New Provider Orientation

Provider Relations Department

2/2/2022

Agenda

- Peach State Health Plan Overview
- Peach State Health Plan Service Model
- Provider Resources
- Provider Responsibilities
- Verification of Member Eligibility
- Utilization Management/Prior Authorization
- Authorization Appeal Process
- Claim Submission & Payment
- Claim Reconsideration/Appeal Process
- Specialty Companies/Vendors
- Contact Information

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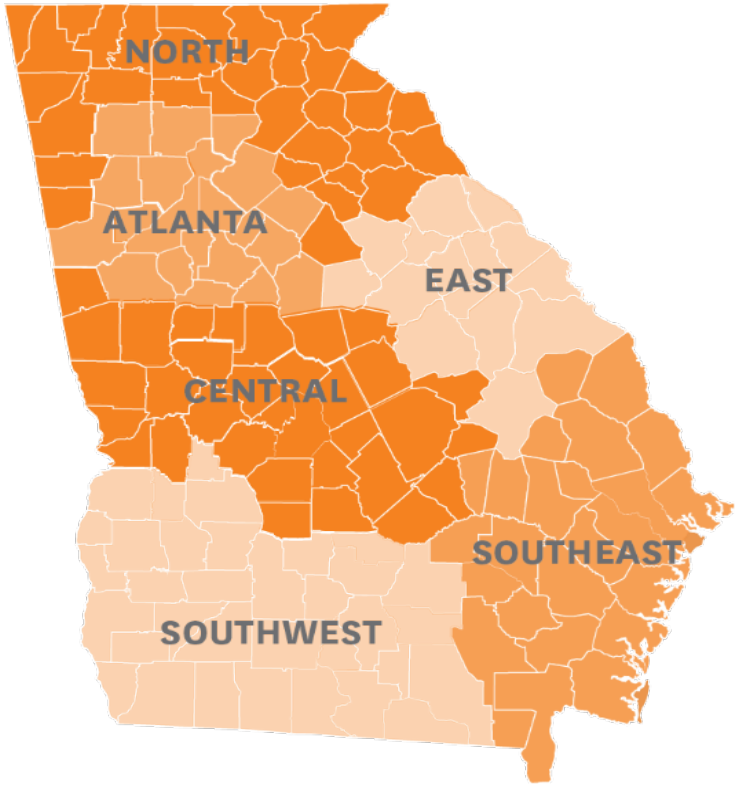
ACCREDITED NCQA HEALTH PLAN ACCREDITED



650 Local Employees

Care Management Organization (CMO) since 2006

Subsidiary of CENTENE® Corporation

956,264 Medicaid Members

50 States with government sponsored healthcare programs

Medicaid (29 States)

3 International Markets

Georgia Families Program

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Who is Georgia Families?

Georgia Families® is a program that delivers health care services to members of Medicaid and PeachCare for Kids®. The program is a partnership between the Department of Community Health (DCH).

Planning for Healthy Babies®

Planning for Healthy Babies® is a program from Georgia Department of Community Health.

Planning for Healthy Babies® offers no cost family planning services. The Planning for Healthy Babies program consists of three services:

- Family Planning (FP)
  - Only includes family planning services.
- Inter-pregnancy Care (IPC)
  - Inter-pregnancy includes family planning and additional services for women who have delivered a very low birth weight (VLBW) baby.
- Resource Mother.
  - Resource Mother is a case management service for women who have delivered a VLBW baby.

Members can apply online at www.gateway.ga.gov or pick up an application at their local:

- Public Health Department
- Division of Family and Children Services (DFCS) office
- Applications are also available at Federally Qualified Health Centers

Provider Resources

What Resources are Available to our Providers?

- Dedicated Provider Relations Contact
- Provider Servicing and Operations Team
- Provider Performance Team contact
- Provider Secure Portal
- Online Provider Training Library
- Provider Communications
- Community Based Medical Director & Clinical Teams
- Community Health Services Team
- Provider Practice HEDIS Education Team

Provider Relations Servicing and Operations Specialist

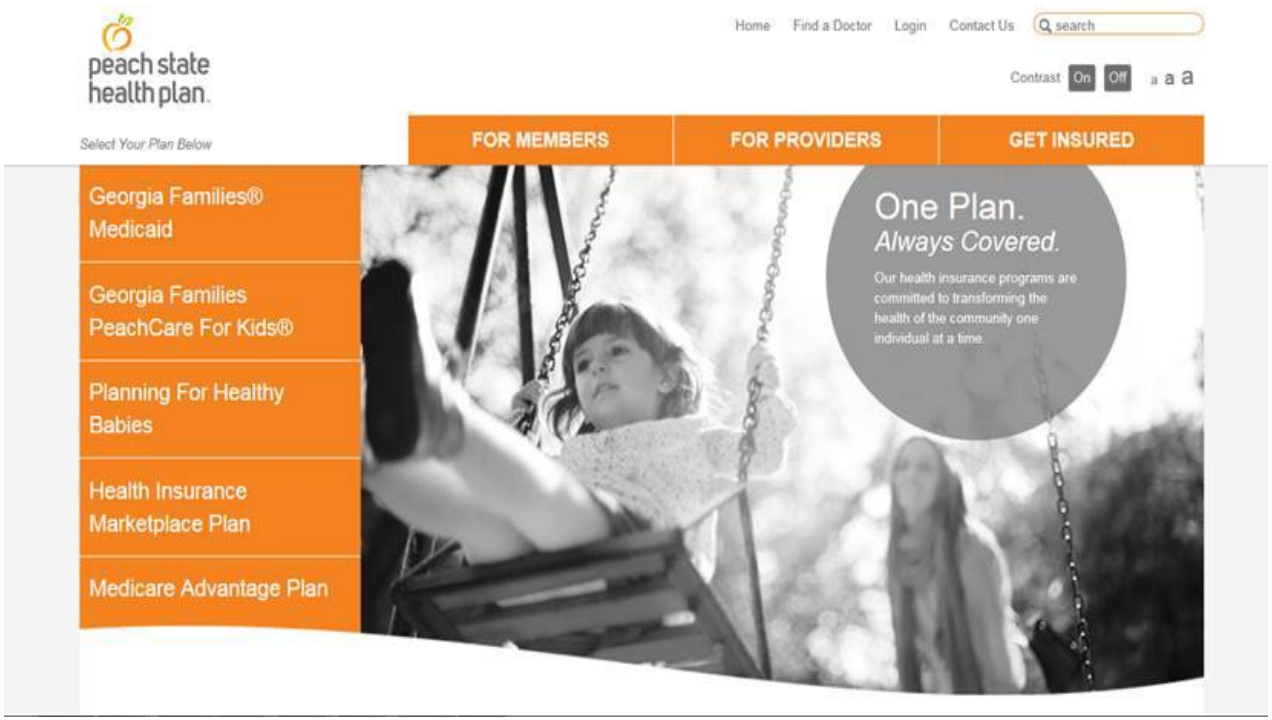
- Serves as the primary liaison between the Plan and our provider network
- Coordinate and conduct ongoing provider education, updates and training
- Clarify plan reimbursement and operational policies
- Demographic Information Update
- Member/Provider roster questions
- Assist in Provider Portal registration and education

Quality Practice Advisors

The Quality Practice Advisors will assist with:

- HEDIS measure education
- Resources available to support HEDIS gap closure in your office
- Education on the improved reporting and accessibility of data through new reporting tools. (i.e., Provider Analytics, Patient Analytics, Availity)
- Incentive Programs

Public Website



- Located at www.pshp.com
- Find-A-Provider Directory
- Quick Reference Materials
- Provider Relations Territory List
- Reimbursement Policies
- Provider Training Materials
- Preferred Drug List
- Pharmacy Forms & Notifications
- Provider Manual
- Provider Newsletters

Secure Portal Features

- Multi-product line and tax id support
- Member Eligibility Check
- Authorization Submission and Authorization Status Check
- Claim Submission and Claim Status Check
- Claim Dispute Submission
- View Explanation of Payment and Payment History
- PCP Patient List
- Care Gap, Disease Management and Case Management Reporting
- Access to Interpreta
- Comprehensive Member Health Record
- Claim Audit Tool
- Secure Messaging to the Provider Services Team

It's all part of the Members plan

Coverage that covers more

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Extra Benefits For Our Members

Over the Counter (OTC) - Each head of household can order $12 of OTC items each month without a script and mailed to your home. Plus, allowances can be rolled over for up to three (3) months at a time.

Adult Dental Members age 21 and over - Provides for members age 21 and over, no co-pay.

- FREE oral exams and cleanings every six (6) months.
- FREE annual bitewing X-ray for members.
- FREE simple tooth removals for members.
- There may be additional benefits for children 21 and under and pregnant members.

Adult Vision Members age 21 and over - Provides for members age 21 and over, no co-pay.

- Free eye exam: one per year.
- $100 to annual allowance toward glasses for members age 21 and over. Members can choose glasses outside of what is covered by Medicaid.

