



INSTIL<sup>®</sup> HEALTH

# Provider Administrative Office Manual

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**Your Partners in Outstanding Quality, Satisfaction and Service**

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*In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and the health plan, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed to be a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.*

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# Section 1: General Information

## 1.1. Contacts

We direct all phone calls to a central distribution center to ensure your inquiries are handled in a timely manner. The phone number to Provider Services is 888-801-9746.

You can also get benefit details, claims status, authorizations and more online using My Insurance Manager<sup>SM</sup>.

### 1.1.1 Other Service Areas

Use this list of contacts for Companion Benefit Alternatives (CBA), Evolent, prior authorizations and other helpful resources.

Other Service Area Contacts			
Name	Contact Description	Telephone	Email/Web
<b>Avalon Healthcare Solutions (Avalon)</b>  <i>Avalon is an independent company that provides laboratory benefit management services on behalf of InStil Health.</i>	Administers laboratory medical management and precertification	844-227-5769	<a href="http://www.AvalonHCS.com">www.AvalonHCS.com</a>
<b>Companion Benefit Alternatives (CBA)</b>  <i>CBA is a separate company that manages behavioral health and substance abuse benefits on behalf of InStil Health.</i>	Behavioral health credentialing and benefits	800-868-1032	<a href="http://www.CompanionBenefitAlternatives.com">www.CompanionBenefitAlternatives.com</a>
<b>OptumRx®</b>  <i>Optum is an independent company that provides pharmacy services on behalf of InStil Health.</i>	Pharmacy benefit management and specialty pharmacy services	877-440-0089	(My Insurance Manager) MBMNow
<b>Electronic Data Interchange (EDI)</b>	Problems submitting claims electronically	N/A	<a href="mailto:EDI.Services@bcbsc.com">EDI.Services@bcbsc.com</a>
<b>Electronic Data Interchange Gateway (EDIG)</b>	Enroll your practice or billing service as a recipient of electronic data or issues with transmissions	N/A	<a href="mailto:EDIG.Support@PalmettoGBAServices.com">EDIG.Support@PalmettoGBAServices.com</a>
<b>Evolent</b>  <i>Evolent is an independent company that provides utilization management services on behalf of InStil Health.</i>	Prior authorization for advanced radiology, interventional pain management, lumbar surgery and radiation oncology procedures	866-500-7664	<a href="http://www.RadMD.com">www.RadMD.com</a>
<b>Technology Support Center</b>	Technical issues with My Insurance Manager	855-229-5720	N/A

## 1.2. Frequently Asked Questions

Frequently Asked Questions (FAQs) can be viewed online. FAQs are created from inquiries received from the provider community or are developed by the plan in anticipation of provider questions.

## 1.3. Health Insurance Portability and Accountability Act (HIPAA) and Electronic Data Interchange (EDI) Services

HIPAA became law in 1996. HIPAA portability provisions ensure that insurance companies do not deny individuals health insurance coverage under pre-existing conditions when the individual moves from one employer group health plan to another. HIPAA includes provisions for administrative simplification. The purpose of these provisions is to improve the efficiency and effectiveness of health care transactions by standardizing the electronic exchange of administrative and financial data, as well as protecting the privacy and security of individual health information that insurance companies maintain or transmit electronically.

HIPAA administrative simplification imposes stringent privacy and security requirements on health plans, health care providers and health care clearinghouses that maintain and/or transmit individual health information in electronic form. In addition, HIPAA mandates that EDI complies with the adoption of national uniform transaction standards and code sets, and requires new, unique provider identifiers.

### 1.3.1 HIPAA Transactions

The health plan gateway processes these ASC X12N Version 4010A1 transactions as required by HIPAA:

- 270 (Health Care Eligibility/Benefit Inquiry)
- 271 (Health Care Eligibility/Benefit Response)
- 276 (Health Care Claim Status Request)
- 277 (Health Care Claim Status Response)
- 278 (Health Care Services Review)
- 834 (Benefit Enrollment and Maintenance)
- 835 (Health Care Payment/Advice)
- 837 (Health Care Claim-Professional)
- 837 I (Health Care Claim-Institutional)

### 1.3.2 Transaction Code Sets

The HIPAA Transactions and Code Sets regulation (45 CFR Parts 160 and 162) required the implementation of specific standards for transactions and code sets by Oct. 16, 2003. We met this deadline and are fully HIPAA compliant.

*Applicability.* The regulation pertains to:

- All health plans.
- All vendors and clearinghouses (e.g., billing services, re-pricing companies and value-added networks that perform conversions between standard and non-standard transactions).
- All providers (physicians, hospitals and others) who conduct any of the HIPAA transactions electronically.

*Purpose.* The intent of HIPAA's Administrative Simplification regulation is to achieve a single standard for claims, eligibility verification, referral authorization, claims status, remittance advice (e.g., Explanation of Benefits) and other transactions. Adoption of standard transactions should streamline billing, enhance eligibility inquiries and referral authorizations, permit receipt of standard payment formats that can post automatically to your accounts receivable system and automate claims status inquiries.

*Your Responsibility.* HIPAA requirements impact most physicians and other providers, but not all. You should assign responsibility for ensuring compliance with the transactions and code sets to a specific person within your office who can work with the information systems vendors, payers and clearinghouses, as applicable. Also, you should establish a process to monitor the status of new regulations and changes to comply with them as they become effective.

## 1.4. Website

Visit the Provider page of [www.InStilHealth.com](http://www.InStilHealth.com) for educational information, news, resources and forms.

To protect privacy and comply with HIPAA standards, we use the latest encryption technology to ensure that no unauthorized person can access protected health information (PHI).

### 1.4.1 News and Updates

We have many informational publications for providers, including this manual. These publications are available on our website. By placing our publications on the website, we can provide you with important information quickly and accurately.

### 1.4.2 Resources

We've developed several resources to make your interactions with InStil Health easy and efficient. Document types include instructional manuals, user guides, managed care magazines, quick reference guides and educational handouts. Resources are available to view online or to print. You can find these documents:

- Provider Office Administrative Manual
- My Insurance Manager User Guides
- FAQs

### 1.4.3 Forms

All forms are available to download and print on the Forms page of [www.InStilHealth.com](http://www.InStilHealth.com). Many are also available in a Spanish version. Some of the forms you may find most useful are explained below.

