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INTRODUCTION
Welcome to Trillium Advantage. Thank you for participating in our network of physicians, hospitals and other healthcare professionals.

Trillium’s Mission is to listen to, respect and empower our members, in partnership with the provider community, to achieve better health by addressing their unique needs and seeking innovative solutions.

Our Vision is to create a strong, community-based healthcare system that focuses on prevention and delivering high quality service to our members through coordination, collaboration, and partnerships.

We at Trillium believe quality healthcare is more than just treatment from a doctor and that health insurance is best delivered on a local level. Our plans are designed to give members:

- Affordable healthcare coverage
- Benefits you need to take good care of yourself
- Access to doctors, nurses and specialists who work together to help you feel your best
- Coverage for prescription drugs
- Extra benefits that aren't covered by Medicare Part A or Part B (Original Medicare).

As part of the Oregon community, Trillium Medicare Advantage treats people with kindness, respect and dignity in everything we do. We also look for ways to improve the total health of the community such as:

- Provide medical and non-medical support for our members to make your days a little easier
- Connect members to community programs and organizations
- Create jobs in Oregon to improve the lives of the people we serve

This Provider Manual is a reference guide for providers and their staff providing services to members who participate in our Trillium Advantage Dual (HMO SNP) plan.

This provider manual serves as an extension of the provider participation agreement (PPA) between Trillium Community Health Plan (Trillium) and all provider types including, but not limited to, physicians, hospitals, PPGs, and ancillary health care providers. This manual contains important information regarding Trillium policies and procedures, claims submission and adjudication requirements, and guidelines used to administer Trillium Advantage health plans.
OVERVIEW
Trillium Advantage is contracted with the Centers for Medicare and Medicaid Services (CMS) to provide medical and behavioral health services to eligible members.

Trillium Advantage is designed to achieve four main objectives:

- Full partnership between the member, their provider and their Trillium Advantage Case Manager
- Integrated case management (medical, social, behavioral health, and pharmacy)
- Improved provider and member satisfaction
- Quality of life and health outcomes

All of our programs, policies, and procedures are designed with these objectives in mind. These objectives mirror and support the objective of CMS and state guidelines to provide covered healthcare services to low-income, elderly and physically disabled members.

The services provided by the contracted Trillium Advantage 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 provider (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care using contracted hospitals and specialists. The PCP is responsible for coordinating our member’s 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, 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 PCPs.

Trillium Advantage appreciates your partnership in achieving these objectives.

PRIVACY
Trillium Advantage takes the privacy and confidentiality of our member’s 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.
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
4. The member's name
5. The member's date of birth

<table>
<thead>
<tr>
<th>HEALTH PLAN INFORMATION</th>
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</tr>
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<tbody>
<tr>
<td>Website</td>
<td>TrilliumAdvantage.com</td>
</tr>
<tr>
<td>Provider Portal</td>
<td>Provider.TrilliumHealthPlan.com</td>
</tr>
</tbody>
</table>
| Health Plan Mailing Address | Trillium Advantage  
                             | PO Box 11756  
                             | Eugene, OR 97440-3956 |
| Phone/TTY/TDD           | Phone | Fax |
| 1-844-867-1156          | 711   |   |
| Department              | Phone |   |
| Provider Services       | 1-844-867-1156 | N/A |
| Provider Relations      | 1-844-820-0754 |
| Member Services         | 1-855-350-4799 |
| Medical Management      | 1-844-371-7765 |
| Inpatient and Outpatient Prior Authorization | 1-844-371-7765 |
| Concurrent Review       | 1-844-371-7765 |
| Clinical Information    | 1-844-371-7765 |
| Admission/Census Reports/Facesheets | 1-844-371-7765 |
| Care Management         | 1-844-207-2459 |
| Behavioral Health       | 1-866-683-5621 |
| Inpatient and Outpatient |   |   |

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<table>
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<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization</td>
<td>1-844-867-1156</td>
<td>N/A</td>
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<tr>
<td>Dental</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td></td>
<td>N/A</td>
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<tr>
<td>Appeals and Grievances</td>
<td>1-844-273-2671</td>
<td></td>
</tr>
<tr>
<td>Claims Department</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Pharmacy (Envolve)</td>
<td>1-877-941-0480</td>
<td></td>
</tr>
<tr>
<td>Envolve Vision</td>
<td>visionbenefits.envolvehealth.com</td>
<td>N/A</td>
</tr>
<tr>
<td>National Imagine Associates (NIA)</td>
<td>radmd.com/radmd-home.aspx</td>
<td>888-879-5922</td>
</tr>
<tr>
<td>24/7 Nurse Advice Line</td>
<td>1-844-647-9667</td>
<td>N/A</td>
</tr>
<tr>
<td>To report suspected fraud, waste and abuse</td>
<td>1-844-353-6874</td>
<td>N/A</td>
</tr>
<tr>
<td>EFT/ERA Services (PaySpan Health)</td>
<td>1-866-685-8664</td>
<td>N/A</td>
</tr>
<tr>
<td>EDI Claims Assistance</td>
<td>1-877-331-7154</td>
<td>e-mail: <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a></td>
</tr>
</tbody>
</table>
MEDICARE REGULATORY REQUIREMENTS

As a Medicare contracted provider, you are required to follow a number of 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. A general list of the requirements can be reviewed below:

- 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 on the basis of race, color, national origin, sex, age, or disability in accordance with subsection 92.8 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 not collect Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from members enrolled in the Qualified Medicare Beneficiaries (QMB) program, a Medicare-Medicaid dual eligible program which exempts individuals from Medicare cost-sharing liability. Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing.
- Providers must allow members to directly access screening mammography and influenza vaccinations.
- Providers must provide female members with direct access to women’s 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.
- Trillium Advantage 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 Trillium Advantage 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 Trillium Advantage members without CMS and/or Trillium Advantage approval of the materials and forms.

- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments, and diverse cultural and ethnic backgrounds.

- Providers will work with Trillium Advantage 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 Trillium Advantage 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 Trillium Advantage 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 Trillium Advantage medical policies, QI programs and medical management procedures.

- Providers will cooperate with Trillium Advantage in disclosing quality and performance indicators to CMS.

- Providers must cooperate with Trillium Advantage 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 Trillium Advantage services for a period of at least ten (10) years following the final date of

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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 Trillium Advantage policy: (a) for all members, for the duration of the Trillium Advantage contract period with CMS, and (b) for members who are hospitalized on the date the CMS contract with Trillium Advantage terminates, or, in the event of an insolvency, through discharge.

- Provider shall disclose to Trillium Advantage all offshore contractor information with an attestation for each such offshore contractor, in a format required or permitted by CMS.

- Providers shall ensure that the provider's information provided in Trillium Advantage online provider directory is complete and accurate by reviewing at least quarterly and notifying Trillium Advantage of any changes.

**SECURE WEB PORTAL FOR TRILLUM ADVANTAGE**

Trillium Advantage offers a robust Secure Web Portal with functionality that will be critical to serving members and to ease administration for the Trillium Advantage products for providers. Each participating provider’s dedicated Provider Network Specialist will be able to assist and provide education regarding this functionality. The Portal can be accessed at [provider.trilliumhealthplan.com](http://provider.trilliumhealthplan.com).

**Functionality**

All users of the Secure Web Portal must complete a registration process.

Once registered, providers may:

- Check eligibility
- 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 claim status and history
- 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 (provider, 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 Trillium Advantage staff

Disclaimer
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 Trillium Advantage, as well as applicable government regulations and standards of accrediting agencies.

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

Notice: In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Trillium Advantage 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.

Whether a state utilizes a standardized credentialing form or a practitioner has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

• Attestation signed within 180 days of submission as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence; and ability to perform essential functions with or without accommodation
• Completed Ownership and Control Disclosure Form
• 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 or prescription plan for each state in which the practitioner will see Trillium Advantage members, if applicable
• Completed and signed W-9 form
• Current Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
• Not required: Curriculum vitae detailing, at a minimum, the previous 5 years of work history. This is needed if the work history section on the application is not completed
reflecting the most recent 5 years. An explanation is also required for Initial Credentialing applications gaps of employment over two months.

- Signed and dated release of information form not older than 120 days
- Current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
- Hospital privileges in good standing or alternate admitting arrangements, where applicable

Trillium Advantage will verify the following information submitted for credentialing and re-credentialing:

- License through appropriate licensing agency (primary source)
- Board certification (primary source)
- If not Board Certified, highest level of training (primary source) n/a at re-credentialing
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions (primary source)
- Hospital privileges in good standing or alternate admitting arrangements (secondary source)
- Review five year work history (secondary source) n/a at re-credentialing
- Review federal sanction activity including Medicare/Medicaid services. OIG-Office of Inspector General, SAM - System of Award Management and state specific exclusion list (primary source)
- Review of Medicare Opt Out List (primary source)
- Review of SSDMF - Social Security Administration Death Master File (primary source)
- Review of NPPES - National Plan and Provider Enumeration System

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

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

Practitioners/Providers must be credentialed prior to accepting or treating members. Primary care practitioners cannot accept member assignments until they are fully credentialed.

**Credentialing Committee**

The Credentialing Committee including the Medical Director or his/her 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.

Updated July 24, 2018
Site reviews are performed at provider offices and facilities when the member complaint threshold of three complaints in six months is met. A site review evaluates:

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

**Re-credentialing**

Trillium Advantage 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, facilities, and ancillary providers previously credentialled and currently participating in the network.

In between credentialing cycles, Trillium Advantage 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, Trillium Advantage reviews monthly reports released by the 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 Trillium Advantage Credentialing Committee that credentialing requirements or standards are no longer being met.

**Practitioner Right to Review and Correct Information**

All practitioners participating within the network have the right to review information obtained by Trillium Advantage 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.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the 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 practitioner. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have the following timeframe to provide a written explanation detailing the error or the difference in information to the Credentialing Committee within thirty (30) days of the initial notification.

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

**Practitioner Right to Be Informed of Application Status**
All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact Independent Professional Services (IPS) at 541-302-6432.

**Practitioner Right to Reconsider 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 thirty (30) calendar days of the date of the notice.

New applicants who are declined participation may reapply for admission no earlier than one (1) year following the initial denial. All written requests should include additional supporting documentation in favor of the applicant’s reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than sixty (60) days from the receipt of the additional documentation.

**Provider Anti-Discrimination**
We do not limit the participation of any provider or facility in the network, and/or otherwise discriminate against any provider or facility 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 his or her license or certification under applicable state law, solely on the basis of that license or certification. If Trillium Advantage declines to include individual or groups of providers in our network, we will give the affected providers 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 behalf of an member
- filed a complaint against us
- appealed a decision of ours

**PROVIDER RELATIONS**

**Primary Care Providers**
The Primary Care Provider (“PCP”) is the cornerstone of Trillium Advantage’s delivery model. The PCP serves as the “medical home” for the member. The “medical home” concept should assist in establishing a patient-provider relationship and ultimately better health outcomes. Members are expected to select a PCP upon enrollment or a PCP will be assigned to them.

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Alternately, a provider can call Trillium Member Services on the member’s behalf to have the member assigned to him/her. As a PCP, you should ensure that you are seeing members who are assigned to your or your clinic. If the member is not assigned to you or your clinic, the member should be referred back to their assigned PCP or contact Trillium Member Services at 1-844-867-1156 to change their PCP assignment. The PCP is responsible for providing all primary care services for Trillium Advantage 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

Trillium’s case managers will partner with the PCP not only to ensure the member receives any necessary care but to also assist the PCP in 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, Trillium Advantage does not guarantee a PCP will receive a set number of patients. A PCP must contact Provider Services if they choose to change their panel size or close their panel and only accept established patients. If Trillium determines a PCP fails to maintain quality, accessible care, then Trillium reserves the right to close the PCP panel if necessary and re-assign members to a new PCP.

Specialist as the Primary Care Provider

Members with disabilities, special healthcare needs, and chronic or complex conditions have the right to designate a specialist as the Primary Care Provider. A specialist may serve as a PCP only under certain circumstances and with approval of a Trillium Advantage Provider. In order for a specialist to serve as a PCP, the specialist must:

- Meet Trillium requirements for PCP participation, including credentialing; and
- Contract with Trillium as a PCP.