Grocery Allowance* - Provides qualified members age 18 and over with a grocery allowance of $50 per quarter. Members must complete three (3) Healthy Rewards activities to qualify. Members who select this benefit will be ineligible to receive the Home Delivery Groceries.

Girl Scouts - Covers the annual membership fee for members and includes supply fee for badges and patches for members in grades K-12. Must have visited their PCP and dentist within the last 12 months. Does not include summer camps.

Boys & Girls Club - Provides membership for children ages 5-18. Must have visited their PCP and dentist within the last 12 months. Does not include summer camps.

YMCA Family Membership - Members ages 6 to 18 may receive a YMCA family membership. Must complete three (3) healthy activities or visit their PCP and dentist within the past 12 months.

* VABS effective May 21-May 22

Provider Responsibilities

Provider Responsibilities

- **Peach State Health Plan's Provider Manual:** Review the manual and comply with the policies outlined in the manual.
- Provider accepts Members for treatment, unless they have a full panel and are accepting no new Georgia Families or commercial patients. Providers do not intentionally segregate Members in any way from other persons receiving services.
- Ensure Members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.
- PCPs and Physicians delivering care to Peach State Health Plan members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives.

Provider Responsibilities (cont'd)

- Prior-authorization requests may be submitted a maximum of thirty (30) days prior to the service/admission.
- Retroactive authorization request may be submitted for urgent services/admissions.
- Prior-Authorization requirements did not change with the implementation of the Centralized PA Portal. Providers are responsible for determining each CMO's prior-authorization requirements.
- Non-participating providers are eligible to submit authorization requests using the centralized portal.
- Peach State Health Plan has a Waste, Abuse and Fraud program that complies with state and federal laws. Peach State Health Plan, in conjunction with it management company, Centene Corporation, operates a billing errors/waste, abuse and fraud unit. The confidential hotline is 1-866-685-8664

Appointment Availability Standards

Provider Type	Waiting Time
PCPs – Routine/Regular visit (Adult and Pediatric)	Not to exceed fourteen (14) calendar days
PCPs – Sick/Urgent (Adult)	Not to exceed twenty-four (24) clock hours
PCPs – Sick/Urgent (Pediatric)	Not to exceed twenty-four (24) hours
PCPs – initial Pediatric health/screening check	Not to exceed ninety (90) calendar days of eligibility or within twenty-four (24) hours of birth (in the hospital) for all Newborns
Maternity care – • Pregnant Women- Initial visit • First Trimester • Second Trimester • Third Trimester	• Not to exceed fourteen (14) calendar days from enrollment • Not to exceed fourteen (14) calendar days • Not to exceed seven (7) calendar days • Not to exceed three (3) business days

Appointment Availability Standards (cont'd)

Provider Type	Waiting Time
Specialists	Not to exceed thirty (30) calendar days
Therapy: Physical, Occupational, Speech, and Aquatic Therapists	Not to exceed thirty (30) calendar days
Vision (Delegated Vendor)	Not to exceed thirty (30) calendar days
Dental Providers Routine visit-(Delegated Vendor)	Not to exceed twenty-one (21) calendar days
Dental Providers-Urgent visit-(Delegated Vendor)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) calendar days

Appointment Availability Standards (cont'd)

Provider Type	Waiting Time
Mental Health Providers • Care is available for a non-life-threatening appointment • Urgent care appointment available for a patient • Initial visit for routine care • Follow-up Routine Care	 • Within six (6) hours • Within forty-eight (48) hours • Within ten (10) business days • Within ten (10) business days
Urgent Care provider	Not to exceed twenty-four (24) clock hours
Emergency provider	Immediately (twenty-four (24) clock hours a day/seven (7) days a week) without prior authorization
High Volume specialist: Ob/ Gyn (excludes Ob/Maternity care visit requirement) Urgent	• Not to exceed thirty (30) calendar days • Within seventy-two (72) hours
High Impact specialist: Oncology Urgent	• Not to exceed thirty (30) calendar days • Within seventy-two (72) hours

Appointment Availability Standards (cont'd)

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Maximum Office Wait Time Standards

Scheduled Appointments	Waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Walk-In Appointments	Waiting time shall not exceed 90 minutes. After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Provider Response Time For After Hour Calls

- Urgent Calls: Shall not exceed twenty (20) minutes
- Other Calls: Shall not exceed one (1) hour.

Providers must provide one of the following after-hours options:

- An Auto Attendant/Answering system that advises the member that urgent calls will be returned within 20 minutes and all other calls will be returned within one hour and the option to page the physician; or

- A live attendant/Advice nurse and/or answering service that advises the member that urgent calls will be returned within 20 minutes and all other calls will be returned within one hour and the option to page the physician.

Cultural Competency

- Cultural Competency within the Peach State Health Plan Network is defined as “a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members.”
- Information on Peach State Health Plan’s Cultural Competency Plan can be found on our website, www.pshp.com.
- Peach State Health Plan offers Interpreter and Translation services both onsite and via telephone. Provider should call Member Services for assistance with interpreters at 1-800-704-1484.
- Language Line services are available in 140 languages to assist providers and enrollees in communicating with each other when there are no other translators available for the language.
- TTY access is available for enrollees who are hearing impaired through 1-800-255-0056.

Clinical Care Management Services

Clinical Management
- Prior Authorization
- IP Utilization: Onsite & Telephonic
- Integrated Care Management

Care Coordination/Care Management
- High Risk OB
- Adult/Pediatric Complex (Face to Face)
- ER
- Lead
- Sickle Cell
- Behavioral Health
- Planning for Healthy Babies / Resource Mothers

Education & Disease Management
- Asthma
- Diabetes
- Hypertension
- Mutual Approach to Partnership and Parenting

Innovative Programs
- Start Smart for Your Baby
- Healthy Start Women & Newborn Program
- Community Health Services
- Embedded FQHC
- Nicotine Screening of Pregnant Members

Care Coordination/Case Management

Case Management

- Adult and Pediatric Complex and Catastrophic
- High Risk Pregnancies
- Short Term Care Coordination
- ER Diversion
- Lead
- Sickle Cell
- Behavioral Health
- P4HB: Resource Mothers

Disease Management

Disease Management

- Asthma (Envolve People Care)
- Diabetes (Envolve People Care)
- Hypertension

Innovative Programs

Peach State Health Plan consistently uses innovative approaches to ensuring that our members receive appropriate, cost-effective care.

Start Smart program (Award winning program)

- Provider Incentive Program for Notification of Pregnancy
- Pregnancy Kits (Pre-Natal Vitamins)
- High Risk Pregnancies – Intensive Case Management
- Health Risk Assessments

Healthy Start Program (Award winning program)

- Promote Early Preventive Care through Face-to-Face education in top delivering hospitals
- Assist members by scheduling Initial Newborn and Post-Partum follow-up appointments
- Educating members on appropriate Family Planning benefits and program

Authorizations Overview

How can I determine if a service requires prior authorization?

- Pre-Auth Check Tool: https://www.pshpgeorgia.com/providers/preauth-check.html
- Peach State Health Plan Prior Authorization Guidelines (PSHP website)

What channels are available for prior authorization request submission?

- DCH Centralized Prior Authorization Portal: https://www.mmis.georgia.gov
- Peach State Health Plan Provider Secure Portal: https://provider.pshpgeorgia.com/
- Fax

What is the turnaround time to process an authorization request?

- Standard – Up to 3 business days
- Expedited – Within 24 hours

What is required for an authorization request to be considered expedited?

The provider must indicate, or Peach State Health Plan must determine, that following the standard review timeframe could seriously jeopardize the Member's life, health or ability to attain, maintain or regain maximum function.

Prior Authorization

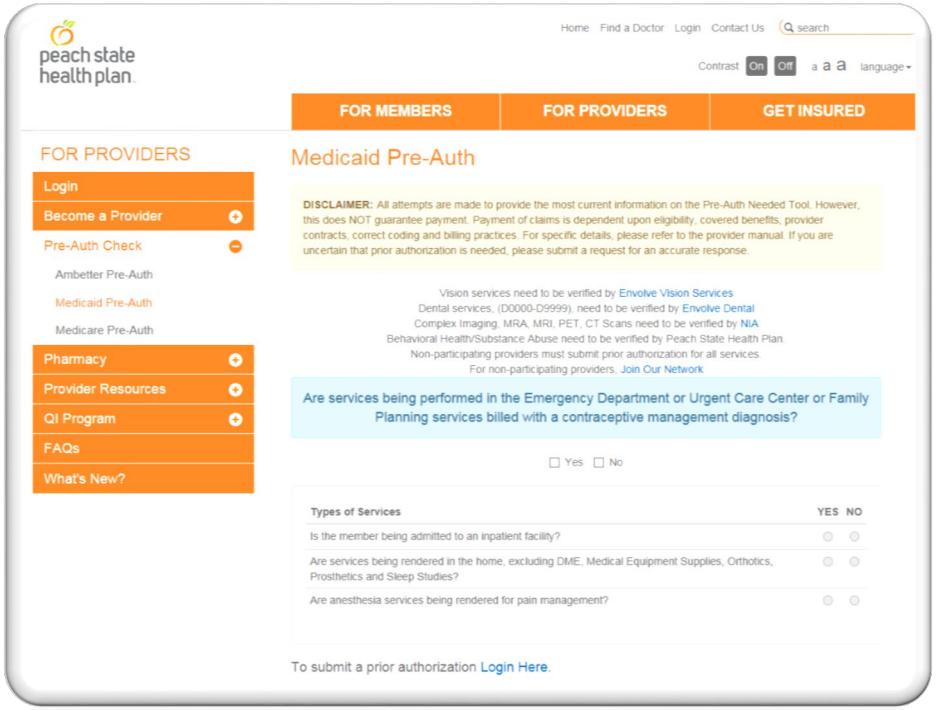
>90% of Services Do Not Require Prior Approval

