American Community
Provider Orientation Manual

The Provider Orientation Manual is a reference tool designed to assist our participating providers, and their office staff, with American Community's administrative procedures.

The Provider Orientation Manual is maintained on-line and updated periodically. Please refer to the Provider Orientation Manual frequently for updates, changes and additions.

If you have questions, please contact the Network Development Department at:

Phone: 800-991-2642 ext 6370
Fax: 734-853-2290
Email: Providers@american-community.com

Thank you for participating in the American Community Provider Network.

December 2008

American Community Provider Orientation Manual

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March 2009

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March 2009

Section 1: Claims

How to Submit a Claim

American Community offers two convenient ways to submit claims:

1) EDI (Electronic Data Interchange)

   Submitting claims EDI offers providers a fast, efficient, cost-effective way to submit claims.

   Please submit EDI claims to American Community by using our Vendor EDI number: 60305

2) Paper Claim Submission

   Please submit paper claims to:

   American Community Mutual
   PO Box 531330
   Livonia, MI 48153-1330

Claim Billing Reminders

For accurate claims adjudication, please remember the following when submitting claims to American Community:

1) Submit claims in the CMS format for HCFA 1500 and UB04.

2) Submit claims using current ICD-9, CPT and Revenue codes in accordance with CMS guidelines. Incorrect or obsolete codes will be rejected.

3) The rendering provider needs to bill with the correct NPI and Tax ID in order to determine network participation status.

4) NPI can be found in box “24J” on the HCFA 1500 or in boxes 76-79 on the UB04.

5) Anesthesia claims need to be billed with the total number of minutes in box “G” of the HCFA 1500.

6) For Coordination of Benefit (COB) claims, please submit the primary carrier’s payment information in the electronic claim. Or, if billing on a paper claim, please attach a copy of the primary carrier’s EOB.

Code Checking Process

American Community uses McKesson's Claim Check® and Code Review® products to validate proper CPT code usage. This process ensures that American Community is properly reimbursing the physician.

CPT code checking (bundling) is performed following McKesson's Claim Check and Code Review standards rather than the standards established by CMS.

Claims Filing Deadline

All Claims must be submitted and received by American Community no later than 180 days from the date of service to be eligible for reimbursement.

Claims received after the 180 day filing limit, will be denied.

Pre-Notification

American Community does not have utilization review requirements or pre-certification requirements. However, we do request that you notify American Community prior to a member's hospital admission.

If you need benefit verification for a member, please contact our Customer Contact Department at 800-233-3444, or visit the American Community website at: **www.american-community.com** and complete the Benefit Verification Form located under the "Benefit Verification Info" link in the Provider section of the website.

Notification does not guarantee coverage.

No Referrals/Gatekeepers

American Community does not require that members obtain a referral from their primary care physician in order to seek treatment from a specialist.

American Community also does not require our members to select a primary care physician and notify us of their selection, nor do we require our members to notify us when they change primary care physicians.

Interim Hospital Bills

American Community cannot accept interim hospital bills and will only reprice and adjudicate final hospital bills.

Coordination of Benefits

American Community applies standard Coordination of Benefits (COB) rules when calculating benefit payments for an insured who is entitled to medical benefits from more than one source.

American Community's policies will coordinate benefits with the following:

1) Group insurance;
2) Other arrangements, whether insured or uninsured, covering individuals in a group;
3) Plans, other than individual insurance policies, designed to pay a fixed-dollar benefit per day while the insured individual is hospital-confined, but which, at the time of the claim, allow the individual to elect an alternate benefit;
4) Plans, other than individual insurance policies, designed to pay a fixed-dollar benefit per day while the insured individual is hospital-confined. COB will only be applied to that portion of the daily benefit, which exceeds the scheduled amount per day;
5) Blue Cross/Blue Shield plans on a group basis;
6) Plans of other hospital or medical service organizations on a group basis;
7) Group practice plans;
8) Group pre-payment plans;
9) Coverage under Federal Government plans or programs;
10) Coverage required or provided by law;
11) Student insurance; (COB does not apply to accident-only coverage for grammar or high school students for which the parent pays the entire premium and which is sponsored by or provided through a school);
12) Group automobile insurance;

13) Individual no fault auto insurance, by whatever name called;

14) Automobile medical payment insurance;

Any policy which does not have this COB provision, or one like it, pays first. Plans providing individual or group no-fault auto insurance coverage and plans providing automobile medical payments insurance coverage pay first.

For plans having a COB provision, or one like it, the following rules apply to determine which benefit plan pays first and the order in which the other plans follow:

1) The plan which covers an individual as an employee/member will be considered before the plan which covers the individual as a dependent;

2) For dependents who are covered under two or more plans, other than children whose parents are divorced or otherwise separated;

    a. The plan of the employee with the earlier birthday will be considered before the other employee's plan;
    b. If the birthdays fall on the same day, the plan which has covered the dependent longer will be considered before the other plan.
    c. If either plan is lawfully issued without a provision similar to this provision, and as a result, each plan determines its benefits before the other, or after the other, the COB procedures of the plan without a birthday rule provision will apply.
    d. If the other plan is without a provision similar to (a), but instead has a rule based on the gender of the parent, the rule of the other plan will apply.

