PROVIDER MANUAL
CLAIMS SUBMISSION PROCEDURES

ALL CLAIMS ARE TO BE SUBMITTED DIRECTLY TO THE FOLLOWING ADDRESS:

Atlantic Imaging Group, LLC
2 Ridgedale Avenue
Suite A-10
Cedar Knolls, NJ 07927

CLAIMS DEPARTMENT PHONE NUMBERS

Phone: 973-451-9415
Fax: 973-451-9473

CLEAN CLAIMS OVERVIEW

ATLANTIC utilizes iHCFA.com a web-based claims processing system developed to allow medical practitioners to submit claims directly through the web and based on evolving Medicare guidelines. The system has enabled ATLANTIC to pre-fund clean claims through the population of a dynamic web based HCFA-1500 form. The system will not allow final payment of the claim when required information is not provided or when the system determines inaccuracies based on Carrier requirements. A "***clean claim"*** for ATLANTIC must also include the Radiology Report from the Provider and the required fields described in this section of the Provider Manual.

INCOMPLETE CLAIMS

If a claim is considered incomplete by the iHCFA.com, a Notice of Missing Information letter will be generated and faxed to the billing fax that has been provided by the facility. ATLANTIC will not internally alter in any way the original claim form. In order for the Claim to be processed as quickly as possible, the required information must be corrected by the Provider. The corrected claim may be faxed directly to ATLANTIC and will be processed and the original and updated claim will be scanned and stored for historical purposes.

The Notice of Missing Information letter will specify the required information needed and the box # from the HCFA-1500. If the required information is not received within 7 days, a second request will be generated and the Provider will be called. If the required information is not received after the third attempt, the claim will be archived and a letter will be generated. All fax confirmations are stored in the system for future reference.

BILL- AROUND

ATLANTIC Claims should not be mailed directly to the Carrier. Mailing Claims directly to the Carrier is considered a *bill-around* and a violation of the Master Facility Agreement and will only delay the processing of the Claim.

Providers who *bill-around* ATLANTIC by sending claims directly to the Carrier may be subject to decreased reimbursement, disciplinary action and expulsion from the Network in accordance with the provisions of the Master Facility Agreement **Claims are always delayed when *billed-around* ATLANTIC.**

ELIGIBILITY & BENEFITS

Eligibility for services depends on many factors, including but not limited to the following:

- Valid Insurance Coverage
- Treatment related to the Accident or Injury
- Maximum Coverage Allowances

ATLANTIC does not determine eligibility nor is liable for any claims eligibility decisions or determination.

ATLANTIC is not responsible or liable for any claims decisions or any benefits determination. ATLANTIC is not an insurer, guarantor or underwriter of the responsibility or liability of any Payor to provide benefits pursuant to any Plan.

PRE- AUTHORIZATION / PRE- CERTIFICATION

ATLANTIC does not pre-certify claims. Claims are pre-certified by the Insurance Carrier medical case managers or their designee.

Providers who render services without receiving written authorization from the Carrier do so at risk of nonpayment or a penalty in accordance with state regulations. Pre-certifications and request for Authorizations of Service must be provided through valid notice mechanisms. Providers who rely on phone calls from referring physicians without written authorizations render services at risk of non-payment or penalty. State regulations define the required steps for Notice to a Carrier and a request for treatment buried in a progress note is generally not acceptable. Pre-authorization is no guarantee of payment eligibility.

Patients should be told to provide their pre-certification authorization at the time of service.

DEDUCTIBLE AND CO- PAYS

Deductible and co-pays are carrier specific. Waiving deductibles and co-payments or failing to bill patients without cause is a violation of the Master Facility Agreement and state insurance laws and may be deemed Insurance Fraud. Co-pay collection is subject to Benefit Plan. Patient responsibility is specified on the Atlantic Explanation of Benefits.

ADDING ATLANTIC CARRIERS TO YOUR SYSTEM

The following procedure implemented by many of our Facilities in their computer systems eliminates the *bill-around* problem:

Step 1. Add a New Carrier with the following name:

New Carrier Name / ATLANTIC

Step 2. Add the following Address with this Carrier:

2 Ridgedale Avenue
Suite A-10
Cedar Knolls, NJ 07927

Step 3. Process all Claims as of the Effective Date of the New Carrier or the effective date of your Master Facility Agreement.