- Peach State Health Plan is an open access health plan; no initial specialist referral needed
- Annual review of prior authorization requirements
- At least annually, Peach State Health Plan updates authorization requirements to ease administrative burden

PRIOR AUTHORIZATION SUMMARY	
Place of Service	**% Not Requiring Prior Approval**
Office – POS 11	94%
Inpatient – POS 21	89%
Outpatient – POS 19 and 22	89%
Ambulatory Surgery Center – POS 24	93%

Pre-Authorization Tool

- The **Pre-Auth Tool** may be used to identify the prior authorization requirement of a service or procedure.
- A search may be conducted by CPT code or HCPCS code.
- The Pre-Auth Check Tool is located on the Peach State Health Plan website at: https://www.pshpgeorgia.com/providers/preauth-check.html
- Tool available for Medicaid, Medicare and Ambetter product lines.



Centralized PA Portal

The Centralized Prior-Authorization (PA) Portal was implemented by the Department of Community Health to streamline the prior authorization process for Georgia Medicaid providers by allowing providers to submit CMO and FFS authorizations in a centralized location.

Newborn delivery notification	In-state transplants
Inpatient hospital admissions and outpatient hospital or ambulatory surgical center procedures	Durable Medical Equipment
Hospital outpatient therapy (includes ambulatory surgical centers)	Children's Intervention Services
Outpatient Behavioral Health	Exclusions: Dental, vision and radiology are processed by third party vendors
Pregnancy notification	

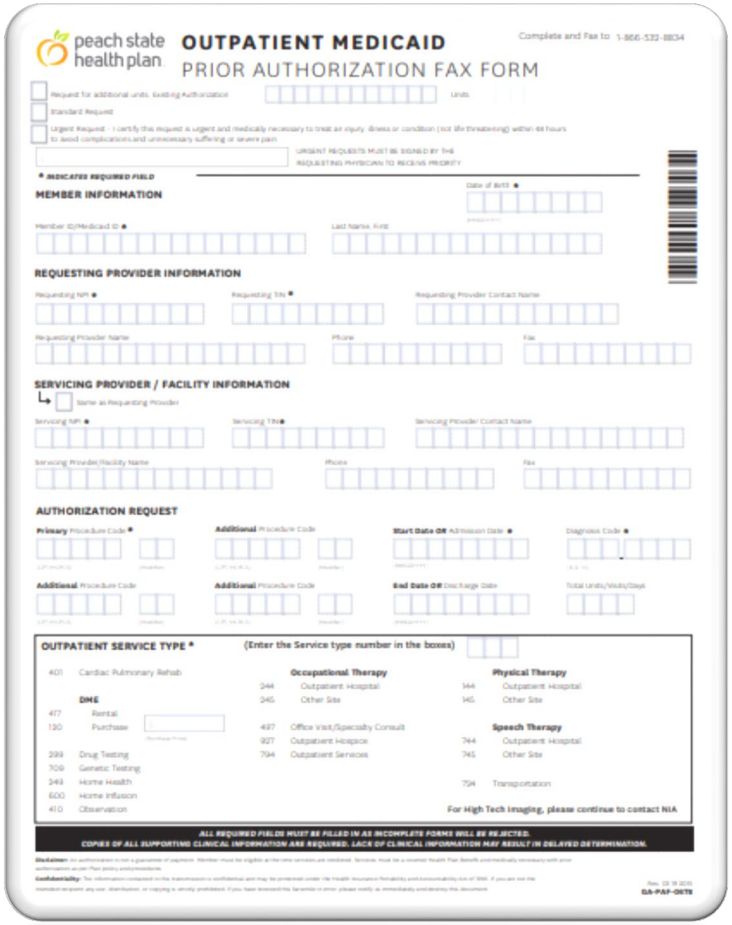
- How can a provider access the Centralized PA Portal? www.mmis.georgia.gov
- Where can Centralized PA Portal training be obtained? The Provider Education section of the GAMMIS website (www.mmis.georgia.gov)

Centralized PA Portal Facts

- Both standard and expedited prior authorization requests may be submitted using the centralized portal. Requests will be subject to traditional processing times.
- Prior-authorization requests may be submitted a maximum of thirty (30) days prior to the service/admission.
- Providers are responsible for determining each CMO's prior authorization requirements.
- Non-participating providers are eligible to submit authorization requests using the centralized portal.

PA Request Submission: Fax

- **Faxed authorization requests must be submitted using the Peach State Health Plan Inpatient or Outpatient Fax Forms.**
- Forms may be typed.
- A new copy of the form must be used for each prior authorization request. No photocopies.
- Faxed requests should be submitted to the UM department fax number associated with the product line.
- Faxed requests should only be submitted if the Centralized PA Portal is unavailable.



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OUTPATIENT MEDICAID

PRIOR AUTHORIZATION FAX FORM

Complete and Fax to: 1-866-532-8834

Request for additional units: Existing Authorization — Units

Standard Request

Urgent Request: I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life-threatening) within 48 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Date of Birth *

Member ID/Medicaid ID *

Last Name, First

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting Title *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI *

Servicing Title *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code *

Additional Procedure Code

Start Date OR Admission Date *

Diagnosis Code *

Additional Procedure Code

Additional Procedure Code

End Date OR Discharge Date

Total Units/Visits/Days

OUTPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

401 Cardiac Pulmonary Rehab

DME
477 Rental
720 Purchase

999 Drug Testing
709 Genetic Testing
249 Home Health
600 Home Infusion
410 Observation

Occupational Therapy
944 Outpatient Hospital
945 Other Site

937 Office Visit/Specialty Consult
927 Outpatient Hospice
764 Outpatient Services

Physical Therapy
944 Outpatient Hospital
945 Other Site

Speech Therapy
944 Outpatient Hospital
945 Other Site

754 Transportation

For High Tech Imaging, please continue to contact NIA

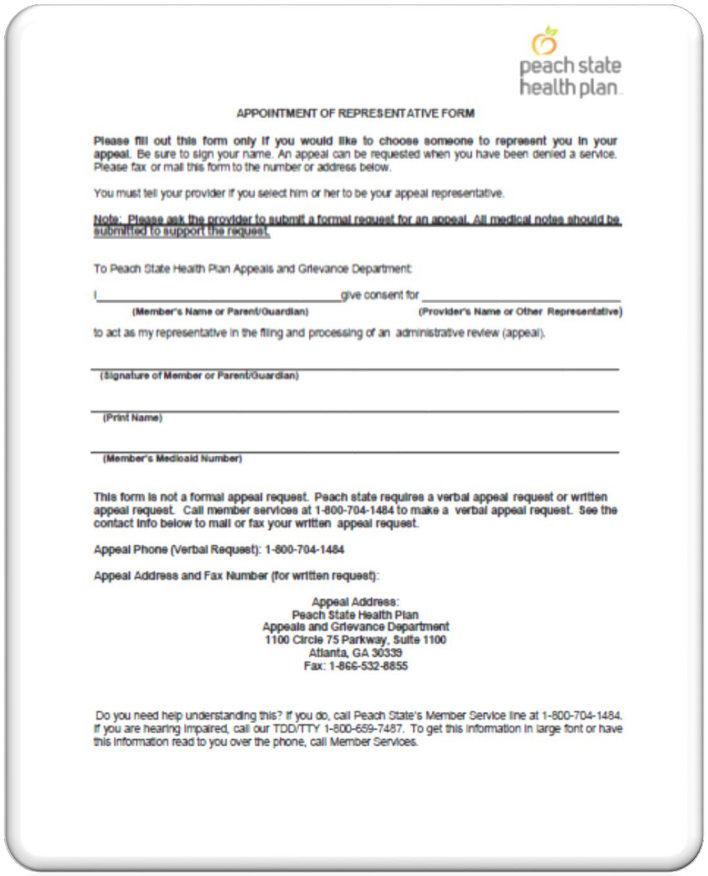
ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient, any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 03.19.2015
GA-PAF-0618

Appeals



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APPOINTMENT OF REPRESENTATIVE FORM

Please fill out this form only if you would like to choose someone to represent you in your appeal. Be sure to sign your name. An appeal can be requested when you have been denied a service. Please fax or mail this form to the number or address below.