3) For dependent children whose parents are divorced or legally separated, the following rules apply:

    a. When the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be considered before the benefits of a plan which covers the child as a dependent of the parent without custody.

b. When the parent with custody of the child has remarried, the benefits of the plan which covers the child as a dependent of the parent with custody will be considered before the benefits of a plan which covers that child as a dependent of his or her step-parent; and the benefits of a plan which covers that child as a dependent of the parent without custody will be considered last.
c. If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, (a) and (b) above will not apply; instead, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be considered before the benefits of any other plan which covers the child as a dependent child.

4) In case the above rules still produce a conflict (such as when two plans cover an individual as an employee) the plan which has covered the individual the longest will be considered first, except as follows:

   a. A plan which covers the individual, as an active employee/member will be considered before a plan which covers the individual as a laid-off or retired employee/member.
   b. A plan which covers the individual as an active employee/member or as the dependent of an active/employee member will be considered before a plan which covers the individual under a continuation of benefits provision by state or federal law.
   c. Rules (a) and (b) will not apply if the other plan is lawfully issued without a provision similar to rule (a) or (b).

Claims Recovery Process

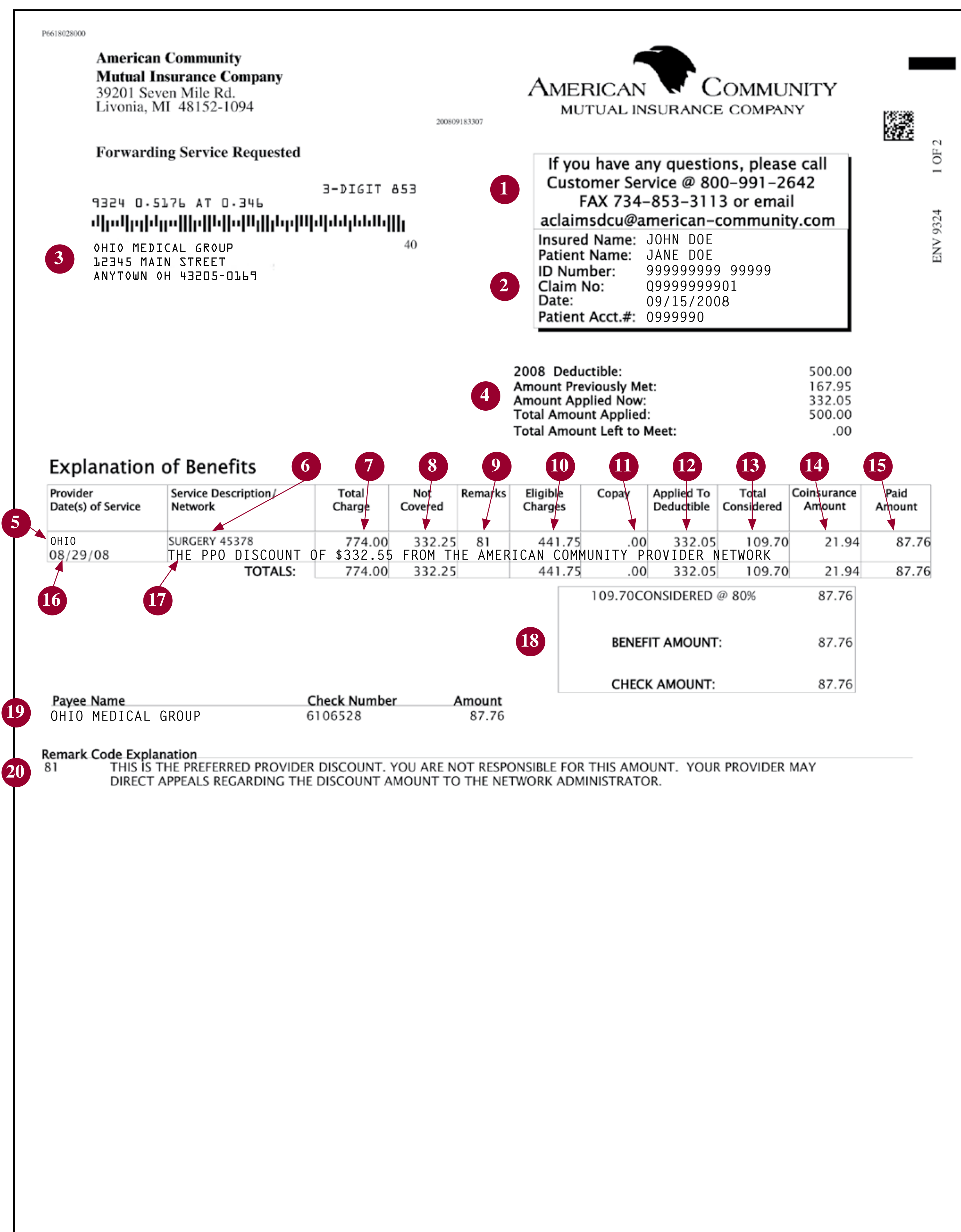
American Community has two approaches to recover overpaid claims:

1) American Community works with AIM Healthcare to identify overpaid claims (duplicates, claims paid after the termination date, excluded services paid in error, etc.).