- Other Health/Dental Insurance Questionnaire* – Ask your patients to update this information annually or when a change occurs in other health and/or dental coverage, including Medicare, that the subscriber or any covered dependent may have.
- Overpayment Refund Form* – Complete this form when sending InStil Health unsolicited (voluntary) refund checks.
- Provider Reconsideration Form* – Use this form to request review of a claim that has processed with an adverse determination. It ensures the medical information and supporting documentation you fax, or mail gets to the right area at InStil Health.

## 1.5. Electronic Solutions and Provider Self-Help

### 1.5.1 My Insurance Manager

My Insurance Manager is an online tool for providers to access:

- Benefits and Eligibility
- Claims Entry
- Prior Authorization Request and Status
- Claims Status
- Remittance Information
- EDI Reports

It is a valuable provider tool that can be freely accessed after you have registered with a valid Tax ID number on our system. Secure encryption technology ensures any information you send or receive is completely confidential. My Insurance Manager is not available during weekly maintenance on Sunday evenings from 5 p.m. to midnight.

*How to Register.* Select the My Insurance Manager tab on [www.InStilHealth.com](http://www.InStilHealth.com). Choose Create a Profile, and then enter your Tax ID number for InStil Health. Create a username and password. Your profile administrator and each authorized user must have a unique username and password registered in My Insurance Manager. Submit the information. You are

now ready to access My Insurance Manager.

### **1.5.2 My Remit Manager**

My Remit Manager is an online tool providers can use to search remittances by patient, account number and check number. It is free to all providers who receive EFT payments and ERAs. It accepts 835s from all commercial InStil Health lines of business, and it works independently of your practice management system or clearinghouse.

Use My Remit Manager to:

- View ERA information by file and see all details. You have the option of viewing the specific American National Standard Institute (ANSI) details the payer sends or the standardized information in a conventional format.
- Instantly see patient errors and denials. The system highlights any claims that have errors or that InStil Health has denied.
- View information categorized by check numbers or by patient. It clearly lists the name of each patient whose EOB is associated with an individual check or EFT.
- Print individual remits for a single patient. Eliminate the need to remove or black out other patient information on the remit.
- Print remits for selected patients. Print individual or group remits.

*How to Register.* You can register to use My Remit Manager by completing the request form on [www.InStilHealth.com](http://www.InStilHealth.com). My Remit Manager is also accessible directly through My Insurance Manager. Look under Resources.

### **1.5.3 Electronic Data Interchange (EDI)**

The health plan's EDI department facilitates electronic transfer of data services to health care providers and serves as a communication link between your office and the health plan.

There are three primary methods available for electronically submitting your claims:

1. Direct submission
2. Clearinghouse submission
3. Data entry via the web using My Insurance Manager

Some of the features and benefits of the electronic claim submission are:

- Shortened reimbursement cycle
- Reduced office administrative costs
- Decreased claim preparation costs
- Verification of receipt of claim
- Error identification for immediate correction

For assistance or information about submitting electronic claims, please contact the EDI Help Desk at 800-868-2505. We require all professional providers to submit electronic claims in the HIPAA X12 format. You can also view a list of vendors who are currently submitting HIPAA-compliant claims to us as certified vendors at [www.InStilHealth.com](http://www.InStilHealth.com).

### **1.5.4 Voice Response Unit (VRU)**

Call Provider Services at 888-801-9746 to use the VRU. It is available 24 hours a day, seven days a week. The VRU is a fully automated tool that provides quick and easy information to providers seeking benefits and eligibility, routine claim status and refund statuses. If the requested information is available in the VRU, you will not have the option to speak to a provider services representative.

See our VRU Guide on our website for information you'll need and tips on navigating menu options. If you still have questions about eligibility, benefits or claims, My Insurance Manager has the answers.

### **1.5.5 VRU Fax Back**

Our Fax Back option is also available through the VRU. Simply enter your fax number, and we will fax the member's benefits or claim status directly to you. You will usually receive the fax in less than five minutes, and you can keep it in the

patient’s file for future reference.

### 1.5.6 STATchat<sup>SM</sup>

STATchat is a fast, free and simple way to talk with a provider services representative after you’ve searched online for the answer to a claim status or eligibility question. To use STATchat, log in to My Insurance Manager. When you view member claims status or eligibility and benefits, select the “Connect” button at the top of the page to speak to a provider services representative online. You will receive priority service and be connected to the next available agent. To ensure quick service for all customers, please limit use to only one issue per call.

#### System Requirements:

- Adobe Flash Player\*
- A compatible web browser: EDGE\*, Mozilla Firefox\* or Google Chrome\*.
- A headset (recommended) or stand-alone microphone and speakers connected to your computer.

\*Must be a version currently supported by the manufacturer.

#### Firewall Configuration:

Your firewall should allow outgoing UDP to the public internet from the browsers that will be using STATchat and allow return traffic in response. If your router includes SIP Application Level Gateway (ALG) function or Stateful Packet Inspection (SPI), disable both these functions for the \*.twilio.com domain.

#### Bandwidth Requirements:

For each concurrent call, allow WebRTC: 8 kB/s. This does not scale based on bandwidth. On browsers using Flash, fallback bandwidth requirement is 6 kB/s.

#### Port Requirements:

Component	Address	Client-side Port Used	Server-side Port Used	Protocol
Signaling	*.twilio.com	Any (1,024 to 65,535)	443	TCP
RTP	54.172.60.0/23, 34.203.250.0/23, 168.86.128.0/18	Any (1,024 to 65,535)	10,000 – 60,000	UDP

If you experience problems, please call for technical help at 855-229-5720.

## 1.6. Contracting

### 1.6.1 Fee Allowances

The Professional Agreement states that a preferred provider will accept the fee allowance for covered services as payment in full. Do not bill the member for any amount that exceeds the fee allowance. The member is not financially responsible for anything other than applicable copayments, coinsurance and deductibles.

### 1.6.2 Language and Provisions

Each preferred provider’s agreement lists the contractual responsibilities of both InStil Health and that preferred provider. Here is a general summary of the agreements:

- The preferred provider will file all claims for all applicable members.
- InStil Health will reimburse the preferred provider for covered services based on the member’s contract. Fee allowances are the lower of the preferred provider’s charge for a procedure or the Preferred Blue fee schedule of maximum allowances.
- The preferred provider will accept InStil Health’ or Associate Plan’s payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The preferred provider will not bill the patient for more than his or her applicable patient liability amount, not to exceed the fee allowance.
- The preferred provider agrees to cooperate fully with the utilization review procedures in the agreements.
- The preferred provider will use other preferred providers for a member’s care unless medically necessary services,

supplies or equipment are not available from a preferred provider, or in cases of medical emergencies or urgently needed services.

