

CLAIMS PAYMENT POLICIES AND NOTICES

The purpose of this document is to advise all providers of the claim payment policies followed by PrimeCare Medical Network, Inc. ("PMNI") and NAMMCalifornia its capacity as a Management Services Organization (MSO) for its contracted IPA's. To administer and adjudicate claims the most current year "CPT Plus" manual for coding standards and formats is utilized.

CPT Standardization and Format

Standard CPT guidelines are followed by PMNI and NAMMCalifornia in the processing of all claims. CPT Plus has educational sections for identifying coding fundamentals and CPT coding and billing issues and is revised on an annual basis.

CPT Plus utilizes a color-coded format for the identification of:

Separate procedure

Unlisted codes

Non-specific codes

Correct Coding Initiative (CCI) to identify services included in primary procedure

CPT Plus identifies codes added or deleted each year. PMNI and NAMMCalifornia allows a 3-month grace period each year (first quarter) for the transition of codes new to CPT, or deleted from previous year. Once the grace period has expired, claims with expired codes will be rejected for accurate coding.

CPT guidelines provide clear criteria for the Evaluation and Management codes, setting standards for providers and supporting documentation needed when billing E&M codes. PMNI and NAMMCalifornia may request additional "relevant" records to support higher levels of care than those services authorized.

Administration of Immunizations and Injectable Medication

Administration of immunizations and injectable medication are not separately payable services unless clearly specified in the individual contract. If the service is provided during the course of a routine office visit, the visit will be compensated by either monthly capitation payments or contracted fee schedule.

Coordination with Other Payers

Benefits will be coordinated with other carriers when we are notified the enrollee has other insurance. Please refer to your individual contract for information on Coordination of Benefits (COB).

PMNI or the IPA's will not assume responsibility for claims for services covered under Worker's Compensation. Always verify if a claim is for a work related injury when treating patients, and obtain specific billing information from them.

Other Billing and Payment Criteria

Services provided to any enrollee must meet the contractual requirements, or a denial may be issued. These requirements include, but are not limited to:

Referral or prior authorization

Submission of invoice

All standard elements as required to process a claim (see section on claim submission found in the downstream provider notification)

All payments and co-payments are subject to the benefit information as defined by the enrollee's employer group specific benefit plan. Claims payment is always dependent on member eligibility status for date of service.

Format and Coding

ANESTHESIA

Anesthesia is processed following the ASA guidelines. One (1) unit is equal to 15 minutes – up to four hours. After four hours, one (1) unit is equal to 10 minutes. Obstetrical anesthesia units are equal to 15 minutes regardless of the duration.

Claim Forms

Hospital and Facility vendors are required to bill on a UB92 claim form.

Professional providers are required to bill on a CMS Form 1500.

Claims from ambulatory surgery centers may be submitted on a UB92 or on a CMS Form 1500 if appropriate modifier is used. (SG or TC)

Electronic claims are accepted via the HIPAA standard format via the contracted clearinghouse.

CODING

Codes must be submitted using the appropriate codes as published in the AMA's CPT Level I, HCPCS Levels II and III, ICD-9-CM and Revenue codes.

FEE SCHEDULES

Unless otherwise stated per contract, reimbursement is based on the current Medicare Fee Schedule for the appropriate geographical area.

For Medicare Fee Schedule and related information go to http://www.medicarenhic.com/cal_prov/fee_sched.shtml or <http://cms.hhs.gov/providers/pufdownload/#dme> for DMEPOS Fee Schedule.

Provider contracts specifying reimbursement at AWP are paid utilizing the Medicare Fee Schedule plus 5%.

If there is not a Medicare allowable for the service, the service is paid at 60% of billed charges unless contract has specific language.

GLOBAL PERIOD

Services rendered within the pre and post global period are included in the global rate. Procedure specific global periods are published in the Federal Register (<http://www.gpoaccess.gov/fr/index.html>). The standards listed in the AMA's CPT Surgery section are followed for surgical global packages.

Modifiers

Industry standard modifiers as published by the American Medical Association are acceptable for billing. The Correct Coding Initiative (CCI) guidelines for claims payments and use of modifiers are utilized when adjudicating claims.

CPT defines the standard, acceptable modifiers to be used for professional claims.

HCPCS also includes acceptable modifiers for services not defined by CPT.

PMNI and NAMMCalifornia accepts all modifiers published by CPT and HCPCS.

Multiple Procedures

Multiple surgeries performed by the same physician on the same patient during the same operative session are reimbursed at 100% of the contracted rate for the highest valued procedure, 50% of the contracted

rate for the secondary procedure and 25% of the contracted rate for all tertiary procedures.

Unbundling and Up Coding

CCI edits are followed for identification of unbundled and up coded services. PMNI and NAMMCalifornia uses Flashcode software to evaluate claims for unbundling and upcoding.

For more information on the proprietary Flashcode software, you may visit the website at <http://www.flashcode.com/>.

The above information represents the standard claims processing policies approved and used by PMNI and utilized by NAMMCalifornia to administer claims for its contracted IPA's. Please refer to your contract for any negotiated modifications to these policies.