All requests for a specialist to serve as a PCP must be submitted to Trillium Case Management in writing. The request should contain the following information:

- Certification by the specialist of the medical need for the member to utilize the specialist as a PCP; and
- A statement signed by the specialist that he or she is willing to accept responsibility for the coordination of all of the member’s needs.

Trillium Advantage will approve or deny the request for a specialist to serve as a PCP and provide notification of the decision to the member no later than 30 days after receiving the
request. The effective date of the designation of a specialist as a member’s PCP may be applied retroactively.

If the request is denied, Trillium Advantage will provide a written notification to the member, which will include the reasons for the denial. The member may file an appeal as a result of the decision to deny the request for their specialist as a PCP. The Member Advocate is available to assist the member with their appeal.

**Specialty Care Providers**
The Specialty Care Provider or Specialist agrees to partner with the member’s PCP and Case Manager to deliver care. As a Specialist, you should ensure that any services provided to Trillium Advantage members is referred or coordinated by their assigned PCP. A key component of the specialist’s responsibility is to maintain ongoing communication with the member’s PCP. Most visits to specialists do not require a prior authorization. Some specialist services may require a written referral from the member’s PCP; however, the referral is not required for the claim to be reimbursed by Trillium Advantage. Specialists can elect to limit their practice to established patients only upon request to their Provider Network Specialist.

Female members can self-refer to an in-network OB/GYN for their annual well-woman checkup or for care related to pregnancy.

Specialty Care Providers include, but are not limited to:

- Cardiology
- Gynecology and Women’s Services
- Endocrinology
- Gastroenterology
- Geriatrics
- Neurology
- Nephrology
- Oncology
- Ophthalmology
- Orthopedics
- Podiatry
- Pulmonology
- Rheumatology
- Urology

**Hospitals**
Trillium Advantage has contracted with several hospitals in the counties we serve; however any facility can be used in the case of an emergency. We also contract with other facilities such as rehabilitation facilities and ambulatory surgery centers to assist our members. It is important that our contracted providers have privileges at a contracted facility or have an agreement with a hospitalist group to care for their member when hospitalized. Please see the Provider Directory for a list of contracted hospitals in each county.

**Ancillary Providers**
Ancillary providers cover a wide range of services from therapy services to laboratory. The following is a sample of ancillary providers:

- Durable Medical Equipment
- Hospice Care
- Home Health

Updated July 24, 2018
- Laboratory
- Prosthetics and Orthotics
- Radiology
- Therapy (Physical, Occupational, Speech)

**APPOINTMENT AVAILABILITY**
The following standards are established regarding appointment availability:

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Accessibility Standard*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIMARY CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 30 calendar days of request</td>
</tr>
<tr>
<td>After hour calls</td>
<td>• By medical staff directly</td>
</tr>
<tr>
<td></td>
<td>• By an answering service that could reach an on-call provider within 1 hour</td>
</tr>
<tr>
<td></td>
<td>• By a recorded or automated message, or that has both emergency instructions and a way to reach medical staff</td>
</tr>
<tr>
<td><strong>SPECIALTY REFERRAL</strong></td>
<td></td>
</tr>
<tr>
<td>Routine</td>
<td>Within 45 days of referral</td>
</tr>
<tr>
<td><strong>BEHAVIORAL HEALTH</strong></td>
<td></td>
</tr>
<tr>
<td>Appointment Type</td>
<td>Standard*</td>
</tr>
<tr>
<td>Non-life-threatening emergency care</td>
<td>Within 6 hours or direct members to the <a href="#">crisis center</a></td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Initial visit for routine care</td>
<td>Within 10 calendar days of referral</td>
</tr>
<tr>
<td>Follow-up routine care</td>
<td>Non-prescribers: within 14 calendar days</td>
</tr>
<tr>
<td></td>
<td>Prescribers: within 90 calendar days</td>
</tr>
</tbody>
</table>
| After hours calls*                  | • By medical staff directly  
|                                  | • By an answering service that could reach an on-call provider within 1 hour  
|                                  | • By a recorded or automated message, or that has both emergency instructions and a way to reach medical staff  |
| Referrals or requests for psychotropic medications | 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   | • Member must not arrive sooner than one hour before his or her scheduled appointment; and  
|                                  | • Member must not have to wait for more than one hour after the conclusion of his or her appointment for transportation home or to another pre-arranged destination.  |

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

**Telephone Arrangements**

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

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 of 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 broken 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 deficient
• 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 his/her designee should contact the urgent care or emergency center to notify the facility.

Trillium Advantage will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program.

Training Requirements
The following training courses are required by CMS as well as Trillium Advantage.

• Annual Waste, Abuse and Fraud 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

Information on training opportunities will be posted on the Provider Resources page on our website at TrilliumAdvantage.com.

TRILLIUM ADVANTAGE BENEFITS

Medical
The summary of benefit list on the hyperlink below is not an all-inclusive list of covered services. All services are subject to benefit coverage, limitations and exclusions as described in the applicable Trillium Advantage coverage guidelines.

The link below displays the Trillium Advantage Summaries of Benefits listing the covered services for members. This is not an exhaustive list and is provided herein for quick reference.
only. Please contact Provider Services at 541-431-1950 with any questions you may have regarding benefits.

A summary of benefits is available on our Member website: https://www.trilliumadvantage.com/learn-about-our-plans.html.

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

- Acupuncture
- Hearing Aids
- Cosmetic Surgery
- Healthcare while traveling outside of the United States
- Urgent and emergent care while traveling outside of the United States
- Routine Foot Care
- Routine Dental Care
- Routine Eye Care
- Custodial Care

Dental
Review covered benefits, annual maximum benefit limits, and billing tips on the benefit grid available on our website TrilliumAdvantage.com.

Missed Appointments and Other Charges
- Trillium Advantage may charge "administrative fees" to MA 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 MAO itself does not charge an administrative fee for missed appointments.

VERIFYING MEMBER BENEFITS, ELIGIBILITY, AND COST SHARES
It is imperative that providers verify benefits, eligibility, and cost shares each time a Trillium Advantage member is scheduled to receive services. All members will receive a Trillium Advantage member identification card.

Member Identification Card
Below is a sample member identification card.
NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Preferred Method to Verify Benefits, Eligibility, and Cost Shares
To verify member benefits, eligibility, and cost share information, the preferred method is the Trillium Advantage secure web portal found at TrilliumAdvantage.com. Using the portal, any registered provider can quickly check member eligibility, benefits and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, member name and date of birth or the member ID number and date of birth.

Other Methods to Verify Benefits, Eligibility and Cost Shares
If you cannot confirm a member’s eligibility using the secure portal, call Provider Services at 1-844-867-1156. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member name, member ID number, and date of birth to verify eligibility.
MEDICAL MANAGEMENT

Care Management
Medical Care Management is a collaborative process which assesses plans, implements, coordinates, monitors and evaluates 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.

An initial Health Risk Assessment (HRA) will be completed by phone or in person 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. Trillium Advantage Care Management teams support physicians by tracking compliance with the Care Management plan, 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 school-based clinics. The managing physician maintains responsibility for the member’s ongoing care needs. The Trillium Advantage Care Manager will contact the PCP, and/or, managing physician if the member is not following the plan of care or requires additional services.

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

Care Management Process
Trillium Advantage’s Care Management 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 Trillium Advantage’s Care Management program.
- Develop and implement a care plan that accommodates the specific cultural and linguistic needs of the member.
- Establish treatment objectives and monitor outcomes.
- Refer and assist the member in ensuring timely access to Providers.
- Coordinate medical, residential, social and other support services.
- Monitor care/services.
- Revise the care plan as necessary.
- Assess the member’s satisfaction with Complex Care Management services.
- Track plan outcomes.
- Follow-up post discharge from Care Management.
- Referring a member to Trillium Advantage Care Management: Providers are asked to contact a Trillium Advantage Care Manager to refer a member identified in need of Care Management intervention.

**Model of Care (MOC) and Care Management**

Trillium Advantage offers a Dual Special Needs Plan (DSNP) available to members.

Dual Special Needs Plan (DSNP) - Serving members with dual eligibility under Medicare and Medicaid

The MOC provides the basic framework under which Trillium Advantage will meet the needs of our Advantage members. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each member is 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 DSNP member must have:

- Initial (within 90 days of enrollment) and annual Health Risk Assessment (HRA)
- Individualized Care Plan (ICP)

Integrated Care Team 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 DSNP members remain in Case Management as required by CMS.

**Purpose**

To improve quality, reduce costs, and improve the member experience:

- Ensure members have full access to the services 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**

- Every DSNP member receives a comprehensive Health Risk Assessment (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 medical and behavioral health history.

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

• Trillium Advantage with the help of the member/designated caregiver and the member’s provider(s), develops an ICP for each DSNP and ISNP member.

• Following the HRA, all DSNP members who choose to participate in the Case Management Program will:
  
  o Participate with a case 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.
  
  o Receive regular telephonic contact with their assigned case manager to monitor progress/regression towards goals of the care plan.
  
  o Benefit from ongoing communication between the case manager and other members of the ICT.
  
  o Receive at minimum, an annual HRA.

**Individualized Care Plan (ICP)**

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

• Problems, Interventions and Goals

• Specific services and benefits to be provided

• Measureable Outcomes

Members receive monitoring, service referrals, and condition specific education. Case Manager’s and PCP’s work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP). Trillium Advantage disseminates evidence-based clinical guidelines and conducts studies to:

• Measure member outcomes

• Monitor quality of care

• Evaluate the effectiveness of the Model of Care (MOC)

DSNP members who can’t be contacted by Trillium Advantage or who refuse the Case Management Program will have an initial communication plan created and sent to their
practitioner. 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 case management participation with their members and refer them to us at any time.

All DSNP members who undergo a transition of care from one setting to any other setting will receive:

- Communication from case 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.

**Interdisciplinary Care Team (ICT)**
The Trillium Advantage case 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. Provider responsibilities include:

- Accepting invitations to attend member’s ICT meetings whenever possible
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member’s medical record when received

Collaborating and actively communicating with:

- Trillium Advantage case managers
- Members of the Interdisciplinary Care Team (ICT)
- Members and caregivers
- Inpatient Care: case managers will coordinate with facilities to assist members with coordinating an appropriate discharge plan meeting the member’s needs. Trillium Advantage will then notify the PCP of the transition of care and anticipated discharge date to ensure members receive the appropriate follow-up care.
- 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.
• Provider ICT Responsibilities: Provider responsibilities include accepting ICT meeting invitations on members when possible, maintain copies of the ICP, ICT worksheets and transition of care notifications in the member’s medical record, and collaborating with Trillium Advantage case managers, ICT, and members or caregivers.

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

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 provide services that 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 or covered by the contract.

Medical necessity determinations will be made in a timely manner and assessed via thorough review by Trillium Advantage clinical staff using nationally-recognized criteria, Medicare National and Local Coverage Determinations and evidenced based clinical policies to determine medical necessity and appropriate level of care for services. 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 it 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 give 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

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the “Grievance Process” section of the provider manual.
Prior Authorization
Prior authorization requires that the provider or practitioner make a formal medical necessity organization determination request to the Plan 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 non-emergent inpatient admissions, all out-of-network services, and certain outpatient services, ancillary services and Specialty injectables as described on the Prior Authorization List. Prior Authorization is not required for emergency services or urgent care services.

Services Requiring Prior Authorization
To see a list of services that require prior authorization please visit the Trillium Advantage website at TrilliumAdvantage.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 Trillium Advantage for an extended period and when, acting in good faith, providers need to deliver services to our members. Trillium Advantage does not reward providers, employees who perform utilization reviews or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve benefit coverage. Trillium Advantage affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Trillium Advantage does not reward practitioners or other individuals for issuing denials of service or care. 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 TrilliumAdvantage.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 Trillium Advantage). 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 his or her dedicated Provider Network Specialist.
- Expedited prior authorization requests may be called to Trillium Advantage at 1-844-867-1156.
• Prior authorization requests may be faxed to 1-844-371-7765. The fax authorization form can be found on our website at trilliumohp.com/providers/helpful-links

**Timeframes for Prior Authorization Requests and Notifications**

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

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 actually performed, it is recommended that within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-844-867-1156 to update the authorization otherwise, this may result in claim denials
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans

**Utilization Determination Timeframes**

Utilization management decision making is based on appropriateness of care and service and the covered benefits of the plan. Trillium Advantage does not reward providers or other individuals for issuing denials of authorization.

