BILLING & CLAIMS ADMINISTRATION

This general reference is one resource to provide guidance on MotivHealth's billing requirements and claims administration. This document is not intended to address every aspect of claims management. Unique circumstances may necessitate departure from normal business practices. In all cases reasonable judgment and discernment are applied.

Welcome to MotivHealth's guide to billing and claims administration! This document contains important information and protocol guidance for our participating providers. Here you will find information on how to bill for covered services and the procedures we use to request information and process your claim.

We know you want prompt payment. Following the procedures outlined in this document is the best way to achieve timely and accurate administration of your payment requests. Reimbursements may be delayed or denied if any of our processes are not followed.

This guide is effective December 1, 2024. It applies to all healthcare professionals and institutional providers. If there is a conflict or inconsistency between the information in this document and federal/state regulatory requirements or our agreement with you, the regulatory requirements and our agreement will apply.

For questions at any time, contact MotivHealth's Providers Services at (385) 308-4410.

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CLAIMS SUBMISSION

All claims submitted to MotivHealth are subject to the member's benefits and their eligibility for services at the date care was provided. Verification of eligibility and benefits prior to the date of service is recommended. When we provide benefit and eligibility information, we are not guaranteeing payment. The actual reimbursement that you receive depends on several factors. These include compliance with our reimbursement policies and billing guidelines, the date of service, the completeness and accuracy of the claim and your response to our requests for medical records and other documents.

WHO CAN SUBMIT A CLAIM?

Licensed providers who rendered the covered service may submit a claim. Providers must bill MotivHealth directly under their own name for covered services in accordance with their agreement with us.

Practitioners not licensed in the state where the services were rendered may not submit claims. Licensed providers who did not perform the services or where services were performed on their behalf even when performed under their supervision may not submit claims.

HOW SHOULD CLAIMS BE SUBMITTED?

If you wish to receive payment for covered services that were provided to our member, you must submit a claim. All claim submission requirements must be met regardless of how the claim is presented. Claims that are incomplete or contain inaccurate information may be rejected or processing may be delayed. For claim submission requirements see the section entitled CLAIM SUBMISSION REQUIREMENTS within this document.

ELECTRONIC CLAIMS

Electronic claim submissions are preferred. When submitting claims electronically use EDI 837 standard format for exchanging healthcare information. MotivHealth's Payor ID is U7632.

For complete information on electronic claim submission, refer to the CMS guidelines below.

- Electronic Billing for Professional Claims
- Electronic Billing for Facility Claims

PAPER CLAIMS

Providers may submit paper claims. Paper claim forms and instructions on how to complete them can be obtained at the CMS links below.

- Facility Paper Claims
- Professional Paper Claims

Send the completed claim to us at:

MotivHealth Insurance Company
PO Box 709718
Sandy, UT 84070-9718

WHEN MUST CLAIMS BE SUBMITTED?

Unless otherwise stipulated by our contract with you or federal requirements, claims must be filed within the timely filing limits stipulated in your agreement with us or within your state's requirements. In general, new claims must be submitted by a participating provider no later than:

- One Hundred Eighty (180) days from the date of service.
- One Hundred Eighty (180) days from the date of receipt of the primary payer's explanation of benefits.

Claims that are not timely filed will be denied and cannot be billed to or collected from the member.

If you filed your claim but we have no record of the filing, we will require that you show proof of its filing on or prior to the filing deadline.

WHAT ATTACHMENTS SHOULD BE SENT WITH THE CLAIM?

Do not send records with your claim submission. Any records we require to process your claim will be requested by us. If we request records, you are responsible to send them within the time frame requested. In instances where we do not receive requested records, or we receive incomplete records, or records other than those requested, the claim will be denied. Claims denied for failure to send requested records are not eligible for appeal or reconsideration. These claims cannot be billed or collected from the member. Once records are received, we will start the claim adjudication procedures.

See MEDICAL RECORDS STANDARDS AND SUBMISSION REQUIREMENTS within this document for additional information on record requests.

