize response time. If you need to call in, there is a voicemail available.

Outpatient Review

To ensure medical necessity, some employers have elected to use the outpatient review program from MedCost. If an employer uses this service, there should be information on the member's insurance identification card that indicates certification is required. Certification requirements will vary by employer and insurance company, so it is important to call and confirm coverage and medical necessity before a procedure is scheduled. Certification requirements can include, but are not limited to, any surgical procedure performed outside of the physician's office, MRI, CT scan, PET scan, and varicose vein treatment.

Inpatient Review

Under your MedCost contract, there are two requirements the MedCost participating practice must meet when admitting a MedCost patient to the hospital:

- The practice must contact the utilization review firm specified on the patient's health insurance card. The UR firm will certify the admission, if appropriate, and the length of the stay.
- The practice should refer to the listing of MedCost participating hospitals to schedule hospital services.

These requirements are explained in detail in the following section.

Preadmission Review

As a participating MedCost provider, it is important to report admissions to the UR firm providing services to the MedCost patient. This protects the interests of the patient and the provider since most plans reduce coverage for non-certified stays.

Preadmission review is required for **ALL** hospital admissions of MedCost patients. As part of the MedCost programs, it is the responsibility of the MedCost participating practice to initiate preadmission review. When review is required, please follow these guidelines:

The patient's identification card typically identifies the UR firm and phone number to call.

A. Non-emergency Admissions

1. Elective, Non-urgent Admissions:

Call UR firm and provide the requested information by phone, at least 3 days prior to the scheduled admission.

2. Maternity Admissions:

- a. Notify the appropriate UR firm at the time pregnancy is confirmed in order to ensure that the patient is registered in the MedCost SmartStarts Program
- b. Vaginal delivery - certification is required for stays longer than 48 hours following delivery.
- c. Cesarean section - certification is required for stays longer than 96 hours following delivery.
- d. Vaginal & cesarean section - certification is required for admissions prior to delivery.

B. Emergency Admissions

An emergency admission is defined as an admission for a medical condition with symptoms of sufficient severity to place the health of an eligible person(s), or with respect to a pregnant woman, the health of the unborn child, in serious jeopardy; serious impairment to a bodily function; serious dysfunction of any bodily organ or part, which would be threatened if hospital care were not obtained immediately. For emergency admissions, the provider practice should notify the appropriate UR firm of the admission as soon as possible by telephone.

C. Identifying MedCost Patients for Preadmission Review Purposes:

Although the initiation of preadmission review is the responsibility of the MedCost participating practice, patients covered under several plans that use MedCost have been instructed to remind the provider practice that preadmission review is required. Patients covered under these plans face a substantial financial penalty if their hospital admissions are not certified.

D. Penalties

At present, the MedCost program does not assess financial penalties against participating provider practices for failing to obtain preadmission certification or extensions of certified hospital stays. However, a pattern of failing to notify a UR firm of MedCost admissions is cause for MedCost to terminate the provider's participation in the MedCost Network.

Notification of the Certified Length of Stay

The appropriate UR firm will analyze the information supplied by the provider practice against medically established criteria for admission and nationally established length-of-stay norms (categorized by age, sex, diagnosis, procedures, and complicating medical conditions) and will produce a certified length of stay. A copy of the certification notice will be sent to the:

- Patient
- Claim Administrator
- Provider
- Hospital

Extensions

Should a complication develop that will delay the patient's discharge, the provider practice should request an extension of the certified stay by calling the appropriate UR firm prior to the end of the certified stay. A certification notice listing the approved extension will be sent to the patient, claim administrator, hospital, and the physician as above.

Appeal Process for Non-certification

In 2002, Department of Labor legislation eliminated the informal reconsideration process and limited the number of appeals processes so that patients would know about certification decisions within the required time limit. When a non-certified medical necessity decision has been rendered, the patient, insured, hospital, or attending provider may appeal the decision. They have these options:

- **Peer-to-Peer Review.** This is a scheduled physician-to-physician discussion to explain the patient's need for the admission and/or procedure. The patient's physician can request a peer-to-peer review by calling the utilization review vendor and providing times when the attending physician is available for discussion.
- **Expedited Appeal.** This can be initiated if the patient is in the hospital at the time of the request or it is an urgent admission. Expedited appeals are conducted via telephone or facsimile. A determination is made within one (1) working day of receipt of the pertinent information. A physician consultant of the same specialty as the patient's physician will review the case information and talk with the patient's provider if requested. The decision will be relayed by telephone to the requesting party within one (1) business day. If the decision is reversed or modified, a written notice is mailed to the insured, the patient's provider, and the claim administrator within one (1) business day of the determination. Expedited appeals that do not resolve a difference of opinion may be resubmitted through the standard appeals process.