- The preferred provider agrees to bill promptly and, in a manner, approved by InStil Health for all services. Electronic claims submission (ECS) in the 837I or 837P HIPAA-compliant format is the preferred method of filing.
- To the extent that a written agreement allows for sub-contracting with participating providers, the written agreement specifies that all sub-contracts will be subject to the terms of the written agreement.

If you have any questions about contracting, please submit a request by going to the Contact Us page on our website.

### **1.6.3 Provider Disputes**

All contracted providers have the right for dispute resolution and are given the benefit of a thorough and consistent approach to timely resolution and response to their dispute.

A dispute can come from any contracted provider invoking the provider dispute mechanism within their contract. The dispute may be sent either directly from the contracted provider or from another area of the health plan. The dispute must be received in writing.

If the dispute is concerning an issue involving Professional Competence or Conduct, the telephone call, email, fax or letter is forwarded to the management of the Credentialing area.

The appropriate management will respond to the provider within 30 days of receipt of the dispute request informing the provider of the receipt of the request and if necessary, any additional relevant information needed from the provider regarding the dispute.

The health plan and contracted provider agree to meet and confer in good faith to resolve any problems or disputes that may arise under the contract. The health plan will attempt to set up a meeting to discuss the dispute with the provider within 30 days of receipt of all information. The health plan will work with the provider in good faith to resolve the dispute for as long as it may take to resolve.

Upon resolution of such dispute, implementation of the resolution will occur, and the provider will be informed of the resolution in writing within seven business days of the decision.

In the event that the parties through mutual negotiation are not able to satisfactorily resolve the contract problem or dispute, the health plan and preferred provider agree to arbitrate such problem or dispute. A single arbitrator shall conduct the arbitration (including conducting pre-hearing matters) under the then current commercial rules of the American Arbitration Association and such rules shall apply in lieu of state or federal rules of civil procedure. The American Arbitration Association shall appoint an arbitrator who is knowledgeable in the healthcare management field. The arbitration shall be held, and any award shall be made in South Carolina. Subject to the terms of the Uniform Arbitration Act, the arbitrator's determination shall be final and binding upon the parties. You can refer to your contract for the complete arbitration process.

# Section 2: Product (Plan) Information

## 2.1. Product (Plan) Overview

### 2.1.1 Benefit Structure

Each plan offers a variety of coverage. In addition, plans may also have different precertification and mental health requirements. Plans may also have separate insurance vendors for certain benefits, such as vision or dental.

### 2.1.2 How Members Access Physicians and Health Care Professionals

Members are encouraged to access care from an in-network doctor. To determine whether you are in network for a particular member's plan, please use the Find a Doctor lookup tool on [www.InStilHealth.com](http://www.InStilHealth.com). Providers participating in the network are displayed based on the member's prefix.

## 2.2. Member Identification (ID) Cards Overview

### 2.2.1 How to Identify Members

When members arrive at your office, remember to ask to see their current member ID cards at each visit. This will help you identify the product the member has and get dental plan contact information. It will also help you with filing claims. Please note that all ID cards do not look the same and are for identification purposes only. They do not guarantee eligibility or payment of your claim.



#### Important Facts About the ID Card Prefix

- Using the correct ID card prefix is critical for electronic routing of specific HIPAA transactions.
- It is important to capture all ID card data at the time of service.
- Do not assume that a member's ID card number is his or her Benefits Identification Number.
- Be sure all your system upgrades accommodate the ID card prefix and all characters that follow it.
- Do not add, delete or change the sequence of characters or numbers in a member's ID card number.
- Make copies of the front and back of the ID card. Share this information with your billing staff.

### 2.2.2 Verifying Eligibility and Benefits

Use My Insurance Manager to verify eligibility and benefits. Select the plan for which you want to review eligibility and benefits. Choose your eligibility view according to general benefits, service type or procedure code. Unless otherwise required by state law, the notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts, such as a deductible, may change as additional claims are processed.

### 2.2.3 Sample ID Card

 <hr/> <b>Member Name</b> SUBSCRIBER NAME <b>Member ID</b> 123456789999 <hr/> <b>RxBIN</b> 021684 <b>RxGRP</b> BXIH <b>PLAN CODE</b> C60 <hr/> <a href="http://www.InStilHealth.com">www.InStilHealth.com</a>	<b>InHealth</b> InHealth Network Referrals Required <hr/> <b>Out-of-Network Emergency Services Only</b>	 <b>Members:</b> Report all emergency admissions within 24 hours.  <b>Providers:</b> Preauthorization required for some hospital outpatient procedures and all hospital inpatient admissions. Authorization required for MRI, MRA, CT and PET procedures. File claims with the local InStil Health Plan where member received services. Benefits are only available in network.  <b>Members have limited out-of-network benefits, which are only available when they receive services for an emergency medical condition.</b>  <b>A primary care physician will be automatically assigned to you. Your PCP will request referrals for next levels of care except for emergency situations.</b> <hr/> <b>X36</b>	<a href="http://www.InStilHealth.com">www.InStilHealth.com</a> <b>Member Resources</b> <b>Member Service Center:</b> 833-738-0978 <b>24/7 Pharmacy Support:</b> 833-730-1720 <b>Mental Health &amp; Substance Use Precertification:</b> 800-868-1032  <b>Provider Resources</b> <b>Provider Services:</b> 888-801-9746 <b>Medical Authorization:</b> 888-801-9617 <b>Pharmacy Help Desk:</b> 855-811-2218 <hr/> <b>InStil Health Insurance Company</b> PO Box 100324 Columbia, SC 29202
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## 2.2.4 Geographic Coverage

Members must reside in Spartanburg or York counties. There are no out-of-network benefits unless for emergency medical conditions when treated in an outpatient hospital emergency room, or urgent treatment center, or for urgent conditions when treated in an urgent treatment center.

## 2.3. Other Benefits

### 2.3.1 Mental Health

Companion Benefits Alternative (CBA) is a separate company that manages behavioral health and substance abuse benefits on behalf of the health plan. Mental health benefits vary between plans. Verify eligibility and benefits for each member.

### 2.3.2 Pharmacy

The health plan uses OptumRx for prescription drug benefits. OptumRx is an independent company that provides pharmacy benefit management services on behalf of the health plan. Pharmacy benefits vary between plans. Verify eligibility and benefits for each member.

### 2.3.3 Vision

Vision benefits vary between plans and are offered through Vision Service Provider (VSP). Verify eligibility and benefits for each member. VSP is an independent organization that provides vision benefits on behalf of the health plan.