Step 4. ATLANTIC currently Pre-Funds multiple Carriers. Repeat this for All Carriers with ATLANTIC added to each Client name:

As ATLANTIC adds Clients repeat the above steps as needed. This will assure you that the bills for the above Carriers are sent to ATLANTIC Imaging Group at the proper address.

THE REQUIRED IHFCA.COM FORM FIELDS

1a, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14 (If accident related), 17, 17a, 21, 23, 24a/b/c/d/e/f/g (For each service line), 25, 27, 28, 29, 30, 31, and 32. **Your Claims submission will be rejected without these fields.**

A description of the HCFA-1500 boxes is as follows:

1. PAY CLASS

This area describes the type of Insurance or the type of Payor.

1a. INSURED'S I.D. NUMBER

This number is found on the member's Identification Card. This number is used to determine eligibility and coverage, therefore, it is essential that the correct Identification Number be on the Claim. An incorrect number may result in denial of payment for services rendered to a Patient whose eligibility could not be verified.

2. PATIENT'S NAME

The name, as it appears on the Claim, is compared by computer to the names registered as eligible dependents to determine whether payment can be made for services rendered to this Patient. A nickname or different spelling than that under which the Patient has been enrolled can delay Claims processing and may even result in denial of payment for services rendered to a dependent whose eligibility cannot be verified.

3. PATIENT'S DATE OF BIRTH and GENDER

Birth date is used in conjunction with name to verify that the Patient is an eligible member. An incorrect birth date can delay Claims processing until a correct birth date is obtained and may result in denial of payment for services rendered to a dependent whose eligibility could not be verified. Sex is important for eligibility verification, as well as detection of errors in procedures/diagnostic coding which might result in incorrect payment for services rendered.

4. INSURED'S NAME

The Insured's name is the person or organization whose name coverage was issued. Always obtain this name from the member's Identification Card to avoid errors which could delay Claims processing.

5. PATIENT'S ADDRESS

The Patient's home address is placed here.

6. PATIENT RELATIONSHIP TO INSURED

This relationship, along with the name, is compared by computer to determine eligibility and coverage. It is also used, along with name and birth date, to access Claims history and to accumulate any deductibles or benefit limits.

7. INSURED'S ADDRESS

The complete home address, including zip code, of the person whose name is in box 4 must be included on the Claim form.

8. PATIENT STATUS

This area assists the Payor in determining eligibility and benefits.

9. OTHER INSURED

This area will allow you to fill-in the name of a person other than the Insured's Name listed in Box 4, who also has insurance benefits for or on the Patient listed in Box 2.

9a. This area is for the Policy or Group Number of the person named in Box 9.

9b. This area is for Date of Birth of the person named in Box 9.

9c. This area is for the Employer or School name of the person named in Box 9.

9d. This area is for the Insurance Plan of the person named in

Box 9.

10. CONDITION RELATED TO EMPLOYMENT OR ACCIDENT

This area is required to assist the Payor in determining the etiology of the patients condition. An **X** must be placed in the box relating to questions A, B, and C. If a question is left unanswered, the claim will be rejected.

11. INSURED'S DATA

The Insured's policy number or Group Policy Number is placed here. This number is common to more than one individual defining a group of individuals having the same type of coverage.

a. The Insured's date of birth and sex which may be different than the Patient.
b. The insured's employer name is placed here.
c. The insured's insurance plan or Carrier.
d. Other benefit plans of the insured are placed here.

12. PATIENT SIGNATURE AND DATE

This signature authorizes the release of medical information by the Patient. As long as the Patient has signed a release, it is acceptable to place Signature on File here. The Date MUST be included.

13. INSURED'S SIGNATURE

This signature authorizes payments to be made directly to the Provider. As long as the Patient has signed an authorization, it is acceptable to place Signature on File here.