CLAIM SUBMISSION REQUIREMENTS

ONLY CLEAN CLAIMS are eligible for payment processing. Below are the requirements for a clean claim:

- In compliance with all applicable federal and state regulatory authority, the provider's participating agreement and MotivHealth billing guidelines.
- Filed on the appropriate industry standard form, either electronically or via paper.
- Includes all relevant member information including other carrier liability.
- Contains all relevant provider information including a valid NPI.
- Includes all services for which reimbursement is sought using only industry standard code sets for the dates of service for the entire encounter. Split billings or interim claims are not accepted. Any services/supplies billed as an extension of the dates of service on a previously paid claim will be denied.
- All charges and units of service on the claim submission and on the itemized bill must reconcile. Submissions where the electronic/paper claim and the itemized bill do not reconcile will be denied.
- All requested documentation supporting the charges and/or information that we request that would allow for the investigation of possible fraud must be received within the time period requested.

Claims that do not meet all these requirements will not be processed until all claim submission requirements are met.

CORRECT CODING GUIDELINES

WHAT CODING GUIDELINES MUST BE FOLLOWED?

MotivHealth uses nationally recognized billing and coding guidelines for all claims processing and claim review procedures. This is usually consistent with CMS standard coding and billing guidelines. These include active Current Procedural Terminology (CPT), NUBC Revenue Codes, Healthcare Common Procedure Coding Systems (HCPCS), and a valid Internal Classification of Disease 10th revision, Clinical Modification (ICD-10-CM) diagnosis code.

Reimbursement will not be allowed for incorrectly reported codes, including revenue codes and inactive National Drug Codes (NDC). This applies to all medical services, surgical procedures, and supplies for both professional and institutional claims.

WHO MUST FOLLOW CORRECT CODING GUIDELINES?

Correct Coding Guidelines apply to all physicians, other health care professionals, hospitals, and other facilities.

WHAT SERVICES DO CODING GUIDELINES APPLY?

Correct coding must be used for all medical and surgical services, supplies and items rendered to members during the encounter. Hospitals and facilities must report all services, supplies and items using accurate Revenue Codes.

MotivHealth considers revenue codes with a description of 'Other' and/or ending with '9' to be unlisted revenue codes and are generally not accepted for reporting services or supplies in any claim type. The revenue code ending with '0' and entitled 'General' may be used, however more specificity as provided by National Uniform Billing Editor (NUBC) is preferred.

UNLISTED CODES

Unlisted CPT/HCPCS codes allow services, supplies, and drugs to be billed and reported for which no code has yet been designated. The American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) identify unlisted codes as follows:

- Not Elsewhere Classified (NEC)
- Not Elsewhere Specified
- Not Listed
- Not Otherwise Classified
- Not Otherwise Specified (NOS)
- Unlisted
- Unclassified
- Unspecified

Fee allowances and relative value units (RVU) cannot be designated in our Claims Processing System for items that are billed with unlisted codes.

WHEN CAN UNLISTED CODES BE USED?

Unlisted codes may be used only when no other HCPCS/CPT code exists that accurately describes the procedure, service, supply, or medication rendered to our member for a specific date of service. When the use of an unlisted code is necessary, adequate details of the item must be provided in your claim for reimbursement. The medical record and/or other supporting documentation must identify the item billed and describe its nature and medical necessity.

CAN MODIFIERS BE APPENDED TO UNLISTED CODES?

Do not append a modifier to an unlisted code. If a modifier is normally used to identify separate services, such as different anatomic locations, bill each service as a separate charge with an unlisted code.

IS PRIOR AUTHORIZATION REQUIRED FOR UNLISTED CODES?

MotivHealth's prior authorization process is consistent for all services and is not modified when the use of an unlisted code becomes necessary. When requesting prior authorization for procedures, the provider should be prepared to supply a detailed description of the service as well as the time, equipment and effort required to perform the procedure. If coding for a similar service is available, that should be included in the prior authorization request also. When billing pharmaceuticals with unlisted codes the NDC must be identified in both the billing and the medical records.

Contact MotivHealth's Personal Health Assistants at (844) 234-4472 if you have any questions regarding prior authorization for an unlisted service, pharmaceutical or supply.