   AIM Healthcare will contact the provider to initiate the recovery, gather the overpayment, and send the refund to American Community.

2) American Community also identifies payment errors which in this case, we will contact the provider directly for the refund.

Sample Explanation of Benefits



P6618028000

American Community
Mutual Insurance Company
39201 Seven Mile Rd.
Livonia, MI 48152-1094

200809183307

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY

Forwarding Service Requested

3-DIGIT 853
9324 0.5176 AT 0.346

40

OHIO MEDICAL GROUP
12345 MAIN STREET
ANYTOWN OH 43205-0169

1 OF 2

ENV 9324

If you have any questions, please call Customer Service @ 800-991-2642 FAX 734-853-3113 or email aclaimsdcu@american-community.com

Insured Name: JOHN DOE
Patient Name: JANE DOE
ID Number: 999999999 99999
Claim No: Q9999999901
Date: 09/15/2008
Patient Acct.#: 0999990

2008 Deductible:	500.00
Amount Previously Met:	167.95
Amount Applied Now:	332.05
Total Amount Applied:	500.00
Total Amount Left to Meet:	.00

Explanation of Benefits

Provider Date(s) of Service	Service Description/ Network	Total Charge	Not Covered	Remarks	Eligible Charges	Copay	Applied To Deductible	Total Considered	Coinsurance Amount	Paid Amount
OHIO 08/29/08	SURGERY 45378	774.00	332.25	81	441.75	.00	332.05	109.70	21.94	87.76
	THE PPO DISCOUNT OF $332.55 FROM THE AMERICAN COMMUNITY PROVIDER NETWORK									
	TOTALS:	774.00	332.25		441.75	.00	332.05	109.70	21.94	87.76

109.70CONSIDERED @ 80%	87.76
BENEFIT AMOUNT:	87.76
CHECK AMOUNT:	87.76

Payee Name	Check Number	Amount
OHIO MEDICAL GROUP	6106528	87.76

Remark Code Explanation

81 THIS IS THE PREFERRED PROVIDER DISCOUNT. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT. YOUR PROVIDER MAY DIRECT APPEALS REGARDING THE DISCOUNT AMOUNT TO THE NETWORK ADMINISTRATOR.

Section 1

A Tour of your Explanation of Benefits (EOB)

1. **Questions?:** Contact information for questions regarding the information on this EOB.

2. **Member/Patient Information:** Name of key insured, name of patient, ID number (policy number), group or plan number (if applicable), claim number, date EOB was issued, patient account number.

3. **Mailing address:** Name and mailing address of patient.

4. **Deductible Information:** This section only displays if all or part of this claim was applied to the calendar or plan year deductible (may include in network and out of network information). It displays the amount of deductible that must be met each year, the amount met from previous claims, the amount applied towards the deductible from this claim, the total amount applied year-to-date, and the amount left to meet for the calendar or plan year shown.

5. **Provider:** Name of provider.

6. **Service Description/Network:** A brief description of the service, followed by the procedure code (if reported by provider).

7. **Total Charge:** Amount billed by the provider.

8. **Not Covered:** The amount not covered by the plan. The policyholder may be responsible for this amount unless the remark code explanation states otherwise.

9. **Remarks:** A code explaining the reason for Not Covered amounts. This code corresponds to the code in the Remark Code Explanation section.

10. **Eligible Charges:** The amount eligible after subtracting the Not Covered amount from the Total Charge.

11. **Copay:** The patient copay for the service. The policyholder is responsible for this amount.

12. **Applied to Deductible:** The amount applied to your calendar or plan year deductible. The policyholder is responsible for this amount.

13. **Total Considered:** The Eligible Charges that we consider after subtracting the copay and/or deductible amounts.

14. **Coinsurance Amount:** The amount of Eligible Charges that the policyholder is responsible for after applying the benefit percentage specified in the policy.

15. **Paid Amount:** The amount of Eligible Charges that we are responsible for after applying the benefit percentage.

16. **Date(s) of Service:** Month, day and year of service. If services were rendered on multiple dates, “from” and “to” date are displayed here.

17. **Network:** For PPO claims, the network is identified here. In some cases a remark is displayed that identifies the PPO network discount amount.

18. **Benefit/Check Section:** Amounts considered at benefit percentages, total benefit amount and total amount of check.

19. **Payee Information:** Name of payee to whom the check was issued, check number and amount of check.

20. **Remark Code Explanation(s):** An explanation of Not Covered Charges. These remarks correspond to the remark codes displayed in the Remarks section.

