When to Call the Customer Care Center

Health care providers may check the status of all submitted claims to MVP online at www.mvphealthcare.com. Through our website you may:

- Check claim status
- Verify member eligibility and benefits
- Find inpatient stays
- Review outpatient services
- Obtain authorization status

Providers who have additional questions about claims or remittance advices may contact the Customer Care Center for Provider Services at 1-800-684-9286 or 1-800-999-3920. Call us if you need help or have questions about:

- How to submit or resubmit a claim to MVP
- Checking the status of a claim already submitted to MVP
- Following up on written correspondence submitted on a *Claim Adjustment Request Form*
- Errors in amounts paid
- Adjusting a denied claim if a referral is now on file.

When to Resubmit a Claim

Providers may resubmit a claim directly to MVP electronically if it was not processed on MVP's system. If correcting a claim that was already processed, providers may resubmit electronically or with a Claims Adjustment Request form, to:

MVP Health Care
P.O. Box 2207
Schenectady, NY 12301

Resubmit Claim Directly - No Claim Adjustment Form Required	Resubmit Claim Directly - Claim Adjustment Form Required UNLESS Sending Electronic EDI Request
For a different or corrected: • Date of service • ID number • Service provider • Procedure or revenue code • Date of birth	• For any other change to the information on the 02/12 1500 claim form, UB-04 form, or a Standard EDI Transaction (ANSI 278) • For a different or corrected name • For claims appeals (see page 8.2) • For claims denied for no EOB from primary carrier and provider submitting EOB • For a different or corrected place of service

Claim Requirements

Claim information provided on the 02/12 1500 claim form must be entered in the designated field for all claims submitted. MVP uses state-of-the art optical imaging and optical character recognition (OCR) for all paper claims. Therefore, print quality and data alignment for paper claims must be of high quality for optimum clarity when scanned into the computer system. Stapled, highlighted, and multigenerational photocopied 02/12 1500 claim forms are difficult for MVP to process and may be rejected and returned to providers. Providers are required to use the most current version of the 02/12 1500 available. Note: The numbers listed in the instructions on page 7.2 correspond to the box number (field) on the 02/12 1500 claim form. Fields required for MVP processing are identified.

INSTRUCTIONS

Clean Claim Submission Requirements ■ = Required ☐ = Required if Applicable ○ = Not Used

FIELD	NAME & NUMBER	INSTRUCTIONS
1 ☐	Medicare Medicaid Tricare Champva Group Health Plan FECA Blk Lung Other	Place an "X" in the appropriate box for the type of health insurance applicable to this claim. If the "other" box contains an "X" complete field 1a with the primary coverage identification number. If secondary coverage, refer to field 9. Mark only one box.
1a ■	Insured's ID number	Enter insured's ID number as shown on insured's ID card for the payer to whom the claim is being submitted. Please include two-digit number at the end of the Member ID.
2 ■	Patient's name	Enter the patient's last name, first name and middle initial as it appears on the ID card. If the insured uses a last name suffix such as Jr. or Sr., enter is after the last name and before the first name. Titles, such as Sister, Capt., and Dr., and professional titles such as PhD., MD., and Esq., should not be included with the name.
3 ■	Patient's birth date Sex	Enter the patient's eight-digit date of birth in (MM/DD/YYYY) format. Place an "X" in the appropriate box to indicate the patient's sex. Mark only one box. If gender is unknown, leave blank.
4 ■	Insured's name	Enter insured's last name, first name and middle initial. If the insured uses a last name suffix, such as Jr. or Sr., enter it after the last name and before the first name. Titles, such as Sister, Capt., and Dr., and professional titles such as PhD., MD., and Esq., should not be included with the name.
5 ■	Patient's address	Enter the patient's address, city, state, zip code and phone number. If the patient's number is unknown, leave blank. Do not use punctuation or other symbols in the address.

		Do not use a hyphen or space as separator within the telephone number. Use two-digit state code and, if available, nine-digit zip code with hyphen.
6 ■	Patient relationship to insured	Place an "X" in the box for "self" if the patient is the insured, "spouse" if the patient is the insured's husband or wife. If none of the above applies, place an "X" to indicate "child" or "other" as applicable. Mark only one box.
7 ■	Insured's address	Enter the insured's address, city, state, zip code and phone number. If insured's address or telephone number is unknown, leave blank. Do not use punctuation. Do not use a hyphen or space as separator within the telephone number. Use two-digit state code and, if available, nine-digit zip code.
8 ☐		Reserved for NUCC use
9 ☐	Other insured's name	When additional group health coverage exists, enter other insured's last name, first name and middle initial. Use commas to separate the last name, first name and middle initial. If the insured uses a last name suffix such as Jr. or Sr., enter it after the last name and before the first name. Titles, such as Sister, Capt., and Dr., and professional titles such as PhD., MD., and Esq., should not be included with the name.
9a ☐	Other insured's policy or group number	Enter the policy or group number of the other insured as indicated.
9b ☐	Reserved for NUCC use	Reserved for NUCC use
9c ☐	Reserved for NUCC use	Reserved for NUCC use
9d ☐	Insurance plan name or program name	Enter the other insured's insurance plan or program name.
10 ☐	Is patient's condition related to: Employment (current or previous) Auto accident Other accident	Only one box can be marked per submission. Place an "X" in the appropriate box. If "yes", complete field 14. Place an "X" in the appropriate box. If "yes", indicate state and also complete field 14. Place an "X" in the appropriate box. If "yes", complete field 14.
10d ○	Claim codes (Designated by NUCC)	Not used.

11 ■	Insured's policy group or FECA number	Enter the insured's policy or group number as it appears on the ID card if present.
11a ■	Insured's date of birth Sex	If known, enter the insured's eight-digit date of birth in (MM/DD/YYYY) format. If insured's date of birth is unknown, leave blank. Place an "X" in the appropriate box to indicate the insured's sex. Mark only one box. If gender is unknown, leave blank.
11b ☐	Other claim ID (designated by NUCC)	The "Other Claim ID" is another identifier applicable to the claim.
11c ■	Insurance plan or program name	Enter the insurance plan or program name of the insured.
FIELD	Name & Number	Instructions
11d ☐	Is there another health plan benefit?	Place an "X" in the appropriate box. If yes, complete fields 9a through 9d.
12 ■	Patient's or authorized person's signature	Enter "Signature on File", "SOF" or legal signature. When legal signature, enter date signed. Enter date in six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format. If there is no signature on file, leave blank or enter "No Signature on File".
13 ■	Insured's or authorized person's signature	Enter "Signature on File", SOF" or legal signature. If there is no signature on file, leave blank or enter "No Signature on File".
14 ■	Date of current illness, injury or pregnancy (LMP)	Enter the first date in six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format of the current illness, injury or pregnancy. For pregnancy, use the date of LMP as the first date. A date is required if injury or emergency. Enter the applicable qualifier to identify which date is being reported. • 431 Onset of Current Symptoms or Illness • 484 Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line.
15 ☐	If patient has had same or similar illness, give first date	Enter the first date the patient had the same or a similar illness. Enter the date in six-digit (MM/DD/YY) or eight-digit format (MM/DD/YYYY). Previous pregnancies are not a similar illness. Leave blank if unknown.
16 ☐	Dates patient unable to work in current occupation	Enter dates patient is unable to work in six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) format. Date must be shown for the "from-to" dates that the patient is unable to work. Leave blank if unknown.
17 ■	Name of referring physician or other source	Enter the name of the physician or other source that referred the patient to the billing provider or ordered the test(s) or item(s).