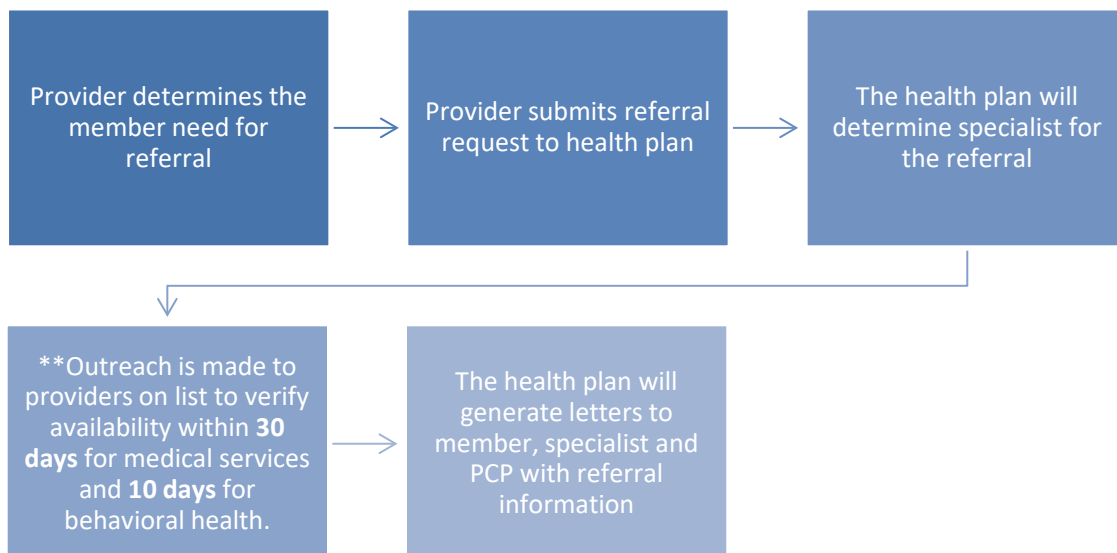
## 2.4. Primary Care Physician Assignment and Referral Process

### 2.4.1 Primary Care Physician (PCP) Assignment

InStil Health members are assigned a PCP and receive a letter notifying them of who their PCP is. If the member has questions, they can contact Customer Service at 833-738-0978.

### 2.4.2 Referral Process

Referrals are required members who live in Chesterfield, Darling, Florence and York counties, and for all services **unless** there is an emergency, or a PCP visit with the member's assigned PCP. Services without a referral will be denied. See the process flow below.



\*\*If provider availability is greater than 30 (medical) or 10 (BH) days, notice is sent to the referring PCP to request clinicals for out-of-network consideration.

# Section 3: Claims and Billing Guidelines

## 3.1. Claims Filing

For prompt payment, we encourage electronic claims submission. Transmit claims in the HIPAA 837 format under the appropriate carrier codes. You should complete all applicable claim information in full to ensure you receive accurate payment without delay. You can also file both professional and institutional claims (primary, secondary and corrected claims) in My Insurance Manager.

### 3.1.1 Using the Correct Provider Identifier

*Tax Identification Number (TIN).* Each participating provider should use his or her nine-digit TIN or NPI when filing claims. This will ensure accurate and timely payment. An exception to this occurs if you do not have a TIN and use your Social Security number to report income.

Place your provider number in the appropriate form indicator for the 837 (I and P) when filing claims. Follow these same instructions for entering the rendering provider's NPI number.

If you have changed your TIN, complete only the Request to Change Tax ID form. You will need to submit a copy of your TIN confirmation before we will update your profile. The IRS will send this confirmation to you. If you have any questions about your TIN, you can visit the IRS website at [www.irs.gov](http://www.irs.gov).

*NPI.* The NPI is a 10-digit, all-numeric identifier. NPIs are only issued to providers of health services and supplies. As a provision of HIPAA, the NPI is intended to improve efficiency and reduce fraud and abuse.

There are several advantages to using the Provider NPI for claims and billing:

- It allows providers to bill with only one number.
- It simplifies the billing process since it is no longer necessary to maintain and use legacy identifiers for each health care plan.
- It simplifies making changes to addresses or locations.

NPIs are divided into two types:

- Type 1: Individual providers, which includes, but is not limited to, physicians, dentists, and chiropractors
- Type 2: Hospitals and medical groups, which includes, but is not limited to, hospitals, residential treatment centers, laboratories, and group practices

For billing purposes, claims must be filed with the appropriate NPI for billing, rendering, and referring providers. Providers can apply for an NPI online at the NPPES website <https://nppes.cms.hhs.gov> or can get a paper application by calling NPPES at 800-465-3203.

*Rendering Provider Number.* We require you to report the rendering provider NPI on all claims. Any claim we receive that is missing the required rendering provider's information will result in a claim denial. We will accept corrected claims if your office inadvertently omits the rendering provider information.

### 3.1.2 Diagnosis Codes, Procedure Codes, Modifiers

Claims filed to the health plan are subject to these procedures: 1) Verification that all required fields are completed on the claim and 2) Verification that all diagnosis codes, modifiers, and procedure codes are valid for the date of service.

*Diagnosis Codes.* All claims must include the proper ICD-10-CM diagnostic code. Using deleted or incorrect codes will result in inability to process your claim or payment delays. These are guidelines CMS established about use of diagnosis codes:

- Code the primary diagnosis first, followed by the secondary, tertiary, and so on.
- Code any coexisting conditions that affect the treatment of the patient for that visit or procedure as supplementary information.
- Do not code a diagnosis that is no longer applicable.

- Code to the highest degree of specificity.
- Code a chronic diagnosis, when it is applicable to the patient’s treatment or when follow-up on the condition is requested during the visit.

*Procedure Codes.* Common Procedure Technology (CPT) is a standardized system of five-digit codes and descriptive terms used to report the medical services and procedures performed by physicians or health care professionals. Accurate CPT coding is crucial for proper reimbursement and compliance with government regulations.

All physicians and health care professionals must use the appropriate procedure codes from the most recent Healthcare Common Procedure Coding System (HCPCS) and CPT coding manuals or quarterly updates. Claim processing cannot be completed without accurate procedure codes, which reflect the services provided to members.

Consult the American Medical Association’s (AMA) website for annual revisions and publications to the CPT Book. The AMA is an independent organization that provides health information on behalf of InStil Health.