Authorization decisions are made as expeditiously as possible. Below are the specific timeframes utilized by Trillium Advantage. 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 Trillium Advantage if you would like a copy of the policy for utilization management timeframes.
<table>
<thead>
<tr>
<th>Level of Urgency</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
<td><strong>Timeframe</strong></td>
</tr>
<tr>
<td>Standard</td>
<td>Expeditiously as the member’s health condition required, but no later than 14 calendar days after receipt of request</td>
</tr>
<tr>
<td>Standard Extension</td>
<td>Up to 14 additional calendar days (not to exceed 28 calendar days from receipt of original request)</td>
</tr>
<tr>
<td>Expedited</td>
<td>Expeditiously as the member’s health condition requires, but no later than 72 hours after receipt of request</td>
</tr>
<tr>
<td>Expedited Extension</td>
<td>Up to 14 additional calendar days (not to exceed 17 calendar days after receipt of original request)</td>
</tr>
<tr>
<td>Concurrent</td>
<td>As soon as medically indicated; usually within 1 business day of request depending on the plan’s policy</td>
</tr>
</tbody>
</table>

**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 his or her Physician 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’s or Physician’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 documents 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 requests may be called to Trillium Advantage at 1-844-867-1156.
**Concurrent Review**
Concurrent review is defined as any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. Decisions are made as expeditiously as the member’s health condition requires, generally within 1 business day of receipt.

**Retrospective Review**
Retrospective requests are requests for authorization of services or supplies that have already been provided to a member. This includes acute hospital stays when initial notification is received after the member has been discharged.

The requestor must submit a claim for payment. If the claim is denied, the provider and/or member will also have the ability to file an appeal. Trillium Advantage will complete a medical necessity review when authorization or timely notification to Trillium Advantage was not obtained due to extenuating circumstances (i.e. Unable to Know situations- member was unconscious at presentation, member did not have their Trillium Advantage ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service or Not Enough Time Situations-the member requires immediate medical services and prior authorization cannot be completed prior to service delivery). If a clinical review is warranted due to extenuating circumstances, a decision will be made within 30 calendar days following receipt of all necessary information.

**Utilization Review Criteria**
Trillium Advantage’s Medical Director reviews, or other health care professionals that have appropriate clinical expertise in treating the member’s condition or disease review, all potential adverse determinations and will make a decision in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from NCD, LCD, nationally recognized criteria or other standards mentioned above. Trillium Advantage’s Clinical Policies are posted at TrilliumAdvantage.com Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-844-867-1156. Providers have the opportunity to discuss any adverse decisions with a Trillium Advantage physician or other appropriate reviewer at the time of an adverse determination. The Medical Director may be contacted by calling Trillium Advantage at 1-844-867-1156 and asking for a Peer to Peer, to speak with a Medical Director. A Trillium Advantage 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. Trillium Advantage does not reward providers or other individuals for issuing denials of authorizations.

A full copy of the criteria used for UM decision can be provided upon request through Trillium customer services or the web link below:
Behavioral Health Services
Advantage has delegated the management of covered mental health and substance use disorder services to Trillium Behavioral Health. If you provide behavioral health services for members, please refer to your contract with Trillium Behavioral Health for specific information related to covered services and authorization requirements. Additional information regarding Behavioral Health services can be found in other sections of this Manual as applicable.

Pharmacy
The covered pharmacy services for Trillium members vary based on the plan benefits. Information regarding the member’s pharmacy coverage can be best found via our secure Provider Portal. Additional resources available on the website include the Trillium formulary, Pharmacy Benefit Manager Provider Manual and Medication Request/Exception Request form. The Trillium formulary is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions and limitations
- The Pharmacy Management Program requirements and procedures
- An explanation of limits and quotas
- How prescribing providers can make an exception request
- How Trillium conducts generic substitution, therapeutic interchange and step-therapy

The Trillium formulary does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the professional judgment of the physician or pharmacist
- Relieve the physician or pharmacist of any obligation to the member

The Trillium formulary will be approved initially by the Envolve Pharmacy Solutions Pharmacy and Therapeutics Committee (P & T), led by the Pharmacist and Medical Director, with support from community based primary care providers and specialists. Once established, the formulary will be maintained by the P & T Committee, using quarterly meetings, to ensure that Trillium members receive the most appropriate medications. The Trillium formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the formulary Change Request policy can be used as a method to address the request. The Trillium P & T Committee would review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the formulary are available on our website, trilliumadvantage.com. Providers may also call Provider Services for hard copies of the formulary.

The majority of prescriptions will be covered based on the Medicare formulary. In addition, Trillium will assist with the following:

- Transitions of prescription drugs
- Quality Assurance
- Utilization Management (Prior Authorization Requirements)
- Exceptions and Appeals
- Locate a pharmacy near you
- Information about any formulary changes
- Out Of Network Coverage
Pharmacy Transition Policy
Under certain circumstances Trillium 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 Trillium formulary or — the drug is now restricted in some way
- The member must be in one of the situations described below:
  o For those members who were enrolled with Trillium last year and are not in a long-term care facility: We will cover a temporary supply of the drug one time only during the first 90 days enrolled in Trillium of the calendar year. This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.
  o For those members who are new to Trillium and are not in a long-term care facility: Trillium will cover a temporary supply of the drug one time only during the first 90 days of the membership in Trillium. This temporary supply will be for a maximum of a 30-day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.
  o For those who are new Trillium members, and are residents in a long-term care facility: We will cover a temporary supply of the drug during the first 90 days of membership in Trillium. The first supply will be for a maximum of a 31-day supply, or less if the prescription is written for fewer days. If needed, we will cover additional refills during the first 90 days in Trillium up to a maximum of 91 – 98 day supply.
  o For those who have been a member of Trillium for more than 90 days, are a resident of a long-term care facility and need a supply right away; Trillium will cover one 31-day supply or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply. An exception or prior authorization should also be requested at the time the prescription is filled.

Pharmacy Prior Authorization Requirements
Trillium has a team of doctors and pharmacists to create tools to help provide quality coverage to Trillium 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, Trillium limits the amount of the drug we will cover per prescription or for a defined period of time.

**Prior Authorization:** Trillium 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 prescription can be filled. If approval is not obtained, Trillium 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.

Trillium 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 Allwell.SunshineHealth.com. In order to ensure your patient receives prompt, you must use the Medicare specific Trillium form and fax it to the number identified on the form. Generally, Trillium must make a decision 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, Trillium must provide a decision no later than 24 hours after receiving the prescriber’s or prescribing doctor’s supporting statement.

ENCOUNTERS AND CLAIMS

Encounter Reporting
What is an Encounter versus a Claim?

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example, if you are the PCP for a Trillium Advantage 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, within 365 days of the service date. Trillium Advantage utilizes 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 a Trillium Advantage Member.

CLAIMS
In general, Trillium Advantage follows the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Advantage 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 or within 365 days of the date of service or discharge.**

**Verification Procedures**
All claims filed with Advantage 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).

- 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

Updated July 24, 2018
• Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.
  o For a CMS 1500 Claim Form, this criteria 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.
  o 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 Advantage 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 Advantage.
• 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 the health plan’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 can be located in Appendix I of this Manual. Upfront rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The 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
Physician shall, within 120 days following the provision of Covered Services, submit to Trillium a completed claim statement in a form and containing such information as Trillium may require.

Who Can File Claims?
All providers who have rendered services for Trillium Advantage members can file claims. It is important that providers ensure Trillium Advantage has accurate and complete information on file. Please confirm with the Provider Services department or your dedicated Provider Network Specialist 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 Trillium Advantage 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

Medical
All medical claims must be submitted to Trillium Advantage. Providers are encouraged to submit clean claims and encounter data electronically. Trillium Advantage can receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP) 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 Trillium Advantage has partnered with, contact:

Trillium Advantage
c/o Centene EDI Department
1-800-225-2573, extension 6075525
or by e-mail 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.

Trillium Advantage has the ability to receive coordination of benefits (COB or secondary) claims electronically. Advantage follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

The Trillium Advantage Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at TrilliumAdvantage.com.

Vision
All claims for routine vision and post-cataract eyewear services must be submitted to Envolve Vision. The Emdeon Payer ID for vision claims processing is 56190.

Updated July 24, 2018
Dental
All claims for dental services must be submitted to Dental Health & Wellness. Please attach the provider’s W-9 for the first claim submission to Dental Health & Wellness. A Dental Health & Wellness payee ID number will be assigned for payment and for future claim submissions.

The Payer ID for dental claims processing is 46278 accepted through the following clearing houses:

- Emdeon (www.emdeon.com)
- DentalXChange (www.dentalxchange.com)
- Trizetto (www.trizetto.com)

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

Electronic Claim Flow Description & Important General Information
In order to send claims electronically to Trillium Advantage, all EDI claims must first be forwarded to one of Trillium Advantage’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 Trillium Advantage. The name of this report can vary based upon the provider’s contract with their intermediate EDI clearinghouse. Accepted claims are passed to Trillium Advantage and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Trillium Advantage 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 on a daily basis 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 Trillium Advantage.
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 Trillium Advantage 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 Advantage. 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 – 837lv5010 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 times are excluded from EDI submission options and must be filed on paper:

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

• Claim for services requiring documentation and a Certificate of Medical Necessity i.e., oxygen, motorized wheelchairs.

**Electronic Billing Inquiries**
Please direct inquiries as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitting Claims through clearinghouses</td>
<td>We use Availity as our primary clearinghouse, which provides us with an extensive network of connectivity. You are free to use whatever clearinghouse you currently do as Availity maintains active connections with a large number of clearinghouses.</td>
</tr>
<tr>
<td>Trillium Advantage Payer ID number for all clearinghouses (Medical) is 68069</td>
<td></td>
</tr>
<tr>
<td>General EDI Questions:</td>
<td>Contact EDI Support at 1-800-225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a></td>
</tr>
<tr>
<td>Claims Transmission Report Questions:</td>
<td>Contact your clearinghouse technical support area.</td>
</tr>
<tr>
<td>Claim Transmission Questions (Has my claim been received or rejected?):</td>
<td>Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a></td>
</tr>
<tr>
<td>Remittance Advice Questions:</td>
<td>Contact Provider Services or check the Secure Provider Portal.</td>
</tr>
<tr>
<td>Provider Payee, UPIN, Tax ID, Payment Address Changes:</td>
<td>Notify Provider Service in writing (W9).</td>
</tr>
</tbody>
</table>

**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 Trillium Advantage 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 Trillium Advantage, and those claims not
meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Trillium Advantage. ALWAYS review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit.

5. MOST importantly, all claims must be submitted with 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**

**Medical**
For providers who have internet access and choose not to submit claims via EDI or paper, Trillium Advantage has made it easy and convenient to submit claims directly to Trillium Advantage on the Secure Provider Portal at TrilliumAdvantage.com.

You must request access to our secure site by registering for a user name 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.

**Vision**
All claims for routine vision and post-cataract eyewear services must be submitted to Envolve Vision. Contracted Trillium Advantage providers are allowed direct data entry into Envolve Vision’s claim system at https://visionbenefits.envolvehealth.com/. This method of filing provides immediate confirmation of claim receipt. Access to the site is restricted and password-protected. A username and password will be provided.

**Paper Claim Submission**

**Medical**
The mailing address for first time claims, corrected claims and requests for reconsideration:

**Trillium Advantage**
P.O. Box 3060
Farmington, MO 63640-3822

Trillium Advantage 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 claims 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 claims. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

**Vision**

All claims for routine vision and post-cataract eyewear services must be submitted to Envolve Vision. The mailing address for vision claims:

Envolve  
**Trillium Advantage Claims**  
P.O. Box 7548  
Rocky Mount, NC 27804

**Acceptable Forms**

*Medical and Vision*

Trillium Advantage only accepts the 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.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Trillium Advantage 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 font, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten and nonstandard forms will be upfront rejected and returned to 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 Advantage.

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 120 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 120 days 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 Trillium Advantage 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 of the following conditions are met:
  - The provider’s records document that the member refused or was physically unable to provide his or her ID Card or information
  - The provider can substantiate that he or she 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 CHANGING the original claim
- Request for Reconsideration – Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
- Claim Dispute/Appeal – Provider disagrees with the outcome of the Request for Reconsideration

**Corrected Claims**

*Medical*

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:

**Trillium Advantage**  
**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 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.

