SECTION 4

CLAIMS AND BILLING

CLAIMS SUBMISSION

Electronic Submission

We encourage participating providers to use electronic claim submissions whenever possible. Doing so can help streamline your administrative processes, help protect your patients' information, and result in faster claims processing and payment. eternalHealth supports electronic submission via the HIPAA transaction set (837P and 837I) and upholds Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

You should submit claims via Zelis with eternalHealth's **Payer ID # RP037**.

Paper submission

eternalHealth also accepts the CMS-1500 and the CMS-1450 paper claim forms.

eternalHealth Billing Department

PO Box 1263

Westborough, MA 01581

Timely filing of claims

You should refer to your Provider Agreement for filing guidelines and documentation requirements. Unless otherwise specified in your Provider Agreement, eternalHealth's standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Agreement, you cannot bill members for services submitted beyond the timely filing limit. Corrected claims must also be submitted within 90 days from the claim date of service, unless otherwise specified in your Provider Agreement.

Claims processing

We use guidelines established by CMS and internal claims processing policies when determining proper coding. These guidelines and policies dictate claims edits, adjustments to payment, and/or a request for review of medical records that relate to the claim.

You can refer to one of the following CMS guidance documents on electronic and paper claim submissions:

Health Care Claim: 837P and Form CMS-1500

Medicare Billing: 837I and Form CMS-1450

You can check the status of claims you've submitted. Please visit the provider portal at: provider.eternalhealth.com

Clean Claims

Clean Claims should have detailed, accurate, and up-to-date patient data. Any relevant referrals should be included or referenced as proof. All the relevant elements of CMS Form 1500 or UB04 Claims Forms should be submitted, including but not limited to Member identification numbers, NPIs, dates of service, and an accurate and full description of the medical services provided. Additionally, there should be no error in coding the claim for the services provided.

Failure to submit a clean claim can result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, provider data mismatches, and use of the wrong claim form(s).

Timely Processing of Claims

eternalHealth is required to uphold standard claims timeliness guidelines, which either are stipulated in your Provider Agreement or follow CMS timeliness requirements.

Refer to the CMS guidelines for more information.

Claims Payment

You will be reimbursed according to the compensation provisions of the Compensation Schedule included in your Provider Agreement.

Sequestration

At eternalHealth, we use the same sequestration reductions as those imposed by the Centers for Medicare & Medicaid Services (CMS). All providers are reimbursed using a fee schedule based on the Medicare payment system, percentage of Medicare Advantage premium or Medicare-allowed amount (e.g., resource-based relative value scale [RBRVS], diagnosis-related group [DRG], etc.) and will have the 2% sequestration reduction applied the same way it would be applied by CMS, unless otherwise specified in your Provider Agreement. This reduction applies to all Medicare Advantage plans.

The amount of the sequestration reduction for each affected claim will be identified as “Sequestration” on the Remittance Advice document that providers will receive from eternalHealth.

Claim Corrections

We will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, you can resubmit a corrected claim within the timely filing period.

PROGRAM INTEGRITY

To ensure that claims payments are issued in accordance with CMS guidelines, the integrity of our payment programs is overseen by dedicated staff and can include the use of contracted vendors. All claims can be subject to prospective, concurrent, or retrospective review for both billing and payment accuracy.

Overpayment Recovery

We abide by CMS guidelines for overpayment recoupments, including: provider notification, opportunity for rebuttal, and the possibility of automatic recoupments from future claims payments.

eternalHealth can reopen and revise its initial determination or redetermination on a claim on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause as defined in CMS Medicare Handbook §10.11; or
- At any time if:
  - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in the Code of Federal Regulations (42 CFR §405.902); or
  - The initial determination is unfavorable, in whole or in part, to the party there to, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error or similar fault as defined in the Code of Federal Regulation (42 CFR§ 405.986).

eternalHealth can collect a monetary penalty against a reimbursement request including, but not limited to, an interest charge.

When refunding an overpayment by check, be sure to include all appropriate information to help us identify the overpaid claim:

- Member name and eternalHealth ID
- Date of service
- Billed and paid amounts
- Provider remittance advice that you received for the claim and/or the refund request letter you received from eternalHealth or one of our contracted vendors

If we determine upon investigation that our overpayment was a result of fraud you have committed, we will report the fraud to the appropriate state and federal regulators as required by law. We can then take action to collect an overpayment by assessing it against payment of any future claim submitted by you.