14. DATE OF ILLNESS OR INJURY

The date of onset of the condition being treated. The date of onset of an accident injury or condition pertinent to provisions and limitations under a health benefit plan.

15. DATE FIRST CONSULTED

The date on which the Provider was first consulted or contacted about the condition for which the Patient is being treated.

16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

If known place this date here.

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

The name of the Provider or other Provider who referred the Patient for services. This name must be on the Claim if services include a consultation. Radiologists and clinical laboratories must complete this section or payment may be delayed. Provider ID Number should also be included.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

If known place this date here.

19. THIS AREA RESERVED FOR LOCAL USE

20. OUTSIDE LAB?
If known place this date here.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
ICD•9•CM Code(s), when applicable, identifying the specific diagnostic radiology condition(s) for which each service was rendered. Diagnosis Code(s) should be listed following the reference number(s) in box 23. The reference number of the primary diagnosis for each service must be indicated in box 24E for each charge if there is more than one diagnosis. ICD•9•CM codes will not be accepted unless valid according to the instructions in the ICD•9•CM books. Fourth and fifth digits must be included when ICD•9•CM defines specific conditions by these decimal positions.

22. MEDICAID RE-SUBMISSION AND ORIGINAL REFERENCE
When resubmitting a previously submitted electronic bill to Medicaid, place the original submission number here.

23. PRIOR AUTHORIZATION NUMBER
Place a pre-certification or authorization for treatment number here. This number is given by the Payor or designee of the Payor. Providing this number reduces incorrect reimbursement by Carriers.

24.A. DATE OF SERVICE
The date the Patient was seen and the service or expense was incurred.

24.B. PLACE OF SERVICE ("POS")
Code indicating the place where the service was rendered. HCFA POS code (standardized by the Health Care Finance Administration) is required for each service.

24.C. TYPE OF SERVICE
This area describes the type of Service, i.e. in-services, hospital, ambulatory, etc.

24.D. PROCEDURES, SERVICES, OR SUPPLIES
This area requires the standard Current Procedural Terminology (CPT) codes defining the type of procedure performed be placed here.

24.E. DIAGNOSIS CODE
A reference number from box 23 must be included to the left of each charge, indicating the primary diagnosis for that service.

24.F-J CHARGES
The Provider's charge for each service represented by a procedure code in box 24E. To insure consideration of all services, charges should be itemized for each procedure represented by a separate Procedure code, except those which are incidental, included in the global allowance for another billed Procedure or for which there is no charge.

25. FEDERAL TAX ID NUMBER
The Provider's federal tax identification number ("TIN") is required for all individual Providers or groups who use such a number for tax purposes. In the absence of a "TIN,"

the Provider's social security number ("SSN) will be used. Incorrect or missing TIN or SSN will delay Claims processing or result in payment to the wrong Provider.

26. PATIENT'S ACCOUNT NUMBER.
This area allows a Facility or Provider to generate a unique tracking or account number for the Claim being submitted.

27. GOVERNMENT ASSIGNMENT BOX
This area allows the Provider or Facility to accept or reject direct payment by the Payor for the services rendered by the Provider or Facility. If the Provider or facility accepts this assignment check the yes box. If the Provider or Facility refuses to accept assignment from the Payor, check the no box.

28. TOTAL CHARGE
The sum of all charges on the Claim form is required as a balancing total for all Claims including more than one line item.

29. AMOUNT PAID
List payment made to Provider by Patient. If the bill is partially paid by other insurance coverage, box 9 should be completed and the EOB from the other Carrier itemizing benefits payment should be attached to the Claims form.

30. BALANCE DUE
The sum of all charges on the Claim form less any applicable payments. If applicable check here.

31. SIGNATURE AND DATE OF PHYSICIAN OR SUPPLIER
Provider's signature on file, signature stamp or other authorized signature.

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
Place facility information here.

33. PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER
If separate Claims are being submitted for more than one Provider from the same office location or for a group practice, be certain that the correct Provider of services is identified on each Claim.