**Vision**  
Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the secure Envolve web site - Follow the instructions on the website for submitting a correction.
- Submit a corrected claim electronically via a Clearinghouse
  - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number
- Submit a corrected paper claim to:

**Envolve Corrected Vision Claims**  
PO Box 7548  
Rocky Mount, NC 27804

- The original claim number must be typed in field 22 (CMS 1500) with the corresponding frequency codes.
- Corrected claims must be typed and submitted on standard red and white claim forms.

**Request for Reconsideration**

**Medical**  
A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. 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 particular 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 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.

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

Trillium Advantage
Attn: Request for Reconsideration
P.O. Box 3060
Farmington, MO 63640-3822

Claim Dispute

Medical
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 at TrilliumAdvantage.com. The claim dispute form must be completed in its entirety. The completed claim dispute form may be mailed to:

Trillium Advantage
Attn: Claim Dispute
P.O. 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.
Trillium Advantage 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.

Vision
Contracted Provider Claim disputes are processed by Envolve. You will find the appropriate form at https://visionbenefits.envolvehealth.com/. Click on For Providers > Online forms > All state providers > Claims appeal request form (5th one down); Then, fill out, print, and MAIL HARD COPY to the address on the form:

MAIL COMPLETED FORM TO:
Envolve Vision, Inc.
Attn: Appeals Department
P.O. Box 7548
Rocky Mount, NC 27804

If all pieces are not included, the appeal will not be processed, and will be returned to you. A denied claim appeal will not be reprocessed. However, it may be re-appealed with additional information and documentation.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)
Trillium Advantage 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 are able to enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact 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
Risk Adjustment and Correct Coding
Risk adjustment is a critical and a 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, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-10 CM, 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 Trillium Advantage of any erroneous data submitted and follow Trillium Advantage’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
Trillium Advantage requires claims to be submitted using codes from the current version of ICD-10-CM, ASA, DRG, CPT, CDT 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 digits
- 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 Trillium Advantage.

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 her 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 Trillium Advantage Provider Services.

**Clinical Lab Improvement Act (CLIA) Billing Instructions**

CLIA numbers are required for CMS 1500 claims where CLIA Certified or CLIA waived services are billed. If the CLIA number is not present, the claim will be upfront rejected. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim type submissions:

**Paper Claims**

If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

*Note: An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory’s name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.**

EDI
If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

*Note: The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory’s CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

Please refer to the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.

**Web**

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

*Note: An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory’s name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

**CODE EDITING**

Trillium Advantage uses HIPAA compliant clinical claims editing software for physician and outpatient facility coding verification. The software will detect, correct, and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards.
and government sources. These principles are aligned with a correct coding “rule.” When the software edits a claim that does not adhere to a coding rule, a recommendation known as an “edit” is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code editing software is a useful tool to ensure provider compliance with correct coding, a fully automated code editing software application will not wholly evaluate all clinical patient scenarios. Consequently, Trillium Advantage 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. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Moreover, Trillium Advantage may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure
CPT codes are a component of the HealthCare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. **Level I HCPCS Codes (CPT):** This code set is comprised of CPT codes that are 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 then used to bill health insurance companies.

2. **Level II HCPCS:** The Level II subset 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 and etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.

3. **Miscellaneous/Unlisted Codes:** The 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 codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical

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documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding 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. **HCPCS Code Modifiers**: Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion; certain procedures require more explanation because of special circumstances. For example, modifier -24 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)**
These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems.

**Revenue Codes**
These codes represent where a patient had services performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

**Edit Sources**
The claims editing software application 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, research and etc.

The software applies edits that are based on the following sources

- Centers for Medicare & Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits includes column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing...
to incorrect payments. Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).

- CMS Claims Processing Manual
- CMS Medicaid NCCI Policy Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources such as, HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- AMA resources
  - CPT Manual
  - AMA Website
  - Principles of CPT Coding
  - Coding with Modifiers
  - CPT Assistant
  - CPT Insider's View
  - CPT Assistant Archives
  - CPT Procedural Code Definitions
  - HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations
  - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
  - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations

**Code Editing and the Claims Adjudication Cycle**

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

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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 appropriate decision is documented on the provider’s explanation of payment along with reconsideration/appeal instructions.

**Replace and Pay**: Code editing recommends the 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**
*CMS National Correct Coding Initiative*

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claims payment. CMS has designated certain combinations of codes that should never be billed together. These are also known as Column 1/Column II edits. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column I code is considered an integral component of the column II code.

The CMS NCCI edits consist of Procedure to Procedure (PTP) edits for physicians and hospitals and the Medically Unlikely Edits for professionals and facilities. While these codes should not be billed together, there are circumstances when an NCCI modifier may be appended to the column 2 code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed. For more information on the CMS National Coding Initiative, please visit www.CMS.gov.
**PTP Practitioner and Hospital Edits**

Some procedures should not be reimbursed when billed together. CMS developed the Procedure to Procedure (PTP) Edits for practitioners and hospitals to detect incorrect claims submitted by medical providers. PTP for practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). The PTP-hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

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

MUE’s reflect the maximum number of units that a provider would bill for a single member, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyte, equipment prescribing information and clinical judgment.

**Code Bundling Rules Not Sourced To CMS NCCI Edit Tables**

Many specialty 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)
This rule 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
This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all of the services performed.

Frequency and Lifetime Edits
The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member’s lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member’s lifetime. Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Duplicate Edits
Code editing will evaluate 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 will also look 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 will analyze multiple services within the same range of services performed on the same day.

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example a nurse practitioner and physician bill for office visits for the same member on the same day.

**National Coverage Determination Edits**
CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services or technologies can be paid under 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**
Rule 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**
CMS guidelines define whether or not 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**
Rules look for claims where the add-on CPT code was billed without the primary service CPT code or if the primary service code was denied, then the add-on code is also 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**
This rule looks for claims where the modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

**Replacement Edits**
These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the same provider bills more than one outpatient consultation code for the same member in the member’s history. This rule will deny the office consultation code and replace it with a more appropriate evaluation and management service, established patient or subsequent hospital care code. Another example, the rule will evaluate if a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. This rule will replace the second submission with the appropriate established patient visit. This rule uses a crosswalk to determine the appropriate code to add.
Missing Modifier Edits
This rule 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
This 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 post-admission 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 rules: 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 -24, -25, -26, -57, -58 and -59.

Age Rules: 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 diagnosis codes incomplete or invalid

Prepayment Clinical Validation
Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Trillium Advantage’s clinical validation services is modifier -25 and -59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of “1.” Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider’s billing should support
Trillium Advantage's clinical validation team uses the information on the prospective claim and claims history to determine whether or not 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.

**Modifier -59**

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier 59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate 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 are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 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.

Trillium Advantage uses the following guidelines to determine if modifier -59 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.

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• 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 in the NCCI policy manual specify that by using a 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.

Trillium Advantage uses the following guidelines to determine whether or not modifier 25 was used appropriately. If any one of the following conditions is met then, the clinical nurse reviewer will recommend reimbursement for the E/M service.

• If 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 appeals process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

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

**Viewing Claims Coding Edits**

**Code Editing Assistant**

A web-based code editing reference tool designed to “mirror” how the code editing product(s) evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking “Claim Editing Tool” in our 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 for accurate billing purposes

The tool will review what was entered, and will 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 provider web portal.

Disclaimer: This tool is used to apply coding logic ONLY. It will not take into account 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 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.

The majority of 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

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

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

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Clinical Policy Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractional Exhaled Nitric Oxide</td>
<td>CP.MP.103</td>
<td>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.</td>
</tr>
</tbody>
</table>

Clinical Payment Policy Appeals

Clinical payment policy denials may be appealed on the basis of 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 may include this type of information:

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.
4. How the proposed treatment will alleviate physical, mental or developmental effects of the patient’s illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.

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6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.

7. How the recommended service has been successful in other patients

THIRD PARTY LIABILITY
Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or 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, Trillium Advantage 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 Trillium Advantage.

No Balance Billing
Providers may not seek payment from Trillium Advantage members for the difference between the billed charges and the contracted rate paid by Trillium Advantage. Providers must not collect Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from members enrolled in the Qualified Medicare Beneficiaries (QMB) program, a Medicare-Medicaid dual eligible program which exempts individuals from Medicare cost-sharing liability. Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing.

Non-Covered Services
Contracted providers may only bill Trillium Advantage 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 Trillium Advantage at the time it was provided, even if Trillium Advantage did not pay the provider for the service because the provider did not comply with Trillium Advantage requirements.
Health Care Acquired Conditions (HCAC) – Inpatient Hospital
Trillium Advantage follows Medicare’s policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicare claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare’s most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as “present” at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

Reporting and Non Payment for Provider Preventable Conditions (PPCS)
Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by Trillium Advantage for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicare providers are required to report the occurrence of a PPC and are prohibited from payment.

Non-Payment and Reporting Requirements Provider Preventable Conditions (PPCS) - Inpatient
Trillium Advantage follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, Trillium Advantage follows Medicare’s billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no-pay TOB claim. Trillium Advantage follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

Other Provider Preventable Conditions (OPPCS) – Outpatient
- Trillium Advantage follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Conditions currently identified by CMS include: Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive surgery performed on the wrong body part; and
- Surgical or other invasive procedure performed on the wrong patient.

Non-Payment and Reporting Requirements Other Provider Preventable Conditions (OPPCS) – Outpatient
Trillium Advantage follows the Medicare guidelines and NCDs, including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights
Providers must comply with the rights of members as set forth below.

1. To participate with providers in making decisions about his/her 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 Trillium Advantage policies

6. To receive information or make recommendations, including changes, about Trillium Advantage’s organization and services, the Trillium Advantage 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 provider 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 serious danger

8. To make recommendations regarding the Trillium Advantage member’s rights, responsibilities and policies

9. To voice complaints or appeals about: Trillium Advantage, any benefit or coverage decisions Trillium Advantage makes, Trillium Advantage coverage, or the care provided

10. 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 provider assignment, providers, advance directive

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information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Trillium Advantage rules and guidelines. Trillium Advantage will notify members before the effective date of the modifications. Such notices shall include the following:

- Any changes in clinical review criteria
- A statement of the effect of such changes on the personal liability of the member for the cost of any such changes

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 preference, 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 provider or other provider. The primary care provider or other provider must discuss different treatment plans with the member. The member must make the final decision

19. To select a primary care provider within the network. The member has the right to change their primary care provider or request information on network 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 provider is their primary care provider

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 provider, 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 Trillium Advantage 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 Trillium Advantage. 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 provider. The member should establish a relationship with their primary care provider. The member may change their primary care provider verbally or in writing by contacting the Trillium Advantage 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 Trillium Advantage 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 provider to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision
12. To follow all health 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 provider
14. To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Trillium Advantage coverage, the member must provide this information to Trillium Advantage
15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service
PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients, who are Trillium Advantage 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 Trillium Advantage 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 Trillium Advantage 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 Trillium Advantage 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 Trillium Advantage for having developed or accumulated a substantial number of patients in Trillium Advantage 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 on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care
4. To maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the 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, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
12. To respect members’ advance directives and include these documents in the 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 Trillium Advantage data collection initiatives, such as HEDIS and other contractual or regulatory programs
17. To review clinical practice guidelines distributed by Trillium Advantage
18. To comply with the Trillium Advantage Medical Management program as outlined herein
19. To disclose overpayments or improper payments to Trillium Advantage
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 Trillium Advantage information regarding other insurance coverage the member has or may have
22. To give Trillium Advantage timely, written notice if provider is leaving/closing a practice
23. To contact Trillium Advantage to verify member eligibility and benefits, if appropriate
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services
26. To object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds

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27. To provide hours of operation to Trillium Advantage members which are no less than those offered to other Medicare patients

**Interference with Health Care Professionals’ Advice**

Trillium Advantage 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, a Trillium Advantage 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; or
- 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**

Trillium Advantage 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 who are members of various racial, religious, age, gender and/or ethnic groups and accommodating 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.

Trillium Advantage is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of Trillium Advantage’s Cultural Competency Program, providers must ensure that:

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• Members understand that they have access to qualified interpreters and TDD/TTY services to facilitate communication without cost to them.
• Medical care is provided with consideration of the members’ primary language, race and/or ethnicity as it relates to the members’ health or illness.
• Office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training.
• Office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order to assist the member in accurately identifying their race or ethnicity.
• 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.
• Office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area.
• 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.