17b ■ UNSHADED	NPI	Enter the ten-digit NPI.
18 ☐	Hospitalization dates related to current services	Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred) using the six-digit (MM/DD/YYY) or eight-digit format (MM/DD/YYYY). If not discharged, leave discharge date blank.
19 ☐	"Additional Claim Information" (Designated by NUCC)	Required when submitting a claim for a covering provider. When MVP is notified that the practitioner has a covering agreement with another practitioner or group of practitioners, enter the name of that practitioner in this box. "Additional Claim Information" identifies additional information about the patient's condition or the claim.
20 ☐	Outside lab? $Charges	Complete this field when billing for purchased services by entering an X in "Yes". A "Yes" mark indicates that the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare's anti-markup rule). A "No" or blank indicates that no purchased services are included on the claim. If "Yes", enter the purchase price under "$Charges" and complete Item # 32. When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs or decimal points. Negative dollar amounts are not allowed.
21 ■	Diagnosis or nature of illness or injury	The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. This field allows for the entry of a one character indicator and 12 diagnosis codes at a maximum of seven characters in length.
23 ☐	Prior authorization number	Enter the prior authorization or service agreement number as assigned by the payer for the current service.
24A-24G ☐ SHADED	Narrative Description	Enter the supplemental information in the shaded section of 24A through 24G above the corresponding service line. If an unlisted code is used, a narrative description must be present.
24A ■ UNSHADED	Date(s) of service	Enter the six-digit date(s) of service in (MM/DD/YY) format. If one date of service only, enter the date under "From". Leave "To" blank or re-enter "From" date. If grouping services, the place of service, procedure code, charge and rendering provider for each line must be identical for that service line. Grouping is allowed only for services on consecutive days. The number of

		days must correspond to the number of units in 24G.
24B ■ UNSHADED	Place of service	Enter the two-digit place of service code. The place of service codes are available at: **www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html**
24C ■ UNSHADED	EMG	EMG means emergency. Enter "Y" for Yes or leave blank for "No".
24D ■ UNSHADED	Procedures, services, or supplies	Enter the CPT or HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four, two-digit modifiers. The specific procedure code(s) must be shown without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box.
24E ■ UNSHADED	Diagnosis code	Enter diagnosis pointer(s) referenced in field 21 to indicate which diagnosis code(s) apply to the related HCPCS code. Do not enter ICD-9-CM codes or narrative descriptions in this field. Do not use slashes, dashes or commas between reference numbers.
24F ■ UNSHADED	$ Charges	Enter the charge amount in (dollars/cents) format. If more than one date or unit is shown in field 24G, the dollar amount should reflect the TOTAL amount of the services. Do not indicate the balance due, patient liability, late charges/credits or a negative dollar line. Do not use decimals or dollar signs.
24G ■ UNSHADED	Days or units	Enter the number of days or units on each line of service. This field is commonly used for multiple visits, units of supplies, anesthesia units or minutes, oxygen volume or ambulance mileage.
24H ☐	EPSDT Family Planning	If related to EPSDT enter "Y" for Yes with a valid referral code. If not related to EPSDT enter "N" for No. If related to Family Planning, enter a "Y" for Yes or leave blank for "No".
24I ■ SHADED	ID Qualifier	Enter the two-character ZZ qualifier identifying that the number is a taxonomy number. Not required when billing as a Group provider.
24J ■	Rendering Provider ID	Enter the ten-digit NPI.
25 ■	Federal tax ID number	Enter your employer identification number (EIN) and place an "X" in the EIN box. If not available, enter your Social Security Number (SSN) and place an "X" in the SSN box. Only one box can be marked.

26 ■	Patient's account number	Enter the patient's account number.
27 ■	Accept Assignment?	For patients with Medicare coverage, place an "X" in the appropriate box.
28 ■	Total charge	Enter the sum of the charges in column 24F (lines 1-6). Enter the total charge amount in (dollars/cents) format. Do not use dollar signs or negative numbers.
29 ■	Amount paid	Enter payment amount from the patient or other payer. Enter the total charge amount in (dollars/cents) format. Do not use dollar signs or negative numbers.
30 ■	Reserved for NUCC Use	Leave blank.
31 ■	Signature of physician or supplier including degrees or credentials	Enter the signature of the physician, provider, supplier or representative with the degree, credentials or title and the date signed.
32 ■	Service facility location information	Enter the name and actual address of the organization or facility where services were rendered. Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code-+4 Providers of service (namely physicians) must identify the supplier's name, address, zip-code and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 02/12 1500 form will need to be submitted for each supplier. Do not use punctuation in the address. Enter a space in between town name and state code. When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided or your claim will be denied, include the hyphen
32a ■ UNSHADED	NPI	Enter the ten-digit NPI.
32b ■ SHADED	Other ID	Enter the taxonomy number in this field.

33 ■	Billing provider info and phone number	Enter this information in the following format: Line 1: name of physician or clinic Line 2: address Line 3: city, state, zip code-+ 4 Name and address is required. Phone number is not required. If providing a phone number, it must be entered in the area to the right of the box title. The area code is entered in parenthesis; do not use a hyphen or space as a separator. Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use punctuation in the address. Enter a space in between town name and state code... When reporting the ZIP code for U.S. addresses, the full nine-digit ZIP code must be provided our your claim will be denied, include the hyphen
33a ■ UNSHADED	NPI	Enter the ten-digit NPI of the billing provider in 33.
33b ■ SHADED	Other ID	Effective May 23, 2008, item 33b is not to be reported.

**Please note that when submitting a paper claim with multiple pages, enter 'continued' in boxes 28-30.

Optical Scanning Instructions:
Providers that are electronic claim submission enabled need to submit electronically.
If you are unable to submit electronically, mail scannable paper claims. MVP uses optical scanner technology to assist in the entry of paper claims into our processing system. Use of an optical scanner improves accuracy and timeliness of claims processing. Special instructions for completing the form are printed below.

Providers must submit paper claims on the official (i.e., forms that meet Government Printing Office Specifications) Drop-Red-Ink 02/12 1500 forms. Claims received that are black-and-white, faxed or in photocopied form may not scan as cleanly, requiring manual keying. Providers who pre-print their names and addresses in field 33 should use a 10 or 12 point font size.

Print:

- Use UPPERCASE characters only
- The print should be 10 or 12 point font size. Do not use multiple font sizes on a claim. This includes re-submissions with corrected information.
- Use standard fonts – typewritten (Courier). Do not use unusual fonts such as sans serif, script, orator, italics, etc.

- Claims that are too light cannot be scanned.
- Enter all information on the same horizontal line.
- Enter all information within the designated field.
- Avoid handwriting anything on the claim form.
- Avoid folding claims.
- A maximum of six line items are allowed per claim in field 24.
- Do not use special characters such as slashes, dashes, decimal points, dollars signs, or parentheses.
- Make sure the claim is aligned correctly and the data is within the box. If information is not contained within the intended field, it may be returned.
- Staple any multiple page claims (with or without attachments).