Explanation of Benefit Remark Code Definitions

Below is a comprehensive listing of American Community's explanation of benefit remark codes:

EOB Remark Codes - Not Covered or Excluded:

1A Your policy provides no benefits for prescription drugs except for those that are obtained through our mail order program.

1B Your policy provides no coverage for prescription drugs.

1C Using your discount drug card at participating pharmacies helps to reduce your out-of-pocket expenses.

1P When you use your discount card at a participating pharmacy, for covered drugs, your claim is automatically submitted to us within two weeks of the fill date. It is not necessary to mail your prescription receipts to us.

1R Policy is currently not active due to outstanding delivery requirements. Please have the policy holder contact our policy
administration department at 1-800-991-2642, extension 4484, for additional information.

2A Your policy provides no benefits for emergency room treatment of a non-emergency illness.

2B Your policy excludes treatment of obesity.

2L We are unable to process your claim without the provider's credentials. Your provider must submit their credentials along with a copy of their license.

2W Your policy does not cover surgery for weight loss.

02 Your policy does not cover expenses incurred for the treatment of conditions excluded from coverage by your policy rider.

3B Your policy does not cover allergy testing and allergy treatment including allergy injections.

3G Your policy excludes expenses as a consequence of a family member being intoxicated or under the influence of any non-prescribed controlled substance or narcotic, unless administered on the advice of a physician.

3F Your policy does not cover expenses incurred for the treatment or removal of nevi, keratoses, skin tags, or warts.

3I Your policy excludes drugs to prevent sickness and drugs to prevent, treat or lessen the symptoms of influenza or respiratory virus.

3J Your policy excludes treatment of nail fungus.

3K Your policy does not provide benefits for losses related to committing or attempting to commit a felony.

3L Your policy does not cover evaluation or treatment of learning disabilities; attitudinal disorders; or disciplinary, social or developmental conditions.

3M Your policy does not cover in-patient expenses incurred for the treatment of mental, nervous, or emotional disorders.

3P We previously applied this claim to your deductible but were subsequently notified by the pharmacy that this prescription was submitted to us in error. This amount has been subtracted from your calendar year deductible.

3R We previously reimbursed you for a prescription and were subsequently notified by the pharmacy that the prescription was submitted in error. We are subtracting the previous overpayment from this prescription.

3T Your policy does not cover treatment or removal of tonsils, adenoids, or myringotomy except if an emergency.

03 Your policy does not cover expenses incurred for the treatment of a pre-existing condition, sickness, or illness, as defined in your policy.

4F We have notified your provider that according to the procedure codes submitted, services were rebundled to a new code. Your provider must resubmit their claim with corrected codes.

04 Your policy does not provide benefits for normal pregnancy and childbirth expenses.

5A Your policy covers medical expenses due to a sickness or injury. This expense is not due to a sickness or injury and, therefore, is not covered.

5B Your policy provides no benefits for experimental, investigational, or unproven procedures or treatments.

5C Your policy does not cover surgery to correct nearsightedness, or farsightedness.

5D Your medical records have been reviewed by a peer review group. They have determined that these services are not medically necessary.

5F There is no documentation in your medical records that this procedure was performed on this date. We will reconsider this expense upon receipt of supporting documentation.

5H We are unable to conclude processing this claim. Coffined Transplant Network providers must submit claims to Coffined. The provider is being notified.

05 Your policy does not cover services that are not medically necessary, as defined by your policy. This determination is based on accepted medical standards.

10 Your policy does not cover expenses incurred for cosmetic surgery and/or treatment, and/or complications thereof.

12 Your policy does not cover expenses incurred as a result of illness and injury if covered by Worker's Compensation or similar laws. Please submit your claim to your Worker's Compensation carrier.

13 Your policy does not cover expenses incurred as a result of intentionally self-inflicted injury.

14 Your policy does not cover expenses incurred for eye examinations or eye refractions, eye glasses, or contact lenses, and their fitting.

15 Your policy does not cover expenses incurred for hearing aids, including fittings and examinations.

16 Your policy does not cover expenses incurred for dental examinations, X-Rays, and treatment.

17 Your policy does not cover expenses incurred for non-prescription drugs or supplies.

18 Your policy covers expenses incurred for prescription drugs only under the prescription drug program.

19 Your policy does not cover expenses incurred for vitamins, herbals, botanicals and dietary food supplements.

20 Copayment means the amount a family member must pay which we do not consider as part of a covered charge. Your policy does not cover this expense.

21 Your policy provides no benefits for this type of provider.

22 The services of an assistant surgeon are not usually required for this procedure. No benefits are payable. If you disagree, please send a copy of the operative report with your appeal.

25 Your policy does not cover services performed for maintenance purposes.

26 Your policy does not cover services or supplies that are for comfort and convenience.

29 Your policy does not cover expenses incurred as a result of distortion, misalignment, or subluxation of the vertebral column.

