Provider Manual

MedCost Network

May 2025

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Introduction

How To Use This Manual

This procedure manual will assist your office staff in administration of MedCost programs. This manual is an extension of your MedCost agreement. You will receive advance notice via email regarding updates and revisions to this manual, and they will also be posted on our web site. You will be responsible for maintaining records of updates. As you receive updates, please insert them in your manual to ensure you have the most current information.

Whenever you have a question about any aspect of the MedCost programs, first check the appropriate section of this manual. If you do not find the answer to your question in the manual, contact MedCost. We are always willing to help.

About MedCost

MedCost offers several major health care cost management programs for payers on behalf of employer groups throughout the Carolinas and Virginia:

- Network of providers.
- Health Management Services - a suite of comprehensive care management programs, including inpatient review, outpatient review, case management, and prenatal.

A network is not an insurance plan. MedCost collaborates with many employers and claim administrators, all of which retain their own benefit plans. **MedCost as a network of providers does not pay claims** but assists in collecting information and repricing the claim for payment to route to the appropriate claim administrator for benefit determination.

When and How to Contact MedCost

Contact us via our web site at www.medcost.com for common links to:

- Link to the payer partners websites for claim status Payer Partners | MedCost
- Find a provider Find A Doctor or Facility | MedCost
- News and updates Provider News | MedCost
- Provider Manual Provider Onboarding | MedCost

Secure password required provider portal Group Login Form (medcost.com)

- Claims repricing inquiry
- Reference Guide for employers and payers accessing MedCost network of providers
- Claim Activity Report
- Fee allowables – limited access
- Provider roster

MedCost Benefit Services (MBS) secure password required provider portal.

- Claims status and eligibility MBS_Provider_Portal_V3 (healthx.com)

Customer Service Contact Center

- Call our Customer Service Contact Center toll-free at 1-800-824-7406, Monday through Friday, from 8:30 a.m. to 5:00 p.m. (EST).

Requirements for Network Participation

These can be found at the following link.

Network Credentialing | MedCost

MedCost collaborates with Verisys Credentialing, LLC to provide credentialing verification services for providers included in our network.

As a MedCost participating provider, you may receive correspondence from Verisys Credentialing, LLC requesting that you update your CAQH application, re-attest to your information, or authorize MedCost as a participating plan.

Verisys Credentialing staff may also contact you directly in the event additional information is needed to complete the application process. Any requests from Verisys Credentialing, LLC are legitimate and vital to MedCost's provider credentialing process. Your prompt response and cooperation with Verisys as our credentialing partner is much appreciated.

A provider can obtain information about the status of their credentialing application at any point during the credentialing or recredentialing process by calling the MedCost Customer Service Contact Center at 1-800-824-7406. In the event an application is incomplete, inaccurate or has conflicting information, providers will be notified and given the opportunity to provide updated information.

Providers will be notified within ten (10) business days after credentialing verification is completed. **A provider will not be considered a participant in the MedCost Network until the Credentialing Committee has approved your credentials. A welcome letter will be sent to the provider indicating the effective date. MedCost will not assign retro-effective dates. Claims sent to MedCost with dates of service prior to the effective date will be processed as out-of-network.**

Participating providers are recredentialed every three (3) years from your original effective date with MedCost.

Professional Providers

On behalf of MedCost, Verisys Credentialing, LLC can access CAQH for professional providers' credentialing information through the Universal Provider Datasource® (UPD).

With CAQH, each health care provider can submit just one standard application to a single database that is designed to meet the needs of all organizations involved in the credentialing process—and there is no cost for submission. Credentialing information can easily be accessed if you add MedCost as one of the health plans authorized to access your information. CAQH will ask you quarterly to verify the accuracy of your information on file, and you can easily update it anytime.

- **If you are registered with CAQH,** please send your CAQH ID to MedCost at e-mail **credentialingapps@medcost.com**. You will also need to log in to the UPD at **https://proview.caqh.org/PO** and add MedCost as one of the health plans authorized to access your information. Please be sure that you have updated your information to include all supporting documentation, including the most current Certificate of Liability Insurance.

- **If you are not registered with CAQH**, please click here **https://proview.caqh.org/PR/Registration** to register and add MedCost as one of the health plans authorized to access your information. Once you receive notification from CAQH that your application is complete, **click here to supply MedCost with your CAQH ID.**

Facility Providers

Facility providers include, but are not limited to hospitals, free-standing surgical centers, office-based surgical suites, endoscopy centers, home health agencies, hospice providers and other ancillary providers.

An Organizational Credentialing application will be sent via fax, email, or mail to the credentialing contact for the facility. The application should be completed and returned as indicated on the request, including all required documentation.

Your Listing in the MedCost Directory

Upon acceptance as a participating provider with MedCost, your demographic information will be listed in our online provider directory at Find A Doctor or Facility | MedCost.

Updates and Changes

It is important for your office to notify MedCost in writing of changes in any demographic information prior to the date the change(s) occur. Please send your changes to us at Update Info | MedCost.