B-04 Minimum Fields Required

Field location UB-04	Description	Inpatient	Outpatient
1	Billing Provider: Name, Address, City, State, Zip, Telephone, Fax, Country Code	Required	Required
2	Billing Provider's Pay-to: Name, Address, City, State, Zip, ID	Situational	Situational
3a	Patient Control Number	Required	Required
3b	Medical Record Number	Situational	Situational
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period * From/Through	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Situational	Situational
8b	Patient Name	Required	Required
9	Patient Address: Street, City, State, ZIP	Required	Required
10	Patient Birth Date	Required	Required
11	Patient Sex	Required	Required
12	Admission Date (Required for Types of Bill 011X, 012X, 018X, 021X, 022X, 032X,033X, 041X, 081X, OR 082X)	Required	Required, if applicable
13	Admission Hour	Required	Required, if applicable
14	Type of Admission/Visit (Required for Types of Bill 011X, 012X, 018X, 021X, 041X)	Required	Required
15	Source of Admission	Required	Required
16	Discharge Hour	Required	N/A

17	Patient Discharge Status (A valid discharge status is required for all institutional claims)	Required	Required
18-28	Condition Codes	Required, if applicable	Required, if applicable
29	Accident State	Situational	Situational
30	Future Use	N/A	N/A
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	N/A	N/A
38	Responsible Party Name and Address	Required, if applicable	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable
42	Revenue Codes	Required	Required
43	Revenue Code Description	Required	Required
44	HCPCS/Rate/HIPPS Code	Required, if applicable	Required, if applicable
45	Service Date	N/A	Required
46	Service Units	Required	Required
47	Total Charges (by Rev Code)	Required	Required
48	Non-Covered Charges	Required, if applicable	Required, if applicable
49	Future Use	N/A	N/A
50	Payer Identification (Name)	Required	Required
51	Health Plan Identification Number	Situational	Situational
52	Release of Info Certification (Primary, Secondary, Tertiary)	Required	Required
53	Assignment of Benefit Certification (Primary, Secondary, Tertiary)	Required	Required
54	Prior Payments (Primary, Secondary, Tertiary)	Required, if applicable	Required, if applicable
55	Estimated Amount Due (Primary, Secondary, Tertiary)	Required	Required
56	NPI * Billing Provider	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required
61	Insured Group Name	Situational	Situational

62	Insured Group Number	Situational	Situational
63	Treatment Authorization Codes	Required, if applicable	Required, if applicable
64	Document Control Number	Required when Type of Bill is Replacement (7) or Void (8)	Required when Type of Bill is Replacement (7) or Void (8)
65	Employer Name	Situational	Situational
66	Diagnosis/Procedure Code Qualifier	Required, if applicable	Required, if applicable
67	Principal Diagnosis Code/Other Diagnosis Codes (Required for Types of Bill 011X, 012X, 013X, 014X, and 021X)	Required	Required
67A-Q	Other Diagnosis and POA Indicator		
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Required, if applicable
70	Patient's Reason for Visit Code	Situational	Situational
71	Prospective Payment System Code	Situational	Situational
72	External Cause of Injury Code and POA Indicator	Situational	Situational
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required, if applicable	Required, if applicable
74a - 74e	Other Procedure Code/Date	Required, if applicable	Required, if applicable
75	Future Use	N/A	N/A
76	Attending Name * NPI/QUAL/ID	Required	Required
77	Operating ID * NPI/QUAL/ID	Situational	Situational
78-79	Other Provider * QUAL/NPI/QUAL/ID	Situational	Situational
80	Remarks	Situational	Situational
81	Code-Code Field/Qualifiers		
	*0-A0	N/A	N/A
	*A1-A4	Situational	Situational
	*A5-AB	N/A	N/A
	AC - Attachment Control number	Situational	Situational
	AD-B0	N/A	N/A
	*B1-B2	Situational	Situational
	*B3	Required	Required

***Please note that when submitting a paper claim with multiple pages, enter the 'page # of page #' on Line 23**

Important NPI Reminder
HIPAA mandates that all health care providers performing standard electronic transactions obtain a 10-digit unique ID number called a National Provider Identifier (NPI). MVP required all participating providers to obtain and report an NPI number to the plan by May 23, 2008, regardless of the claim submission format (electronic or paper) or website transaction use, in accordance with the CMS contingency plan.

To ensure timely and more accurate claim processing, MVP requires NPIs on paper claims. Up-to-date NPI information, revised EDI Companion Guides, and a link to the CMS website are available on the MVP website **www.mvphealthcare.com**. MVP also publishes NPI updates in *Healthy Practices*.

NPI Impact
The NPI replaces the MVP provider ID number on all HIPAA standard electronic transactions; however, it does not replace providers' DEA or tax ID number. Since the May 23, 2008 effective date, the following HIPAA-covered transactions require an NPI:

- 270 - Eligibility inquiry (single transaction)
- 271 - Eligibility response (single transaction)
- 276 - Claim status inquiry
- 277 - Claim status response
- 278 - Referral submission
- 835 - Remittance advice
- 837 - Claim submission

Also effective May 23, 2008, the following MVP website transactions defined under HIPAA require an NPI:

- Online claim submission
- Online claim status inquiry
- Online eligibility inquiry
- Online referral submission

Note: Providers also need to submit with the correct taxonomy code and taxonomy Code qualifiers.

Apply for Your NPI
If you have not done so, apply to the Centers for Medicare & Medicaid Services (CMS) for your NPI. CMS has contracted with Fox Systems, Inc., to serve as the NPI Enumerator. Apply online at **http://nppes.cms.hhs.gov/NPPES/Welcome.do**.

Report Your NPI to MVP
All participating providers must report their NPIs to MVP online using the MVP website by following these steps:

- Go to **www.mvphealthcare.com** and click on *Providers*
- Click the *Reference* link in the top green toolbar
- Click on the *NPI Information* link on the *Reference* page
- Click *Report Your NPI* at the top of the page
- There are two options for reporting your NPI; follow the instructions provided

To reduce potential claim issues, report your NPI to MVP prior to submitting claims.

Clean Claim Processing Timeframes

MVP will process post-service claims (claims filed after services have been provided) within the following time frames. (Please note that all professional fees must be billed on a 02/12 1500 claim form or the 837P).

Clean Claim Definition

A completed and accurate UB-04 or 02/12 1500 claim form including but not limited to the following elements: complete/current CPT-4 codes, ICD-9 codes, revenue codes, HCPCs codes, as applicable; valid member number, and provider tax identification number that is submitted by a provider of services with all necessary information necessary to process the claim requiring no additional information from the provider of service or from a third party; no more than 180 days after the date of discharge or 180 days after a service is rendered.

Additional information required, but not limited to, to define a claim as clean:

- EOB is MVP is secondary insurer
- Member must be eligible for the date of service billed
- Provider Tax ID/Address must match current Provider Tax ID/Address information on MVP's claim payment system
- Student Waiver Form is on file
- Requested Medical Records have been received
- Authorization for services (if applicable) is on file and correct for diagnosis and service billed
- Authorization was submitted and entered prior to initial date of service
- COB information is up to date and accurate—letters sent and received
- Provider must not have a negative balance (monies owed to health plan)
- Member is not a member of a self-insured plan
- Member is not a Federal Government Employee

A. If the provider submits a "clean claim" including all requisite information to process the claim at the time of submission, MVP will:
    1. Pay the claim or any undisputed portion of the claim within applicable Regulatory timeframes,
    2. Notify the provider of any adverse determination, in writing, within 30 days (15 days for New Hampshire providers) after MVP's receipt of the claim. However, if a claim is denied for lack of medical records, requested information must be resubmitted within 180 days from receipt of MVP's notice. If the provider receives

an adverse determination, the provider may request reconsideration or appeal the denial on the member's behalf as described in this manual's Appeals Section.

B. If the provider does not submit a clean claim, it will be rejected and returned to the provider. MVP must receive a clean claim in order to trigger the time frames detailed above.