ARE THERE CIRCUMSTANCES WHEN AN UNLISTED CODE WILL NOT BE PAID?

Some circumstances, though not limited to the following, may cause a denial of the service, pharmaceutical or supply billed with an unlisted code:

- If a service, procedure, supply, or drug is billed with an unlisted code and there exists a more specific code to describe the item claimed for reimbursement.
- If the medical record does not adequately identify the item billed with an unlisted code or the billing of the service is not sufficiently described in the itemized bill or claim for reimbursement.
- If an unlisted code is used to unbundle procedures, services, pharmaceuticals or supplies that are a component of another procedure, pharmaceutical or the global surgery period.

If an item with an unlisted code was paid and we subsequently discover that the use of the modifier caused the payment, we will recoup the payment as a billing error.

CAN DENIALS FOR UNLISTED CODES BE APPEALED?

Denials and recoupments of services, pharmaceuticals and supplies billed with an unlisted code are eligible for appeal or reconsideration.

OTHER PARTY LIABILITY (OPL) AND SUBROGATION

MotivHealth will recover benefits paid for a member's care when a third party causes the injury or illness as permitted by law and the member's benefit plan. Some examples where this may occur include but not limited to:

- Auto accident
- Slip and fall injury on business or other property

- Work related injury or illness

MotivHealth will recover benefits paid for a member's care when another health insurer or Medicare is primary.

HOW ARE OPL CLAIMS PROCESSED

Once a claim is identified as being related to an accident/injury or where MotivHealth is not primary, claim processing is suspended. Currently the member is sent a letter with a request to provide additional information. The member has 30 days from the date of the letter to respond and provide any applicable documentation. If the member does not respond within the allotted time frame the claim is closed and charges for services becomes member responsibility.

CLAIM PROCESSING

We know you want prompt payment. Please carefully comply with the protocols outlined below. Reimbursements may be delayed or denied if any of our processes are not followed.

WHEN CAN PAYMENT OF THE CLAIM BE EXPECTED?

We will process clean claims and issue an Explanation of Benefits and payment, if applicable, within thirty (30) days of the day the claim is received.

Claims that do not satisfy all submission requirements are denied or will experience a delay in payment. Review the CLAIM SUBMISSION REQUIREMENTS section in this document to review the requirements for claim submission.

DOES THE CLAIMS PROCESSING SYSTEM HAVE AUTOMATED EDITS?

To prevent improper payment, MotivHealth utilizes automated industry standard CMS National Correct Coding Initiative (NCCI) edits. NCCI edits are applicable to the time-period for which the edits are effective. Any charges on the claim triggering an NCCI edit will be denied automatically by MotivHealth's Claims Processing System. These denials are eligible for appeal or reconsideration.

For complete information on NCCI edits, refer to the CMS Website .

WHAT EDITS DOES MOTIVHEALTH USE?

The following edits are those we use at the present time. These edits may change as NCCI updates their edits. We will update our Claims System as soon as new edits become available.

PROCEDURE TO PROCEDURE (PTP) CODE PAIR EDITS

PTP code pair edits are applied to claims submitted by physicians, non-physician practitioners, and Ambulatory Surgery Centers (ASC's).

PTP edits are also applied to Types of Bills (TOBs) codes subject to the Outpatient Code Editor (OCE) for the Outpatient Prospective Payment System (OPPS). These edits are applied to outpatient hospital services and other facility services including, but not limited to, therapy providers (Medicare Part B Skilled Nursing Facilities), Comprehensive Outpatient Rehabilitation Facilities (CORFs), outpatient physical therapy and speech-language pathology providers (OPTs), and certain claims for home health agencies (HHAs) billing under TOBs 22X, 23X, 75X, 74X, 34X.

Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass a PTP code pair edit if the clinical circumstances do not justify its use. MotivHealth follows the Medicare Program's use of modifiers. If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass a PTP code pair edit if the Medicare restrictions are fulfilled.

For guidance on reporting modifiers, refer to CMS Coding Edits Guidelines .