You must tell your provider if you select him or her to be your appeal representative.

Note: Please ask the provider to submit a formal request for an appeal. All medical notes should be submitted to support the request.

To Peach State Health Plan Appeals and Grievance Department:

I _____ give consent for _____

(Member's Name or Parent/Guardian) (Provider's Name or Other Representative)

to act as my representative in the filing and processing of an administrative review (appeal).

_____

(Signature of Member or Parent/Guardian)

_____

(Print Name)

_____

(Member's Medicaid Number)

This form is not a formal appeal request. Peach state requires a verbal appeal request or written appeal request. Call member services at 1-800-704-1484 to make a verbal appeal request. See the contact info below to mail or fax your written appeal request.

Appeal Phone (Verbal Request): 1-800-704-1484

Appeal Address and Fax Number (for written request):

Appeal Address:
Peach State Health Plan
Appeals and Grievance Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
Fax: 1-866-532-8855

Do you need help understanding this? If you do, call Peach State's Member Service line at 1-800-704-1484. If you are hearing impaired, call our TDD/TTY 1-800-659-7487. To get this information in large font or have this information read to you over the phone, call Member Services.

- An **Appeal** is a formal request for the review of an adverse authorization determination.
- An adverse authorization decision is a denied, partially-denied or reduce authorization determination.
- A **Notice of Adverse Benefit Determination** (letter) is issued to the provider and the member when an adverse authorization determination is received.
- An appeal request must be submitted within sixty (60) calendar days from the date of the Notice of Adverse Benefit Determination to be considered timely.

Appeals (con't)

- An appeal request may be submitted by:
  - Member
  - Authorized Representative of the Member
  - Provider with member's written consent
  - A legal entity of a deceased member's estate
- Appeal requests may be submitted via phone, fax or mail.
- Verbal request for an appeal must be followed with a written request from the member or the member's written consent.
- A signed Appointment of Representative Form may be used by the provider to obtain the member's written consent.
- Faxed requests should be submitted to: 1-866-532-8855

Appeals (con't)

- Mailed requests should be submitted to:
  - Peach State Health Plan
  - Attn: Appeals and Grievance Department
  - 1100 Circle 75 Parkway, Suite 1100
  - Atlanta, GA 30339
- An acknowledge letter will be provided to the member and provider within 10 calendar days of the receipt of the request.
- A determination will be made within thirty (30) calendar days for a pre-service and post-service.
- The member and the provider will be notified of the outcome of the appeal request in writing during the review time frame.
- The appeal will be conducted by a health care provider with clinical training and experience in treating the member's condition or disease.

Expedited Appeals

- An **expedited appeal** request may be submitted if a decision on an appeal is required immediately based on a member's health needs.
- A provider may submit a request for an expedited appeal by calling Peach State Health Plan Provider Services at 1-866-874-0633.
- The expedited review request will be reviewed, and a determination will be provided in writing within 72 hours or as expeditiously as the member's health requires.
- An expedited review may be reclassified as a standard appeal if there is not sufficient evidence that an expedited review is required.
- If the review is reclassified as a standard review the requestor will be notified by telephone immediately and a letter will be sent within two (2) calendar days advising that the appeal will be reviewed through the standard review process.

Administrative Law Hearing

- An **Administrative Law Hearing (ALH)** is the final step in the authorization appeal process.
- A provider must exhaust all available appeal and provider compliant options before submitting a request for an Administrative Law Hearing.
- Administrative Law Hearing requests must be submitted within thirty (30) calendar days days of the Notice of Adverse Action.
- All request for an Administrative Law Hearing must be submitted in writing to:

Peach State Health Plan
Attn: Administrative Law Hearing Coordinator
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339

Specialty Company/Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-888-642-4723 www.radmd.com
Vision Services	Envolve Vision	1-866-458-2139 https://visionbenefits.envolvehealth.com/
Dental Services	Envolve Dental	1-844-464-5632 https://dental.envolvehealth.com/
Retail Pharmacy Services	Envolve Pharmacy Solutions	1-866-399-0928 (PA line) https://www.covermymeds.com
Specialty Pharmacy Services	Acaria Health	1-855-535-1815 https://acariahealth.envolvehealth.com/
Chemotherapy, Radiation	New Century Health	1-888-999-7713 https://www.newcenturyhealth.com/

Claims

Claim Submission

Peach State Health Plan offers the following claim submission options:

1. Provider Secure Portal: https://provider.pshpgeorgia.com

2. EDI/Clearinghouse: Payor ID 68069*

3. Mail /Paper claim submission:

   Peach State Health Plan
   P.O. Box 3030
   Farmington, MO 63640-3812

*Review the Peach State Health Plan Provider Quick Reference Guide for a list of approved clearinghouse vendors and applicable Payor ID's.

Claim Submission Timelines

Claim Type	Timely Submission Deadline
Original Claim	Six (6) months from the date of service
Corrected Claim	Six (6) months from the month in which the service was rendered or three months (3) from the month in which the denial occurred, whichever is later.
Claim Reconsideration	Six (6) months from the month in which the service was rendered or three months (3) from the month in which the denial occurred, whichever is later.
Claim Appeal	30 Days from the Claim Reconsideration Denial Date
Claim Life Cycle	Claims submissions and adjustments to denied claims completed within 365 days.
Administrative Law Hearing (ALH)	15 days from the Claim Appeal Denial
Secondary (COB) Claim	Within one (1) year from date of service

Claims Processing Timelines

“Clean” Claims:

- **Clean Claims** are defined as claims received by Peach State Health Plan for adjudication, in a nationally accepted format in compliance with standard coding guidelines which require no further information, adjustment or alternation to be processed for payment.
- Clean Claims will be adjudicated within 15 business days from the date of receipt.

“Non-clean” Claims

- **Non-clean claims** are submitted claims that required further information or investigation for processing.
- Non-clean claims may be subject to a front-end rejection.
- Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) business days from the date of submission.

Claims Payment

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PaySpan

- Peach State Health Plan partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT).

- The following options are available for PaySpan registration:
  - Phone: 1-877-331-7154
  - Web: https://www.payspanhealth.com/

Claim Submission Policies

- **CLIA Requirement:** Peach State Health Plan requires that a valid and appropriate CLIA certification or waiver number be included on all professional claims that contain laboratory services.

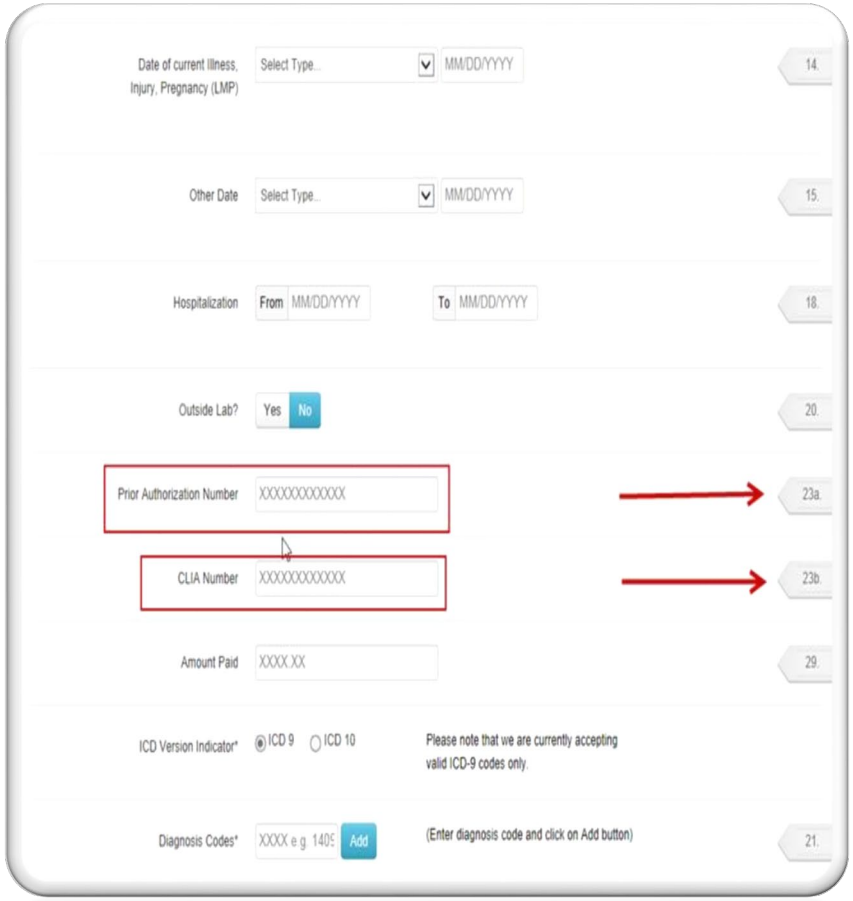
- **Ordering, Prescribing & Referring (OPR) Requirement:** In accordance with the Affordable Care Act, Peach State Health Plan currently edits medical claims for the presence of an Ordering, Referring or Prescribing Medicaid provider NPI.