Trillium Advantage considers 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 preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:
• Denying a member a covered service or availability of a facility.
• Providing a Trillium Advantage member a covered service that is 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).

**Americans with Disabilities Act**
Trillium Advantage strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:
• Full and equal access to healthcare services and facilities; and
• Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services.

The term "disability" means, with respect to an individual -

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A physical or mental impairment that substantially limits one or more of the major life activities of such individual;

A record of such an impairment; or

Being regarded as having such an impairment.

If an individual meet any one of these three tests, he or she is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

**General Requirements**

General prohibitions against discrimination.

- No qualified individual with a disability shall, on the basis 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, on the basis of disability --
  
  o Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

  o 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 others;

  o 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;

  o 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;

  o Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

  o Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

  o Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Trillium Advantage, 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:
  o That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;
  o 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
  o That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

• A public entity may not, in determining the site or location of a facility, make selections:
  o That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
  o 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 on the basis of disability.

• A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis 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 on the basis 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 on the basis 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.
o 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.

o 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.

o 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.

o 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

Trillium Advantage does not delegate member grievances. All member grievances and appeals (standard and expedited) received by a provider must be forwarded immediately to the Trillium Advantage Member Grievances and Appeals Department.

Grievances

Members must follow the grievance process as listed below when a member is dissatisfied with the manner in which Trillium Advantage or a delegated entity provides healthcare services. Grievances may include:

- Timeliness
- Appropriateness
- Access to provided health services
- Setting of health services
- Procedures
- Items
- Standards for delivery of care
Members or their representative may submit a grievance verbally, in writing, via phone, mail, facsimile, electronic mail or in person 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 twenty-four (24) hours for expedited grievances and thirty (30) calendar days for standard grievances. Extensions of up to fourteen (14) calendar days can be granted for standard grievances if the enrollee requests the extension or if Trillium Advantage justifies the need for additional information and the delay is in the best interest of the member.

Appeals and Grievances Medicare Operations
7700 Forsyth Blvd
St. Louis, MO 63015
Member Services: 1-844-867-1156 TTY: 711

Appeals
Members, or their representatives, may file a formal appeal if they are dissatisfied with a medical care or drug coverage decision made by Trillium Advantage. Appeals must be submitted within sixty (60) days of the decision. Expedited determinations/reconsiderations/determinations will be made on medical care or drug coverage not yet received if standard deadlines can cause serious harm to the member’s health. Resolution for reconsiderations of medical care will be made no later than seventy-two (72) hours for expedited reconsiderations and thirty (30) calendar days for standard reconsiderations. Extensions of up to fourteen (14) calendar days can be granted for both standard and expedited reconsiderations if the enrollee requests the extension, or if Trillium Advantage justifies the need for additional information and the delay is in the best interest of the member. Resolution for redeterminations of drug coverage will be made no later than seventy-two (72) hours for expedited redeterminations and seven (7) days for standard redeterminations. Written appeals must be mailed to:

Trillium Advantage
Attention: Appeals and Grievances Medicare Operations
7700 Forsyth Blvd.
St. Louis, MO 63105

For process or status questions, members or their representatives can contact Member Services at 1-844-867-1156.

PROVIDER COMPLAINT AND APPEAL PROCESS

Complaint
A Complaint is a verbal or written expression by a provider which indicates dissatisfaction with Trillium Advantage’s policies, procedure, or any aspect of Trillium Advantage’s functions. Trillium Advantage logs and tracks all complaints whether received verbally or in writing. A

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provider has thirty (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, Trillium Advantage shall provide a written or verbal notice to the provider within thirty (30) calendar days from the received date of Trillium Advantage’s decision. If the complaint is related to claims payment, the provider must follow the process for claim reconsideration and claim dispute as noted in the Claims section of this Provider Manual prior to filing a complaint.

Authorization and Coverage Appeals

An Appeal is the mechanism which allows providers the right to appeal actions of Trillium Advantage such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Trillium Advantage. A provider has thirty (30) calendar days from Trillium Advantage’s notice of action to file the appeal. Trillium Advantage shall acknowledge receipt of each appeal within ten (10) business days after receiving an appeal. Trillium Advantage 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 thirty (30) calendar days from the date Trillium Advantage receives the appeal. Trillium Advantage may extend the timeframe for resolution of the appeal up to fourteen (14) calendar days if the member requests the extension or Trillium Advantage 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, Trillium Advantage shall provide written notice to the member for the delay.

Expedited appeals may be filed with Trillium Advantage 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 seventy-two (72) hours from the initial receipt of the appeal. Trillium Advantage may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if Trillium Advantage 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 PLAN

Overview

Trillium Advantage’s culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Management and Improvement (QMI) Program utilizes a systematic approach to quality improvement initiatives using reliable and
valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system incorporates a continuous cycle for assessing the level of care and service for members through initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Trillium Advantage requires all practitioners and providers to cooperate with all quality improvement activities, as well as to allow Trillium Advantage to use practitioner and/or provider performance data to ensure success of the QMI program.

Trillium Advantage will arrange for the delivery of appropriate care with the primary goal being to improve the health status of its members. Where the member’s condition is not amenable to improvement, Trillium Advantage will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Trillium Advantage QMI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QMI Program Structure

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

The Executive Quality Improvement Committee (EQIC) is a supervisory and managerial level committee that is directly accountable to the Trillium Executive Committee. The purpose of the EQIC is to:

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

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the QI, UM, and Credentialing and Re-credentialing programs.

There are several standing and ad-hoc that report directly to the EQIC. The EQIC is able to call sub-committees or workgroups as needed. Participation on these sub-committee and
workgroups are selected based on topic and scope of sub-committee/workgroup. Committees include:

- Credentialing Peer Review Committee
- Quality Improvement Committee
- Pharmacy and Therapeutics Committee

Practitioner Involvement
Trillium Advantage recognizes the integral role that practitioner involvement plays in the success of its QMI Program. Practitioner involvement in various levels of the process is highly encouraged through provider representation. Trillium Advantage promotes PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the EQIC Credentialing Committee, and select ad-hoc committees.

Quality Management and Improvement Program Scope and Goals
Trillium’s integrated medical and behavioral healthcare model is committed to Continuous Quality Improvement (CQI) to conduct meaningful activities internally and externally to ensure members receive care to improve their health and well-being.

Trillium’s commitment to the integrated model is reflected in the following goals and objectives:

- Build and promote quality throughout Trillium’s organizational structure, processes and practitioner/provider community
  - Monitor data for outcomes and health disparities to identify gaps in systems of care
  - Provide information and education to practitioners/providers and members regarding status of quality activities and applicable measurements
- Promote member safety.
  - Monitor data to identify and address trends in member safety issues, including:
    - Claims, pharmacy and utilization management data
    - Health risk stratifications and assessments
    - Model of Care (MOC) guidelines for Complex Case Management (CCM) and Disease Management (DM)
    - Clinical site reviews and medical record audits
    - Complaints, grievances, appeals and adverse events
    - Member experience and satisfaction surveys
- Collaborate with practitioners/providers and establish mechanisms to support and promote safe clinical practices and delivery of care (e.g., information and education regarding status of member safety initiatives)
- Evaluate practitioner/provider credentialing and re-credentialing documentation/licensure to verify qualifications for established standards of care and service
- Promote clinically appropriate, safe and cost-effective use of pharmaceuticals based on sound clinical evidence and decision making
- Educate members to broaden their knowledge of clinical safety and encourage patient-centered care, including:
  - Information posted to member and practitioner/provider websites
  - Member and practitioner/provider newsletters
  - CCM and DM educational materials
- Ensure access to appropriate medical and behavioral healthcare services
  - Collaborate with practitioners/providers to ensure sufficient access and capacity
  - Monitor practitioner/provider data to ensure member has access to timely, effective and efficient healthcare services
- Ensure members receive quality care in a culturally and linguistically appropriate manner
  - Maintain a practitioner/provider network linking members with services to meet cultural, racial, ethnic and linguistic needs and preferences
  - Assess practitioner/provider chart and site review reports to identify differences in provided care and outcomes achieved
  - Provide training and tools to staff and practitioners/providers to support culturally-competent communication
  - Analyze cultural, ethnic, racial and linguistic data to determine disparities and ensure member needs are met
  - Provide appropriate translation and interpretative services to members
- Identify and reduce barriers to services for members with special or complex medical and/or behavioral healthcare needs
  - Data sources include:
    - Health Assessment
    - Mental Health Assessment
- Claims and pharmacy data
- Hospital discharge and Emergency Department data
- Chart notes and Electronic Health Record (EHR) reviews
- Risk stratification
- Activities of Daily Living
- Referrals by Trillium CCM and DM program staff, Trillium Behavioral Health (TBH) Care Coordinators, hospital discharge planners, medical and behavioral healthcare practitioners/providers, members and caregivers
  - Coordinate care and facilitate delivery of appropriate and effective medical and behavioral healthcare to assist members in regaining optimum health or improved functional capacity, in the most appropriate setting and cost-effective manner
  - Maximize health outcomes by developing and adopting evidence-based clinical practice guidelines providing criteria for delivery of medical and behavioral healthcare services
- Ensure high level member satisfaction
  - Provide member education regarding rights to file complaints, grievances and appeals
  - Monitor member complaints, grievances and appeals data to identify trends in dissatisfaction and concerns related to medical and behavioral healthcare disparities
  - Collaborate with practitioners/providers regarding member satisfaction to address identified medical and behavioral healthcare trends
- Maintain compliance with state and federal regulatory requirements and accreditation standards
  - Monitor and incorporate updated regulatory requirements and accreditation standards
  - Revise annual QMI Program Work Plan to incorporate accreditation and regulatory audit findings and actions

A focus and attitude toward improving processes to enhance the quality of outcomes is embedded in Trillium’s mission and promoted to reflect how Trillium conducts internal and external business. QMI Program activities include review and evaluation of medical and behavioral healthcare members receive. The QMI Program is structured to monitor, analyze,
process and implement quality measures internally and externally to improve outcomes and the overall health of the community.

**Practice Guidelines**
Trillium Advantage, whenever possible, adopts evidence-based 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 Clinical Quality Committee 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.

Trillium Advantage adopts clinical practice guidelines for at least two non-preventive acute or chronic medical conditions. Trillium Advantage 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 Trillium Advantage. Guidelines will be based on health needs of population and/or opportunities for improvement as identified through the QMI program.

Clinical Practice guidelines (CPG) may include, but are not limited to:
- Asthma Guidelines
- Chronic Obstructive Pulmonary Disease
- Diabetes Care Guidelines
- Sickle Cell Guidelines
- Congestive Heart Failure

Trillium Advantage 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 at trilliumohp.com/clinicalcriteria.

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

At any time, Trillium Advantage providers may request additional information on the health plan programs including a description of the QMI Program and a report on Trillium Advantage’s progress in meeting the QMI Program goals by contacting the Quality Management and Improvement (QMI) Department.
Additionally, Trillium Advantage develops and implements chronic care improvement programs and quality improvement projects required by CMS. Trillium Advantage encourages all providers to participate in these initiatives.

**Patient Safety and Level of Care**

Patient Safety is a key focus of the Trillium Advantage QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual level of care events. A potential level of care issue is any alleged act or behavior that may be detrimental to the level 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. Trillium Advantage employees (including medical 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 level of care issues. Adverse events may also be identified through claims based reporting and analyses. Potential level of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential level 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 Trillium Advantage 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 Trillium Advantage to monitor improvement over time.

Annually, Trillium Advantage 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.

Updated July 24, 2018
Trillium Advantage communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Trillium Advantage website at <website address>.

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

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

**Office Site Surveys**

Trillium Advantage 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 Trillium Advantage Representatives may include:

- Staff information
- Access for the disabled
- Licensure
- Office policies/general information, in particular, verifying that a confidentiality policy is in place and maintained
- Cultural competence
- 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
- Clinical lab (CLIA) standards
- Medication administration/dispensing/storage of drug samples
- 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 you 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 aid beneficiaries in choosing a MA or MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time.