Provider Accessibility and Availability

All MedCost provider must meet the following availability standards for average appointment wait times:

Primary Care:

Routine Appointments:	fourteen (14) calendar days
Urgent Appointments:	Same day
Emergency Appointments:	Immediately or triage

Specialists:

Routine Appointments:	thirty (30) calendar days
Urgent Appointments:	Same day
Emergency Appointments:	Immediately or triage

Emergency Care:

Emergency care shall be available 24 hours a day, 7 days a week.

In Network Referrals

If you need to refer a MedCost member to another provider for any service, please ensure that the provider is also in-network with MedCost. To verify MedCost contracted providers, please refer to our MedCost Provider Directory located on our web site at Find A Doctor or Facility | MedCost or call our Customer Service Contact Center at 1-800-824-7406.

Member Identification

Identification Cards

The health identification card is used to identify members who access the MedCost NC/SC Network. Members may have access through a TPA that leases the MedCost Network OR because their health plan is administered by MedCost's own TPA, MedCost Benefit Services (MBS). Regardless of how members access the MedCost Network, the identification card presented by eligible members for MedCost NC/SC Network is Medical EDI 56162 for electronic claims submission.

****For MedCost Virginia Network, the Medical EDI is 54138 for electronic claims submission.

For members accessing the MedCost Network because their health plan is administered by MedCost's own TPA, MedCost Benefit Services (MBS), the ID card:

- **Will include** the MBS icon logo (shown below).
- **Will include** some version of the MedCost Network logo (shown below).
- **May include** logos for other network partners, including but not limited to, First Health Network, 4Most Health Network, MagnaCare, and Cigna.

For members accessing the MedCost Network through a TPA other than MedCost Benefit Services (MBS), the ID card:

- **Will include** some version of the MedCost Network logo (shown below).
- **May include** logos for other national network partners outside of NC, SC, and VA (e.g., American Healthcare Alliance).

If the member cannot provide proper identification showing the member is eligible to access any MedCost Network, you may collect your actual charge from the member at the time of service. If the claim for the member is processed and a fee reduction amount is indicated on the Provider Claim Activity Report, you must refund the member accordingly.

Versions of MedCost Network Logos

MEDCOST®

MEDCOST® ULTRA

MEDCOST VIRGINIA PLUS

MEDCOST VIRGINIA ULTRA

MEDCOST VIRGINIA

MBS Icon Logo

MBS

Requests for Verification of Eligibility and Benefits

MedCost Benefit Services (MBS)

MBS_Provider_Portal_V3 (healthx.com)

All Other MedCost Payer Partners

Providers should contact the claim administrator indicated on the member's identification card for benefit and eligibility information. The claim administrator name, phone number, and web site can also be found in the MedCost Reference Guide or at the following link.

Payer Partners | MedCost

MedCost recommends that providers verify benefits for all services rendered to MedCost members. Verifying benefits allows the provider to collect any co-payment, co-insurance, deductible, etc., at the time of service.

Claims Filing

Timely Filing

Provider will file claims within ninety (90) days of the date of service, except:

For North Carolina providers, pursuant to North Carolina General Statute 58-3-225, 'Prompt Payment Under Health Benefit Plans', the filing limit for claims filed under fully-insured Plans is extended to 180 days after the date of the provision of care by the Provider and, in the case of facility claims, 180 days after the date of discharge from the facility. In such cases, the failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the Provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Eligible Person, later than one year from the time submittal of the claim is otherwise required.

South Carolina providers, Section 38-59-200 of the 'South Carolina Health Care Financial Recovery and Protection Act', are allowed by this legislation to extend their claims filing limit to 120 days for fully-insured plans.

MedCost will not reprice a claim greater than two (2) years from the date of service. There is no guarantee of payment based on status of employer group and member eligibility.

Failure to file promptly may result in denials by the claim administrator based upon the plan's timely filing limitations. If you receive denials on these claims due to untimely filing, please be advised that the member should not be penalized.

Assignment and Claims Routing

As a MedCost NC/SC Network participating provider, you have agreed to accept assignment and file claims for all services rendered to MedCost eligible members.

MedCost encourages you to file claims to us electronically. Refer to section "Filing Your Claims Electronically" for detailed information about electronic claims filing.

Should you need to file your claims in paper format, submit them to MedCost at the following address:

MedCost
P. O. Box 25307
Winston-Salem, NC 27114-5307

As a reminder, the billing provider and service facility addresses *must* be a **physical street address for both electronic and paper claims.**

If filing **electronically**:

- It is *no longer acceptable* to use a **PO Box, lock box**, or any other address other than a physical street address.
- The *billing provider* address **must** be a physical street address.
- A **PO Box** or **lock box** should only be sent in the *"Pay-To Provider"* address field in loop 2010AB.
- A PO Box cannot be in loop 2010AA.

If filing **paper claims**:

- The **billing provider address** *cannot* contain a **PO Box** or **lock box**.
- The physical address of the practice must be submitted in Box 33 of the HCFA1500 form.

Failure to file in accordance with these requirements will result in electronic claims being rejected and paper claims being returned.

Itemized Bills

Our payer partners may require an itemized bill on high dollar claims and will request that directly if needed. Not necessary to send in unless requested.