Hospital Inpatient Claim Itemized Bill Requirement

Provider must submit an itemized bill for all inpatient hospital claims that exceed a request amount greater than or equal to $50,000. Inpatient claims that are reimbursed with DRG methodology will be excluded, unless they qualify for an additional high cost outlier payment. MVP will suspend all claims received that meet criteria and do not include an itemized bill. MVP will send the provider notice of the pended claim and along with a request for the required itemized bill. Provider must submit such itemized bill with MVP's request letter for claim to be processed. Failure to provide an itemized bill may result in a claim denial.

Electronic Claim Submission

MVP is prepared to receive standard EDI Transactions (ANSI 837) for institutional, professional claims. Refer to the MVP EDI Companion Guide for additional information. Contact MVP's EDI Services Department toll-free at **1-877-461-4911** or **1-800-933-3920**, **ext. 2239** to initiate electronic submission of claims with MVP. Please refer to the following documents for additional information related to electronic claim submission:

- Companion Guides on MVP's website for information specific to MVP electronic claim submissions are located at **www.mvphealthcare.com/provider/electronictransactions.html**.

- The HIPAA Technical Report Type 3 (TR3) guides, which contains complete information for each of the mandated EDI transactions. You can obtain copies of these guides from Washington Publishing Company at **www.wpc-edi.com**.

Electronic Replacement and Void Claims Submission

MVP Health Care's claims processing system recognizes claim frequency codes on professional electronic claim transactions (ANSI 837P) and institutional electronic claim transactions (ANSI 837I). Using the appropriate code will indicate that the claim is an adjustment of a previously adjudicated (approved or denied) claim. The claim frequency codes are as follows:

Claim Frequency Code	Description
1	Indicates the claim is an original claim.
7	Indicates the new claim is a replacement or corrected claim – the information present on this bill represents a complete replacement of the previously issued bill.
8	Indicates the claim is a voided/canceled claim.

Professional (837P) Claim Submission
Replacement Claims

Replacement claims (sometimes referred to as corrected claims or recall claims) submitted electronically will assist with prompt and accurate processing. A replacement claim is any claim that has a change to the original claim (e.g., changes or corrections to charges, procedure or diagnostic codes, dates of service, member name). Corrected claims may be submitted immediately. When a replacement claim is being submitted, you may submit the correction electronically with a "7" as the frequency code.

An example of the ANSI 837P file containing a replacement claim, along with the required REF segment and Qualifier in Loop ID 2300 – claim information, is provided below.

Claim Frequency Code

↑

CLM* 1 2345678*500***11:B:**7***Y*A*Y*I*P~

In the above illustration, "11" (segment and data element CLM05-1) is an example of the place of service, which is used to identify where services were performed. "B" (CLM05-2) is the place of service code qualifier, which is required in ANSI v501 0 to identify the place of service codes for professional claims. "7" (CLM05-3) is the claim frequency code.

The value F8 must be reported in the REF segment, element 01 and the **original claim number** in the REF segment, element "02" in the 837 claims submission. **(If the original claim number is not included, the submission will be rejected.)**

The replacement claim will replace the **entire** previously processed claim. Therefore, when submitting a correction, send the claim with all changes **exactly** how the claim should be processed.

Examples:

1. A claim was submitted with procedure codes 99213, 88003 and 77090. The 88003 should have been 88004. An electronic replacement claim should be submitted for the line that needs to be corrected, along with the appropriate frequency code of 7 with procedure codes 99213, 88004 and 77090. This indicates to MVP that all charges need to be deleted and the claim will then be processed with procedure codes 99213, 88004 and 77090.

2. A claim was submitted with procedure codes 99214, 70052 and 99213. Procedure codes 70052 and 99213 were submitted in error and need to be removed. An electronic replacement claim should be submitted with frequency code 7 and procedure code 99214. This claim will then be adjusted to remove 70052 and 99213; only procedure code 99214 will be included in the claim.

Note:

- If a charge was left off the original claim, please submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.
- Paper Adjustment requests will still be required for additional documentation submissions or timely filing.
- Claims that were not previously accepted (returned or rejected) should be re-submitted as an original claim.
- The correct member number (and suffix) needs to be submitted with the recalled claim, otherwise, the submission will error.

Void Claims

If a claim was submitted to MVP in error and needs to be voided, the claim to be voided should be submitted exactly as it was submitted previously, along with frequency code "8" to indicate that the claim should be voided.

Examples:

- Incorrect payer ID
- Incorrect subscriber ID
- Incorrect billing provider

Void only claims should be submitted with an "8" as the third position of the bill type (XX8). The bill type must be reported in the CLM segment, element "05" in the 837 claim submission. The first two positions of the bill type are reported in the sub-element one and the third position is reported in the sub-element three.

Example:

Claim Frequency Code

↑

CLM* E12345678900*500***21:A :**8***Y*A*Y*Y****N~

The value F8 must be reported in the REF segment, element 01 and the **original claim number** in the REF segment, element "02" in the 837 claims submission. If the original claim number is not included, the submission will be rejected.

Example:

REF*F8*(Enter the Claim Original Reference Number)

Note:

- The provider may wish to follow a void bill with a bill containing the correct information when a Payer is unable to process a replacement to a prior claim. The appropriate frequency code must be used when submitting the new bill.

INSTITUTIONAL (837I) CLAIMS SUBMISSION:

Replacement Claims (UB-04)

Corrected claims should be submitted with a "7" as the third position of the bill type (XX7). The bill type must be reported in the CLM segment, element "05" in the 837 claim submission. The first two positions of the bill type are reported in the sub-element one and the third position is reported in the sub-element third.

Example:

Claim Frequency Code

↑

CLM* E12345678900*500***21:A :**7***Y*A*Y*Y****N~

The value F8 must be reported in the REF segment, element 01 and the **original claim number** in the REF segment, element "02" in the 837 claims submission. (If the original claim number is not included, the submission will be rejected.)

Example:

REF*F8*(Enter the Claim Original Reference Number)

The replacement claim will replace the entire processed claim. Therefore, when submitting a correction, send the claim with all changes exactly how the claim should be processed.

Note:

- If a charge was left off the original claim, please submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.
- Paper adjustment requests are still required for additional documentation submissions or timely filing.
- Claims that were not previously accepted (returned or rejected) should be re-submitted as an original claim.
- The correct member number (and suffix) needs to be submitted with the recalled claim, otherwise, the submission will error.

Void Only Claims

Void only claims should be submitted with an"8" as the third position of the bill type (XX8). The bill type must be reported in the CLM segment, element "05" in the 837 claim submission. The first two positions of the bill type are reported in the sub-element one and the third position is reported in the sub-element three.

Claim Frequency Code

↑

CLM* E12345678900*500***21:A :**8***Y*A*Y*Y****N~

The value F8 must be reported in the REF segment, element "01" and the **original claim number** in the REF segment, element "02" in the 837 claims submission. (If the original claim number is not included, the submission will be rejected.)

REF*F8*(Enter the Claim Original Reference Number)

Note:

- The provider may wish to follow a void bill with a bill containing the correct information when a Payer is unable to process a replacement to a prior claim. The appropriate frequency code must be used when submitting the new bill.