- **Taxonomy Requirement**: Peach State Health Plan requires that all professional and facility claims be submitted with the applicable taxonomy code and qualifier code consistent with the provider's specialty.

- **Corrected Claim Submission**: Peach State Health Plan requires that all corrected claims be submitted with the appropriate claim resubmission code "7" and the original claim number. Claims should be free of handwriting.

CLIA Requirement

- The **CLIA Number** is required on the CMS 1500 claim form in all instances in which a CLIA waived or CLIA certified laboratory service is billed.
- The CLIA number should be populated in **Box 23** on a paper CMS 1500 claim.
- The CLIA number should be populated in **Box 23b** of the CMS 1500 claim form on the provider web portal.
- The CLIA number SHOULD supersede the authorization number on a paper claim.
- Failure to populate the CLIA number on the claim will result in a service denial.



Taxonomy: CMS-1500

Taxonomy Requirements:

- All claims are required to be submitted with the appropriate taxonomy code.
- Rendering and billing taxonomy are required on the claim.
- Referring taxonomy is conditionally required on the claim.
- Claims will be subject to a front-end rejection if taxonomy is omitted from the claim.

Rendering Taxonomy (Required)

Box 24i should contain the qualifier of "ZZ." Box 24j (shaded area) should contain the taxonomy code.

Billing Taxonomy (Required)

Box 33b should contain the qualifier of ZZ along with the taxonomy code.

Referring Taxonomy (Conditionally Required)

If field 17 is completed, then taxonomy is required in 17a with the "ZZ" qualifier.

Taxonomy: CMS-1500 (cont'd)

Rendering Provider: Box 24i/24j

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
														ZZ	208D00000X
														NPI	REQUIRED
														NPI	

Billing Provider: Box 33b

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. NPI	b.	John Doe M.D. 1313 Any Street Atlanta, GA 30339
			a NPI REQUIRED / b. ZZ208D00000X

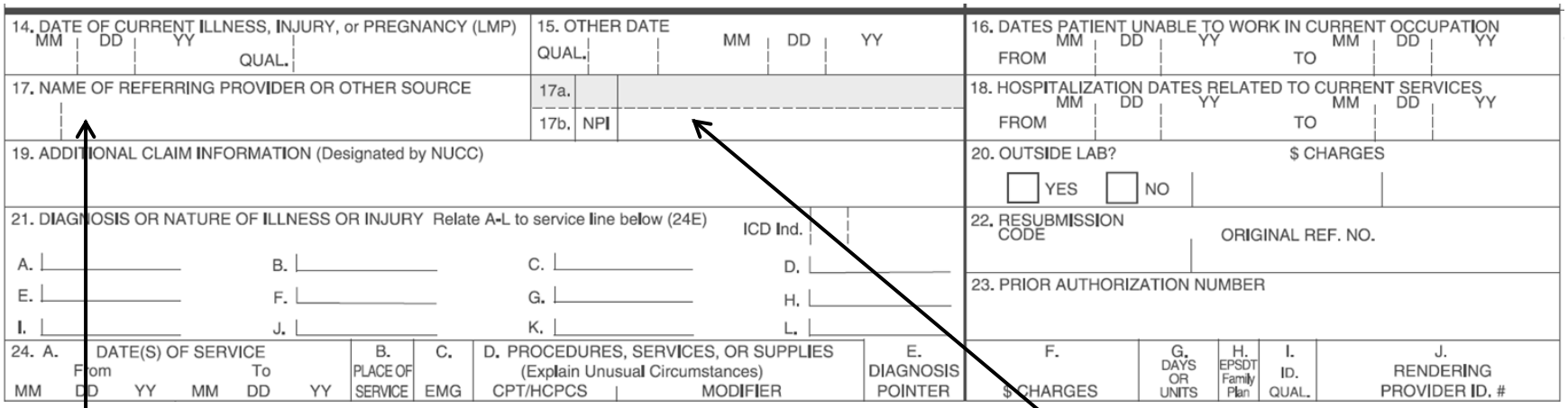
Taxonomy: CMS-1500 (cont'd)

Referring Provider: Box 17a

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE **Jane Doe MD**	17a. **ZZ** **208D00000X**	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
	17b. NPI **REQUIRED**	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES

OPR Requirement
CMS 1500 Claim Form

Enter the OPR information in **Box 17** and **Box 17b** of the CMS 1500 claim form.



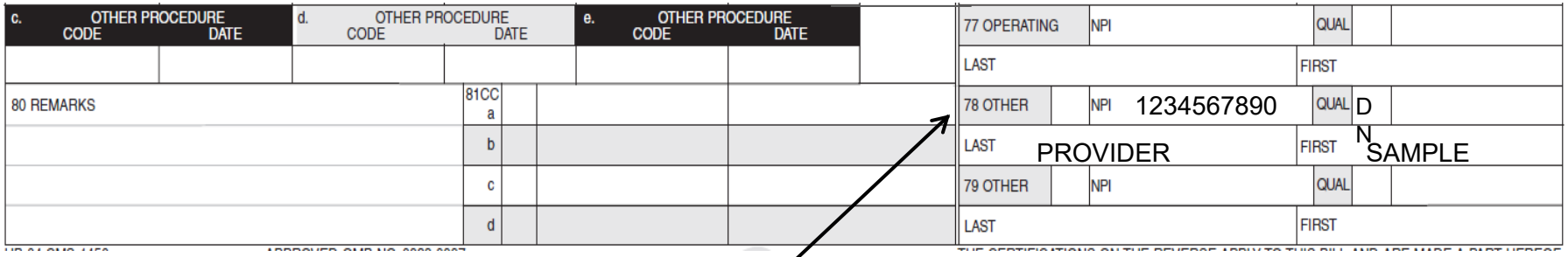
Box 17:

- Enter ordering, referring or supervising provider name to the right of the dotted line.
- Enter the 2-digit qualifier (ordering=DK, referring=DN, or supervising =DQ) to the left of the dotted line.
- Note: 2-digit qualifier not required for pharmacy claims.

Box 17b: Enter Individual Type 1 NPI number of the ordering, prescribing or referring provider.

OPR Requirement
UB-04 Claim Form

Enter the OPR information in **Box 78** of the UB-04 claim form.



c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

80 REMARKS	81CC			
	a			
	b			
	c			
	d			

77 OPERATING	NPI		QUAL		
LAST			FIRST		
78 OTHER		NPI 1234567890	QUAL	D	
LAST PROVIDER			FIRST	N SAMPLE	
79 OTHER		NPI	QUAL		
LAST			FIRST		

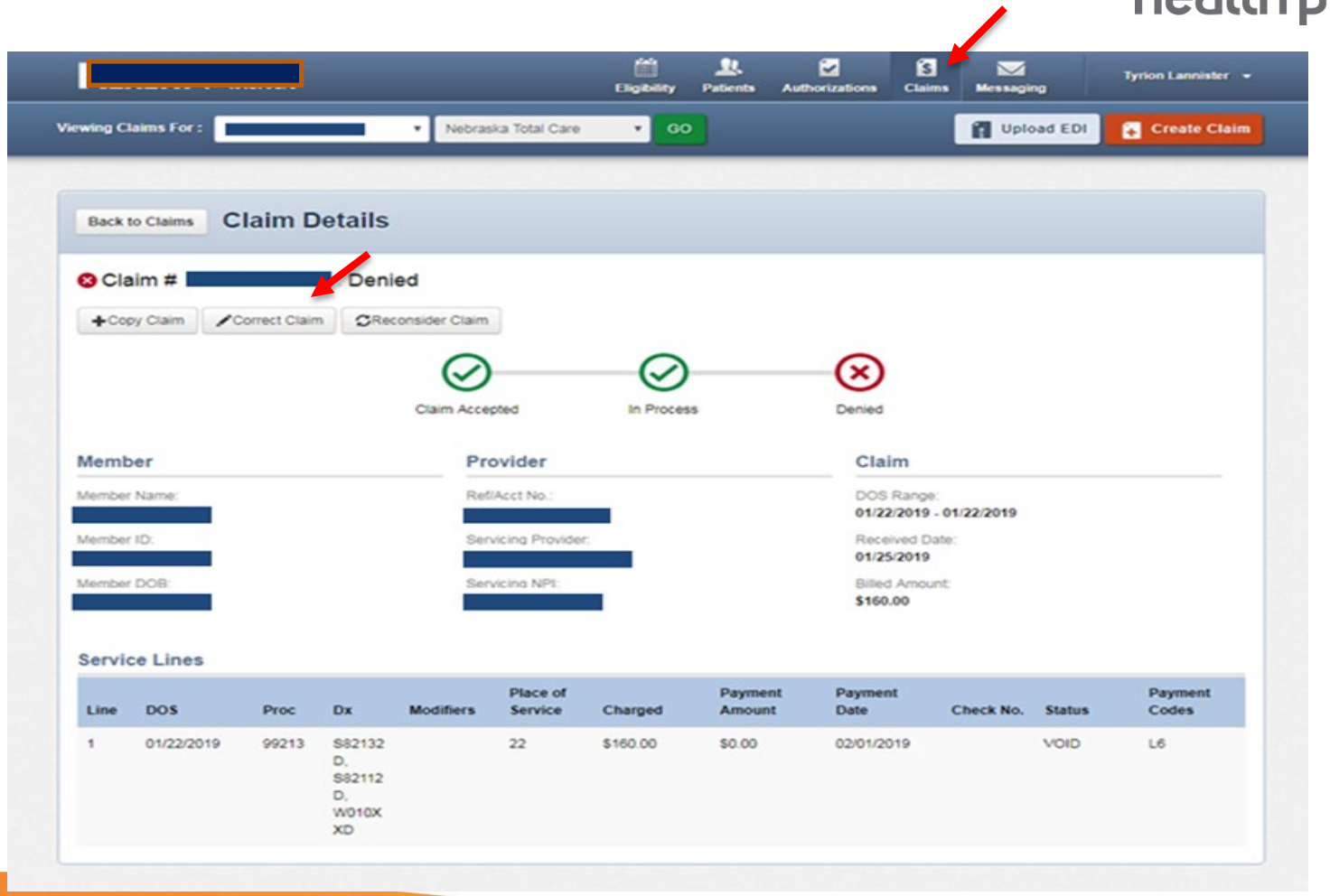
Box 78:

- Enter the ordering, referring or supervising provider's name and Individual Type 1 NPI number.
- Enter the 2-digit qualifier (ordering=DK, referring=DN, or supervising =DQ) in the box next to the "QUAL" field.

Corrected Claim Submission

- A **corrected claim** may be submitted to correct or change information submitted on the original provider claim.
- Corrected claims are subject to timely filling deadlines and must be submitted within six (6) months from the month of service or within three months from the EOP, whichever is later.
- A corrected claim may only be submitted **after** the original claim has completed the adjudication process.
- Corrected Claim submission options:
  - Paper
  - Electronically: Provider Secure Portal or approved Clearinghouse
- The “Correct Claim” button on the claim detail screen should be used to correct a claim on the Provider Secure Portal.

Correct Claim: Web Portal



Claim Reconsiderations

peach state health plan

Provider Adjustment Request Form

Please use this form to request a review of claim payment received that does not correspond with the payment expected. Matters addressed via this form will be acknowledged as requests for adjustment only.

Note: Requests must be submitted within 3 months of the original disposition of the claim. Claims can be sent individually or as a batch of similar or like claims. Please complete the appropriate section for resubmission type.

IMPORTANT: PLEASE COMPLETE ALL REQUIRED FIELDS BELOW

SIMPLE CLAIM ADJUSTMENT

Provider Name: _____ Provider Number: _____
Control Number: _____ Date(s): _____
Member Name: _____ Member Number: _____

REASON FOR ADJUSTMENT REQUEST:

☐ Denied for no authorization: authorization # _____ obtained
☐ Denied for no authorization: no referral required
☐ Denied for timely filling in error (please attach proof of timely filing)
☐ Paid to incorrect provider
☐ Incorrect payment amount
☐ Other (please explain below)

_____
_____
_____

BATCH SUBMISSION OF SIMILAR/LIKE CLAIMS FOR ADJUSTMENT

Provider Name: _____ Provider Number: _____
Control Claim Numbers: _____ # of Claims Attached _____

Explain the Issue in Detail: _____
_____
_____
_____

Note: If a claim requires a correction, such as a valid procedure, location code or modifier, please circle the claim number on the EOP and attach a copy of the new CMS 1500 or UB 04 marked **"RESUBMISSION."** Mail completed form(s) and attachments to:

Peach State Health Plan
P.O. Box 3030
Farmington, MO 63640

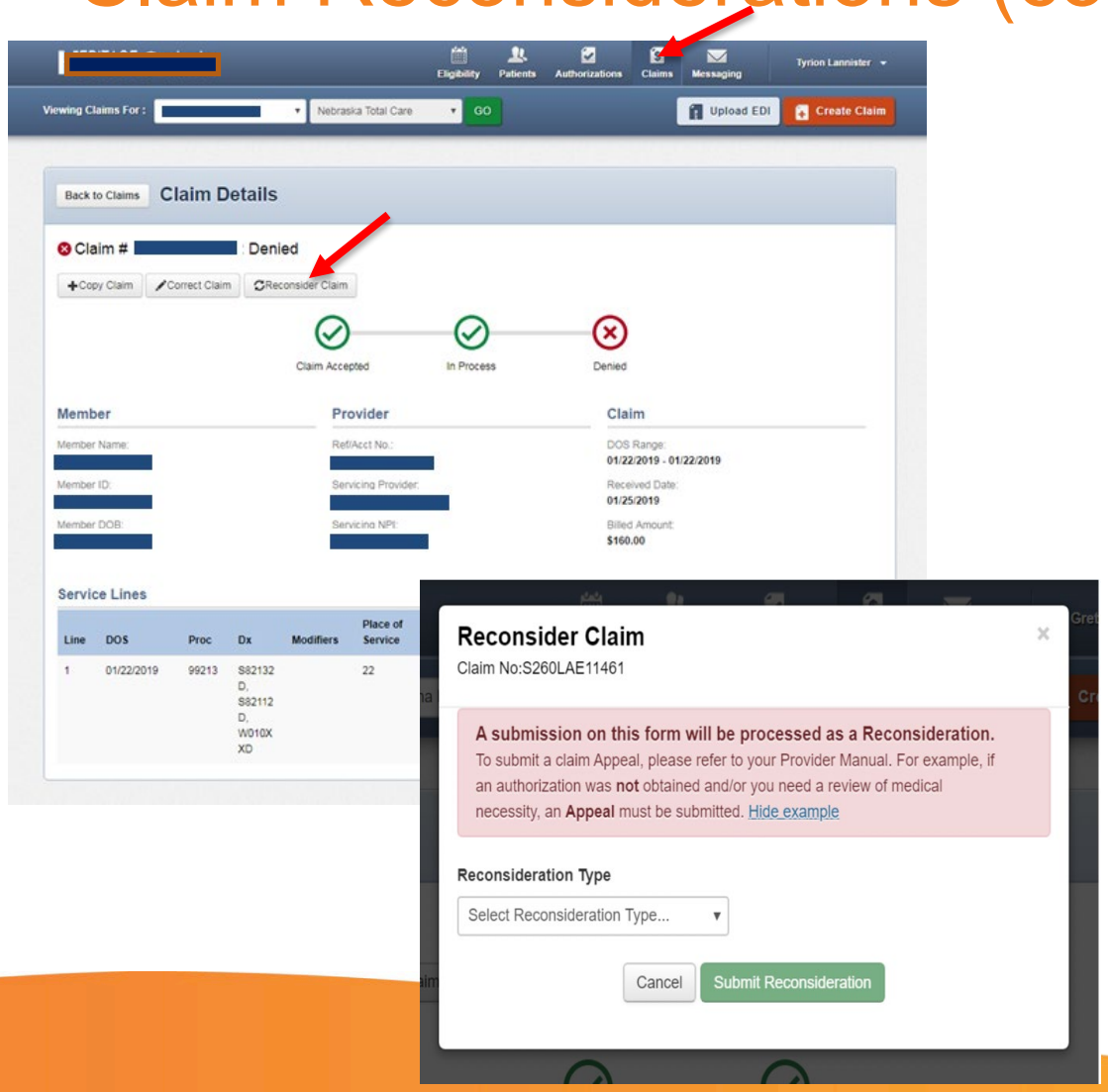
A photocopy of this form is permissible.

- A **claim reconsideration** is a formal request to have a claim that has received an adverse determination "reconsidered."
- A claim reconsideration is the first step in the claim dispute process.
- Claims reconsiderations must be submitted within six (6) months from the month of the date of service or three (3) months from the claim denial (EOP), whichever is later.
- The **Provider Adjustment Request** form is used to submit a claim reconsideration request.

Claim Reconsiderations (con't)

- Claim reconsideration requests may be submitted electronically via the Provider Secure Portal or by mail.
- Mailed claim reconsideration requests should be submitted to:
  - Peach State Health Plan
  - PO Box 3030
  - Farmington, MO 63640-3812
- The Provider Adjustment Request Form is required for claim reconsideration requests submitted by mail and by provider secure portal.