Filing Your Claims Electronically

MedCost NC/SC receives electronic claims via Availity as our exclusive EDI gateway. Availity Client Services can be contacted at 1-800-282-4548.

Requirements for electronic claims filing:

MedCost NC/SC payer ID number - 56162
MedCost Virginia payer ID number - 54138
Loop 2010BB
Segment NM109
Data element 67

Group number
Loop 2000B
Segment SBR03
Data element 127

Group name
Loop 2000B
Segment SBR04
Data element 93

Group Name should only be submitted when there is no value for Loop 2000B SBR03 (Group Number). Passing both constitutes a broken situational validation rule. Our leased payer claims submitted without a group number will be rejected.

Rendering provider's name and credentials:

Loop 2310B	Last Name	Segment NM103	Data element 1035
	Qualification Degree	Segment NM107	Data element 1039
	First Name	Segment NM104	Data element 1036
	Middle Initial	Segment NM105	Data element 1037
	Professional Rendering Provider NPI Number	Segment NM109where NM108 = xx	Data element 67
	Institutional Rendering Provider NPI Number	Segment NM109 where NM108 = xx	Data element 67

Loop 2310B (Rendering Provider) should only be submitted when the Rendering Provider information is different than Loop 2010AA (Billing Provider) information.

Valid member date of birth:
If member equals subscriber: 2010BA, DMG02, 1251 (ccyymmdd)

If member is not subscriber: 2010CA, DMG02, 1251

Filing claims electronically to MedCost is recommended and preferred. All EDI claims, regardless of type (institutional or professional), submitted for MedCost Payer IDs 56162 and 56205 will be received by MedCost through Availity.

If you wish to submit claims directly to Availity or would like to obtain more information, please contact Availity Client Services at 1-800-282-4548.

The following edits are monitored on all submitted claims to MedCost through Availity:

Standard National Implementation Process (SNIP) Edits 1, 2, 3 and 5:

- SNIP 1 – Message syntax and valid data types
- SNIP 2 – Additional format edits and valid values
- SNIP 3 – Balancing service levels to claim level
- SNIP 5 – Code set verification, i.e., ICD, CPT, etc.

- Provider NPI format must be valid wherever it is submitted on a claim, depending on claim form type. The NPI should match the provider that you are filing the claim for.
- For MedCost Benefit Services (MBS) members, the NM 109 element will be checked for valid subscriber/member ID. If this is blank or not valid, the claim will not be able to be processed.

- For members of leased payer groups, Loop 2000B Segment SBR03 Data element 127 will be checked for a valid group identifier. If this is blank or not valid, the claim will not be able to be processed.

- Claims failing any of the above edits will be returned to the submitting provider for correction and will delay the claim from processing.

Coding Guidelines

Providers should be utilizing the current Uniform Billing, ICD-10, CMS, AMA, and CPT manuals when submitting claims. In addition, MedCost also requires compliance with the HIPAA standardized code sets and thus only considers valid and current ICD-10 (or its successor), CPT, and HCPCS codes with their appropriate modifiers.

Improper coding may result in incorrect repricing, and/or payment delays. Services may also be denied by our payer partners based on the payment policies defined for correct coding.

Please remember that inclusion or exclusion of a procedure does not imply any health insurance coverage or entitlement to reimbursement.

Filing Tips

Quick Tips to Ensure Successful Electronic Filing to MedCost

We have identified various reasons an electronic claim may be rejected at your clearinghouse/vendor level or result in the claim being converted to paper and mailed to MedCost.

- **Ensure your claim contains a valid member number.**
- **Claim must contain a valid employer group number.**
- **Routinely review your rejection/confirmation report.**
- **Ensure your claim contains complete diagnosis codes.**
- **Certify your claim contains a valid member date of birth.**

Corrected Claims

When resubmitting a claim to MedCost as a corrected claim, the guidelines shown below must be followed to ensure timely and accurate adjudication using the corrected information. Corrected claims that are not filed according to these guidelines will be denied.

A corrected claim is the resubmission of an existing claim with a specific change or addition to the original information, filed with the appropriate corrected claim indicator.

All corrected claims should be filed through your normal claim submission channel. The successful submission of a corrected claim will result in the retraction and replacement of the original claim. For faster and more accurate processing, the preferred method for submitting claims to MedCost is via electronic data interchange (EDI).

- **Guidelines for Filing a Corrected Claim to MedCost**
  - For UB-04 claims, a "7" must be present as the third digit of the Type of Bill field.
  - For paper claims, the original claim number should be entered in Field 64.
  - Professional claims also should reflect a claim frequency code of "7." For paper claims, the original claim number should be entered in Box 22.
  - Edit the claim with the corrected information.

  - Include the payer's original claim number in the 2300 claim loop - segment REF01=F8 and REF02=the original claim number with no dashes or spaces.
    - Enter the original claim number of the paid/denied claim when submitting a replacement with frequency of "7" (Replacement of Prior Claim). CLM05-03 (837P).
    - In the 2300 Loop, the REF02 segment [Original Reference Number (ICN/DCN)] must include the original claim number issued to the claim being corrected. The original claim number can be found on your Remittance Advice.
    - Resubmit through normal channel.