MEDICALLY UNLIKELY EDITS (MUE)

An MUE for a HCPCS/CPT code is the maximum units of service allowable by the same provider for the same patient on the same date of service. MotivHealth follows CMS's use of MUE's. For additional information on how MUE's are used to reduce improper payments, refer to CMS Medically Unlikely Edits .

NATIONAL PHYSICIAN FEE SCHEDULE (NPFS) STATUS B AND T CODES

All codes published on the NPFS by CMS are assigned a status code. If the service is covered by CMS, the status code indicates whether the code will be paid separately or bundled into the payment for another service.

MotivHealth follows the CMS guidelines for Status B and Status T codes. We will not reimburse for status B codes regardless of whether they are billed alone or in conjunction with other services. We will reimburse for Status T codes if there are no other services payable under the NPFS billed on the same date by the same provider. If any other services payable under the NPFS are billed on the same date by the same provider, these services are bundled into the services(s) for which payment is made.

For a listing of the current Status B and Status T codes refer to CME Physician Fee Schedule Relative Value Files for B and T Codes .

CAN PREVIOUSLY SUBMITTED CLAIMS BE CORRECTED OR RESUBMITTED?

Below are the categories of claim resubmissions that we recognize.

CORRECTED CLAIM/REBILLED CLAIM

You may rebill or send a corrected claim for errors you find in the original submission or that we find on review. For errors that we find that do not require appeal, you must follow the instructions for billing the charge on a corrected/rebilled claim and use the appropriate frequency code. Claims without the correct coding may be denied as a duplicate. Adjustment requests for corrected claims must be submitted within one hundred eighty (180) days from the date of original payment or denial.

RESUBMITTED CLAIM

These are claims that you submit after we have determined your original claim was NOT CLEAN. This is a new claim submission to correct the defects of the original claim submission. Such claims should be resubmitted with all defects cured. Resubmitted claims must be submitted within one hundred twenty (120) days from the date of denial or receipt of Explanation of Benefits.

SPLIT BILLINGS

These are claims for which services or supplies are billed AFTER the member has discharged and are an extension of the dates of services on a previously paid claim. These claims are not accepted and will be denied. These claims cannot be billed or collected from our members.

INTERIM CLAIMS

These are claims for which services or supplies are billed BEFORE the member has discharged and are an extension of the dates of services on a previously billed or paid claim. These claims are not accepted and will be denied. These claims cannot be billed or collected from our members.

CLAIM REVIEWS

MotivHealth has the right to review providers' claims prior to payment or after payment if a claim was not reviewed prior to the reimbursement. Our reviews help to ensure that our members' care is covered under their benefit plans and to ensure payment integrity. Our evaluations may include but are not limited to medical necessity assessments if pre-authorization was not obtained, line-by-line reviews, assignment of DRG's, and assessment for policy compliance and correct coding.

We will request any medical, financial, or administrative records needed to verify accurate billing practices. Please cooperate with our claim payment reviews. Claims will be denied until all requested documents are received. Claims denied for records are not eligible for appeal or reconsideration and cannot be billed or collected from our members. For additional information on record requests, see MEDICAL RECORDS STANDARDS AND SUBMISSION REQUIREMENTS within this document.

Any medical or surgical service, supply, or item, either inpatient or outpatient, reported by any code, must be clearly documented in an appropriate medical record and consistent with our documentation policies. Reimbursement is not allowed for non-compliant or undocumented professional, inpatient or outpatient medical and surgical services, supplies, and items.

Procedures should be reported with the CPT/HCPCS code that describes the services performed to the greatest specificity possible and only if all services described by that code are performed. Procedures that are a component of other procedures even if the component procedure(s) have CPT codes will not be reimbursed. Unbundling occurs when multiple codes are used to report a procedure covered by a single comprehensive CPT/HCPCS code. Unbundling of services or supplies will be denied.

When you submit a claim to us you acknowledge that you or any of your staff has not been excluded or debarred from participation in the Medicare program or any other federal program.

OVERCHARGES

If our prepayment review finds that the billed charges were more than allowed, we will deny the charge. If a charge can be rebilled on a corrected claim, our letter informing you of the outcome of our review will provide instructions. Any denials are eligible for appeal or reconsideration.