Quick Review Grid

Question	Definition	Examples	How to Submit Claims
What is a replacement (or corrected or recall) claim? (Type of bill ending in 7)	A replacement claim is sent when an element of data on the claims was either missed or needs to be corrected on the claim.	• Incorrect date of service (DOS) • Incorrect units • Procedure code missing • Diagnosis code change or addition • Revenue code changes • Line being added • Change to injury date • Change to related cause code • Change to place of service • Change to rendering provider with no billing provider change	If claim was previously processed on Facets and was billed via paper, send in CARF. If claim was previously processed on Facets and billed electronically, follow EDI/MVP replacement claim submission guidelines. *Claims that require timely filing review or additional documentation need to be submitted via CARF.
What is a voided	When	• Payer information	Whether original claim

claim? (Type of bill ending in 8)	identifying elements change, a void submission is required to eliminate the previously submitted claim.	change • Subscriber information change • Billing provider change • Patient information change • Statement covers period • Patient did not want insurance billed • Bill type changes from IP to OP or OP to IP.	was submitted by paper or electronically, the void may be sent electronically. The void should be sent along with the new original claim. Follow EDI/MVP submission guidelines.

Direct Electronic Options

MVP offers the following electronic transactions in the approved HIPAA standard format:

- 837P – Professional Claims
- 837I – Institutional Claims
- 837D – Dental Claims
- 835 – Electronic Remittance Advice
- 270/271 – Electronic Eligibility and Benefits Request and Response
- 276/277 – Electronic Claim Status Request and Response
- 278 – Electronic Authorization Request

When submitting claims electronically to MVP, the covering provider should refer to MVP's HIPAA EDI Companion Guide. For questions about electronic claims submission, contact MVP's EDI Services Department at **1-877-461-4911** or at **ediservices@mvphealthcare.com**.

Electronic Claim Filing Tips

When filing claims electronically, it is important to review the "Payer Reports" to ensure MVP has accepted the claim. When billing claims electronically through a clearinghouse, the claim is checked by clearinghouse edits to ensure that all required fields are complete and the format is correct. If the claim passes the clearinghouse edits, it is then forwarded to MVP. MVP also performs edits prior to processing claims.

Below are some examples of MVP's edits:

- Is the member ID number valid for the date of service billed?
- Does the name on the claim match the name attached to the ID number in MVP's system?
- Does the date of birth on the claim match the date of birth attached to the ID number and the name in MVP's system?
- Is the provider's NPI number billed on the claim valid?

If MVP rejects a claim for processing, it is returned to the clearinghouse with a rejection reason. The provider must correct the claim based on the edit he/she receives on their Payer Unprocessed Claim Report and resubmit the corrected claim to MVP.

Coordination of Benefits—EDI
When MVP is the member's secondary carrier, claims can be submitted via an 837 transaction. Please be sure to include the following information from the primary payer:

- Total Charge
- Primary Approved Amount
- Primary Paid Amount
- Patient Responsibility
- Other Insurance Information

Please contact MVP's EDI Services Department for more information at **ediservices@mvphealthcare.com** or at **1-877-461-4911**.

Timely Claims Submission Reminder
MVP applies a timely filing limitation of 180 days, or as specified in your contract, from the date(s) of service for the filing of claims. All claims received after the time period will be denied as exceeding the timely filing limitation. MVP members cannot be billed for services denied because of timely filing issues. There are two exceptions to the timely filing limitation:

- Claims that involve coordination of benefits where MVP is the secondary payer have a timely filing limitation of 180 days, or as specified in your contract, from the date of the primary's EOB but no more than two years after the date of service.
- Claims for Worker's Compensation or No Fault are not subject to the timely filing limitation, of two years after the date of service, provided that MVP receives the claim with appropriate denials/documentation no later than the contracted filing limit.

For inquiries of Workers' Compensation, No Fault, or Coordination of Benefits (COB) claims, call MVP's COB Unit at **1-800-556-2477 option 2 or 3**. In addition to filing claims in a timely manner, MVP imposes the timely filing limit on adjustment requests.

An adjustment is defined as a request to correct a processing error, whether the claim was denied or modified by MVP erroneously, or the provider has amended the claim for a billing error or omitted data. Providers may request an adjustment within 180 days, or as specified in your contract, from the date of MVP's denial or incorrect payment to submit an adjustment request. For all timely filing reconsiderations, supporting documentation to overturn a denial for exceeding MVP's timely filing limitation will be required.

Member Balance Billing
Participating providers with MVP have agreed by contract not to bill members for covered services, except to collect applicable copayment, coinsurance, or deductibles, as indicated in the gray section in providers' remittance advice.

Participating providers also agreed not to bill MVP members for non-covered services, except under the following circumstances:

- Prior to rendering service(s), the provider has advised the member that the service(s) is not a covered service, and the member will be held financially responsible for all charges.

- The member is not covered by the plan at the time services were rendered. MVP participating providers should look to the terms and conditions of their provider contract for additional information.

Plan-Directed Care

When a participating provider furnishes non-covered services or refers a Medicare Advantage member to a non-contracted provider for services the member believes are covered, Federal law prohibits holding the member financially liable for the service. In these circumstances, the service may be referred to as "Plan Directed Care."

A member will generally be deemed to believe the service is covered unless the member received an adverse organization determination from MVP. Therefore MVP requires the following:

- Participating Providers should not refer to out-of-network providers without prior authorization from MVP (See Section 5, page 5.7, Utilization Management, and Prior Authorization).

- If a participating Provider knows or believes an item or service the out-of-network provider will furnish is not covered, the member or provider must request a pre-service or organization determination from MVP. **As noted below, an ABN may not be used.** In the case of a member who routinely receives the same non-covered service, one organization determination (denied authorization) received at the beginning of the course of service may be used, as long as it is clear that the member understands that the services will never be covered.

Pursuant to law, if a Participating Provider fails to follow these authorization requirements, MVP may decline to pay the claim, in which case the provider will be held financially responsible for services received by the member.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf
PLEASE NOTE—AN MVP-PARTICIPATING MEDICARE ADVANTAGE PROVIDER MUST **NEVER USE AN ADVANCE BENEFICIARY NOTICE (ABN) WITH A MEDICARE ADVANTAGE ENROLLEE**

YME/YUV Denials

A claim denied for remark code "YME – Provider Tax ID/Address discrepancy" or 'YUV – The tax ID and/or address billed are not on file for the NPI billed' are an indicator that the demographic information billed on your claim form does not match the demographic information on file with MVP. You may update your demographic information, address, tax ID information, new billing locations or additional office locations with MVP by sending the update in writing to your MVP Professional Relations Representative.

Clinical Edits

MVP utilizes McKesson Claims XtenTM Clinical Editing software to facilitate efficient and consistent claim processing and payment. This software applies a predetermined set of rules to each claim so that as many claims as possible can be automatically approved or denied rather than manually reviewed. Clinical edit updates and enhancements continue to be sourced to nationally recognize correct coding standards including but not limited to: American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), National Correct Coding Initiative (NCCI), various specialty societies, and McKesson's Physician Advisory Panel content. MVP publishes all custom and significant claims and clinical editing information online at www.mvphealthcare.com/provider/ny/reference.

Interim Bills

Interim bills are required once a member has been an inpatient for 120 days and then every 120 days thereafter. Once the 120 day threshold is met, the hospital must submit an interim bill to MVP within 30 days of the 120th inpatient day. Claims will be adjusted to pay the difference as an interim payment for each submission until final discharge.

Imaging Payment Policy

When imaging studies are performed on certain contiguous adjacent body part(s), within a family of codes but not across families of codes (as defined by CMS), provided during the same session on the same date of service, MVP will reimburse the technical component only as follows:

- First Code: 100 percent of Fee Schedule
- Subsequent Codes: 75 percent of Fee Schedule
- The First Code is defined as the code with the highest RVU as defined by CMS.

This policy will apply to all MVP products but not for Case Rates or when a Medicaid APG or Medicare APC methodology is used. This policy will apply to the technical component only regardless of the setting (i.e., outpatient or physician operated setting).