Failure to include the original claim number and/or use a corrected claim indicator may impact the processing of your claim. ***Please note, a corrected claim does not constitute an appeal***.

Failure to file in accordance with these requirements will result in the claim being rejected. An image of the claim with a cover letter will be mailed back to you, delaying your claim processing time.

All corrected claims should be sent to MedCost for applicable repricing. ***The original claim # is required to be submitted on the corrected claim***. Please send corrected claims to the appropriate claims filing address.

Claims Payment Appeals

For **MedCost Benefit Services (MBS)** *payer payment* appeals, you may submit a written appeal within 180 days after receiving the EOB to:

MedCost Benefit Services (MBS)
Attention: Appeals Coordinator
PO Box 25987
Winston-Salem, NC 27114-5987

For **MedCost Benefit Services (MBS)** *benefit* appeals, you can send to:

MedCost Benefit Services (MBS)
Attention: Benefit Appeals
PO Box 25987
Winston-Salem, NC 27114
Fax# 336-774-4420

Appeals related to *benefit denials,* such as plan exclusions, timely filing limit, member responsibility disputes (co-pay, deductible, coinsurance), should be sent to the applicable payer on the member's ID card. Benefit appeals could be for denials related to services not covered by the plan or reconsideration of a non-covered service.

You may email the appeal to **mbscs@medcost.com**.

MedCost Benefit Services (MBS) follows CMS guidelines on reimbursement related to NCCI (National Correct Coding Initiative) editing, including but not limited to procedure-to-procedure edits and medical unlikely edits. All appeals, claim disputes or claim denials related to code editing should be sent to the following:

Zelis
Attention: Inquiries Department
2 Crossroads Drive
Bedminster, NJ 07921
appeals.integrity@zelis.com
Fax# 855-787-2677

If a corrected claim is necessary as part of an appeal with changes to repricing, the corrected claim must first be sent to the MedCost Network for repricing.

For **Leased Payers**, the EOB will provide information on where to submit disputes and/or appeals.

Repricing of Your Claim

How MedCost Collects Information and Adjusts Claims

When MedCost receives a claim, the claim is repriced based upon the contractual terms of your Participating Provider Agreement.

MedCost Claims Adjustment Policies

The following claims adjustment policies are part of the claims repricing process and may impact the amount allowed by MedCost. Any disallowed amounts will appear on your Provider Claim Activity Report and should be adjusted off the member's account.

Each claim administrator may have additional policies and procedures that may affect the payment based on the benefit plan of the employer group and correct coding initiatives.

Modifiers that Affect MedCost Repricing

The MedCost allowable may be affected when the following modifiers are added to the CPT codes. Please file modifiers that affect repricing in the applicable position.

Modifier	Effect on MedCost Repricing
24	Allows unrelated evaluation and management services by the same physician during a postoperative period.
25	Allows significant, separately identifiable evaluation and management service by the same provider on the same day as other procedures.
26	If no allowable has been established reduces the MedCost allowable to 40% of the global allowable.
TC	If no allowable has been established, reduces the MedCost allowable to 60% of the global allowable.
50	Reduces the MedCost allowable to 150% of the global allowable.
51	100% for the primary procedure and 50% for each of the other codes.
57	Allows the evaluation and management service when billed on the same day as a non-starred surgical service.
80	Reduces the MedCost allowable to 20% of the global.
81/AS	Reduces the MedCost allowable to 14% of the global.
82/AS	Reduces the MedCost allowable to 14% of the global.

There are many other modifiers listed in the Current Procedural Terminology (CPT) and ASA Manuals, and some may affect the actual payment received from the claim administrators. Ensure you are filing according to the most current CMS, CPT, and AMA coding guidelines.

Adjustment for Bilateral Surgical Procedures:

Claims for bilateral procedures should be filed with one procedure code appended with a modifier 50. Modifier–50 designates the performance of a bilateral procedure. Charges for bilateral procedures (modifier-50) will be approved at 150% of the MedCost allowable fee for that procedure unless your contract states otherwise. MedCost follows CPT guidelines with respect to bilateral surgeries.

MedCost will not accept claims for bilateral services billed on two detail lines.

Charges for Hospital Admission and Daily Care When a Surgical Procedure Is Performed during the Same Admission:

When a surgical procedure is performed during a hospital admission, no charges for hospital admission, daily management, or hospital discharge of the member can be approved for the provider who performed the procedure. MedCost follows CMS guidelines to make this determination. MedCost does allow for a new member visit and a procedure to be performed on the same day. If the new member care occurs in an inpatient setting, please provide documentation the services were for a new member. Without this documentation, MedCost will assume is established and will not allow the charge. Charges made for daily consultation by providers in other specialties may be approved if they are necessary because of the member's medical condition.

Global Charges for Surgical Procedures:

Charges for surgical procedures are considered global and include pre- and post-operative care. MedCost uses CMS standards for follow-up days in evaluating out-of-hospital postoperative charges.

Emergency Room Visit Charges:

Emergency Room visit charges will not be approved when a hospital admission charge is made by the same provider with the same date of service on the claim.