UNDERCHARGES

If our prepayment review finds that the billed charges were less than allowed, our letter informing you of the outcome of our review will notify you of the undercharges and provide instructions on how to rebill the charge on a corrected claim.

OVERPAYMENTS

If our post-payment review finds that we overpaid the claim, we will recoup the funds. Refunds of overpayments are to be returned to MotivHealth within sixty (60) days of identification of overpayment or a voucher deduction on subsequent claims will be taken depending on our agreement with you and applicable state laws.

UNDERPAYMENTS

If our post-payment or prepayment review finds that we underpaid or may underpay the claim, our letter informing you of the outcome of our review will notify you of the undercharges. Additional payment will be made to you within sixty (60) days of identification of the underpayment.

MEDICAL RECORDS STANDARDS AND SUBMISSION REQUIREMENTS

Medical records are an important part of patient evaluation and treatment. They provide evidence of actions and decisions made during the rendering of care and are also necessary for the appropriate administration and payment of a provider's reimbursement requests. Adherence to the guidance in this policy will provide more efficient claims processing and expedient payment.

To the extent permitted by law and unless otherwise stated in our agreement, we have the right to request and inspect medical, financial, and administrative documents that we believe would ensure the appropriate reimbursement of a provider's request for payment for covered services rendered on behalf of our members. We will request all documentation needed to support the services billed.

Please cooperate with our requests for the documentation we need to assess your payment requests. While we endeavor to notify of all the records we need in a single initial request, there are times when a more in-depth analysis of the claim is required. Please promptly comply with any requests for additional records also. When available, please provide access to electronic medical records (EMR). This type of data sharing capability improves efficiency, is cost effective and expedites record retrieval.

Our requests for records are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule which allows release of medical information for treatment, payment, and healthcare operations without the express written consent of the patient. For further information, refer to 45 CFR § 164.506

There are specific record requirements for our Concurrent Review Program and for dispute resolution of claim payments.

HOW ARE DOCUMENTS REQUESTED?

When we receive your claim, we will send you an **Initial Records' Request Letter** listing all the records we believe we need to assess the claim and make a payment determination. The time frame in which you should submit all requested records will also be included. Your claim will be closed in our system until we receive all requested documentation.

If, after the stipulated time frame, we find that no records were sent to us, we will send you another notification. If records are not received after the time indicated on that letter, the claim will be permanently closed in our system. Claims denied for records are generally not eligible for appeal and should not be billed or collected from our members.

WHAT ARE THE REQUIREMENTS FOR ACCEPTABLE MEDICAL RECORDS?

There are four criteria that we utilize to determine whether a document is considered acceptable for any review that we may conduct on your reimbursement request:

- Authenticity: document was created by the person, for the member at the time the record represents
- Reliability: complete and accurate
- Probity: integrity maintained; record is unaltered and protected against unauthorized alteration
- Usability: provides the information requested in a system that allows quick access and timely retrieval.

All four of the above elements must be present simultaneously for each document you provide. We have no requirement as to the way the care you provide to our member is recorded. Requested documentation may be handwritten or electronic. Regardless of the format or the mode of delivery, however, the requested documentation we receive from you must be comprehensive, legible, and consistently organized.

Below are the general guidelines for medical records that must be met. Documentation submissions that do not meet all these requirements, as applicable, will be considered incomplete. Claims with incomplete records will be denied. Claims denied for records are generally not eligible for appeal and should not be billed or collected from our members.

- Each page of the documentation we receive from you must contain the member's name or member ID. This will ensure HIPAA compliance in our review and administration of your claim.
- Documentation must support all diseases, disorders, infirmities, and complications coded on the claims you submit. Each claim must include a diagnosis.
- Each diagnostic and therapeutic procedure and all medications must have a signed order by a physician or healthcare professional licensed in the state where the service or medication was administered.
- Treatment plans, counseling, member education and coordination of care must be included.
- Hospital acquired conditions (HAC), Iatrogenic Complications, Never Events and Serious Reportable Events (SRE) must be clearly identified in the medical record. The claim you submit must also identify the condition with the Present on Admission indicator of "N."
- Documentation for surgical procedures must indicate if a similar surgery was performed within the last 30 days or if the current procedure was performed to repair a surgery or complication that was performed within the last 30 days.
- All medications administered to the member during an encounter must include NDC, dosage, date of administration, and drug waste as appropriate and must be documented in the Medication Administration Record (MAR).