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. 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 when recommended
- 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 clinically appropriate HEDIS-compliant codes and properly document medical charts for all members
- Review and act on member gaps in care available on our secure online care gap management application: trillium.novillus.com
- Establish transitional care management services workflows to receive admit and discharge notifications, and complete post hospitalization patient visit and medication reconciliation within 30 days after discharge

Updated July 24, 2018
Work with your Trillium Advantage QI Specialist to identify opportunities for your office to increase impact on measures while easing your administrative burden.

**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 three ways: administrative data, medical record data, or hybrid data. Administrative data consists of claims, encounter, and EHR data submitted to the health plan. Measures typically calculated using administrative data include Breast Cancer Screening (routine mammography), 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, encounter, or EHR data. Monthly EHR extracts and accurate and timely claims and encounter data 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, and dilated retinal eye exams), Medication Review Post Hospitalization and Controlled Blood Pressure.

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

Trillium Advantage 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 Trillium Advantage that allows them to collect PHI on our behalf.

**How can Providers improve their HEDIS scores?**

- Understand the specifications established for each HEDIS measure.

Updated July 24, 2018
• Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Trillium Advantage. 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.

• Submit monthly EHR extracts for every measure possible. Partner with your Trillium Advantage QI Specialist to develop the extract and improve upon the data captured.

• 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 II codes related to HEDIS measures such as diabetic eye exam, functional and pain assessments, medication reviews 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 QMI Department at 1-844-867-1156.

**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 are meeting the members’ expectations. Member responses to the CAHPS survey are used in various aspects of the quality 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 and prescriptions

• Whether the personal doctor’s office followed up to give the member test results

• Appointment availability and wait times

**Medicare Health Outcomes Survey (HOS)**
The Medicare HOS is a patient-reported outcomes measure used in the Star rating program. The goal of the Medicare HOS is to gather data to help target quality improvement activities. 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. HOS questions that may reflect on the service of providers includes:

- Whether the member perceives their physical and mental health are maintained or improving
- Whether the member has seen their provider and discussed starting, increasing, or maintaining their level of physical activity
- If provider has discussed fall risks and bladder control with the member

REGULATORY MATTERS

Medical Records
Trillium Advantage providers must keep accurate and complete patient medical records which are consistent with 42 CFR §456 and National Committee for Quality Assurance (NCQA) standards, and financial and other records pertinent to Trillium Advantage members. Such records will enable providers to render the most appropriate level of health care service to members. They will also enable Trillium Advantage to review the level and appropriateness of the services rendered. To ensure the member’s privacy, medical records should be kept in a secure location. Trillium Advantage requires providers to maintain all records for members for at least ten (10) years after the final date of service, unless a longer period is required by applicable state or federal law.

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 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

Updated July 24, 2018
• 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 Trillium Advantage 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 women or infant risk assessment for newborns
• Signed and dated required consent forms are included
• Unresolved problems from previous visits are addressed in subsequent visits
• 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 initialled 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 10 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.

**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 Trillium Advantage 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**
Trillium Advantage will conduct random medical record audits as part of its QMI 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. Trillium Advantage will provide written notice prior to conducting a medical record review.

**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.

Updated July 24, 2018
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 Trillium Advantage network are independently obligated to know, understand and comply with these laws.

Trillium Advantage 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 Trillium Advantage Compliance Officer by phone at 1-844-867-1156 or in writing (refer to address below) with any questions about our privacy practices.

Trillium Advantage
Attn: Compliance Officer
PO Box 11756
Eugene, OR 97440-3956

WASTE, ABUSE, AND FRAUD
Trillium Advantage takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with the federal and state laws. Trillium Advantage, in conjunction with its parent company, Centene, operates a waste, abuse and fraud unit. Trillium Advantage 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 Billing and Claims 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 waste, abuse, and/or fraud. 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

Updated July 24, 2018
Some of the most common WAF 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 WAF hotline at 1-866-685-8664. Trillium Advantage takes all reports of potential waste, abuse or fraud very seriously and investigates all reported issues.

OIG/GSA Exclusion – 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 Waste, Abuse and Fraud safeguards to identify excluded providers and entities.

Medicare payment may not be made for items or services furnished or prescribed by an 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) excluded by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) or the General Services Administration (GSA). Trillium Advantage will review 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 Trillium Advantage immediately so that if needed Trillium Advantage can take appropriate action. Providers may contact the Trillium Advantage Compliance Officer at 1-844-867-1156.
WAF Program Compliance Authority and Responsibility
The Trillium Advantage Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Trillium Advantage is committed to identifying, investigating, sanctioning and prosecuting suspected waste, abuse and fraud.

The Trillium Advantage 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.

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:

1. knowingly presenting, or causing to be presented a false claim for payment or approval
2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
3. conspiring to commit any violation of the False Claims Act
4. falsely certifying the type or amount of property to be used by the Government
5. certifying receipt of property on a document without completely knowing that the information is true
6. knowingly buying Government property from an unauthorized officer of the Government
7. 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.hhs.gov](http://www.cms.hhs.gov).

Provider Incentive Programs

On an annual basis and in accordance with Federal Regulations, Trillium Advantage must disclose to the Centers for Medicare and Medicaid Services, any Provider Incentive Programs that could potentially influence a provider’s care decisions. The information that must be disclosed includes the following:

- Effective date of the Provider Incentive Program
- Type of Incentive Arrangement
- Amount and type of stop-loss protection
- Patient panel size
- Description of the pooling method, if applicable
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services
- The calculation of substantial financial risk (SFR)
- Whether Trillium Advantage does or does not have a Provider Incentive Program
- The name, address and other contact information of the person at Trillium Advantage who may be contacted with questions regarding Provider Incentive Programs
Provider Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Provider Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stop-loss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Provider Incentive Program regulations.

Substantial financial risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold which 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/provider group’s referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Provider Incentive Program Regulations, please contact your Provider Network Specialist.

First-Tier and Downstream Providers

Through written agreement, Trillium Advantage may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 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. Trillium Advantage oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities’ performance is inadequate. Trillium Advantage will ensure written agreements which specify these responsibilities by Trillium Advantage and the delegated entity are clear and concise. Agreements will be kept on file by Trillium Advantage for reference.

APPENDIX

Appendix I: Common Causes for Upfront 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.

<table>
<thead>
<tr>
<th>EX Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0B</td>
<td>ADJUST: CLAIM TO BE REPROCESSED CORRECTED UNDER NEW CLAIM NUMBER</td>
</tr>
<tr>
<td>0I</td>
<td>ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER</td>
</tr>
<tr>
<td>1D</td>
<td>DENY: DISCHARGE STATUS INVALID FOR TYPE OF BILL</td>
</tr>
<tr>
<td>52</td>
<td>DENY - PAYMENT INCLUDED IN ALLOWANCE FOR ANOTHER PROCEDURE</td>
</tr>
<tr>
<td>57</td>
<td>DENY - AUTHORIZATION LIMITATION EXCEEDED</td>
</tr>
<tr>
<td>64</td>
<td>DENY - PROCEDURE INCONSISTENT WITH DIAGNOSIS</td>
</tr>
<tr>
<td>65</td>
<td>DENY-MISSING OR INVALID INFORMATION</td>
</tr>
<tr>
<td>71</td>
<td>DENY-MEMBER NOT ELIGIBLE ON DATE OF SERVICE</td>
</tr>
<tr>
<td>76</td>
<td>DENY - MAXIMUM BENEFIT HAS BEEN PAID</td>
</tr>
<tr>
<td>78</td>
<td>DENY: INVALID OR MISSING PLACE OF SERVICE LOCATION</td>
</tr>
<tr>
<td>82</td>
<td>DENY-NON COVERED SERVICES</td>
</tr>
<tr>
<td>83</td>
<td>DENY - DUPLICATE OF PREVIOUS SUBMITTED CLAIM</td>
</tr>
<tr>
<td>A1</td>
<td>APC - OCE LINE ITEM REJECTION</td>
</tr>
<tr>
<td>A2</td>
<td>APC - OCE LINE ITEM DENIAL</td>
</tr>
<tr>
<td>A4</td>
<td>APC - OCE CLAIM LEVEL RETURN TO PROVIDER (RTP)</td>
</tr>
<tr>
<td>A5</td>
<td>APC - OCE CLAIM LEVEL REJECTION</td>
</tr>
<tr>
<td>AN</td>
<td>DENY - SERVICE DENIED FOR NO AUTHORIZATION ON FILE</td>
</tr>
<tr>
<td>BT</td>
<td>DENY:TYPE OF BILL INVALID</td>
</tr>
<tr>
<td>C5</td>
<td>DENY:CODE REPLACED BASED ON CODE AUDITING</td>
</tr>
<tr>
<td>dh</td>
<td>DENY - NON-EMERGENCY OUT OF AREA SERVICES ARE NOT COVERED</td>
</tr>
<tr>
<td>DZ</td>
<td>DENY: RESUBMIT WITH CORRECTED COUNT</td>
</tr>
<tr>
<td>EB</td>
<td>DENIED BY MEDICAL SERVICES</td>
</tr>
<tr>
<td>EC</td>
<td>DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>Es</td>
<td>INVALID OR MISSING REQUIRED ESRD OR HHA CLAIMS DATA</td>
</tr>
<tr>
<td>FT</td>
<td>INVALID FORM TYPE FOR PROCEDURE(S) SUBMITTED</td>
</tr>
<tr>
<td>Hn</td>
<td>HHA GROUPER INVALID OR NO TREATMENT AUTHORIZATION CODE PROVIDED</td>
</tr>
<tr>
<td>Jq</td>
<td>ORIGINAL CHECK NOT CASHED-PAY TO/ADDRESS VERIFICATION NEEDED</td>
</tr>
<tr>
<td>MR</td>
<td>MODIFIER REQUIRED FOR PROCEDURE</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>NN</td>
<td>MODIFIER NOT REQUIRED FOR THIS PROCEDURE</td>
</tr>
<tr>
<td>NV</td>
<td>DENY: PLEASE RESUBMIT WITH INVOICE FOR SERVICES RENDERED</td>
</tr>
<tr>
<td>PM</td>
<td>DENY - INVALID PROCEDURE MODIFIER COMBINATION SUBMITTED</td>
</tr>
<tr>
<td>QR</td>
<td>DENY: ADJUSTMENT WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT</td>
</tr>
<tr>
<td>S9</td>
<td>DENY - CODE BILLED IS NOT COVERED FOR PROVIDER TYPE</td>
</tr>
<tr>
<td>TF</td>
<td>DENY - FILING LIMIT EXCEEDED</td>
</tr>
<tr>
<td>x2</td>
<td>SERVICE(S) OR SUPPLIES DURING GLOBAL SURGICAL PERIOD</td>
</tr>
<tr>
<td>x3</td>
<td>PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE</td>
</tr>
<tr>
<td>x8</td>
<td>MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED</td>
</tr>
<tr>
<td>ya</td>
<td>DENY: DENIED AFTER REVIEW OF PATIENT'S CLAIM HISTORY</td>
</tr>
<tr>
<td>ye</td>
<td>CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS</td>
</tr>
<tr>
<td>yO</td>
<td>DENY: ADD ON CODE BILLED WITHOUT PRIMARY PROCEDURE</td>
</tr>
<tr>
<td>zW</td>
<td>AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS</td>
</tr>
</tbody>
</table>
Appendix IV: Instructions for Supplemental Information  
(CMS- 1500 02/12) FORM, SHADED FIELD 24-A-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:

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZ</td>
<td>Narrative description of unspecified/miscellaneous/unlisted codes</td>
</tr>
<tr>
<td>N4</td>
<td>National Drug Code (NDC)</td>
</tr>
<tr>
<td>CTR</td>
<td>Contract Rate</td>
</tr>
</tbody>
</table>

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
- UN – Unit
- GR – Gram
- ML - Milliliter

- Quantity
  - The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999)
  - When entering a whole number, do not use a decimal (ex. 2)
  - Do not use commas
### Unspecified/Miscellaneous/Unlisted Codes

<table>
<thead>
<tr>
<th>NDC Code</th>
<th>Description</th>
<th>Date of Service</th>
<th>Procedure Code</th>
<th>Diagnosis Code</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Laparoscopic Ventral Hernia Repair</td>
<td>10/01/05</td>
<td>E1399</td>
<td>12</td>
<td>165.00</td>
</tr>
</tbody>
</table>