Adjustment for Charges Made by an Assistant Surgeon:

MedCost requires all assistant surgeon charges be filed with the applicable 80, 81, 82, or AS modifiers. MedCost will determine the allowable based on the policy and procedures in place for the modifier and provider of service billed. **Please note:** *The claim administrator makes payment consideration for assistant surgeon charges based on the plan design.*

Charges for Medically Unnecessary Services:

Charges for procedures or services which, based on repricing guidelines, are unnecessary will be reduced to zero. Providers may not balance bill for the services that are deemed unnecessary. Example: MedCost would deem charges for assistant surgeons medically unnecessary based on Medicare guidelines. If operative notes are required, the payer would request that information from the provider for review.

Limitation on In-Hospital Daily Visits:

For medical (i.e., non-surgical) admissions, charges for only one hospital visit per day by the attending provider (or his covering provider) will be allowed. Charges by another specialist for daily consultation will be approved if warranted by the member's medical condition.

Multiple Evaluation and Management Codes Billed on the Same Day:

MedCost will reduce the lesser charge(s) to zero for claims billed with two or more E&M codes on the same day when filed without the appropriate modifier. In addition, a hospital discharge and subsequent care cannot be billed on the same day.

Allergen Immunotherapy

CPT codes 95115-95199 include professional services necessary for allergen immunotherapy. Office visit codes may be used in addition to allergen immunotherapy **IF** other identifiable services are provided at that time. If an office visit is billed in the absence of other identifiable services, MedCost will reduce the charges to zero.

Adjustment for Multiple Surgical Procedures:

When multiple procedures, other than E/M services, physical medicine and rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier 51 to the additional procedure or service code(s).

Note: This modifier should not be appended to designated "add-on" codes.

- Modifier 51 is defined as multiple surgeries/procedures.
- Multiple surgeries performed on the same day, during the same surgical session.
- Diagnostic imaging services are subject to the Multiple Procedure Payment Reduction that are provided on the same day, during the same session by the same provider.

Appropriate System Usage

Modifier 51 is appended when:

- The same physician performs more than one surgical service at the same session (Indicator 2).
- The technical component of multiple diagnostic procedures, Multiple Procedure Payment Reduction rule applies (Indicator 4).
- The multiple surgical procedures are done on the same day but billed on two separate claims.
- The surgical procedure code is the lower physician fee schedule amount.
- The diagnostic imaging procedure with the lower technical component fee schedule amount.

Inappropriate System Usage

- Do not append to add-on codes (See Appendix D of the CPT manual).
- Do not report on all lines of service.
- Do not append when two or more physicians each perform distinctly, different, unrelated surgeries on the same day to the same member.

Additional Information

- MedCost will consider the procedure with the highest relative value unit (RVU) as primary. The procedure with the highest RVU should be listed first on the claim, and modifier 51 appended to the subsequent lower RVU procedures.
- Reimbursement will be 100% for the primary procedure and 50% for each of the other codes.
- Multiple surgery pricing also applies to assistant surgery services.
- Multiple surgery pricing applies to bilateral services (modifier 50) performed on the same day with other procedures.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, MedCost may:

- Reject or deny the claim.
- Recover and/or request a refund of claim payment.

If no modifier is appended, for Medcost Benefit Services (MBS), reimbursement may be adjusted to reflect the appropriate services and/or procedures performed.

Physician Assistant (PA) and Nurse Practitioner (NP) Reimbursement

PA's and NP's should be credentialed as participating providers in the MedCost network. For existing practices, you may submit a request to credential your Physician Assistant(s) or Nurse Practitioner(s). Add a Provider to a Participating Practice | MedCost

- For brand new practices to the network, a request can be submitted through the provider portal of our web site at Apply to Join | MedCost

Filing Claims For Anesthesia Services

Anesthesia services should be filed using the appropriate ASA (American Society of Anesthesiology) codes. Anesthesia claims should include the total minutes for anesthesia services, not the number of units. MedCost will calculate the units based on the total time reported on the claim. For electronic claims, the total minutes should be filed in Loop 2400, SV104 Segment, with the preceding qualifier of MJ in the SV103 segment.
Per ASA guidelines, when multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code with the highest base unit value should be reported. The time reported should be the combined total for all procedures. Add-on anesthesia codes are an exception to this policy. Add-on codes are listed in addition to the primary procedure.

MedCost does not recognize physical status modifiers or qualifying circumstance codes (99100, 99116, 99135, and 99140). If these codes are filed on a claim, they priced at $0, and the Medcost member cannot be billed for these services.

Filing Claims for Locum Tenens

MedCost recognizes standard claims filing guidelines for locum tenens in circumstances where a participating provider has a locum tenen covering their practice for a period no greater than sixty (60) days. After the sixty (60) day period, the locum tenen must either be credentialed or no longer submit claims to MedCost. During the initial sixty (60) day period, claims should be submitted to MedCost under the participating provider's name and tax ID for whom the locum tenen is covering; and include the modifier Q6 to indicate the use of a locum tenen. It is important for the participating provider to confirm that the locum tenen has the applicable licensure, malpractice insurance coverage, and any other specific requirements needed to treat members.

Claims Editing

Services that are inappropriately billed, unbundled or subject to a reduction, should not be billed to the member.