*Modifiers.* Use modifiers to report that the procedure has been altered by a specific circumstance. Modifiers provide valuable information about the actual services rendered, reimbursement and payment data. Modifiers also provide for coding consistency and editing for Level I (CPT Codes) and Level II (HCPCS). Because the use of modifiers is frequently the only way to alter the meaning of a CPT code, it is very important to know how to use modifiers correctly.

### 3.1.3 Carrier Code

The health plan uses carrier codes (payer ID) to route electronic transactions to the appropriate line of business once the Gateway accepts the claim. Failure to use the correct electronic carrier code will result in misrouted claims or delayed payments. If you transmit through a clearinghouse, check with the clearinghouse to see if it requires a different carrier code for claim submission. Use carrier code 00C60 for direct electronic claim submission to the health plan.

### 3.1.4 Electronic Loops and Data Segments

Each individual loop on an electronic claim has a segment component where the data is entered. The loops and segments contain the readable information that provides the clearinghouse the identifying information for the claim that was filed. The loops on an electronic claim are organized by categories of information that match data elements on the CMS-1500 claim form.

Here are examples and solutions of common edits that apply to loops and segments for professional claims, institutional claims, and dental claims.

- 837 Professional Edit HA9 – Invalid Rendering Physician ID Number Loop(s) and Segment(s) Impacted:  
2310B | NM109

Corrective action: Validate the rendering physician provider identification number is sent. Call the appropriate provider service area for InStil Health BlueShield of South Carolina to validate the rendering provider identification number needs any additional paperwork to update the provider database.

- 837 Institutional Edit QAC – Medicare COB amounts from Medicare remit were entered incorrectly Loop(s) and Segment(s) Impacted:  
2320 | AMT  
2320 | CAS  
2430 | SVD  
2430 | CAS

Corrective action: Sum of CAS Segments and Medicare payment must equal Total Charges.

- 837 Dental Edit L25 – Missing or invalid tooth number submitted on claim Loop(s) and Segment(s) Impacted:  
2400 | TOO

Corrective action: Submit a valid tooth number for the service given on the claim. Visit the [www.InStilHealth.com](http://www.InStilHealth.com) for more information.

## 3.2. Claims Management

As a participating network provider, you agree to submit claims electronically. You should complete all applicable claim information in full to ensure you receive accurate payment without delay. Supplemental Implementation Guides (SIGs) are available in the HIPAA Critical Center at [www.InStilHealth.com](http://www.InStilHealth.com). These will help you with the electronic claim-filing process. You can also file both professional and institutional claims (primary, secondary, and corrected claims) by using My Insurance Manager.

We currently accept these claim submission formats:

- CMS-1500 claims (filed via the web or paper)
- CMS-1500 claims filed via the Superbill tool in My Insurance Manager
- CMS UB-04 claims (filed via the web or paper)
- HIPAA 4010A1 electronic format claims (professional and institutional)

### **3.2.1 Electronic Medical Claim (EMC)**

Submit claims electronically to the health plan using the HIPAA-compliant 837 (I or P), X12 format. This is more efficient because it allows hospitals and physicians to receive payment five to seven days faster than for claims they file via hard copy. EMC filing also ensures claims accuracy through system edits.

You can file both CMS-1500 and CMS UB-04 claims to the health plan via the web using My Insurance Manager. You can also submit CMS-1500 claims to the health plan using the Superbill tool within My Insurance Manager. This tool is ideal for providers who want to submit primary claims for one date of service only.

You can submit primary, secondary, and corrected claims for both professional and institutional providers. File online, and most claims with amounts due will process in three to five days.

### **3.2.2 National Drug Code (NDC) Requirements**

The health plan requires the reporting of the NDC, NDC unit of measure and NDC quantity for all outpatient-administered drug claims. When submitting NDCs on professional electronic and paper (CMS-1500) claims, you must include this related information:

- 11-digit NDC
- NDC qualifier (N4)
- NDC quantity
- NDC unit of measure [Unit (UN), Milliliter (ML), Gram (GR) and International Unit (F2)]

You can find additional NDC information, as well as an NDC to HCPCS crosswalk, on the CMS website.

### **3.2.3 Timely Filing**

Timely filing to submit original claims is 12 months from the date of service. For corrected claims, you have 90 days.

### **3.2.4 Claim Status**

You can check the status of a claim in My Insurance Manager. You can also access claim status through the voice response unit by calling 888-801-9746.

### **3.2.5 Corrected Claims**

File corrected claims electronically via the HIPAA X12N format or via My Insurance Manager at no charge. You can submit hard copy corrected claims that include the rendering provider NPI as well by filing to the address on the back of the member's ID card. Corrected claims require manual intervention and may increase your claim adjudication times.

*Using My Insurance Manager.* You can log in to My Insurance Manager to submit a corrected claim. From the Patient Care menu, choose Professional Claim Entry. The Plan Information page will list your profile information first. Select a plan and indicate whether the plan is the primary payer. Select the billing location, rendering provider and/or referring provider when prompted. You can opt to choose a patient or manually enter the patient's information on the Patient Information page.

On the Claim Information page, select Replacement of Prior Claim from the Claim Type menu. Enter the prior claim number in the required field. Enter the information from the line of your claim. When you are done, select Continue. Confirm the claim information you entered. After reviewing your claim, select Submit.

*Using a Clearinghouse.* If you file through a clearinghouse, please contact your vendor for additional information about submitting corrected claims.

If you don't know where the 2300 loop or 2300 NTE ADD fields are in the form you use, contact your software vendor. If your software vendor has additional questions, direct it to call the EDI Helpline.

- a. Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM\*05 03.
- b. To ensure we process the claim accurately, add a note explaining the reason for the resubmission in loop 2300 NTE (segment) ADD (Qualifier). For example: NTE\*ADD\* (changed CPT).
- c. Enter the original claim number in the 2300 loop in the REF\*F8\*.
- d. 7 - Replace (replacement/correction of prior claim).
- e. 8 - Void (void/cancel of prior claim).

### **3.2.6 Duplicate Claims**

The health plan will deny any claims you submit after the originals as duplicates. If you have not received payment for a claim, do not resubmit the claim. You should check claim status through My Insurance Manager or VRU.

Our EDI department can work with your clearinghouse if there is a problem with us not getting your claims submissions. Contact EDI by email at [EDI.Services@instilhealth.com](mailto:EDI.Services@instilhealth.com) or by phone at 800-868-2505.

### **3.2.7 Facts About Resubmitting Claims**

Before you resubmit a claim because you have not received your payment or a response regarding your payment, stop and think. By sending another claim, you are adversely affecting the claims payment process and potentially creating confusion for the member.