- Unresolved issues must be noted. Adverse reactions to medications and allergies to substances or supplies must also be conspicuously documented.
- Evaluation and Management (E&M) claims must prominently note the chief complaint as well as appurtenant history, physical examination, past medical history as well a member's subjective/objective information.
- All diagnostic services and therapeutic procedures must be clearly documented. If diagnostic services have not resulted and procedures are without a description of the process and outcome, these records will be considered incomplete.
- Behavioral health claims must contain information regarding the level of member participation in the formulated treatment plan. Records without this information will be considered incomplete.
- The itemized bill and the claim must be consistent in number of units and amounts charged for all revenue codes where payment is expected. Itemized bills that do not reconcile with the claim you send us will not be processed.
- Amending or correcting a medical record should be done by striking through. Do not delete or overwrite the original entry. Claims where the documentation is found to have been altered retrospectively will not be paid. These claims are generally not eligible for appeal or reconsideration. If the altered documentation is found during an appeal or reconsideration review, the dispute will be denied, and any funds paid on such a claim will be recouped.

If we identify opportunities for improvement in your records' management, our Quality Department will present these to you and offer suggestions for implementation.

WHEN MUST REQUESTED RECORDS BE SUBMITTED?

All requested documentation must be provided to us within 30 days of the initial records' request or as indicated in the most recent correspondence you receive from us on a particular claim.

HOW SHOULD REQUESTED RECORDS BE SUBMITTED?

You are responsible for sending all requested documentation in a manner that is compliant with HIPAA standards and within the timeline stipulated on the Records Request Letter that we send to you.

You may send the documentation in the following modes:

Fax: (844) 533-1289

USPS, FedEx, UPS:

MotivHealth Insurance Company
10421 S. Jordan Gateway, Suite 300,
S. Jordan, UT 84059

Secure email: Correspondence@MotivHealth.com

We do not accept CD's or DVD's.

ACCESS TO RECORDS

It is the provider's responsibility to maintain medical records in a system that permits timely access to the requested documents. Records that do not meet our documentation standards, submission requirements and/or timelines will be denied. Claims denied for noncompliance with our records' standards and requirements are not eligible for appeal or reconsideration and cannot be billed to our member.

PRESERVATION OF RECORDS

Unless otherwise stated in our agreement or specifically mandated by law, documentation to support the claim, verify compliance with our policies and identify fraudulent billing practices should be maintained for ten (10) years and twenty-one (21) years for maternity/pediatric claims.

RECORD FEES

Unless otherwise stated in our agreement or specifically mandated by law, we will not pay any documentation fees or delivery charges to you or any supplier that you may hire or delegate to generate the records we request. We will not pay access or subscription fees for our use of your EMR system to review the records needed to make a payment determination of your claim or assess medical necessity of the care you provided to our member.

INSUFFICIENT DOCUMENTATION AND FINAL WARNING LETTER

If you have sent us documentation but we did not receive all the records we requested or the documentation you sent is not legible, we will deem the documentation to be insufficient to make a payment or medical necessity determination. At this time, we will send you a **Final Medical Request Letter** informing you of the time within which you must send all requested records.

If you do not respond with the requested documentation within the time frame stipulated, we will deem the records already received from you to that point to be complete and in their entirety and appropriate for review. At that time, we will begin our review and process your claim with the records already on hand.

Insufficient documentation may forfeit payment of some or all the claim. Additional documentation provided after our review and payment may not, at our sole discretion, be accepted for either a post payment review or for an appeal of our original decision on reimbursement. Our members may not be balanced billed for denials related to insufficient documentation.

APPENDIX OF DEFINITIONS

Appeal: A request from a provider or Member for the Plan to review an adverse determination of either a preauthorization or claim denial, where the Member may have some financial responsibility.