Modifiers

For more information regarding modifier payment please refer to the *Modifier Payment Policy* in Section 15.

MVP made the following custom claim edits to our FACETS clinical edits software.

- HCPCS codes Q0091 and G0101 are denied as a subset to sick visits. The denial can be reconsidered with proper medical documentation as to a separate service from the problem visit.
- MVP will reimburse separately for a venipuncture when the Lab work is sent to an external lab and billed with a modifier CG. MVP will reimburse for a venipuncture, when it is the sole service provided Infusion billed with 96410-96414 and J9000-J9999 is only allowed if billed with Modifier 59

- CRNA billing with place of service 21/22 and with a hospital TIN is considered global to Surgery
- Allergy testing/treatment is only allowed when performed by allergists, ENTs and Dermatologists
- Percutaneous tests will be denied when more than 50 units are billed. Percutaneous tests billed with food allergy diagnosis will be denied when more than 65 units are billed. Intradermal tests will be denied when more than 50 units are billed.
- IP professional charges (visits, consults, anesthesia, etc.) billed by providers employed/staffed by a hospital will be denied "global" (subject to exceptions).
- Surgical Trays are not covered when billed by anesthesiologists (exception: unless billed in conjunction with pain management).
- Surgical procedures that can only be performed in an office/IP/ER setting are defined on the MVP In-Office Procedure list and are not subject to an enhanced fee.
- Heparin and saline will be denied "global" when billed with home infusion.
- B-12 injections billed under injection administration codes will be denied to resubmit with HCPCS code.
- When two IP physician visits are billed for the same date of service by the same provider for the same/related condition, only one visit will be approved.
- Lab services that must be performed in office are documented on the *MVP Regional In-Office Lab List* and are not subject to enhanced fees.
- Mental health codes billed with a quantity greater than one will be denied.
- More than one mental health session billed on the same date of service will be denied.
- For pelvic and abdominal procedures on the same date of service – the major procedure is reimbursed at 100 percent, minor procedure reimbursed at 50 percent (Mid-Hudson Region).
- Pap smear code Q0091 will be denied "subset" when billed with an E&M code (including preventive care codes).
- If the first prenatal office visit is billed with a TH modifier but not a prenatal form, the claim will be denied.
- If a prenatal form is submitted after 90 days, the first prenatal visit will be denied.
- Telephone calls from physicians to patients, etc., are not covered and will be denied "incidental to other procedures".
- Therapeutic codes billed with non-chemo J codes must be billed with modifier 59 when billed in addition to chemo admin, chemo J codes, Q codes or E&M codes.
- Specimen handling is not covered and will be denied "incidental to other procedures".
- Testing (including hearing and vision testing) is not allowed when billed during a Well Care visit and will be denied "incidental to other procedures" or "included in global fee".
- If 99070 are billed with a description of a supply and a valid HCPCS code exists for the supply, will be denied to resubmit with valid HCPCS code.
- Local anesthesia charges billed by providers other than anesthesiologists with office surgery will be denied.
- Caine Injectables billed with Arthrocentesis are not allowed and will be denied "global".

- If a Biophysical Profile is billed on the same date of service as a fetal or obstetrical ultrasound, the ultrasound should be reimbursed at 100 percent of allowable, the Biophysical Profile should be reimbursed at 50 percent of allowable (applies to Central Region).
- OB ultrasounds performed by OB/GYNs in the office will be denied "global" to the OB delivery claim (applies to Mid-state Region).
- New York State Physicians Pelvic and Transvaginal Ultrasound Policy – codes 76830 and 76817 will be reimbursed at 100 percent of allowable, other codes will be reimbursed at 50 percent of allowable when billed with 76830, 76817.
- Unless otherwise specified in your MVP contract, MVP will not make payment on drug screenings (AMA CPT code range 80300 – 80377). In lieu of a code in this range, the appropriate CMS approved HCPCS G-code should be billed.

Appealing Any Clinical Editing Denial

You may appeal a clinical edit denial by using a *Claims Adjustment Request Form* with the clinical and or coding rationale supporting why you feel the denial is incorrect. Please make sure that you include any medical records/operative reports that will substantiate the appropriateness of your appeal. MVP publishes all custom and significant claims editing information online at **www.mvphealthcare.com/ provider/onlineresources.html**. You need to log in with your unique MVP user ID to access this information. Information about MVP policies and procedures is available online at **www.mvphealthcare.com/provider/onlineresources.html** or from an MVP Professional Relations representative.

Modifiers Effect on Payment

Please see *Section 15 - Payment Policies*

Anesthesia

- MVP reimburses in accordance with ASA guidelines.
- Anesthesia groups must submit anesthesia-specific claims with ASA codes, not surgical codes.
- Anesthesia groups must submit claims with the total time minutes in the quantity field. MVP automatically calculates the base units from the ASA code billed, and then adds the time units by using the information in the quantity field.
- MVP reimburses based upon 15-minute time units, and will calculate the time units automatically based upon the total time minutes billed by group. MVP reviews all claims submitted with P modifiers. The diagnosis must justify billing of these modifiers/codes.
- Deleted code 01997 should no longer be used. Per CPT guidelines, use the appropriate evaluation and management (E&M) code.
- MVP reimburses 01996 once per day at three units.

Invoice Requirement for Radiopharmaceuticals (Contrast Materials)
This policy applies to Physician Claims only

For MVP Commercial, Marketplace and Medicaid Managed Care and Child Health Plus lines of business:

Radiopharmaceutical Codes that are billed less than $50 will be reimbursed at 100 percent of the charges per standard MVP policy.

The following Radiopharmaceutical codes will be paid up to $100 without an invoice

- A9541
- A9560

The following Radiopharmaceutical codes will be paid up to $160 without an invoice

- A9500
- A9502
- A9505
- A9538
- A9552

The following Radiopharmaceutical codes will be paid up to $250 without an invoice

- A9562
- A9556

Any other Radiopharmaceutical code, not listed in the above tiers, will require an invoice.

For the Medicare line of business:
Radiopharmaceutical Codes that are billed less than $50 will be reimbursed at 100 percent of the charges per standard MVP policy.

An invoice is required for any required for any billed charge over $50. If an invoice is not submitted we will pay at a reasonable and customary rate as set by MVP. If the reasonable and customary rate does not meet the invoice cost a CARF can be submitted with the invoice.

Coordination of Benefits (COB) Determination
COB determines the order in which benefits are paid when a person is covered by two or more group health plans or insurance programs that provide similar benefits. MVP will coordinate its benefits with the other plan benefits. This prevents overpayment and duplicate payments for the same service. Contact the COB Department at
1-800-556-2477, option 2 for Benefits, and **option 3** for No Fault or Worker's Compensation.

If MVP is to make payment as the secondary plan, the rules and procedures of MVP as stated in the member's MVP contract must be followed before MVP will make payment. When MVP is the secondary plan, it will not pay more than it would have paid if it were the primary plan.

When billing MVP as the secondary carrier, all MVP primary billing requirements & codes must be followed for the services provided. If your contract with MVP requires specific coding to be billed, it is expected that MVP will be billed those codes, regardless of what was billed to the primary insurance. MVP will not make a secondary payment on a service that is not contracted.