Provider Claim Activity Report

How MedCost Notifies Providers of Repriced Claims

MedCost provides an online Provider Claim Activity Report that shows the MedCost fee adjustments. The Claim Activity Report allows you to publish a detailed report for all claims repriced under your facility or practice for any date range up to 31 days. You may either run the report for all claims repriced or for a specific member. The report includes:

Member's name
Repricing date
Member ID
Date of service
Specific procedures billed
Billed amount
Allowed amount
Fee reduction
Claim Administrator
Claim Administrator phone #

This report also contains information about the claims MedCost **could not reprice** during the specified date range. There are several reasons that MedCost may not be able to reprice a claim you file to us. Some examples of those reasons are:

- Policy number or group name missing
- Diagnosis code missing or invalid
- CPT code inappropriate, missing, or invalid
- Date of service is prior to the policy's participation or after the policy's termination.

It is recommended the provider regularly log into the MedCost web site and download the Provider Claim Activity Report.

MedCost Claim Repricing Disputes

For any repricing disputes specific to the MedCost contractual allowable, please contact NMFees@MEDCOST.com as soon as possible. Your dispute will be reviewed, and a response provided to confirm the pricing and methodology and/or the claim will be repriced as applicable.

All claim repricing disputes not made within 12 months from the date of receipt of the Explanation of Benefits will be considered final and no adjustments will be made.

For any claim appeals specific to billing, coding, or medical necessity follow the section outlined under Claims Payment Appeals.

Billing and Collection

Collection of Co-payment and Co-insurance

All applicable co-payments or co-insurance amounts may be collected at the time of service. Any amounts collected above the final member responsibility should be credited to the member's account or refunded accordingly as indicated on the online Provider Claim Activity Report.

Explanations of Benefits

Claims will be adjudicated by the claim administrator based on the negotiated allowable. Providers should convert member accounts to self-pay when applicable. Amounts from co-payments, co-insurance, etc., should not remain in your MedCost accounts receivable categories.

Non-covered Services

Services that are determined to be non-covered prior to the service being provided to the member, may be billed to member so long as the provider has notified the member in writing upfront and the member has agreed to move forward with the non-covered service.

Individual Office Policies

Individual office policies (including signed member waivers) do not supersede the MedCost contract.

Coordination of Benefits

It is the responsibility of the claim administrator to handle all coordination of benefits, including, but not limited to, cases involving workers' compensation claims, Eligible Persons covered by more than one Health Benefits Plan, and Eligible Persons who have a right to recover costs of Covered Services through subrogation (i.e., third-party insurance) or first-party insurance (i.e., automobile, or medical). MedCost providers are required to file claims for all MedCost plans regardless of the order of benefit determination. Providers cannot pursue collection from the member for more than the MedCost contractual allowance if the payment was based on the MedCost allowable.

Claim Inquiries

MedCost encourages network providers to follow up on outstanding claims instead of filing duplicate claims. You may follow up with the claim administrator directly by calling the telephone number listed on the member's identification card, the MedCost Provider Claim Activity Report, and on the MedCost Reference Guide. Many claim administrators also have online claims follow-up; you can link to these sites directly from our web site at **https://www.medcost.com/providers/coverage-and-claims/payer-partners** or link from our Claims Repricing Inquiry tool.

If after following up with the claim administrator, your claim issue is still not resolved, you may ask MedCost for assistance in resolving the issue.

Balance Billing

In the event a claim submitted by a Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are denied or reduced based on applicable billing guidelines, it is the Plan's position that the Plan Participant or member should not be responsible for payment of any denials or reductions as a result of the medical bill review or medical chart audit. Also, members should not be balance billed for the difference between the billed charges and the allowable as outlined on the Explanation of Payment. However, the Plan has no control over non-network providers that engage in balance billing practices.

The member is responsible for any applicable payment of copayment, coinsurance, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Services that are inappropriately billed, unbundled or subject to a reduction, should not be billed to the member.

Utilization Management

As a MedCost provider, you have agreed to comply with utilization review requirements. MedCost recommends that members not be charged for the completion of forms associated with utilization review.

NOTE: For many companies who participate with MedCost, review is performed by MedCost Health Management; **however**, there are companies whose utilization management is performed by the claim administrator or alternate utilization review organization.

MedCost Health Management Phone Number: 1-800-722-2157

Other UR firms: The member's ID card will identify the appropriate UR organization and telephone number to call. You also can locate the UR organization and telephone number for a particular employer group on the MedCost Reference Guide.

MedCost offers certifications via our web portal 24/7 at https://www.medcost.com/providers/my-account/provider-login-or-register. Providers will get an automatic certification about 70% of the time for inpatient procedures. All scans can be initiated online and clinical may be submitted to optimize response time. If you need to call in, there is a voicemail available.

Outpatient Review

To ensure medical necessity, some employers have elected to use the outpatient review program from MedCost. If an employer uses this service, there should be information on the member's insurance identification card that indicates certification is required. Certification requirements will vary by employer and insurance company, so it is important to call and confirm coverage and medical necessity before a procedure is scheduled. Certification requirements can include, but are not limited to, any surgical procedure performed outside of the physician's office, MRI, CT scan, PET scan, and varicose vein treatment.