30 Your policy does not cover expenses incurred for treatment of acne.

31 Your policy does not cover expenses incurred for the treatment of mental, nervous or emotional disorders.

32 Your policy does not cover expenses incurred for the treatment of substance abuse.

33 Your policy does not cover this type of foot care.

34 Your policy does not cover expenses incurred for the treatment of Temporomandibular Joint Dysfunction, malocclusion, or misalignment of the jaw.

58 Your coverage has been rescinded. Therefore, no benefits are payable for these expenses.

59 This policy was never in force. Therefore, no benefits are payable for these expenses.

60 Your policy does not cover expenses incurred prior to the effective date of your coverage. Therefore, benefits are not payable.

61 Your policy does not cover expenses incurred after the termination date of your coverage. Therefore, benefits are not payable.

62 Your policy does not cover expenses incurred during the lapse period your policy was not in force. Therefore, benefits are not payable.

63 Your policy does not cover expenses incurred for sickness, illness, or conditions which occur within 10 days of the policy reinstatement date.

64 We previously requested information from the insured that was necessary to process this claim. Until we receive this information, we are unable to conclude processing.

65 Your policy does not cover expenses which were not submitted within the acceptance period as stated in your policy. Since these expenses were not submitted on a timely basis, benefits are not payable.

66 Your policy does not cover expenses billed prior to the date the service is performed. Therefore, benefits are not payable in advance.

67 We cannot process this claim as submitted. Please send a complete itemized statement from the provider.

68 This is the benefit we can allow at this time. There are other charges which require further review. You will hear from us soon.

69 This is a duplicate of an expense which we previously applied to your deductible or copay. You are responsible for expenses applied to the deductible, or copays.

7E We requested a copy of the emergency room report from the hospital. Until we receive a copy of this report, we are unable to determine benefits.

70 Your policy is a hospital indemnity policy which provides benefits for hospital confinement only.

71 Your policy provides no major medical coverage. Therefore, benefits are not payable for these expenses.

72 Your policy provides no health coverage. Therefore, benefits are not payable for these expenses.

73 This is a duplicate expense which we previously considered. We sent you an explanation of benefits at the time our benefits payment was issued.

75 This is a duplicate of an expense that was submitted previously. We requested information necessary to determine coverage of this expense. As soon as we receive the information, we will notify you of our decision.

84 Your policy does not cover expenses incurred for voluntary sterilization and reversal of sterilization.

85 Your policy does not cover expenses incurred for voluntary abortion.

86 Your policy does not cover expenses incurred for contraceptives or contraceptive methods.

87 Your policy does not cover expenses incurred for fertility drugs, artificial insemination or in vitro fertilization.

88 Your policy does not cover expenses incurred for drugs prescribed for mental or nervous conditions.

89 Your policy does not cover medical expenses unless the patient is confined in a hospital as an inpatient.

9B Your policy does not cover expenses related to the diagnosis and/or treatment of infertility or fertilization procedures.

90 Your policy does not cover expenses incurred for injuries resulting from ownership, operation, maintenance or use of a motor vehicle.

91 Your policy does not cover travel expenses, except for emergency local ambulance.

92 Your policy does not cover care and services performed by volunteers, relatives and residents of the insured's household.

93 Your policy does not cover care, treatment, and services provided by your employer.

94 Your policy does not cover expenses incurred for the treatment of eating disorders.

95 Your policy does not cover expenses incurred for weight loss programs, exercise programs or equipment.

96 Your policy does not cover expenses incurred for smoking cessation.

A1 We have notified the hospital that they must send an itemization of charges for each day of confinement to 39201 Seven Mile Rd., Livonia, MI 48152. We are unable process this claim based on the summary of total charges submitted.

A2 Your provider billed us for an unidentified service. We have notified them that they must submit a description of services to 39201 Seven Mile Rd., Livonia, MI 48152.

A3 Benefits have been reduced because this service was not pre-certified within the time requirements specified in your policy. This amount is the patient's responsibility.

A5 We previously requested information from a provider that was necessary to process this claim. Until we receive this information, we are unable to conclude processing.

A6 This procedure is usually not performed more than once in a single day. We have notified your provider that we will reconsider this service if they submit an explanation for performing it more than once.

A7 The amount of therapy rendered is not consistent with your diagnosis. We have notified your provider that they must submit medical records before we can consider these services.

A9 Your policy provides no benefits for prescription drugs, except prescription drugs provided by a hospital during a hospital confinement.

AD We can process your claim as soon as you provide us with information about how, when and where your injury occurred. Please obtain our injury form at www.american-community.com, or call our injury hotline at 888-799-4977.

AS Procedure does not require Assistant Surgeon.

AT We are unable to process your claim at this time. Please submit a copy of your Auto/Motorcycle declaration page to 39201 Seven Mile Road, Livonia, MI 48152, attention COB Team. Or you may fax this information to: 734-853-3113.

B5 We previously requested information from your employer that was necessary to process this claim. Until we receive this information, we are unable to conclude processing.