Rules to Determine Payment

In order to determine which plan is the primary plan, the following rules have been established:

A. If a plan does not have a COB provision, then it will be the primary plan.
B. If a member is covered by two plans, then the plan that covers the member as a subscriber (employee) is the primary plan.
C. If a member is covered as a child dependent by two plans, then the rules are as follows:
    1. The plan of the parent whose birthday is first in a year will be primary, and the parent whose birthday is second in the year will be secondary. This is called the Birthday Rule. (ex.: If the mother's birthday is January 28, and the father's is April 11, then the mother's plan is considered primary).
    2. The Gender Rule dictates that the father's plan is primary and the mother's plan is secondary. If the other plan follows the Gender Rule and MVP follows the Birthday Rule so they do not agree on which plan is primary, then the Gender Rule will determine which is primary.
D. Rules for a child of separated or divorced parents:
    1. If a court decree specifies which parent is responsible for the child's health care expenses, then that parent's plan is primary.
    2. If no such court decree exists, the child's benefits are determined in the following order:
        a. First, the custodial parent's plan is primary;
        b. Then the custodial parent's spouse's plan;
        c. Then the non-custodial parent's plan; and
        d. Finally, the non-custodial parent's spouse's plan.
    3. If there is joint custody, the Birthday Rule applies.

E. A plan that covers a member as an active employee is primary; a plan that covers a member as a laid-off or retired employee is secondary. This rule also applies to a member's dependents. If the other plan does not have this rule but MVP does so that the plans do not agree on which plan is primary, then this subsection E is ignored. Medicaid, CHAMPUS/TRICARE, and any plan whose benefits are, by law, in excess to those of any private insurance plan or other non-governmental plan shall be secondary plans.

MVP is Secondary

If a member has an accident and is covered for accident-related expenses under any of the following types of coverage, the other payer is primary and MVP may be secondary:

- No-fault auto insurance
- MedPay Insurance
- Group auto insurance
- Traditional fault-type auto insurance that you
- Workers' compensation
- Other property/liability insurance providing medical payment benefits
- Personal injury protection insurance
- Financial responsibility insurance
- Homeowner's insurance
- Uninsured/underinsured motorists insurance
- Automobile-medical payment insurance
- Medical reimbursement insurance coverage that you did not purchase

Note: The above list varies by state.

Effect of Medicare

When a member becomes eligible, he/she must enroll in Medicare Part B when Medicare is determined to be the member's primary plan. If the member fails to enroll in Part B when eligible and Medicare is primary, MVP will reduce plan benefits by the amount Medicare would have paid for the services or care. The reduction in benefits will occur even if the member fails to enroll in Medicare, does not pay premiums or charges to Medicare, or receives services at a hospital or from a provider that cannot bill Medicare. If a member is Medicare eligible, this exclusion will not apply and Medicare is considered the secondary plan if the member is:

A. Medicare-eligible by reason of age and the subscriber is currently employed by an employer group with 20 or more employees, or
B. Medicare-eligible by reason of end-stage renal disease (ESRD) and there is a waiting period before Medicare becomes effective.
C. Disabled (by reason other than ESRD) and the subscriber is currently employed by an employer group with 100 or more employees.

MVP Contracted Vendors

MVP contracts with several vendors who may reach out to providers for additional information. These vendors are:

- Xerox Recovery Services, Inc. (formerly known as ACS)
  1301 Basswood Road, Suite 105
  Schaumburg, IL 60173

  Xerox reviews our claims and eligibility data extracts, which are provided to them monthly, for possible other insurance that may be primary over MVP. This is a second review after the MVP COB team's review. They use various methods to analyze the data to determine which Members to investigate for other insurance. While not the only focus of their attention, Medicare makes up much of their investigations, end stage renal disease and disability cases in particular. In addition to the above services, effective Marcy 1, 2014, Xerox has been contracted to provide the additional services of, Credit Balance Audits, Hospital Bill Audits and Data Mining Services.

- CDR
  307 International Circle, Suite 300
  Hunt Valley, MD 21030

  CDR receives monthly paid claims extracts to perform bill audits on end stage renal disease facilities.

- Trover Solutions, Inc. (formerly Healthcare Recoveries, Inc.)
  9390 Bunsen Parkway
  Louisville, KY 40220

  Trover Solutions, Inc. receives claims and eligibility data extracts from MVP on a monthly basis. They use software that sorts and analyzes the data compiling high probability cases for investigation.

  Trover Solutions, Inc. concentrates on Workers Compensation, No Fault and Third Party Liability cases.

- Equian
  Attn: Medical Claims Coordinators600 12th St. Suite 300
  Golden, CO 80401

  Equian reviews inpatient facility claims for billing and coding accuracy, as compared to the submitted itemized bill.

Remittance Advice

The following information was effective the first quarter of 2012:

An MVP Remittance Advice Statement (RA) explaining approved and denied claims, accompanies each check. If the claim is denied or adjusted, the appropriate claim adjustment code is provided. A sample MVP Remittance Advice Statement follows. Providers will receive separate RAs for each of MVP's lines of business.

SECTION I – HEADER INFORMATION

1. **The MVP address on your remittance advice**
   The Line of Business (LOB) or funding indicator directly correlates to the address shown below. For example:

   MVP Health Insurance Co. and MVP Health Insurance Co. of New Hampshire
   625 State St.
   Schenectady, NY 12305
   *check represents our HMO LOB (HMO only)

   MVP Select Care, Inc.
   625 State St.
   Schenectady, NY 12305
   *check represents our self-funded LOB (ASO only)

   MVP Health Plan Inc. & MVP Health Insurance Co. of New Hampshire
   625 State St.
   Schenectady, NY 12305
   *check represents our Insured LOB (PPO, POS, EPO)

   (Insert IPA name here)
   625 State St.
   Schenectady, NY 12305
   *check represents IPA-funded services

2. **Check Reference ID number**
   A new reference number associated with remit. If providers need to call MVP about this remit for any reason, they can give this number to a Customer Care Center representative so they may readily access this remit in the system and answer your questions.
   Note: An overpayment created in a particular LOB can only be satisfied with claims paid within the same LOB. Therefore, multiple negative balances across LOB can occur.

SECTION II – CURRENT CLAIMS

This section will show all new claims, including a "total" line for each claim, and how they were processed. This section includes details on:

3. **Contractual-Disallowed**
   This field represents the difference between billed charges and the eligible amount, based on your contract. It was designed to assist you in reconciling the disallowed amount to your billed charges. The following is a summary of the scenarios you will see:
   - Fee Maximum – indicates the difference between the billed charges and the allowable amount based on your contract.
   - Discount – indicates the dollar amount of billed charges based on the contractual discount.
   - DRG/Per Diem – represents the difference between the DRG or Per Diem rate and the total billed charges.
4. **Withhold**
   This field represents the withheld payment amount, based on contract, if applicable.
5. **Net Pay**
   This is the payment amount, minus COB, copayment/ coinsurance, deductible, and withhold, if applicable.
6. **Explanation Codes**
   This code is present on each claim line when an adjustment is made and explains MVP's disposition.
7. **ADJ/COB Calculations**
   If applicable, COB information from a primary insurance carrier appears in this field. COB amounts are calculated on each claim line if an MVP copayment is to be taken in accordance with the member's MVP contract. If a copayment is not applicable, then the COB calculations are done for the entire claim amount. That is, the primary insurer's payment will be systematically distributed over all claim lines submitted.
8. **Patient Responsibility**
   This amount includes coinsurance, copayment, deductible, and any charges that are not covered under a member's contract.

SECTION III – RECOVERY DETAILS

If MVP is recovering overpayment on the current remittance advice, it will appear in this section of the remittance with the MVP claim number, patient name, MVP ID number, your patient account number and dates of service for the claim in which overpayment was made.