Inpatient Review

Under your MedCost contract, there are two requirements the MedCost participating practice must meet when admitting a MedCost member to the hospital:

- The practice must contact the utilization review firm specified on the member's health insurance card. The UR firm will certify the admission, if appropriate, and the length of the stay.
- The practice should refer to the listing of MedCost participating hospitals to schedule hospital services.

These requirements are explained in detail in the following section.

Preadmission Review

As a participating MedCost provider, it is important to report admissions to the UR firm providing services to the MedCost member. This protects the interests of the member and the provider since most plans reduce coverage for non-certified stays.

Preadmission review is required for **ALL** hospital admissions of MedCost members. As part of the MedCost programs, it is the responsibility of the MedCost participating practice to initiate preadmission review. When review is required, please follow these guidelines:

The member's identification card typically identifies the UR firm and phone number to call.

A. Non-emergency Admissions

1. Elective, Non-urgent Admissions:

Call UR firm and provide the requested information by phone, at least 3 days prior to the scheduled admission.

2. Maternity Admissions:

a. Notify the appropriate UR firm at the time pregnancy is confirmed in order to ensure that the member is registered in the MedCost SmartStarts Program
b. Vaginal delivery - certification is required for stays longer than 48 hours following delivery.
c. Cesarean section - certification is required for stays longer than 96 hours following delivery.
d. Vaginal & cesarean section - certification is required for admissions prior to delivery.

B. Emergency Admissions

An emergency admission is defined as an admission for a medical condition with symptoms of sufficient severity to place the health of an eligible person(s), or with respect to a pregnant woman, the health of the unborn child, in serious jeopardy; serious impairment to a bodily function; serious dysfunction of any bodily organ or part, which would be threatened if hospital care were not obtained immediately. For emergency admissions, the provider practice should notify the appropriate UR firm of the admission as soon as possible by telephone.

C. Identifying MedCost Members for Preadmission Review Purposes:

Although the initiation of preadmission review is the responsibility of the MedCost participating practice, members covered under several plans that use MedCost have been instructed to remind the provider practice that preadmission review is required. Members covered under these plans face a substantial financial penalty if their hospital admissions are not certified.

D. Penalties

At present, the MedCost program does not assess financial penalties against participating provider practices for failing to obtain preadmission certification or extensions of certified hospital stays. However, a pattern of failing to notify a UR

firm of MedCost admissions is cause for MedCost to terminate the provider's participation in the MedCost Network.

Notification of the Certified Length of Stay

The appropriate UR firm will analyze the information supplied by the provider practice against medically established criteria for admission and nationally established length-of-stay norms (categorized by age, sex, diagnosis, procedures, and complicating medical conditions) and will produce a certified length of stay. A copy of the certification notice will be sent to the:

- Member
- Claim Administrator
- Provider
- Hospital

Extensions

Should a complication develop, that will delay the member's discharge, the provider practice should request an extension of the certified stay by calling the appropriate UR firm prior to the end of the certified stay. A certification notice listing the approved extension will be sent to the member, claim administrator, hospital, and the physician as above.

Appeal Process for Non-certification

In 2002, Department of Labor legislation eliminated the informal reconsideration process and limited the number of appeals processes so that members would know about certification decisions within the required time limit. When a non-certified medical necessity decision has been rendered, the member, subscriber, or providers may appeal the decision. They have these options:

- **Peer-to-Peer Review**. This is a scheduled physician-to-physician discussion to explain the member's need for the admission and/or procedure. The member's physician can request a peer-to-peer review by calling the utilization review vendor and providing times when the attending physician is available for discussion.

- **Expedited Appeal.** This can be requested in emergency situations. Expedited appeals are conducted via telephone or facsimile. A determination is made within 72 hours of the request for appeal. A physician consultant of the same specialty as the member's physician will review the case information. The decision will be relayed by telephone to the requesting party within 72 hours of the request. If the decision is reversed or modified, a written notice is mailed to the insured, the member's provider, and the claim administrator within one (1) business day of the determination. Expedited appeals that do not resolve a difference of opinion may be submitted for External Review.

- **Standard Appeal**. A standard appeal may be requested for any non-certified confinement or procedure. The appeal must be requested within 180 days of the receipt of the non-certification. A standard appeal is done for pre-service and post-service services. A second physician consultant who was not involved in the original decision to non-certify and is of the same specialty as the member's physician will review all clinical information. Pre-service appeals are requested prior to the scheduled procedure and are completed within 15 days of the receipt of the request for appeal. Post-service appeals are requested retrospectively and are completed within 30 days of the receipt of request. To request a standard appeal, submit the request in writing to the specific utilization review vendor. Provide any additional supporting medical information when requesting the appeal. The member, providers, and claim administrator will be notified in writing of the appeal outcome.

- **External Review.** A member may be eligible for an external independent review if they have a non-certification or upheld appeal. This is an additional level of appeal conducted by an independent review organization (IRO). Upon request and an IRO is assigned. The IRO will alert the member of their assignment and allow for receipt of additional information. The IRO will communicate their decision directly to the member.