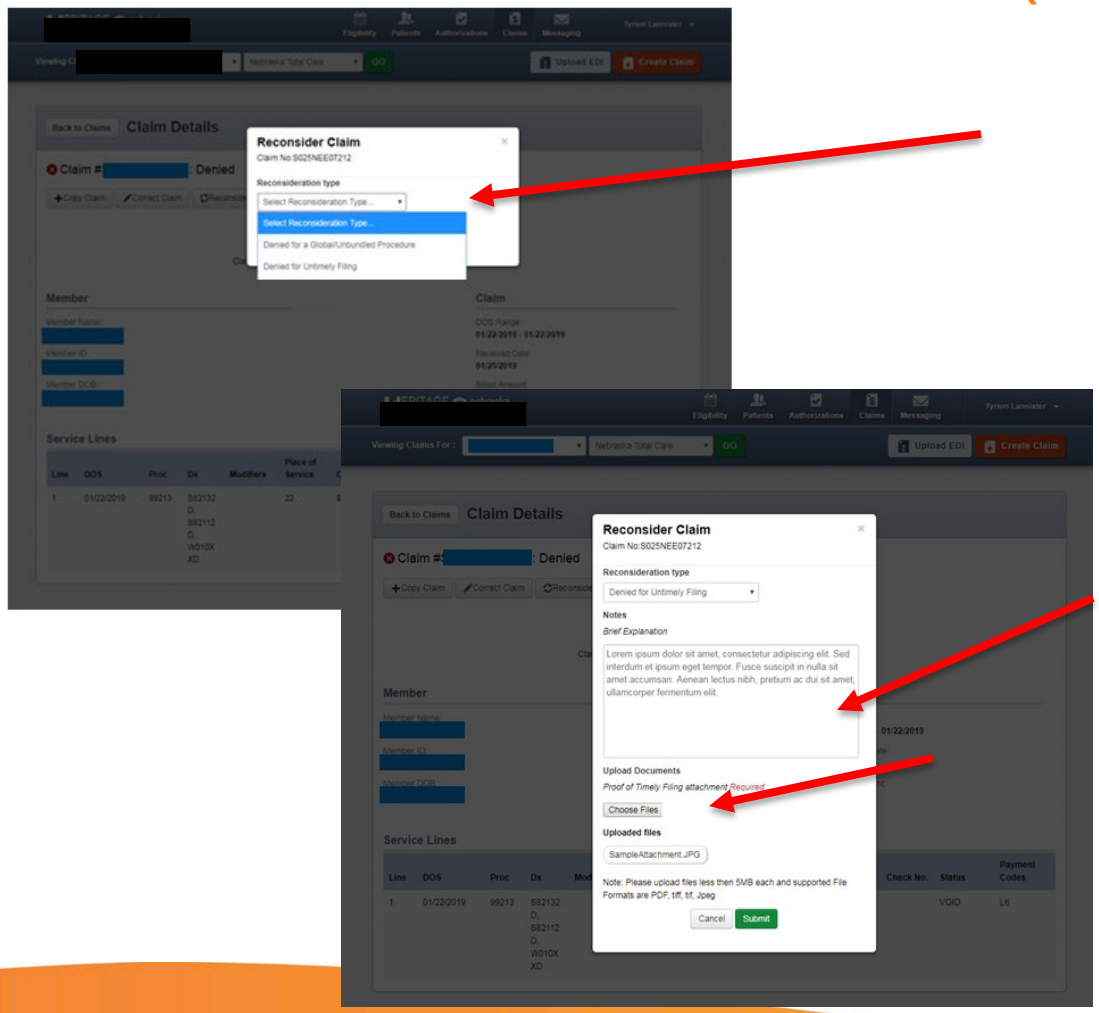
Claim Reconsiderations (con't)



- Within the Claims tab, navigate to the Claim Details page of a paid or denied claim.
- The **Reconsider Claim** button will be visible unless a web-initiated reconsideration is already in progress.
- Select **Reconsider Claim** to open Reconsider Claim pop-up window with a Reconsideration type dropdown.

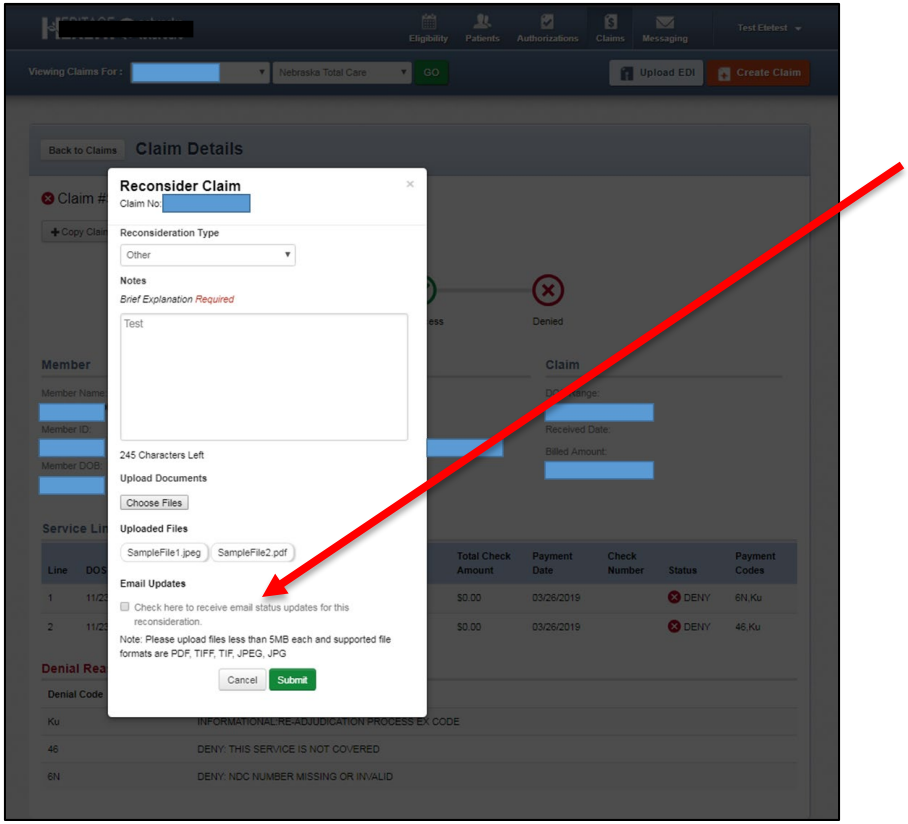
- **Please Note: Claims Tracker is only for Reconsiderations. Providers are not to use this for Appeals**

Claim Reconsiderations (con't)



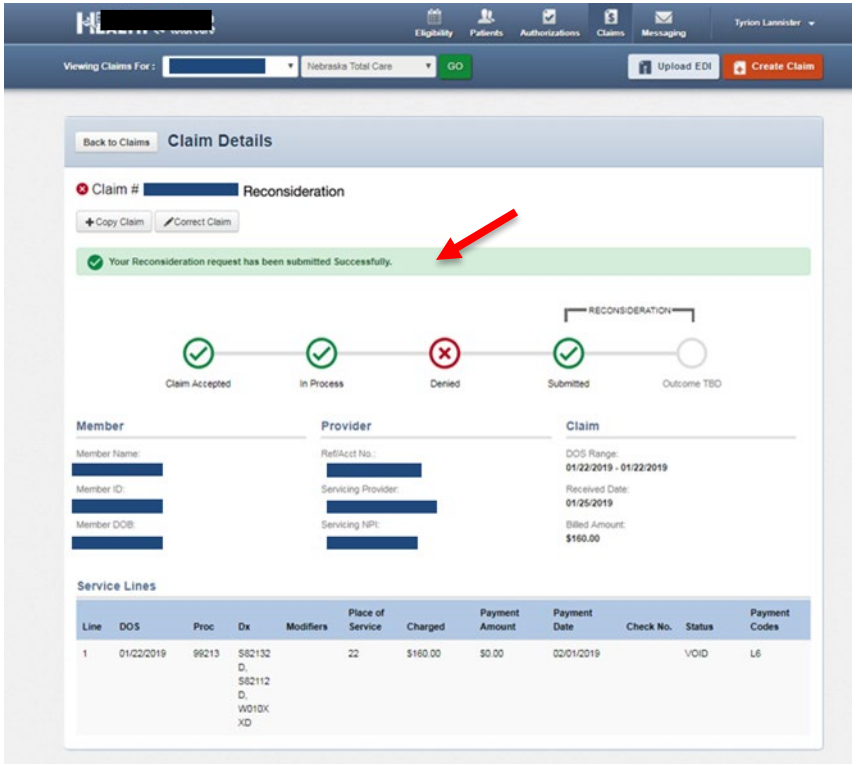
- From the dropdown, select a Reconsideration Type.
  - Examples:
    - "Denied for Global/Unbundled Procedure"
    - "Denied for Untimely Filing"
    - "Other"
- Ability to add notes and upload documents.
  - The form is dynamic; depending on the dropdown item selected, notes and/or documents may be required.