To initiate an expedited appeal, call the specific utilization review vendor and request this option. Provide any additional supporting medical information when requesting the appeal.

- **Standard Appeal.** A standard appeal may be requested for any non-certified confinement or procedure. The appeal must be requested within 180 days of the receipt of the non-certification. A standard appeal is done for non-urgent services. A second physician consultant who was not involved in the original decision to non-certify and is of the same specialty as the patient's physician will review all clinical information. Pre-service appeals are requested prior to the scheduled procedure and are completed within 15 days of the receipt of request for appeal. Post-service appeals are requested retrospectively and are completed within 30 days of the receipt of request. To request a standard appeal, call or write the specific utilization review vendor. Provide any additional supporting medical information when requesting the appeal. The insured, the patient's provider, hospital and claim administrator will be notified in writing of the appeal outcome.
- **External Review.** Patient may be eligible for an external review if they have a non-certification or upheld appeal. This is an additional level of appeal conducted by an independent review organization that is available to non-grandfathered groups.

Appeal information can be submitted as follows:

Fax: 336-970-2098

Physical address: 165 Kimel Park Drive
Winston-Salem, NC 27103

Mailing address: PO Box 25347
Winston-Salem, NC 27114

The process described above will be completed with written notification to the covered person, covered person's provider(s), and insurer no later than thirty (30) days following receipt of the written request of appeal and the complete medical record.

All components of MedCost's Health Management/Review Program comply with North Carolina GS 58-50-61 & 62 and all other applicable state and federal laws, rules, and regulations. Providers are required to comply with all federal and state regulations.

Q&A about MedCost's Utilization Review Process

MedCost has received numerous questions from providers regarding our utilization review process. Many of these questions relate directly to federal legislation enacted by the Department of Labor (DOL) in July 2002. This legislation called for:

- 1) More timely benefit determinations
- 2) Improved access to information used to make benefit determinations
- 3) A full and fair review of denied claims

To comply with the more stringent timeline imposed by the DOL, MedCost had to make changes in our utilization review processes. This has prompted questions from providers such as:

Q. Why does MedCost only allow until 2:00 p.m. the following day to obtain clinical information for hospital utilization review before calling the doctor's office?

A. The DOL requires that certification decisions on urgent admissions and concurrent care admissions be completed within three calendar days of the request. MedCost calls for the hospital utilization review immediately upon notification of a current hospital admission. After waiting approximately 24 hours, a call is made to the patient's physician. MedCost will wait another 24 hours to get information from the patient's physician. This allows MedCost the last 24 hours to arrange a physician consultant review (if necessary) and make a determination within the three-day time limit. MedCost operates within the Department of Labor requirements as stated above. There is no 2:00 p.m. deadline for receipt of information from hospital utilization review departments.

Q. What happens if information is not received within the specified timeframe?

A. MedCost issues a non-certification for "lack of medical information" if medical information is not received within the required timeframe. Information received retrospectively will be reviewed for medical necessity and a determination will be completed as soon as possible but not later than three business days.

Q. Does MedCost give the hospital an opportunity to provide additional information?

A. Any provider, including hospitals, may give additional information to support medical necessity.

Q. MedCost only gives us 15 days to provide medical records to support an appeal. Why is this time so limited?

A. The Department of Labor requires that a standard appeal be completed within 30 days of the request. To comply with this timeline, additional information must be provided within 15 days. This allows enough time to forward the record to a second off-site physician consultant and provide a decision letter within 30 days.

Q. What can I do to simplify the process and eliminate unnecessary steps?

A. There are two things you can do. First, provide clinical information within 24 hours of the request. Information may be submitted via phone, or facsimile. Second, answer the question, “Why does the patient need acute care?” Provide information that supports the need for the procedure and/or acute care. Give the diagnosis, procedure, history leading up to admission, conservative treatment and response to treatment, tests, labs, vital signs, presenting signs and symptoms, and comorbidities. Provide the treatment plan: medications with routes, tests and labs with results, treatments, diet, activity level, and discharge needs.

MedCost SmartStarts Prenatal Program

Providing the best care and information to expectant mothers is the most effective way to advance a healthy start for babies. This doesn't just make sense from a humanitarian perspective – it also makes economic sense by helping to avoid premature births. SmartStarts offers a preventive approach that encourages prenatal education and mentoring for the expectant mother to eliminate the costs associated with premature and low birth weight babies.

Expectant mothers who use SmartStarts have fewer low birth weight infants than the national average. To ensure that expectant mothers are given an opportunity to enroll as early as possible, MedCost asks providers to contact MedCost Health Management at 1-800-722-2157 at the time pregnancy is confirmed. After you make this initial call, if the expectant mother is eligible for SmartStarts, a prenatal nurse will contact her to see if she wishes to participate in this voluntary program. No additional intervention is required from you or your medical staff.