### NDC Codes

<table>
<thead>
<tr>
<th>NDC Code</th>
<th>Description</th>
<th>Date of Service</th>
<th>Procedure Code</th>
<th>Diagnosis Code</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fentanyl, 0.6 mg/mL</td>
<td>07/10/14</td>
<td>M99100</td>
<td>J00001</td>
<td>12345</td>
</tr>
</tbody>
</table>

Updated July 24, 2018
Appendix V: Common HiPAA Compliant EDI Rejection Codes

These codes on the follow page are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

<table>
<thead>
<tr>
<th>ERROR_ID</th>
<th>ERROR_DESC</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Invalid Mbr DOB</td>
</tr>
<tr>
<td>02</td>
<td>Invalid Mbr</td>
</tr>
<tr>
<td>06</td>
<td>Invalid Prv</td>
</tr>
<tr>
<td>07</td>
<td>Invalid Mbr DOB &amp; Prv</td>
</tr>
<tr>
<td>08</td>
<td>Invalid Mbr &amp; Prv</td>
</tr>
<tr>
<td>09</td>
<td>Mbr not valid at DOS</td>
</tr>
<tr>
<td>10</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS</td>
</tr>
<tr>
<td>12</td>
<td>Prv not valid at DOS</td>
</tr>
<tr>
<td>13</td>
<td>Invalid Mbr DOB; Prv not valid at DOS</td>
</tr>
<tr>
<td>14</td>
<td>Invalid Mbr; Prv not valid at DOS</td>
</tr>
<tr>
<td>15</td>
<td>Mbr not valid at DOS; Invalid Prv</td>
</tr>
<tr>
<td>16</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv</td>
</tr>
<tr>
<td>17</td>
<td>Invalid Diag</td>
</tr>
<tr>
<td>18</td>
<td>Invalid Mbr DOB; Invalid Diag</td>
</tr>
<tr>
<td>19</td>
<td>Invalid Mbr; Invalid Diag</td>
</tr>
<tr>
<td>21</td>
<td>Mbr not valid at DOS; Prv not valid at DOS</td>
</tr>
<tr>
<td>22</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS</td>
</tr>
<tr>
<td>23</td>
<td>Invalid Prv; Invalid Diag</td>
</tr>
<tr>
<td>24</td>
<td>Invalid Mbr DOB; Invalid Prv; Invalid Diag</td>
</tr>
<tr>
<td>25</td>
<td>Invalid Mbr; Invalid Prv; Invalid Diag</td>
</tr>
<tr>
<td>26</td>
<td>Mbr not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>27</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>29</td>
<td>Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>30</td>
<td>Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>31</td>
<td>Invalid Mbr; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>32</td>
<td>Mbr not valid at DOS; Prv not valid; Invalid Diag</td>
</tr>
<tr>
<td>33</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag</td>
</tr>
<tr>
<td>34</td>
<td>Invalid Proc</td>
</tr>
<tr>
<td>35</td>
<td>Invalid DOB; Invalid Proc</td>
</tr>
<tr>
<td>36</td>
<td>Invalid Mbr; Invalid Proc</td>
</tr>
<tr>
<td>37</td>
<td>Invalid or future date</td>
</tr>
<tr>
<td>38</td>
<td>Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>39</td>
<td>Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>40</td>
<td>Invalid Prv; Invalid Proc</td>
</tr>
<tr>
<td></td>
<td>Invalid Prv; Invalid Proc; Invalid Mbr DOB</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>Invalid Mbr; Invalid Prv; Invalid Proc</td>
</tr>
<tr>
<td>3</td>
<td>Mbr not valid at DOS; Invalid Proc</td>
</tr>
<tr>
<td>4</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc</td>
</tr>
<tr>
<td>6</td>
<td>Prv not valid at DOS; Invalid Proc</td>
</tr>
<tr>
<td>8</td>
<td>Invalid Mbr; Prv not valid at DOS, Invalid Proc</td>
</tr>
<tr>
<td>9</td>
<td>Invalid Proc; Invalid Prv; Mbr not valid at DOS</td>
</tr>
<tr>
<td>11</td>
<td>Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>12</td>
<td>Invalid Mbr DOB; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>13</td>
<td>Invalid Mbr; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>15</td>
<td>Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc</td>
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<td>17</td>
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</tr>
<tr>
<td>18</td>
<td>Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>19</td>
<td>Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>20</td>
<td>Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>21</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>23</td>
<td>Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>24</td>
<td>Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>25</td>
<td>Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>26</td>
<td>Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>27</td>
<td>Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>28</td>
<td>Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>29</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>30</td>
<td>Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>31</td>
<td>Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>32</td>
<td>Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>33</td>
<td>Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>34</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>35</td>
<td>Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>36</td>
<td>Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>37</td>
<td>Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>38</td>
<td>Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>39</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>40</td>
<td>Reject. DOS prior to 6/1/2006; OR Invalid DOS</td>
</tr>
<tr>
<td>41</td>
<td>Invalid Unit</td>
</tr>
<tr>
<td>42</td>
<td>Original claim number required</td>
</tr>
<tr>
<td>43</td>
<td>INVALID CLAIM TYPE</td>
</tr>
<tr>
<td>44</td>
<td>Invalid Unit; Invalid Prv</td>
</tr>
<tr>
<td>45</td>
<td>Invalid Unit; Invalid Mbr &amp; Prv</td>
</tr>
<tr>
<td>46</td>
<td>Invalid Prv; Mbr not valid at DOS; Invalid DOS</td>
</tr>
<tr>
<td>47</td>
<td>DIAGNOSIS POINTER INVALID</td>
</tr>
<tr>
<td>48</td>
<td>CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT</td>
</tr>
<tr>
<td>49</td>
<td>Rendering and Billing NPI are not tied on state file</td>
</tr>
<tr>
<td>50</td>
<td>Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim</td>
</tr>
<tr>
<td>51</td>
<td>Missing/incomplete/invalid CLIA certification number</td>
</tr>
<tr>
<td>52</td>
<td>ICD9 is mandated for this date of service.</td>
</tr>
<tr>
<td>53</td>
<td>Incorrect use of the ICD9/ICD10 codes.</td>
</tr>
<tr>
<td>54</td>
<td>ICD10 is mandated for this date of service.</td>
</tr>
<tr>
<td>55</td>
<td>Claim not processed</td>
</tr>
</tbody>
</table>
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 Jan. 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 UNION CREDIT COMMITTEE (NUCC) 2010**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MEDicare MEDicaid HIP HOP</td>
<td>Medicare/Medicaid/HIP HOP</td>
</tr>
<tr>
<td>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>3. PATIENT'S DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>4. PATIENT'S RELATIONSHIP TO INSURED</td>
<td></td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS (No., Street)</td>
<td></td>
</tr>
<tr>
<td>6. CITY</td>
<td></td>
</tr>
<tr>
<td>7. STATE</td>
<td></td>
</tr>
<tr>
<td>8. ZIP CODE</td>
<td></td>
</tr>
<tr>
<td>9. TELEPHONE (Include Area Code)</td>
<td></td>
</tr>
<tr>
<td>10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>11. PATIENT'S CONDITION RELATED TO CLAIM</td>
<td></td>
</tr>
<tr>
<td>12. OTHER INSURED'S POLICY OR GROUP NUMBER</td>
<td></td>
</tr>
<tr>
<td>13. EMPLOYMENT (Current or Previous)</td>
<td></td>
</tr>
<tr>
<td>14. PLACE OF EMPLOYMENT</td>
<td></td>
</tr>
<tr>
<td>15. AUTO ACCIDENT</td>
<td></td>
</tr>
<tr>
<td>16. OTHER INCIDENT</td>
<td></td>
</tr>
<tr>
<td>17. INSURED PLAN NAME OR PROGRAM NAME</td>
<td></td>
</tr>
<tr>
<td>18. INSURED PLAN CODES (Assigned by NUCC)</td>
<td></td>
</tr>
<tr>
<td>19. INSURED ON AUTOMOBILE INSURANCE POLICY ARE HEREIN</td>
<td></td>
</tr>
<tr>
<td>20. INSURED OR AUTHORIZED PERSON'S SIGNATURE (signature visible payment to medical services to the undersigned physician or supplier for services described below)</td>
<td></td>
</tr>
<tr>
<td>21. DATE OF SERVICE</td>
<td></td>
</tr>
<tr>
<td>22. DATE OF ENCOUNTER</td>
<td></td>
</tr>
<tr>
<td>23. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td></td>
</tr>
<tr>
<td>24. STATE</td>
<td></td>
</tr>
<tr>
<td>25. INSURED CLAIM INFORMATION (Assigned by NUCC)</td>
<td></td>
</tr>
<tr>
<td>26. OUTPATIENT AMOUNT CHARGED</td>
<td></td>
</tr>
<tr>
<td>27. INPATIENT AMOUNT CHARGED</td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN OR SUPPLIER INFORMATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. DATE OF SERVICE</td>
<td></td>
</tr>
<tr>
<td>29. PLACE OF SERVICE</td>
<td></td>
</tr>
<tr>
<td>30. PAYOR/s ELECTED TO PAY BILL</td>
<td></td>
</tr>
<tr>
<td>31. SERVICE FACILITY LOCATION INFORMATION</td>
<td></td>
</tr>
</tbody>
</table>

**NUCC Instruction Manual available at: www.nucc.org **

**PLEASE PRINT OR TYPE**

**APPROVED OMB-0938-1977 FORM 1550-02-12**

Updated July 24, 2018
<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INSURANCE PROGRAM IDENTIFICATION</td>
<td>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”.</td>
<td>R</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER</td>
<td>The 9-digit identification number on the member’s I.D. Card</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>PATIENTS NAME (Last Name, First Name, Middle Initial)</td>
<td>Enter the patient’s name as it appears on the member’s I.D. card. Do not use nicknames.</td>
<td>R</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE/SEX</td>
<td>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</td>
<td>R</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME</td>
<td>Enter the patient’s name as it appears on the member’s I.D. Card</td>
<td>C</td>
</tr>
</tbody>
</table>
| 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                      |
<p>| 6      | PATIENT’S RELATION TO INSURED                                | Always mark to indicate self.                                                         | C                      |</p>
<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instructions or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>INSURED’S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)</td>
<td>Enter the patient’s complete address and telephone number including area code on the appropriate line. <strong>First line</strong> – 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). <strong>Second line</strong> – In the designated block, enter the city and state. <strong>Third line</strong> – 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). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.</td>
<td>C</td>
</tr>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.</td>
<td>C</td>
</tr>
<tr>
<td>9a</td>
<td>*OTHER INSURED’S POLICY OR GROUP NUMBER</td>
<td>REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.</td>
<td>C</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.</td>
<td>C</td>
</tr>
<tr>
<td>10a,b,c</td>
<td>IS PATIENT’S CONDITION RELATED TO</td>
<td>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 marked Yes, primary insurance information must then be shown in Item Number 11.</td>
<td>R</td>
</tr>
<tr>
<td>10d</td>
<td>CLAIM CODES (Designated by NUCC)</td>
<td>When reporting more than one code, enter three blank spaces and then the next code.</td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>11</td>
<td>INSURED POLICY OR FECA NUMBER</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>11a</td>
<td>INSURED’S DATE OF BIRTH / SEX</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS’ COMPENSATION OR PROPERTY &amp; CASUALTY: Required if known. Enter the claim number assigned by the payer.</td>
<td>C</td>
</tr>
<tr>
<td>11c</td>
<td>INSURANCE PLAN NAME OR PROGRAM NUMBER</td>
<td>Enter name of the insurance health plan or program.</td>
<td>C</td>
</tr>
<tr>
<td>11d</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN</td>
<td>Mark Yes or No. If Yes, complete field’s 9a-d and 11c.</td>
<td>R</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>13</td>
<td>INSURED’S OR AUTHORIZED PERSONS SIGNATURE</td>
<td>Obtain signature if appropriate.</td>
<td>Not Required</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)</td>
<td>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. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period</td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>--------</td>
<td>------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>15</td>
<td>IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>16</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).</td>
<td>C</td>
</tr>
<tr>
<td>17a</td>
<td>ID NUMBER OF REFERRING PHYSICIAN</td>
<td>Required if field 17 is completed. Use ZZ qualifier for Taxonomy code</td>
<td>C</td>
</tr>
<tr>
<td>17b</td>
<td>NPI NUMBER OF REFERRING PHYSICIAN</td>
<td>Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used</td>
<td>C</td>
</tr>
<tr>
<td>18</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>19</td>
<td>RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>20</td>
<td>OUTSIDE LAB / CHARGES</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>21</td>
<td>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</td>
<td>Enter the codes to identify the patient’s diagnosis and/or condition. List no more than 12 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.</td>
<td>R</td>
</tr>
<tr>
<td>22</td>
<td>RESUBMISSION CODE / ORIGINAL REF.NO.</td>
<td>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</td>
<td>C</td>
</tr>
<tr>
<td>23</td>
<td>PRIOR AUTHORIZATION NUMBER or CLIA NUMBER</td>
<td>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</td>
<td>If auth = C If CLIA = R (If both, always submit the CLIA number)</td>
</tr>
</tbody>
</table>