- **Adjust Date -** This will show the date MVP created the overpayment.
- **Original Amount to Recover -** This will represent the total amount of the overpayment made by MVP.
- **Previous Recovery Balance -** This amount represents the original adjustment amount subtracted by any amount previously taken for recovery by MVP.
- **Current Recovery Amount -** The actual dollar amount MVP is recovering on this remittance advice.

- **Amount Due on Claim -** This is the remaining dollar amount after recoveries are applied.

SECTION IV – PAYMENT DETAIL SUMMARY

Check Amount

The formula to balance your remit is the total payment for Current Claim, minus Current Recovery total; if Current ADJ Totals is a positive figure (additional reimbursement) it should also be added.

- Recoveries to be Taken
  This field represents the still-outstanding overpayment balance on your account for this LOB, including any other overpayments identified in the Current Adjustment (Section III).
- Recoveries Taken on this Remittance Advice
  This will show the current recovery taken on this remit (see field 15).
- Recoveries owed
  Outstanding monies owed to MVP from prior or current claims adjustments.

Recovery Information

Do not send the check to MVP to satisfy overpayments unless MVP sends the provider a report outlining the overpayment and a request for payment. Following the notification to the provider on their remits and every 30 days until satisfied; the provider will receive a Refund Request on the outstanding overpayment. For questions about overpayment or recovery issues, call the Customer Care Center for Provider Services at **1-800-684-9286**.

You have the right to challenge an overpayment recovery; you may do so by contacting the Customer Care Center for Provider Services at **1-800-684-9286**. The provider will have 180 days from the notification date to determine if the member has other insurance that was in effect on the date of service. MVP will allow a provider to submit a claim that was previously denied by another insurer due to the member's transfer or termination of coverage.

For recoveries performed on claims as specified under "Recoveries on Overpayments"; there is **no** time limit for MVP to collect and recoup on the outstanding negative balance.

Recoveries on Overpayments

In the event of an overpayment to a health care provider, MVP may pursue recovery efforts as permitted by law and in accordance with the following timeframes:

1. For the **Medicare** line of business, MVP shall not initiate overpayment recovery efforts more than -twenty-four (24) months after the original payment was received by a health care provider.

2. For the **Medicaid** line of business, MVP shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a health care provider.

3. For **Self-Insured** lines of business, MVP shall initiate overpayment recovery efforts in accordance to the employer group's contract or twenty-four (24) months after the original payment was received by the health care provider which includes Medicare primary claims.

4. For **New York** providers, MVP shall not initiate overpayment recovery efforts more than twenty-four (24) months after the original payment was received by a health care provider; provided, however, that no such time limit shall apply to overpayment recovery efforts that:
    - Involve fraud, intentional misconduct or abusive billing; or
    - Are required by, or initiated at the request of, a self-insured plan; or
    - Are required or authorized by a state or federal government program or coverage that is provided by New York State or a New York municipality or its respective employees, retirees or members; or
    - The claims payment was incorrect because the provider was already paid for the services.

5. For **Vermont** providers, MVP shall not initiate overpayment recovery efforts more than twelve (12) months after the original payment was received by a health care provider; provided, however, that the retrospective denial of payment shall be allowed beyond the twelve (12) month period if:
    - The plan has a reasonable belief that fraud or other intentional misconduct occurred; or
    - The health care provider was already paid; or
    - The health services identified in the claims were not in fact delivered by the provider; or
    - The claim payment is subject of adjustment by another health plan; or
    - The claim payment is the subject of litigation.

The recovery overpayment guidelines are adhered to by MVP, as well as MVP's Contracted Recovery Vendors. MVP participating providers should look to the terms and conditions of their provider contract for additional information.

MVP is regularly audited by external auditing agencies, such as the New York State Department of Financial Services, CMS and ASO group audits. MVP is required to comply with time limits established by these auditing agencies. Audits may include up to three years of claim data. MVP has no time limit for provider-initiated refunds to MVP.

Services Provided Free of Charge

MVP will not cover services provided to our members free of charge, or when those services are at no cost to the provider as they are subsidized through a Government or related program, i.e., vaccinations. Services that are provider free of charge should be billed to MVP with the modifier SL.

New CMS Code and Relative Value Units (RVU) Updates

The Center for Medicare and Medicaid Services (CMS) creates new medical codes and assigned RVUs on a quarterly basis. MVP will begin updating fee schedule with the appropriate assigned RVU to all CMS codes on a quarterly basis. Contracts will still be reimbursed at the agreed upon percentage of Medicare as stated in the fee schedule.

Claim Auditing

MVP audits a random sampling of 3-5 percent of all processed claims to ensure processing accuracy.

Special Investigations Unit (SIU)

MVP is required by insurance laws to establish and maintain a process to investigate potential occurrences of health care fraud and/or abuse. Each year, fraudulent and/or abusive health insurance claims and activities increase overall health care costs. Special Investigations Unit's (SIU) mission is to assist MVP in detecting and addressing situations where fraud and/or abuse may have occurred.

SIU utilizes a formal process for detecting, investigating and preventing these types of activities. The investigation process includes investigators and nurses with backgrounds in insurance fraud investigations and medical claim reviews. The SIU staff surveys and evaluates claim data—including provider/facility history, specialty profiles, common fraud schemes and/or abuse and claim patterns that differ from past history or peer norms for a given condition or specialty.

SIU's investigative process also includes the use of high-tech software, STARSentinel™ to detect, track, analyze and report instances of health care fraud; abuse or misrepresentation STARSentinel™ identifies suspicious claims for:

- Falsification of procedure codes
- Falsification of diagnosis codes
- Manipulation of modifiers
- Up-coding
- Over-utilization of diagnostic procedures and tests
- Over-utilization of treatment modalities

It may be necessary for SIU to obtain medical records in order to complete its investigation as efficiently and accurately as possible. However, if SIU requests information from your practice, it does not necessarily indicate a problem exists. MVP also relies on our participating facilities, providers and their office staff to help us fight insurance fraud and/or abuse. Please report any suspicious activity by calling MVP's Special Investigations Unit (SIU) toll-free at **1-877-TELL-MVP (1-877-825-5687)**. All information will be kept confidential.

Routine Vision Claims for MVP Medicaid, Child Health Plus, and Essential Plans 3 & 4

Superior Vision adjudicates **routine vision** claims (dates of service 1/1/16 and forward) and responds to benefit and eligibility inquiries on behalf of MVP Health Plan, Inc., for our Medicaid, Child Health Plus and Essential Plans 3 & 4.

If MVP receives a routine vision claim with a date of service on or after 1/1/16, the claim will be denied and you will be instructed to submit directly to Superior Vision for processing and payment.

Please continue to submit any demographic changes for you or your practice (e.g. change/addition of address, phone number, and payee information) directly to MVP.

Claims can be submitted to Superior Vision, please use on of the following processes:

- Clearinghouse Claim Submissions:

  Superior Vision's contracted healthcare clearinghouse is RelayHealth. The Payor ID to utilize when submitting electronic claims to Superior Vision through RelayHealth is 3402. Please call the Superior Vision's EDI Department at (800) 243-1401 to facilitate this connection.

- ASC X12N 837 HIPAA Standard Format – Direct

  Any provider wishing to submit claims in the ASC X12N 837 format directly to Superior Vision should contact their EDI Department at (800) 243-1401.

- Paper Claims on a CMS 1500 Claims Form

  Paper claims must be typed and mailed to:

  Claims Department Superior Vision
  939 Elkridge Landing Rd, Suite 200
  Linthicum, Maryland 21090