Appeal request should be submitted in writing as follows:

Fax:	336-970-2098
Physical address:	165 Kimel Park Drive Winston-Salem, NC 27103
Mailing address:	PO Box 25347 Winston-Salem, NC 27114

The process described above will be completed with written notification to the covered person, covered person's provider(s), and insurer no later than thirty (30) days following receipt of the written request of appeal and the complete medical record.

All components of MedCost's Health Management/Review Program comply with North Carolina GS 58-50-61 & 62 and all other applicable state and federal laws, rules, and regulations. Providers are required to comply with all federal and state regulations.

Pharmaceutical Management

Pharmaceutical management procedures and updates set forth by the Pharmacy Benefit Manager (PBM) can be viewed online. Please identify the Pharmacy Benefit Manager on the member ID card and navigate to the Provider Portal of that PBM, or outreach to the PBM directly.

For OptumRx, please visit https://professionals.optumrx.com/.

MedCost SmartStarts Prenatal Program

Providing the best care and information to expectant mothers is the most effective way to advance a healthy start for babies. This does not just make sense from a humanitarian perspective – it also makes economic sense by helping to avoid premature births. SmartStarts offers a preventive approach that encourages prenatal education and mentoring for the expectant mother to eliminate the costs associated with premature and low birth weight babies.

Expectant mothers who use SmartStarts have fewer low birth weight infants than the national average. To ensure that expectant mothers are given an opportunity to enroll as early as possible, MedCost asks providers to contact MedCost Health Management at 1-800-722-2157 at the time pregnancy is confirmed. After you make this initial call, if the expectant mother is eligible for SmartStarts, a prenatal nurse will contact her to see if she wishes to participate in this voluntary program. No additional intervention is required from you or your medical staff.

We appreciate your assistance in introducing moms-to-be to the SmartStarts Program.

MedCost Case Management Program

This program is designed to proactively identify and intervene when a member is identified with serious, catastrophic, or chronic medical conditions. With the member's permission, you may be contacted to discuss action plans or to be advised of clinical alerts.

Provider Profiles

MedCost analyzes and evaluates claims, health, and case management data to turn it into a valuable tool that our clients can use to effectively manage their health plans costs. The information is used to determine how a provider compares to their peer providers in the network and is based on how the provider utilizes services compared to peers; how the practice compares to peers in terms of the MedCost population accessing it; and costs per member as a result of how providers bill for services.

If you receive feedback from MedCost as a result of this data analysis, utilize this data to help examine your own practice billing patterns. MedCost performs these reviews as a quality initiative measure. The long-term goal is to have the highest quality, most cost-effective provider network for our clients.

Grievance Procedure

The MedCost grievance procedure is designed to address and respond to complaints, contractual differences, and/or grievances submitted in writing by participating providers, covered persons, or claim administrators.

The issues resolved by these procedures are administrative or contractual in nature. Issues may include, but are not limited to, the timeliness of claims payment, contracted reimbursement rates, explanation of benefits, and application of MedCost claims adjustment policies. Complaints and/or grievances related to utilization management decisions should be resolved through the utilization management firm making the decision.

Grievances may be submitted to the address below:

MedCost, LLC
Attention: **Director, Network Management**
P. O. Box 25347
Winston-Salem, North Carolina 27114-5347

After reviewing the grievance, MedCost will record the following information:

- Name of person submitting grievance
- Practice/facility name
- Date of the complaint or grievance
- Name of employer
- Name of claim administrator
- Brief statement concerning the nature of the complaint or grievance

A representative from the Network Operations department may need to contact the party filing the complaint/grievance to obtain additional details. Upon completion of a thorough assessment, the representative will supply the party filing the complaint/grievance with an action plan to resolve the grievance. The action plan for resolving grievances may include, but is not limited to:

- Review and action by MedCost
- Review and action by the claim administrator organization
- Review and action by the MedCost medical director
- Review and action by the provider

MedCost will attempt to resolve all complaints and/or grievances within 10 (ten) business days after receiving all relevant information. If resolution requires more than 10 (ten) business days, MedCost will notify the party who submitted the grievance. MedCost will notify all concerned parties of resolution.

A claim administrator grievance may be filed directly with the claim administrator as per North Carolina GS 58-50-61 & 62.

Privacy and HIPAA

MedCost and HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 has created many changes in health care. MedCost has implemented numerous safeguards and processes to ensure our compliance with HIPAA.

During some functions of MedCost's repricing process, we operate as a clearinghouse. Because of this, MedCost has signed Business Associate Agreements (BAA) with our clients (claim administrators and third-party administrators). We also have signed a BAA with our clearinghouse vendors with whom we have partnered for electronic claims transactions. It is not necessary for MedCost to execute these agreements with providers as we are performing repricing functions only on behalf of our clients.

MedCost is fully compliant with HIPAA privacy regulations and has numerous precautions and security safeguards in place to ensure the confidentiality of protected health information (PHI). Disclosures of PHI between MedCost and providers for purposes of treatment, payment, and health care operations are permitted under HIPAA.

In cases of requests from insureds regarding PHI, MedCost will refer the inquirer to the originator of the PHI (i.e., the claim administrator or the provider).