TIMELINESS OF CLAIM SUBMISSION

Providers should submit an accurate and complete HCFAS-1500 within seven (7) days of the date of service but no later than fourteen (14) days of the date of service. Failure to bill for services within twenty-one (21) days of the date of services/discharge may result in forfeiture of all rights to bill for such services.

In the event Provider is unable to submit a Claim within seven (7) days because of circumstances beyond Provider's control, the time for submission of such bill may be extended as reasonably necessary as determined by the ATLANTIC Claims Department. Claims payments may be affected by coordination of benefits and exhaustion of benefits when not submitted in a timely manner..

PRE- FUNDING

ATLANTIC will use all reasonable efforts to pre-fund the Provider within 72 hours of the receipt of a clean claim. The Provider will receive a check for the service attached to a **Pre-Funding Statement** form. The Pre-Funding Statement will have a check attached to the bottom of the statement. The claim should not be closed until the Provider receives a final **Explanation of Benefits** (EOB). These are two different forms.

The Explanation of Benefits (EOB) does not have a check attached, but provides the documentation necessary for the Provider to close the claim and balance bill the patient if necessary. The pre-funding statement and check is a prepayment to the preferred provider in good faith that the Provider has performed its duties with respect to Claim submission, pre-certification and patient protocols. The Carriers payment to Atlantic should come within 60 days of receipt of the ATLANTIC Claim depending upon the specific Provider and the Providers will receive an Explanation of Benefits (EOB) on every patient. Pre-Funding is not a guarantee of Benefits or Eligibility. The Explanation of Benefits (EOB) statement provides a detailed description of how the benefits were paid and if any payments were reduced due to co-pays or deductible or other eligibility or benefit reasons. The Pre-Funding statement will note any reductions in reimbursements due to overpayments on previous patients. Any disallowances or denials will be indicated and explained on the Explanation of Benefits (EOB).

ATLANTIC EOB

Atlantic EOB's will contain the following information:

- Total PPO Fee
- Covered Amount
- Administrative Fee
- Total Pre-Funded
- Deductible or Co-Pay
- Total Covered
- Overpayments thorough Pre-Funding
- iHCFA reference Number
- Provider's Patient's Account Number

UNPAID CLAIMS

If a service is unpaid for sixty (60) days after filing and notice has not been received from the Payer/Client that the Claim is pending further information or review, the Provider should contact ATLANTIC. ATLANTIC will assist in researching the payment status, as well as tracking the incidents of late payments by Claims Administrators.

CLAIM REVIEW PROCESS

If a Provider feels an ATLANTIC Carrier has improperly or unfairly processed a service which has resulted in denial or inequitable reimbursement, the Provider may request reconsideration. For reconsideration of payment, please contact the Claims Department.

Any notification or correspondence concerning Claims should include the Claim number from the EOB (if available), the member name, the subscriber's name and social security number, and the group name.

If the Claim dispute remains unresolved after the informal review, the Provider can request an appeal. ATLANTIC may request additional information from the Provider when a payment received is lower than the expected amount. The Provider should act within 72 hours to return the requested information. ATLANTIC uses a variable tickler system to determine its follow-up to requested documentation. Providers who do not comply will not receive ATLANTIC' follow-up.

OVERPAYMENTS

According to the terms of the Preferred Provider Agreement, Provider agrees to refund any payment in excess of 100% of Provider's allowable charges less deductible or co-pay. Overpayments can also occur as a result of erroneous Claims payments or payments issued to the wrong Provider. If such an error is detected, Provider will refund the overpayment.

NOTIFICATION OF CHANGES

Providers are responsible for notifying ATLANTIC immediately of any changes including, but not limited to:

- TIN
- Billing address
- Office address
- Errors or omissions from the bill

Failure to do so may result in delay or incorrect reimbursements.

ARBITRATION

ATLANTIC providers agree not to arbitrate or litigate any claims against ATLANTIC carriers for 60 days from the date of notification to ATLANTIC that a claim is to be challenged.

ATLANTIC will review the claim and submit the notice directly to the carrier arbitration/litigation department. ATLANTIC will assist in mediating the outstanding dispute, before legal fees are generated. If the results are not satisfactory, the Provider may arbitrate the claim after the 60 day period.