Updated July 24, 2018
<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>24a-j</td>
<td>General Information</td>
<td>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. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. 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 on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.</td>
<td></td>
</tr>
<tr>
<td>24 A-G</td>
<td>SUPPLEMENTAL INFORMATION</td>
<td>The shaded top portion of each service claim line is used to report supplemental information for: *NDC *Narrative description of unspecified codes *Contract Rate *For detailed instructions and qualifiers refer to Appendix IV of this guide.</td>
<td>C</td>
</tr>
<tr>
<td>24A</td>
<td>DATE(S) OF SERVICE</td>
<td>Enter the date the service listed in field 24D was performed (MM</td>
<td>DD</td>
</tr>
<tr>
<td>24B</td>
<td>PLACE OF SERVICE</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>24C</td>
<td>EMG</td>
<td>Enter Y (Yes) or N (No) to indicate if the service was an emergency.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>24D Un-shaded</td>
<td>PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER</td>
<td>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. 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.</td>
<td>R</td>
</tr>
<tr>
<td>24 E Un-shaded</td>
<td>DIAGNOSIS CODE</td>
<td>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-10-CM 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-10 Codes for the date of service or the claim will be rejected/denied.</td>
<td>R</td>
</tr>
<tr>
<td>24 F Un-shaded</td>
<td>CHARGES</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>24 G Un-shaded</td>
<td>DAYS OR UNITS</td>
<td>Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.</td>
<td>R</td>
</tr>
<tr>
<td>24 H Shaded EPSDT (Family Planning)</td>
<td>Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>24 H Unshaded EPSDT (Family Planning)</td>
<td>Enter the appropriate qualifier for EPSDT visit.</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>24 I Shaded ID QUALIFIER</td>
<td>Use ZZ qualifier for Taxonomy Use 1D qualifier for ID, if an Atypical Provider.</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>24 J</td>
<td>NON-NPI PROVIDER ID#</td>
<td><strong>Typical Providers:</strong> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. <strong>Atypical Providers:</strong> Enter the Provider ID number.</td>
<td>R</td>
</tr>
<tr>
<td>24 J</td>
<td>NPI PROVIDER ID</td>
<td><strong>Typical Providers ONLY:</strong> 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.).</td>
<td>R</td>
</tr>
<tr>
<td>25</td>
<td>FEDERAL TAX I.D. NUMBER SSN/EIN</td>
<td>Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN</td>
<td>R</td>
</tr>
<tr>
<td>26</td>
<td>PATIENT'S ACCOUNT NO.</td>
<td>Enter the provider’s billing account number</td>
<td>C</td>
</tr>
<tr>
<td>27</td>
<td>ACCEPT ASSIGNMENT?</td>
<td>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</td>
<td>C</td>
</tr>
<tr>
<td>28</td>
<td>TOTAL CHARGES</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>29</td>
<td>AMOUNT PAID</td>
<td>REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing when Trillium Advantage is listed as secondary or tertiary.</td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>30</td>
<td>BALANCE DUE</td>
<td>REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). 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.</td>
<td>C</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td>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. Note: Does not exist in the electronic 837P.</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
<td>REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) <strong>First line</strong> – Enter the business/facility/practice name. <strong>Second line</strong> – 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). <strong>Third line</strong> – In the designated block, enter the city and state. <strong>Fourth line</strong> – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.</td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>32a</td>
<td>NPI – SERVICES RENDERED</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>32b</td>
<td>OTHER PROVIDER ID</td>
<td>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).</td>
<td>C</td>
</tr>
<tr>
<td>33</td>
<td>BILLING PROVIDER INFO &amp; PH#</td>
<td>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 code) is a requirement for paper and EDI claim submission.</td>
<td>R</td>
</tr>
<tr>
<td>33a</td>
<td>GROUP BILLING NPI</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
</tbody>
</table>
| 33b     | GROUP BILLING OTHERS ID | Enter as designated below the Billing Group taxonomy code.  
Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier.  
Atypical Providers: Enter the Provider ID number. | 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 Trillium Advantage. 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 Trillium Advantage 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
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
</table>
| 1       | UNLABELED FIELD   | LINE 1: Enter the complete provider name.  
LINE 2: Enter the complete mailing address.  
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.  
LINE 4: Enter the area code and phone number. | R |
<p>| 2       | UNLABELED FIELD   | Enter the Pay- to Name and Address | Not Required |
| 7       | UNLABELED FIELD   | Not used | Not Required |
| 30      | UNLABELED FIELD   | NOT USED | Not required |
| 37      | (UNLABELED FIELD) | REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim. | C |</p>
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Information Fields 42-47</td>
<td>SERVICE LINE DETAIL</td>
<td>The following UB-04 fields 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.</td>
<td></td>
</tr>
<tr>
<td>42 Line 1-22</td>
<td>REV CD</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>42 Line 23</td>
<td>Rev CD</td>
<td>Enter 0001 for total charges.</td>
<td>R</td>
</tr>
<tr>
<td>43 Line 1-22</td>
<td>DESCRIPTION</td>
<td>Enter a brief description that corresponds to the revenue code entered in the service line of field 42.</td>
<td>R</td>
</tr>
<tr>
<td>43 Line 23</td>
<td>PAGE ___ OF ___</td>
<td>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)</td>
<td>C</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/RATES</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>45 Line 23</td>
<td>CREATION DATE</td>
<td>Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).</td>
<td>R</td>
</tr>
<tr>
<td>46</td>
<td>SERVICE UNITS</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>47 Line 1-22</td>
<td>TOTAL CHARGES</td>
<td>Enter the total charge for each service line.</td>
<td>R</td>
</tr>
<tr>
<td>47 Line 23</td>
<td>TOTALS</td>
<td>Enter the total charges for all service lines.</td>
<td>R</td>
</tr>
<tr>
<td>48 Line 1-22</td>
<td>NON-COVERED CHARGES</td>
<td>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.</td>
<td>C</td>
</tr>
<tr>
<td>48 Line 23</td>
<td>TOTALS</td>
<td>Enter the total non-covered charges for all service lines.</td>
<td>C</td>
</tr>
<tr>
<td>49</td>
<td>(UNLABELED FIELD)</td>
<td>Not Used</td>
<td>Not Required</td>
</tr>
<tr>
<td>50 A-C</td>
<td>PAYER</td>
<td>Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary</td>
<td>R</td>
</tr>
<tr>
<td>51 A-C</td>
<td>HEALTH PLAN IDENTIFICATION NUMBER</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>52 A-C</td>
<td>REL INFO</td>
<td>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 &quot;Y&quot;.</td>
<td>R</td>
</tr>
<tr>
<td>53</td>
<td>ASG. BEN.</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>Enter the amount received from the primary payer on the appropriate line when Trillium Advantage is listed as secondary or tertiary.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>56</td>
<td>NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID</td>
<td>Required: Enter providers 10-character NPI ID.</td>
<td>R</td>
</tr>
<tr>
<td>57</td>
<td>OTHER PROVIDER ID</td>
<td>a. Enter the numeric provider identification number. Enter the TPI number (non-NPI number) of the billing provider.</td>
<td>R</td>
</tr>
<tr>
<td>58</td>
<td>INSURED'S NAME</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>59</td>
<td>PATIENT RELATIONSHIP</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>60</td>
<td>INSURED'S UNIQUE ID</td>
<td>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.</td>
<td>R</td>
</tr>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Enter the Prior Authorization or referral when services require pre-certification.</td>
<td>C</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>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 Trillium Advantage Health Plan from field 50. 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). * Please refer to reconsider/corrected claims section.</td>
<td>C</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>66</td>
<td>DX VERSION QUALIFIER</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>67</td>
<td>PRINCIPAL DIAGNOSIS CODE</td>
<td>Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD/10-CM Volume 1 &amp; 3 for the date of service.</td>
<td>R</td>
</tr>
<tr>
<td>67</td>
<td>OTHER DIAGNOSIS CODE</td>
<td>Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-10-CM Volume 1 &amp; 3 for the date of service. Diagnosis codes submitted must be valid ICD-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. Note: Claims with incomplete or invalid diagnosis codes will be denied.</td>
<td>C</td>
</tr>
<tr>
<td>68</td>
<td>PRESENT ON ADMISSION INDICATOR</td>
<td></td>
<td>R</td>
</tr>
<tr>
<td>69</td>
<td>ADMITTING DIAGNOSIS CODE</td>
<td>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-10-CM Volume 1 &amp; 3 for the date of service. Diagnosis Codes submitted must be valid ICD-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” are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>70</td>
<td>PATIENT REASON CODE</td>
<td>Enter the ICD-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. Diagnosis Codes submitted must be valid ICD-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. NOTE: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>R</td>
</tr>
<tr>
<td>71</td>
<td>PPS/DRG CODE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>72</td>
<td>a,b,c EXTERNAL CAUSE CODE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>73</td>
<td>UNLABELLED</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>74</td>
<td>PRINCIPAL PROCEDURE CODE/DATE</td>
<td>CODE: Enter the ICD-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).</td>
<td>C</td>
</tr>
<tr>
<td>74</td>
<td>a-e OTHER PROCEDURE CODE DATE</td>
<td>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-10 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-10 Procedure Codes may be entered. 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).</td>
<td>C</td>
</tr>
<tr>
<td>75</td>
<td>UNLABELLED</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>76</td>
<td>ATTENDING PHYSICIAN</td>
<td>Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #, 1G – Provider UPIN, G2 – Provider Commercial #, B3 – Taxonomy Code. LAST: Enter the attending physician’s last name. FIRST: Enter the attending physician’s first name.</td>
<td>R</td>
</tr>
<tr>
<td>77</td>
<td>OPERATING PHYSICIAN</td>
<td>REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #, 1G – Provider UPIN, G2 – Provider Commercial #, B3 – Taxonomy Code. LAST: Enter the attending physician’s last name. FIRST: Enter the attending physician’s first name.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>78 &amp; 79</td>
<td>OTHER PHYSICIAN</td>
<td>Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number</td>
<td>Conditional</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>81</td>
<td>CC</td>
<td>A: Taxonomy of billing provider. Use B3 qualifier.</td>
<td>R</td>
</tr>
<tr>
<td>82</td>
<td>Attending Physician</td>
<td>Enter name or 7 digit Provider number of ordering physician</td>
<td>R</td>
</tr>
</tbody>
</table>
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 are limited to 13xs-14x range
- Late charge claims are not allowed. Only replacement claims. Claims with late charges will be denied to be resubmitted.
- Claims spanning two calendar years will be required to be submitted by the 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. CMS is proposing significant changes to observation rules and payment level for 2014, and this will be updated accordingly.

• 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 99
• 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.

Updated July 24, 2018
• Services provided to members prior to their Trillium Advantage effective date, should be correctly coded and submitted to the payer responsible.

• Services provided to the member on or after their Trillium Advantage effective date, should be correctly coded and submitted to Trillium Advantage.

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

    o Procedure must be billed on a single claim line with the 50 modifier and quantity of one.

    o RT and LT modifiers or quantities greater than one should not be billed when using modifier 50

• GN, GO, GPModifiers – 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 is by a different practitioners than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.
- Services not billed following the above guidelines will be denied as EX code AT.

POA

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

Rehabilitation Services – Inpatient Services

- Functional status indicators must be submitted for inpatient Rehabilitation Services.

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
As a general rule, Trillium Advantage 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

Updated July 24, 2018
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 billed charges do not exceed the negotiated 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 Trillium Advantage Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid 85% of what a physician is paid under the Trillium Advantage 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.

Surgical Physician Payment Rules

For surgeries billed with either modifier 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.

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,

Updated July 24, 2018
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 Trillium Advantage 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)**

In order 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.
Trillium Advantage
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Eugene, OR 97440-3940

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TTY: 711