C1 This claim was submitted with an incorrect policy identification number, resulting in a processing delay. Please submit future claims with the correct identification numbers, as indicated on the front side of this document.

DP This procedure is usually not performed more than once in a single day. We have notified your provider that we will reconsider this service if they submit an explanation for performing it more than once.

G1 Your policy provides no benefits for genetic testing.

G2 Your policy provides no benefits for growth hormones/treatment.

G5 Your policy does not cover services that are not medically necessary. Upon request we will provide you, free of charge, with an explanation of the scientific or clinical judgment for this determination.

G6 A peer review group has determined that these services are not medically necessary. Upon request we will provide you, free of charge, with an explanation of the scientific or clinical judgment for this determination.

G7 Your policy provides no benefits for experimental or unproven procedures or treatments. Upon request we will provide you, free of charge, with an explanation of the scientific or clinical judgment for this determination.

G8 We previously requested medical records from this provider. Until we receive the medical records we are unable to determine benefits.

H1 Your policy provides no benefits for the treatment of hair loss.

LL Your benefits have been exhausted for this level of coverage.

MA Maternity benefits cannot be provided at this time because you have not yet satisfied your maternity benefits waiting period.

M4 Claim submitted with incorrect provider information. Please contact provider to have your claim resubmitted to the network with complete billing information.

M5 Claim submitted without provider name/credentials. Please have provider resubmit your claim to the network with complete provider name/credentials and billing information.

S3 Your policy provides benefits for rehabilitative speech therapy to restore speech following an injury or illness. Speech therapy for developmental reasons is not considered treatment of an illness or injury.

S4 Your policy provides no benefits for the treatment of sexual dysfunction.

S5 Your policy excludes treatment and testing of sleep disorders.

TH Please resubmit your therapy claim with each actual date of service instead of a date span. This information is needed to accurately determine benefits.

T1 This claim was submitted electronically. We are unable to conclude processing because of an error in the data transmission. The provider is being notified regarding the resubmission of the claim.

V1 Claims for eye exams for refractions are not covered by your medical benefits. We have notified your provider to file this claim with VS.

V2 Your policy excludes eye training exercises or vision therapy.

W1 Your policy excludes injury which arises out of the course of employment.

EOB Remark Codes – PPO

23 Your policy provides no benefits for emergency room treatment of a non-emergency illness, unless treatment is received from a PPO Network provider.

24 The PPO Network Administrator has determined that these are not allowable expenses. Provider appeals may be directed to the Network Administrator.

7I Your claim was not received in a timely manner from the Network. Therefore, additional interest is due. Our payment includes this additional amount.

78 We are unable to conclude processing this claim. PPO Network providers must submit claims directly to the network named on the insured's identification card, or on the other side of this statement. The provider is being notified.

79 This provider has agreed to accept a reduced payment for these services. However, you are responsible for deductible, copayment and coinsurance amounts.

81 This is the preferred provider discount. You are not responsible for this amount. Your provider may direct appeals regarding the discount amount to the network administrator.

82 We have combined expenses for mother and child according to the policy, and allowed the PPO negotiated daily rate.

5G The provider has agreed to accept a reduced payment amount from us. You are not responsible for the amount shown as "not covered". You are responsible for deductible and coinsurance amounts.

5J The provider has agreed to accept a reduced payment amount from LifeTrac. You are not responsible for the amount shown as "not covered". You are responsible for deductible and coinsurance amounts.

P1 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit hardcopy paper claims directly to Ohio Health Choice, PO Box 1068, Newark, OH 43055.

P3 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Sagamore Health Network, PO Box 6051, Indianapolis, IN 46206-6051.

P4 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Cofinity/PPOM, PO Box 2720, Farmington Hills, MI 48333.

P6 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to the AZ Foundation for Medical Care, PO Box 2909, Phoenix, AZ 85062-2909.

P7 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Healthlink, PO Box 419104, St. Louis, MO 63141-9104.

P8 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Midlands Choice, PO box 5809, Troy, MI 48007-5809.

P9 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to the AZ Foundation Plus, PO Box 2909, Phoenix, AZ 85062-2909.

PH As a courtesy to our member we have processed your claim. Please be advised that all future claims must be submitted by paper to PHCS, PO Box 759, Buckeystown, MD 21717, or the claim will be denied for repricing information.

Q1 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Multiplan, PO Box 643, Buckeystown, MD 21717.

Q2 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Health EOS Multiplan, PO box 6090, DePere, WI 54115-6090.

Q4 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Encore Health Network, PO Box 80612, Indianapolis, IN 46280-0612.

Q5 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Beech Street Corporation, PO Box 853925, Richardson, TX 75085-3925.

Q7 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Intergroup, 101 Lindenwood Dr., Suite 150, Malvern, PA 19355.

R1 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to ADN, PO Box 610, Southfield, MI 48037-0610.

