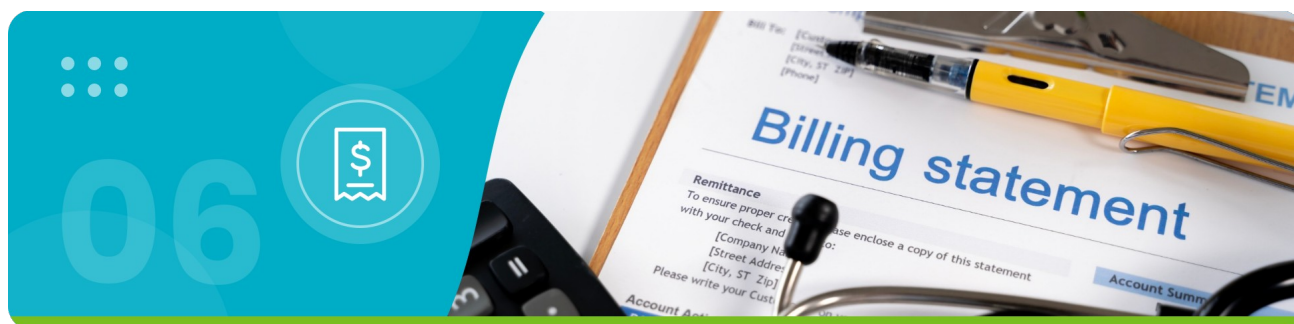




SECTION 06

Claims and Billing

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Overview

eternalHealth is committed to accurate and timely claims adjudication in accordance with Centers for Medicare & Medicaid Services (CMS) requirements, applicable regulatory standards, and provider contractual agreements. Participating providers are responsible for submitting complete, accurate, and timely claims that comply with industry-standard coding and billing requirements.

This section outlines claims submission procedures, billing requirements, payment processes, and provider responsibilities related to claims administration.

Claims Submission

Providers are encouraged to submit claims electronically whenever possible to support faster processing, improved accuracy, and enhanced security of protected health information.

Claims must be submitted using the appropriate coding standards, billing guidelines, and claim forms required by CMS and eternalHealth. Providers are responsible for ensuring all submitted claims accurately reflect the services rendered.

Electronic Claims Submission

eternalHealth supports electronic claims submission through Change Healthcare using HIPAA-compliant transaction standards. Electronic submission is the preferred method of claim submission and may reduce processing delays.

Electronic Claims Information

Description	Information
Clearinghouse	Change Healthcare
Payer ID	RP037

Providers should submit:

- Professional claims using the 837P transaction format.
- Institutional claims using the 837I transaction format.

Electronic claims must comply with CMS electronic claims standards and applicable HIPAA requirements.

Paper Claims Submission

Although electronic submission is strongly encouraged, eternalHealth accepts paper claims submitted on approved CMS claim forms.

Accepted Claim Forms

- CMS-1500 (Professional Claims)
- UB-04 / CMS-1450 (Institutional Claims)

Mailing Address

eternalHealth Billing Department

PO Box 1263

Westborough, MA 01581

Attn: eternalHealth Medicare

Providers should ensure all paper claims are legible and contain complete and accurate information.

Clean Claim Requirements

A clean claim is a claim that can be processed without obtaining additional information from the provider, member, or another party.

To be considered a clean claim, a submission must include:

- Member identification number
- Provider National Provider Identifier (NPI)
- Date(s) of service
- Appropriate diagnosis codes
- Appropriate procedure codes
- Place of service information
- Required modifiers
- Authorization information, when applicable
- Any supporting documentation necessary to adjudicate the claim

Claims that are incomplete, inaccurate, improperly coded, or missing required information may be denied, rejected, pending for review, or returned for correction.

Timely Filing Requirements

Providers must submit claims within the filing deadlines specified in their Provider Agreement. Unless otherwise stated in the Provider Agreement, the standard timely filing requirement for participating providers is ninety (90) calendar days from the date of service.

Claims submitted beyond the applicable filing deadline may be denied.

Providers may not bill members for covered services denied solely due to provider failure to comply with timely filing requirements.

Corrected Claims

A corrected claim may be submitted when changes are needed to a previously submitted claim due to missing information, coding corrections, billing errors, or other claim inaccuracies.

Corrected claims should:

- Reference the original claim when applicable.
- Clearly identify the submission as a corrected claim.
- Include all corrected information.
- Be submitted within applicable filing deadlines.

Failure to properly identify a corrected claim may result in delays or duplicate claim denials.

Claims Processing

Claims are processed in accordance with:

- CMS Medicare Advantage requirements
- National coding standards
- National Correct Coding Initiative (NCCI) edits
- Medicare payment methodologies
- eternalHealth claims policies and procedures

Claims may be subject to:

- Coding edits
- Medical necessity review
- Authorization verification
- Payment integrity review
- Coordination of Benefits review
- Documentation requests

Additional information or medical records may be requested when necessary to determine coverage, coding accuracy, or payment eligibility.

Claims Status Inquiries

Providers may monitor claim activity and review claim status through the eternalHealth Provider Portal.

Provider Portal:

provider.eternalhealth.com

The Provider Portal provides access to:

- Claim status information
- Claim payment information
- Claim history
- Corrected claim status
- Authorization status
- Member eligibility and benefit information
- Remittance advice information
- Payment history
- Denied and pended claim information

Providers are encouraged to utilize the Provider Portal as the primary source for claim status inquiries and payment information.

For additional assistance, providers may contact Provider Services at 1-800-680-9255.

Claims Payment

Participating providers are reimbursed according to the reimbursement terms and methodologies outlined in their Provider Agreement.

Payment methodologies may include:

- Medicare-based fee schedules
- Diagnosis Related Group (DRG) methodologies
- Resource-Based Relative Value Scale (RBRVS) methodologies
- Contracted rates
- Other payment arrangements specified in the Provider Agreement

Providers should review remittance advices carefully and reconcile all payments received.

Medicare Sequestration

eternalHealth applies Medicare sequestration adjustments in accordance with applicable CMS requirements. Unless otherwise specified in the Provider Agreement, reimbursement for covered services may be subject to federally mandated sequestration reductions.

When applicable:

- A sequestration adjustment of two percent (2%) may be applied.
- Sequestration reductions are applied consistent with CMS guidance.
- The adjustment will be identified on the provider remittance advice as “Sequestration.”

Providers should review remittance advice statements for details regarding any sequestration-related adjustment.

Claim Denials and Additional Information Requests

A claim may be denied, rejected, or pended when:

- Required information is missing.
- Coding is inaccurate or incomplete.
- Eligibility cannot be verified.
- Prior authorization requirements were not met.
- Medical necessity requirements are not supported.
- Timely filing requirements were not satisfied.

Providers should review denial information carefully and submit corrected claims, additional documentation, or payment disputes as appropriate.

Provider Responsibilities

Participating providers are responsible for:

- Submitting complete and accurate claims.
- Complying with coding and billing guidelines.
- Maintaining documentation supporting billed services.
- Responding promptly to requests for records or additional information.
- Monitoring claim status and payment activity.

- Identifying and reporting overpayments when discovered.
- Complying with all applicable contractual, CMS, and regulatory billing requirements.

Failure to comply with claims submission requirements may result in processing delays, denials, payment adjustments, or other actions permitted under the Provider Agreement and applicable regulations.