- a. By resubmitting your service(s), we must conduct an additional investigative step that lengthens the claim processing time.
- b. If you resubmit a claim, we will ultimately deny the claim as a duplicate.
- c. The member will receive multiple EOBs for the same service, often resulting in a call to your office and/or ours.
- d. Most claims submitted to InStil Health are processed before 30 days.
- e. In fact, most electronically submitted claims are processed within 14 days.

### **3.2.8 Balance Billing**

Participating hospitals, physicians or health care professionals may not bill the health plan's members for deductible and coinsurance or balances above our allowable fees. In your contract with us, it states that you shall not look to the health plan's members for payment for covered services:

"[Provider] agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge, or have any recourse against a Member or persons acting on behalf of a Member, except to the extent that the applicable Plan specifies a copayment, coinsurance or deductible."

If the service is not covered, there must be prior written agreement to bill the member for these non-covered services.

You may collect only the applicable cost sharing (i.e., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Providers are responsible for getting prior authorization for inpatient facility services for out-of-area members. The member will not be responsible when prior authorization is required but not received for inpatient services. Failure to get necessary prior authorizations will result in claim penalties or denials. Here's what you should know:

- We base the amount of the penalty on your contract and applicable pricing methods.
- The member's plan will continue to determine which services require prior authorization.

- The member will not be responsible and cannot be balance billed, unless the member has signed a written consent to be billed prior to the service being rendered. Members are liable for services denied as not medically necessary.

### **3.2.9 Overpayment and Refunds**

There may be times when we must request refunds of payments previously made to you. When refunds are necessary, we notify you of the claim in question 30 days before any adjustment. The notification letter explains that we will deduct the amount owed from future payments unless you contact us within 21 days.

If you identify we made an overpayment and have not received a notice from us, you can return the overpayment with the Overpayment Refund Form found on our website. Provide documentation supporting the refund and include a check for the appropriate amount.

*Solicited Refunds.* We request solicited refunds when we determine there is a claims overpayment, or we made a payment in error.

Please send the refund to us within the requested 30 days from the date of the letter. You must include a copy of the refund request letter for accurate and timely processing. Send your refund to:

InStil Health Insurance Company  
Attn: Lock Box  
P.O. Box 100216  
Columbia, SC 29202-3216

It is critical that you return the refund within the specified time frame. If we do not receive the refund within 30 days of the date of the refund request letter, we will systematically offset the amount on a future remittance. The systematic offset is the preferred method for many providers to reconcile refunds. This approach reduces the administrative costs associated with paper processing and minimizes the potential for duplicate refunds.

If you still need more information about a refund, please log in to My Insurance Manager and submit your question using "Ask Provider Services."

*Unsolicited Refunds.* Unsolicited refunds are those you voluntarily submit as the result of a possible claims overpayment, or a payment made due to a billing and/or processing error.

Please complete all the information on the Overpayment Refund Form.

We will review the information to determine the validity of the unsolicited refund request. We'll then determine if we will either adjust the claim to process the unsolicited request or return the request and check with a written explanation of our findings.

### **3.2.10 Split Billing Pre-op Charges**

If lab work is performed within 72-hours of an inpatient surgery, the charges can be billed on the inpatient claim. They do not have to be split unless the 72-hour timeframe has passed.

## **3.3. Release of Medical Records**

In some instances, we may require medical records to process a claim. Please note: We do NOT pay for fees for supplying medical records. Please send the requested information, so we can expedite the processing of your claim(s).

We may also need medical records when an admission review is performed or for appeals.

### **3.3.1 When Medical Records are Required**

If we need records from your office for a member, you will receive a letter from the health plan, or the denial on the claim will advise what type of records are needed.

We also collect medical records to gather data to measure our performance, develop quality initiatives — such as member

outreach programs – and enhance educational programs for providers and members.

You should only receive requests for records from the health plan.

### 3.3.2 Non-Payment for Medical Record Requests

You or any entity designated for such responsibilities should not charge the health plan for the creation or submission of medical records. As a participating provider, you agree to permit the health plan or one of our business partners to inspect, review and acquire copies of records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment.

## 3.4. Guidance for Physician Office

Physicians should file claims electronically to the health plan in the HIPAA-compliant 837P (CMS HCFA 1500) format. File with the appropriate place of service codes, procedure codes, modifiers, NDCs, diagnoses and referring physician. Prior authorization follows each specific group requirement.

## 3.5. Guidance for Hospitals and Facilities

### 3.5.1 Ambulatory Surgery Center (ASC)

ASCs should file claims electronically to the health plan in the HIPAA-compliant 837I UB-04 format. File with the appropriate bill type, revenue code and the CPT codes. You will not need the SG modifier on these institutional forms. Prior authorization follows each specific group requirement.

### 3.5.2 Home Health

Home health providers should file claims electronically to the health plan in the HIPAA-compliant 837I (UB-04) format. File with the appropriate bill type and revenue code for the type of treatment as a single line item. You must get prior authorization for all home health services.

Revenue Codes	Type of Home Health
551	Skilled Nursing
421	Physical Therapy
441	Speech Therapy
561	Medical Social Worker
571	Home Health Aide
431	Occupational Therapy
279	Wound Care

### 3.5.3 Hospice

Bill hospice care electronically to the health plan in the HIPAA-compliant 837I (UB-04) format using revenue code 651, 655 or 656. You must get prior authorization and re-authorization for all hospice services.

Revenue Codes	Type of Home Health
651	Home Hospice Care
655	Respite Care
656	General Inpatient Care

### 3.5.4 Long-Term Acute Care (LTAC)

LTAC facilities should submit claims electronically to the health plan in the HIPAA-compliant 837I (UB-04) format using the appropriate revenue codes. You must get prior authorization for all LTAC services.

### 3.5.5 Skilled Nursing Facility (SNF)

Skilled nursing providers should file claims electronically to the health plan in the HIPAA-compliant 837I (UB-04) format. File with the appropriate bill type and revenue code for the type of treatment as a single line item. You must get prior authorization for all skilled nursing services.

We may consider skilled nursing coverage medically necessary when all these criteria are met:

- Services require an SNF level of care (LOC) and cannot be provided in a less intensive setting.
- Services require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, speech language pathologists or audiologists.
- These skilled nursing or skilled rehabilitation personnel directly provide or generally supervise services to ensure the safety of the patient and to achieve the medically desired result.
- You provide services under a plan of care a physician establishes and periodically reviews.

### 3.5.6 Dialysis

Dialysis providers should file claims electronically to the health plan in the HIPAA-compliant 837I (UB04) format.