R2 Your provider is being notified that we are unable to conclude processing this claim. PPO Network providers must submit claims directly to Michigan Dental Plan, 30400 Telegraph Rd., Suite 327, Bingham Farms, MI 48025.

R3 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Private Healthcare Systems, PO Box 759, Buckeystown, MD 21717.

R4 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims with key insured's social security number to Medical Mutual, PO Box 94648, Cleveland, OH 44101-4648.

R6 In the future, please submit all claims to American Community Mutual Insurance Company, at 39201 Seven Mile Rd, Livonia, MI 48152-1094.

R7 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to the AZ Foundation Select, PO Box 2909, Phoenix, AZ 85062-2909.

R8 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to Lakeland Care Network, PO Box 20570, Indianapolis, IN 46220.

R9 Your provider is being notified that we are unable to conclude processing this claim. Providers must submit claims directly to First Health Network, PO Box 531330, Livonia, MI 48153.

EOB Remark Codes – Maximums

2P Your policy provides benefits for a maximum supply per prescription of 30 days. We have provided benefits for a 30 day supply.

3A Your policy provides benefits for medical expenses up to the lifetime maximum amount shown on your schedule page. Since your lifetime maximum has been exhausted, we are unable to provide further benefits under this policy.

3C This is the maximum amount allowed for this service by your policy's fee schedule. You may be balance billed by your provider if they do not accept this as payment in full.

3S Your policy provides a maximum payment for preventive services every year. The maximum benefit has been allowed for this year. You were also eligible for additional benefits as required by law.

3Z Your policy provides a maximum payment for childhood immunizations every benefit period. The maximum benefit has been allowed for this benefit period.

35 Your policy provides a maximum benefit for expenses incurred for this service. The maximum benefit has been allowed.

36 Your policy limits benefits to Usual, Customary, and Reasonable charges, which we determine are usually accepted by providers in the general area where the charges are incurred.

37 Your policy provides a maximum benefit for expenses incurred for this condition. The maximum benefit of your policy has been allowed.

38 Your policy provides a maximum payment for preventive services every year. The maximum benefit has been allowed for this year.

39 Your policy provides a maximum benefit each calendar year for this condition. The maximum benefit has been allowed.

4A The allowable amount represents the difference between the amount normally charged for a routine delivery and the amount your provider charged for your Cesarean delivery. Your policy excludes normal pregnancy expenses.

40 Your policy provides a maximum number of eligible visits for each calendar year. We have allowed the maximum number.

41 Your policy provides a maximum number of eligible visits for each 365 day period. We have allowed the maximum number.

42 Your policy provides a maximum benefit of one visit per day.

43 This procedure is included in another billed procedure and should not be billed separately. If your provider wishes to have this reviewed, they can submit medical records to 39201 Seven Mile Road, Livonia, MI 48152.

44 Your policy provides a maximum amount for expenses incurred for each visit. The maximum benefit has been allowed.

45 Your policy provides a maximum benefit for room and board. The maximum has been allowed.

77 Your benefits have been reduced by the premium due amount for the grace period. If you wish to continue your coverage beyond the grace period, you must send in the required premium amount.

EOB Remark Codes – Preventive

06 Your policy provides benefits for preventive services performed by a PPO Network provider. Preventive services by a Non-Network provider are not covered.

7A Your policy covers expenses incurred for treatment of illness and injury. Preventive services, such as physical examinations and immunizations, are not covered.

07 Your policy covers expenses incurred for treatment of illness and injury. Preventive services, such as physical examinations and immunizations, are not covered.

08 Your policy does not cover expenses incurred for the care of a well newborn child.

9A Your policy does not provide benefits for this type of preventive service. The preventive services that your policy covers are listed in your policy.

09 Preventive services, including well child exams and immunizations, are not covered after the age limit specified in your policy.

11 Preventive and routine health screening services are covered, up to the maximum benefit, after a waiting period. This service was performed prior to the expiration of the waiting period.

EOB Remark Codes - Penalties/Utilization Review

AZ The Arizona Foundation of Medical Care has determined that these services are not medically necessary.

51 Your policy requires a second surgical opinion prior to surgery. Benefits have been reduced because this requirement was not met. This amount is the patient's responsibility.

52 The provider has agreed to accept a reduced payment amount from us. You are not responsible for the amount shown as "not covered". You are responsible for deductible and coinsurance amounts.

53 Your policy requires pre-admission certification for any hospital confinement. Benefits have been reduced because this requirement was not met. This amount is the patient's responsibility.

54 Your policy provides full benefits for a certified length of hospital stay, only. Benefits have been reduced for the days not certified. This amount is the patient's responsibility.

55 Benefits related to this surgery have been reduced. The procedure was approved as out-patient surgery only. This amount is the patients responsibility.

56 Your policy requires prior approval of this type of medical service. Benefits have been reduced because this requirement was not met. This amount is the patient's responsibility.

57 We are unable to conclude processing this claim. United Resource Network providers must submit claims directly to URN. The provider is being notified.