Corrected Claim: These are claims that we receive from the claimant after we have reviewed and paid your claim.

CPT: Current Procedural Terminology. A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

Evaluation and Management (E/M) Services: Services that requires three key components; problem or comprehensive history examination; medical decision making; counseling and/or coordination of care with physician or other qualified health care provider.

HCPCS: Healthcare Common Procedure Coding System

HCPCS Level II: A standardized coding system that is used primarily to identify medical supplies, durable medical equipment, non-physician services, and services not represented in the Level I code set CPT

Hospital Acquired Condition (HAC): A condition that is not present with the patient is admitted to or arrived at the hospital or other facility but occurs during or after the stay. HAC's include infections and medical errors.

Iatrogenic Complications: An adverse condition that is a direct result of treatment by a physician or other health care professional.

Interim Billing: These are claims for which services or supplies are billed BEFORE the member has been discharged and are an extension of the dates of services on a previously billed or paid claim.

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM, ICD-10): A morbidity classification system for classifying diagnoses and reason for visits in all health care settings for the purpose of coding and reporting.

Medical Necessity: Any health care services, supplies or treatment provided for an illness or injury which is consistent with the Member's symptoms or diagnosis provided in the most appropriate setting that can be used safely, without regard for the convenience of a member or provider. However, such health care services must be appropriate with regard to standards of good medical practice in the state of Utah and could not have been omitted without adversely affecting the Member's condition or the quality of medical care the Member received as determined by established medical review mechanisms, within the scope of the Provider's licensure, and/or consistent with and included in policies established and recognized by MotivHealth. Any medical condition, treatment, service, equipment, etc. specifically excluded in the Master Policy is not an "Eligible Benefit" regardless of Medical Necessity.

Medically Unlikely Edits (MUE): An MUE for a HCPCS/CPT code is the maximum Units of Service (UOS) that a provider would report under most circumstances for the same beneficiary on the same date of service.

Medicare Severity Diagnosis Related Group (MS-DRG or DRG): A classification system statistically designed to calculate inpatient hospital claim pricing. DRG's are defined by a specific set of patient attributes which include principal diagnosis, specific secondary diagnoses, procedures, sex, and discharge status, and the present of complications or comorbidities.

National Correct Coding Initiative (NCCI or CCI): The Centers for Medicare & Medicaid Services (CMS) developed these edits to promote consistent, correct coding and appropriate payment. These coding edits are developed based on the AMA CPT code set and the HCPCS code set, as well as analysis of standard medical and surgical practice and input from various groups, including specialty societies, other national health care organizations, Medicare contractors, providers, and consultants.

National Uniform Billing Committee (NUBC): Committees responsible for the revenue code definitions and requirements for use.

Never Events/Serious Reportable Events (SRE): Errors in medical care that are of concern to both the public and health care professionals and providers and of a nature that the risk of occurrence is significantly influenced by the policies and procedure of the health care organization.

Procedure to Procedure Code Pair Edits (PTP): Automated prepayment edits that prevent improper payment when certain CPT/HCPCS codes are submitted together on a claim form.

Provider Reconsideration: A request from the provider to the Plan to review an adverse determination without a preauthorization or claim denial where the Member or patient has no financial responsibility.

Rebilled Claim: These are claims we receive from the provider prior to our payment of a clean claim.

Resubmitted Claim: These are claims that you submit after we have determined your original claim was not clean.

Revenue Codes: Revenue codes are 4-digit numbers that are used on hospital bills to identify where a member was in a facility when they received treatment or services, or what service a member received as a patient.

Split Billing: These are claims for which services or supplies are billed AFTER the member has discharged and are an extension of the dates of services on a previously paid claim.

Unbundling: The use of multiple CPT/HCPCS codes to report a procedure or supply when a single comprehensive code exists that adequately describes the service or supply, either unintentionally or in an effort to maximize reimbursement.

Uniform Billing Editor (UBE): A reference tool utilized by facilities to manage the constant changes to Medicare billing and reimbursement processes. The UBE provides detailed, accurate, and timely information about Medicare and UB-04 billing rules and requirements.