When filing secondary to Medicare, please be sure to use the appropriate revenue code to ensure secondary processing. Please refer to Exhibit A of your contract for additional billing guidelines.

### 3.5.7 Inpatient Non-Reimbursable Charge/Unbundling Policy

The health plan implemented a policy Oct. 1, 2018, to address charges considered to be non-reimbursable, unbundled or are otherwise not allowed to be billed separately. This policy is applicable only to inpatient charges and is not intended to impact care decisions. You can view this policy on [www.InStilHealth.com](http://www.InStilHealth.com).

## 3.6. Guidance for Ancillary Providers

Ancillary providers are independent clinical laboratory, durable/home medical equipment and supplies and specialty pharmacy providers. You should file claims for your Blue Plan patients to InStil Health BlueShield of South Carolina as your local Plan. There are unique circumstances, however, when claims-filing directions will differ based on the type of provider and service.

*Durable Medical Equipment (DME).* File to the Plan in whose state the equipment was shipped to or purchased at a retail store. You must file all DME claims with the referring provider NPI number. If you do not include this information, it will delay the accurate processing of your claim.

*Independent Clinical Laboratory (Lab).* File to the Plan where the specimen was drawn. The location of where the specimen was drawn is determined by the physical location of the referring provider.

*Specialty Pharmacy.* File to the Plan in whose state the ordering physician is located.

If you contract with more than one Plan in a state for the same product type (i.e., PPO or traditional), you can file the claim with either Plan.

## 3.7. Most Common Denials

- Authorization or referral number invalid or missing
- Confirm authorization requirements prior to rendering services
- Contact the appropriate benefits manager to complete prior authorization requests
- Billed charges missing or incomplete
- Rendering NPI not listed on claim
- Include the rendering physician NPI for all claims
- NDC/NDC unit of measure not listed on claim
- Include the NDC, unit of measure and quantity
- Diagnosis, procedure, or modifier codes invalid or missing
- DRG codes missing or invalid

- Duplicate claims
- Submit modifiers as appropriate
- Verify claim status prior to submitting claims a second time
- Coordination of benefits (COB) information missing or incomplete
- Verify if the member has other insurance that may be primary
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) information missing or incomplete
- Eligibility/enrollment is not valid on date of service (DOS)
- EOB missing or incomplete
- Submit the primary payment information as necessary
- Spanning dates of service do not match the listed days/units

# Section 4: Provider Administration

## 4.1. Medical Policies

Medical policies consist of medical guidelines that are used when making clinical determinations in connection with a member's coverage under a health plan. The medical policies and associated medical guidelines are interpreted and applied at the sole discretion of the health plan fiduciary and may be subject to state or federal laws.

These guidelines are accessible to you on our provider websites. You can also contact our Medical Affairs department if you have questions about our medical policies.

Medical guidelines are based on medical research that provides evidence of scientific merit (or the lack of scientific merit) for medical services as related to medical conditions. Medical guidelines are based on appropriate and available medical research available at the time they are written. Because of the changing nature of medical science, medical guidelines are reviewed and updated periodically. Accordingly, the information on the web is provided for information only and may not reflect a recent policy change or all the applicable medical guidelines.

The inclusion of a medical guideline on the website does not indicate that the referenced service (or supply) is necessarily available to a member. For a determination of the benefits that a particular member is entitled to receive under his or her health plan, such member's health plan must be reviewed. In the event of a conflict between the medical policy and any health plan, the express terms of the health plan will govern. The existence of a medical guideline is not an authorization, certification, Explanation of Benefits, or a contract for the service (or supply) that is referenced in the medical guideline.

Medical guidelines are written to address frequently occurring clinical situations. Because of the variety of clinical circumstances, however, some services (or supplies) or conditions addressed in the medical guidelines may be appropriate for additional, individualized review.

Medical policies ARE NOT medical advice and DO NOT guarantee any results or outcomes.

## 4.2. Utilization Management (UM)

UM is the evaluation of the appropriateness and medical need of health care services, procedures, and facilities according to evidence-based criteria or guidelines, and under the provisions of an applicable health benefits plan. Typically, UM addresses new clinical activities or inpatient admissions based on the analysis of a case, but may relate to ongoing provision of care, especially in an inpatient setting.

UM describes proactive procedures, including discharge planning, concurrent planning, precertification, and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer, or patient. A UM program comprises roles, policies, processes, and criteria.

UM roles may include UM reviewers (often an RN with UM training), a UM program manager and a physician adviser. UM policies may include: the frequency of reviews, priorities, and balance of internal and external responsibilities.

UM processes may include escalation processes when a clinician and the UM reviewer are unable to resolve a case, dispute processes to allow patients, caregivers or patient advocates to challenge a point of care decision and processes for evaluating inter-rater reliability among UM reviewers.

### 4.2.1 Prior Authorizations

There are some services that routinely require precertification or admission certification for the health plan. Other services require precertification due to the member's contract benefits, type of service or other criteria.

We require you to submit initial precertification requests for certain services.

To improve the efficiency and quality of processing initial precertification requests, we must have you submit, at minimum, this information with your request:

- a. Member's Name
- b. Database Number/Subscriber ID
- c. Date of Birth
- d. ICD-9 and/or ICD-10 Diagnosis
- e. Service: CPT, HCPCS and/or Notification of Emergent Admission
- f. Provider's Name and TIN or NPI number

Incomplete or missing patient information can prolong the response time to your precertification request. The health plan will send a response to the requestor that notifies you of the missing data.

Currently, to submit a prior authorization, you can:

- Email: [Med.Auth.Request@instilhealth.com](mailto:Med.Auth.Request@instilhealth.com) (include the appropriate form).
- Call 888-801-9617 for medical services.
- Call 800-868-1032 for behavioral health services.

In the table are the business partners that provide care management services on behalf of the health plan.

Business Partner	Description	Contact Information
Avalon	Precertification for certain lab procedures	Call 844-227-5769 or fax 813-751-3760
Evoltent	Precertification for certain advanced radiological procedures, radiation oncology procedures and musculoskeletal interventional pain management/spine surgery	Call 866-500-7664 or visit <a href="http://www.RadMD.com">www.RadMD.com</a>
OptumRx	Precertification for certain medical (injectable/infusible) specialty drugs through MBMNow.	(My Insurance Manager) MBMNow

#### 4.2.2 Case Management

Case Management bridges the gap between standard utilization management processes and the need for innovative approaches for persons afflicted with chronic conditions that may require high levels of benefit usage. It is a voluntary service offered to members to help guide them through difficult conditions.