5K We are unable to conclude processing this claim. LifeTrac transplant network providers must submit claims to LifeTrac. The provider is being notified.

Section 1

Other Insurance Remark Codes

27 Your provider agreed to accept a reduced payment from your other insurance. Your policy with our company provides benefits up to the balance you would owe the provider.

28 Your policy with our company is secondary to your other insurance. Please submit the claim to the primary insurance carrier, then return it to 39201 Seven Mile Rd., Livonia, MI 48152, with a copy of their Explanation of Benefits.

4B Your Medicare supplemental policy only covers your Medicare deductible and coinsurance under Part B. Therefore, no benefits are eligible for this service.

4C Benefits have been reduced. We estimated the amount that Medicare would have paid if you had Part D.

4E We are unable to conclude processing this claim. Your provider should send your claims to us at 39201 Seven Mile Rd., Livonia, MI 48152 with a copy of the Medicare-Equivalent remittance advice form.

4M Benefits have been reduced. We estimated the amount that Medicare would have paid if you had Part B.

4X We have denied your prescription until we receive your Medicare Part D explanation of benefits.

46 We are unable to conclude processing this claim. Your provider should send your claims to us at 39201 Seven Mile Rd., Livonia, MI 48152, with a copy of the explanation of Medicare benefits.

47 The amount not covered is the amount paid by Medicare.

48 Your policy does not cover expenses that were not approved by Medicare.

49 The amount we considered was reduced because of a prior payment made by your other insurance company.

50 Your policy coordinates benefits with other sources of coverage. Benefit payments from other sources exceed our allowable amount. As a result, benefits are not payable at this time.

A4 The amount not covered is the amount paid by Medicare and/or your Medicare deductible. Your policy covers your Medicare coinsurance amounts. You are responsible for your Medicare Part A & Part B deductibles.

A8 This payment represents the amount you would owe if you had received services from a provider covered by Medicare. Medicare does not cover services rendered at VA Medical Centers.

Miscellaneous Remark Codes

76 This is an adjustment of a previously processed claim.

TP Third Party Liability.

Fraud & Abuse

The definition of fraud is “a deception deliberately practiced in order to secure unfair or unlawful gain.”

In the insurance industry the fraudulent act is most often a misrepresentation, deliberate omission or false statement, which is known to be false, but is used to encourage the insurance company to issue payment.

The following are indicators of possible fraud:

- Apparent alterations of dates, amounts, etc.
- Disparity between provider and patient geographical locations
- Frequent claims history, especially accidents and repetitive claims involving the same groups of people, employers, physicians, hospitals, social organizations, etc.
- Inordinate number of claims for similar injuries
- Numerous lab tests which are inappropriate for the diagnosis
- Photocopied medical bills with alterations where benefits are not assigned
- Repetitive treatment by the same provider to several different family members for the same diagnosis or treatment
- Several claimants, same doctor, hospital and/or attorney
- Total hospital bill paid in full (in cash)
- Undue pressure to pay quickly
- Unusual time lapse between date of service and date submitted
- Unusually high number of patient visits in a given time frame

Section 1

The following statement appears on all explanation of benefit statements (EOB) American Community sends to members:

“Help Us Reduce the Cost of Health Care by Reporting Suspicions of Fraud or Abuse by Calling 1-800-991-2642. You Can Make a Difference”.

All cases of suspected fraud will be reviewed by American Community’s Claims Management.

If needed, Claims Management will refer the incident to American Community’s fraud consultants.

Section 2: ID Cards & Eligibility

Sample ID Card

Front:

Participant: **Group**
ABC Company- AC NETWK
Group No: **93220**
Policy/Certificate No: **4162949**
Office Visit Copay:

Back:

Vendor EDI # 60305

MAIL CLAIMS TO:

American Community
PO Box 531330
Livonia, MI 48153-1330

Call American Community for eligibility, benefits and claim questions. **(800) 991-2642**

TO FIND PARTICIPATING PROVIDERS CALL:

(800) 991-2642

First Health Network

Outside the American Community service area call First Health:
(800) 226-5116

Or visit us at http://www.American-Community.com

Section 3: Web-Based Provider Tools

Provider Website Account Registration

To create an online account for the first time, please follow the below instructions:

1) Go to **www.american-community.com**
2) Click on the "For Providers" link
3) Click on the "Create a New Account" link
4) Create an account using the following information:

- ✓ Contract Number (found on the Welcome letter and the front of your contract)
- ✓ Tax ID Number
- ✓ Access Key (found on your Welcome letter)

For questions regarding your online account, please contact American Community's Customer Contact Department at:

Phone: 800-233-3444
Email: **AC-CustomerContact@american-community.com**

Section 4: Provider Relations

Simplified Credentialing

American Community does not require providers to go through a rigorous credentialing process. We simply verify state license and liability coverage.

To become a participating provider, please contact the Network Development Department at:

Phone: 800-991-2642 ext 6370
Fax: 734-853-2290
Email: **Providers@american-community.com**