Claim Reconsiderations (con't)



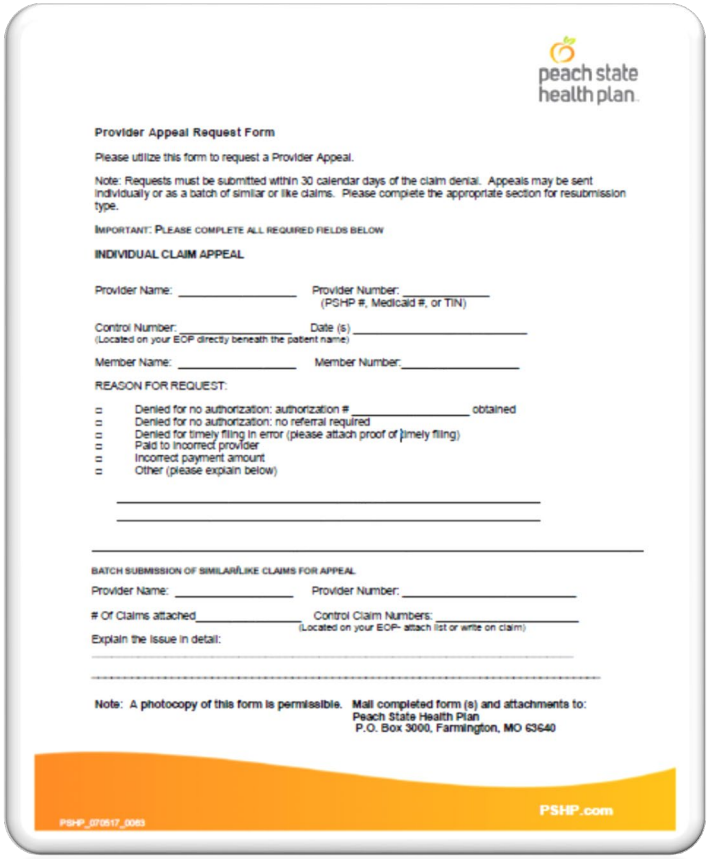
- Providers may opt in or out of email updates using the **Email Updates checkbox**
- Email Updates are triggered when Reconsideration Letters are posted
- Provider's email address populates from portal
  - Not editable on form
- Emails will only generate for submitted cases
- Select **Submit** after populating all required fields.

Claim Reconsiderations (con't)



- Upon submission, a success banner will be displayed.
- The tracker graphic will be updated to reflect that a reconsideration is in progress.
- **Reconsider Claim** button is no longer available.
- Claim status is updated.

Claim Appeals



peach state health plan

Provider Appeal Request Form

Please utilize this form to request a Provider Appeal.

Note: Requests must be submitted within 30 calendar days of the claim denial. Appeals may be sent individually or as a batch of similar or like claims. Please complete the appropriate section for resubmission type.

IMPORTANT: PLEASE COMPLETE ALL REQUIRED FIELDS BELOW

INDIVIDUAL CLAIM APPEAL

Provider Name: _____ Provider Number: _____
(PSHP #, Medicaid #, or TIN)

Control Number: _____ Date (s) _____
(Located on your EOP directly beneath the patient name)

Member Name: _____ Member Number: _____

REASON FOR REQUEST:

- ☐ Denied for no authorization: authorization # _____ obtained
- ☐ Denied for no authorization: no referral required
- ☐ Denied for timely filing in error (please attach proof of timely filing)
- ☐ Paid to incorrect provider
- ☐ Incorrect payment amount
- ☐ Other (please explain below)

_____

_____

_____

BATCH SUBMISSION OF SIMILAR/LIKE CLAIMS FOR APPEAL

Provider Name: _____ Provider Number: _____

Of Claims attached_____ Control Claim Numbers: _____
(Located on your EOP- attach list or write on claim)

Explain the issue in detail:

_____

_____

Note: A photocopy of this form is permissible. Mail completed form (s) and attachments to:
Peach State Health Plan
P.O. Box 3000, Farmington, MO 63640

PSHP.com

PSHP_070517_0063

- A **claim appeal** is a formal request for a review of an adverse claim reconsideration determination.
- A claim appeal must be filled within thirty (30) calendar days from the date of the claim denial (EOP).
- A **Provider Appeal Request Form** must be submitted to request a claim appeal.
- A claim appeal acknowledgement letter will be sent within ten (10) business days of the claim appeal.

Claim Appeals (con't)

- If the initial adverse claim determination is upheld, the provider will be notified of the decision in writing within thirty (30) calendar days of the receipt of the claim.
- If the decision is overturned, the provider will be notified through a newly issued Explanation of Payment (EOP).
- Claim Appeal requests should be submitted to:

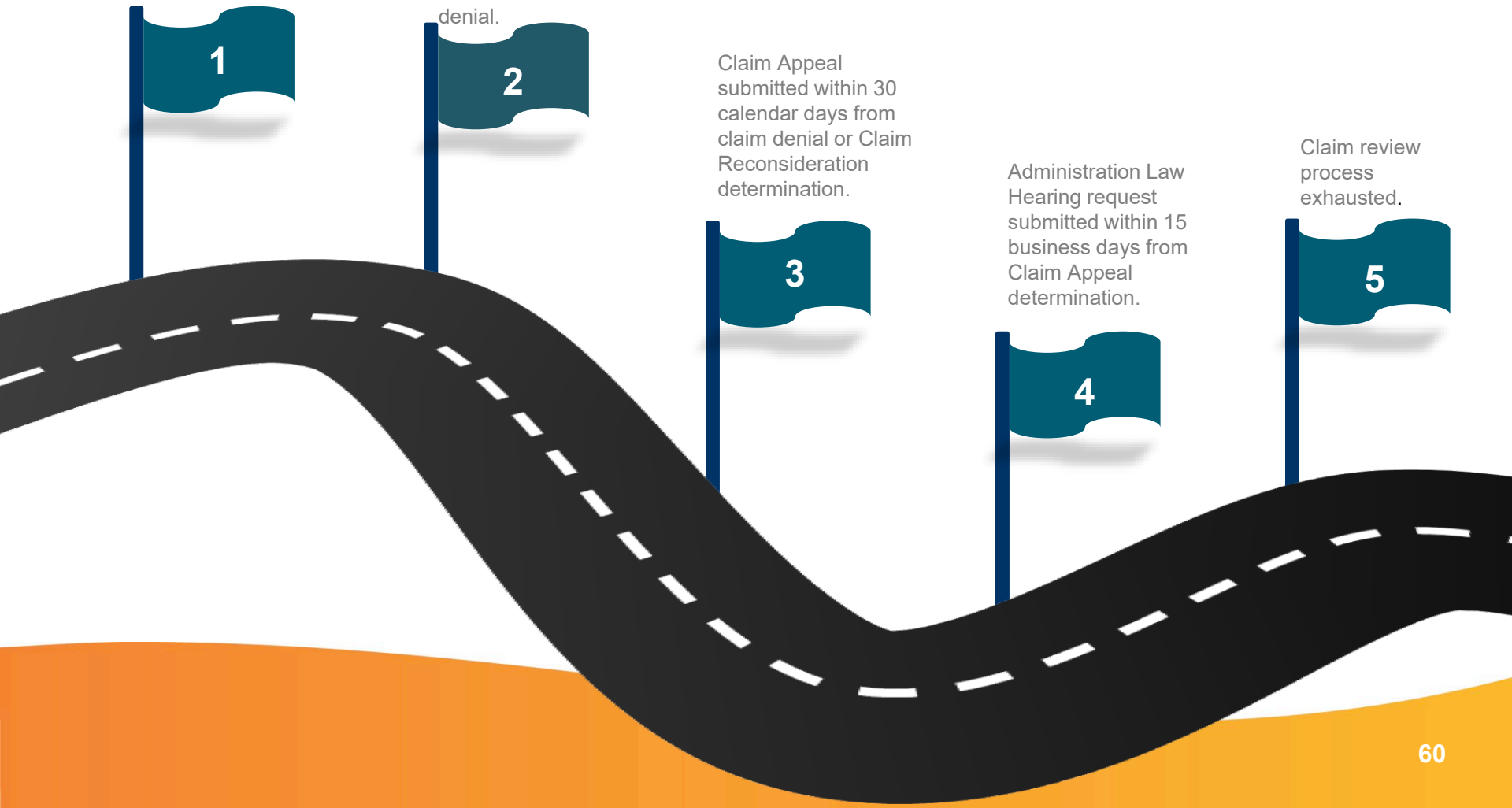
  Peach State Health Plan
  PO Box 3000
  Farmington, MO 63640-3812

Administrative Law Hearing

- An **Administrative Law Hearing (ALH)** is the final step in the claim appeal process.
- A provider must exhaust all available appeal and provider compliant options before submitting a request for an Administrative Law Hearing.
- Administrative Law Hearing requests must be submitted within fifteen (15) business days of the claim appeal being upheld.
- All request for an Administrative Law Hearing must be submitted in writing to:

Peach State Health Plan
Attn: Administrative Law Hearing Coordinator
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339

Claim Dispute Roadmap



Payment Integrity Vendors

Service	Specialty Company/Vendor
Credit Balances	AIM
Claim Overpayment	Connolly Health
Claim Overpayment , Third Party Liability	HMS
DRG Validation of inpatient claims	Cotiviti (iCRS)
Credit balance, Claim overpayment	Optum

Contact Information

Peach State Health Plan

Provider Services: 1-866-874-0633

Website: www.pshpgeorgia.com

Provider Portal: https://provider.pshpgeorgia.com