This is a collaborative process involving the identified patient, service providers and the case manager that includes assessing, care planning, coordinating, monitoring, and evaluating options and services to meet a patient's needs. Through increased communication with and involvement of the patient in a mutually agreed upon care plan and use of available resources to promote quality, cost-effective outcomes, the primary goal of case management is to facilitate continuity of care and support of chronic conditions while effectively managing the available health insurance benefits.

A physician can contact Health Care Services to request evaluation for case management services or to discuss a member's treatment. A registered nurse case manager will then review information from the physician, member, and other appropriate sources to determine if the member is a candidate for case management. Once we have reviewed a referral, we either accept or decline the case. If we accept the case, the case manager will contact the member, identify problems, develop a care plan, develop primary goals, and establish interventions, all in coordination with the physician's treatment plan for the member.

You may be provided with resources to integrate your patient care with our services.

### **4.2.3 Peer-to-Peer (P2P) Review**

Clinical reviews are offered for cases when an adverse decision for medical necessity is reached. These requests must be submitted within two business days of the denial for inpatient or continued stay requests, or five business days for all other preservice requests.

When a P2P request is received, one of our physicians will call the treating provider on the requested date to discuss the medical necessity non-certification decision. A physician with the health plan will make two attempts to contact the treating physician on the date requested and within the four-hour window indicated on the completed form. It is critical that you provide a direct phone number to ensure we are successful in contacting you for the review. If you have questions, please contact us at 803-264-8114.

Requests for P2P reviews received through our call center will be transferred to the appropriate reviewer for disposition. Expedited appeal time frames will not be impacted, as the P2P process is not part of the appeals process.

## **4.3. Medical Review**

If a provider submits an appeal without written consent from the member, this is referred to as provider reconsideration. Physicians and physician groups may file provider reconsideration if they disagree with the adjudication of a claim.

Provider reconsiderations are forwarded to and handled by the Provider Services team. Member appeals are forwarded to and handled by the Appeals team.

### **4.3.1 Member Appeals**

Members of the health plan have the right to submit an appeal if a claim has processed with an adverse determination. An adverse determination is a denial or penalty that unfavorably affects the member (such as increased liability). Members can give written authorization for a physician or physician group to appeal on their behalf. The Designation of Authorized Representative to Appeal Form is optional for use by any individual or physician to appeal on behalf of a member. This form is located in the Forms section on the Provider page of [www.InStillHealth.com](http://www.InStillHealth.com).

### **4.3.2 Provider Reconsiderations**

Provider reconsideration is a provider's written request for review of a prior benefit decision. This is a voluntary process we offer to ensure the benefit decision was correct.

A provider can pursue provider reconsideration by using the Provider Reconsideration Form. This form is intended for use by physicians and other health care professionals in South Carolina only. It is located in the Forms section on the Provider page of [www.InStillHealth.com](http://www.InStillHealth.com). Complete the form in its entirety and use it as a cover for all supporting documentation. Send the Provider Reconsideration Form to the appropriate Plan fax number or address as provided on the form.

If a provider is found to consistently file provider reconsideration requests for inappropriate reviews, an education specialist may initiate a training session to discuss proper procedure.

### **4.3.3 Determinations**

It generally takes the health plan 30 days to complete provider reconsideration reviews. After the review is complete, the appropriate service area will initiate claim adjustments or generate letters of denial to providers.

## **4.4. Subrogation and Coordination of Benefits**

### **4.4.1 Subrogation**

The health plan's member's health contract contains an important clause called "subrogation" or "reimbursement." This means when the health plan pays medical bills for an injury or illness that has been caused by a third party, we have a right to seek reimbursement of those medical bills from the third party, their insurance company or the member's insurance company.

The health plan's staff of physicians has established a list of diagnosis codes that indicate an injury or illness may be accident-related or work-related. When claims are processed through our system, a questionnaire is generated if the patient has received treatment for an injury or illness that has one of these "accident-type" diagnosis codes.

You should have members complete our Subrogation (Accident) Questionnaire available on the Forms page of the Provider section at [www.InStilHealth.com](http://www.InStilHealth.com). A Spanish version of this form is also available. The answers will help us properly administer claims and determine if we need to seek reimbursement from a third party or an insurance company for these claims. If the questionnaire is not returned, we may withhold payment on medical claims.

#### **4.4.2 Coordination of Benefits (COB)**

Member contracts contain a COB provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan.

Have your patient complete the Other Health/Dental Insurance Questionnaire form to give the health plan information about possible other health/dental coverage, including Medicare, to process your claims correctly. A Spanish version of this form is also available. Download a form by going to the Forms page of the Provider section at [www.InStilHealth.com](http://www.InStilHealth.com).

### **4.5. Provider Reviews, Audits and Availability**

#### **4.5.1 Fraud, Waste and Abuse (FWA)**

If you suspect fraud, we encourage you to let us know anonymously. Include as many details as possible. To report fraud, call the InStil Health Fraud Hotline at 800-763-0703 or fax to 803-264-4050. You can also complete an online form available on the Contact Us page at [www.InStilHealth.com](http://www.InStilHealth.com).

#### **4.5.2 Provider Report Cards**

Many provider report cards are made available to you during site visits from your designated provider education representative and upon request. Use these reports to gauge and improve performance in your practice.

- Gaps in Care Provider Report (Detail and/or Summary) Card – lists patient data and practice information in relation to quality measurements; also displays provider rating for Rewarding Excellence Program
- OB/GYN Report Card – shows how your patient care impacts our maternity quality initiatives
- Provider Report Card – encompasses an overview of the provider's EMC percentage, duplicate filing provider on claim

#### **4.5.3 Responding to Patient Reviews**

Patient reviews provide insight into their experiences with your medical office and their interaction with your practitioners. These reviews – submitted by our members via My Health Toolkit® – can also attract new patients to your practice. My Health Toolkit is an online resource for your patients to manage their benefits, locate an in-network doctor and many other tools to take charge of their health care.

You should log in to My Insurance Manager to respond to each patient review. By making it a priority to respond to online reviews in a way that reflects a high level of personal care, you can build rapport with current patients. This increases your practice's appeal and credibility with potential patients.

#### **4.5.4 Appointment Availability**

Outreach is made to providers on the referral list to verify availability within 30 days for medical services and 10 days for behavioral health services. If the provider's availability is greater than 30 days for medical services or 10 days for behavioral health services, notification is sent to the referring PCP to request clinicals for out-of-network consideration.