We appreciate your assistance in introducing moms-to-be to the SmartStarts Program.

MedCost Case Management Program

This program is designed to proactively identify and intervene when a patient is identified with serious, catastrophic, or chronic medical conditions. With the patient's permission, you may be contacted to discuss action plans or to be advised of clinical alerts.

Provider Profiles

MedCost analyzes and evaluates claims, health and case management data to turn it into a valuable tool that our clients can use to effectively manage their health plans costs. The information is used to determine how a provider compares to their peer providers in the network and is based on how the provider utilizes services compared to peers; how the practice compares to peers in terms of the MedCost population accessing it; and costs per patient as a result of how providers bill for services.

If you receive feedback from MedCost as a result of this data analysis, utilize this data to help examine your own practice billing patterns. MedCost performs these reviews as a quality initiative measure. The long-term goal is to have the highest quality, most cost-effective provider network for our clients.

Grievance Procedure

The MedCost grievance procedure is designed to address and respond to complaints, contractual differences, and/or grievances submitted in writing by participating providers, covered persons, or claim administrators.

The issues resolved by these procedures are administrative or contractual in nature. Issues may include, but are not limited to, the timeliness of claims payment, contracted reimbursement rates, explanation of benefits, and application of MedCost claims adjustment policies. Complaints and/or grievances related to utilization management decisions should be resolved through the utilization management firm making the decision.

Grievances may be submitted to the address below:

MedCost, LLC
Attention: **Manager, Network Services**
P. O. Box 25347
Winston-Salem, North Carolina 27114-5347

After reviewing the grievance, MedCost will record the following information:

- Name of person submitting grievance
- Practice/facility name
- Date of the complaint or grievance
- Name of employer
- Name of claim administrator
- Brief statement concerning the nature of the complaint or grievance

A representative from the Network Operations department may need to contact the party filing the complaint/grievance to obtain additional details. Upon completion of a thorough assessment, the representative will supply the party filing the complaint/grievance with an action plan to resolve the grievance. The action plan for resolving grievances may include, but is not limited to:

- Review and action by MedCost
- Review and action by the claim administrator organization
- Review and action by the MedCost medical director
- Review and action by the provider

MedCost will attempt to resolve all complaints and/or grievances within 10 business days after receiving all relevant information. If resolution will require more than 10 business days, MedCost will notify the party who submitted the grievance. MedCost will notify all concerned parties of resolution.

A claim administrator grievance may be filed directly with the claim administrator as per North Carolina GS 58-50-61 & 62.

Privacy and HIPAA

MedCost and HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 has created many changes in health care. MedCost has implemented numerous safeguards and processes to ensure our compliance with HIPAA.

During some functions of MedCost's repricing process, we operate as a clearinghouse. Because of this, MedCost has signed Business Associate Agreements (BAA) with our clients (claim administrators and third party administrators). We also have signed a BAA with our clearinghouse vendors with whom we have partnered for electronic claims transactions. It is not necessary for MedCost to execute these agreements with providers as we are performing repricing functions only on behalf of our clients.

MedCost is fully compliant with HIPAA privacy regulations and has numerous precautions and security safeguards in place to ensure the confidentiality of protected health information (PHI). Disclosures of PHI between MedCost and providers for purposes of treatment, payment, and health care operations are permitted under HIPAA.

In cases of requests from insureds regarding PHI, MedCost will refer the inquirer to the originator of the PHI (i.e., the claim administrator or the provider).

Appendix A: Resource List

The following is a list of resources to which MedCost, LLC periodically refers for business purposes:

American Society of Anesthesiologists – (ASA Codes)

<p>Headquarters Office 520 N. Northwest Highway Park Ridge, IL 60068-2573 Telephone: (847) 825-5586 E-mail: communications@asahq.org</p>	<p>Washington Office 1501 M Street, N.W. Suite 300 Washington, DC 20005 Telephone: (202) 289-2222</p>
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Optum

Ambulatory Surgery Center (ASC Codes)

Diagnosis Related Groups (DRG Codes)

International Classification of Diseases (ICD-9-CM & ICD-10-CM Codes)

Health Care Procedure Coding System (HCPCS Codes)

Resource Based Relative Value System (RBRVS)

Current Procedural Coding (CPT Codes)

2525 Lake Park Blvd.

Salt Lake City, UT 84120

Telephone: (800) 464-3649

<https://www.encoderpro.com> and www.optum.com

RJ Health Systems

Average Wholesale Price (AWP)

30 Cold Spring Rd

Rocky Hill, CT 06067

Telephone: (866) 615-9475

<http://rjhealthsystems.com>