

CLAIMS MANUAL



Table of Contents

50% and Catastrophic Claim Notification	3
FORM: Catastrophic and 50% Notification	4
Trigger Diagnosis List	5
Trigger Treatment and Services	9
Large Case Management	10
Monthly Paid Claims	11
➤ FORM: Monthly Paid Claims Summary	12
Directions for Advanced Funding	13
Aggregated Specific Claims	14
Out-of-Network Claims	15
Hospital Bill Audits	15
Reimbursement of Discounting Fees	15
Initial Specific Claim Reimbursement Request	16
> FORM: Specific Stop-Loss Claims	17
Subsequent Specific Claim Reimbursement Request	18
Aggregate Claim Reimbursement Request	19
> FORM: Aggregate Claim Reimbursement Request	20
Monthly Accommodation Claims	21
FORM: Monthly Accommodation Benefit	22

Claims Department Information

Claims Email: claims@iatmgu.com

Phone: 615-790-6908

Forms: Download at www.iatmgu.com or email claims@iatmgu.com

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50% and Catastrophic Claim Notification

Management of a claim begins with the TPA. We expect that the TPA will have procedures in place to identify potential large claims through the TPA's benefit verification unit, customer service unit, reports reflecting 50% penetration of the specific deductible, and the group's Utilization Review Company. All inpatient confinements greater than five (5) days must be reported.

Notification to IAT can be made by completing our form, the TPA's form, or by report that includes all required information. The notification can be submitted by mail, fax, or email. The notification should include the case name, claimant's name, employee's name, employee's social security number, the claimant's relationship, the claimant's date of birth, and diagnosis.

Additional information that would be helpful and perhaps save a phone call to your office is:

- Length of confinement
- Date of surgery
- Current and future treatment
- Case Manager's name and phone number
- Treating physician's name and phone number
- Prognosis
- Pending Charges

Email claims@iatmgu.com for state-specific filing forms.



CATASTROPHIC AND 50% NOTIFICATION

Case:		Policy Period:
EE Name:		EE SSN:
Claimant Name:		DOB:
Relationship:		Original Effective Date on the Plan:
Date Coverage Terminated or Last Date th	at EE Worked:	
Diagnosis/ICD9:		Prognosis:
Is Claimant in Case Management? ☐ Ye	s □ No If	YES, provide Case Manager information below.
Case Manager's Name:		Case Manager's Phone:
Treating Physician's Name:		Treating Physician's Phone:
Length of Confinement:		Date of Surgery:
Current and Future Treatment:		
PAID TO DATE THIS POLICY YEAR:	\$	
PENDING CHARGES THIS POLICY YEAR	₹: \$	
In lieu of the above infor	mation. a Pa	id Claims Report reflecting diagnosis and
		can be substituted.
Submitted by:		Date:
IPA Company Name:		
Address:		
Phone:	Ext.:	Email:



TRIGGER DIAGNOSIS LIST

ICD-10-CM Diagnosis Codes for Disclosure Notification

Please list all Plan Participants who have been diagnosed with or treated for any of the codes listed under the following categories during the current Benefit Period:

under the followi	ng categories during the current Benefit Period:
A00 – B99	Certain Infectious and Parasitic Diseases
A40	Streptococcal sepsis
A41	Other Sepsis
B15 – B19	Viral hepatitis
B20	Human immunodeficiency virus (HIV) disease
C00 - D49	Neoplasms
C00 - C96	Malignant neoplasms
D46	Myelodysplastic syndromes
D50 – D89	Diseases of the Blood and Blood-Forming Organs and Disorders Involving the Immune Mechanism
D57	Sickle-cell disorders
D59	Acquired hemolytic anemia
D60 – D64	Aplastic and other anemias
D65 – D69	Coagulation defects, purpura and other hemorrhagic conditions
D70 – D77	Other diseases of blood and blood-forming organs
D80 – D89	Certain disorders involving the immune mechanism
E00 - E89	Endocrine, Nutritional, and Metabolic Diseases
E10 – E13	Diabetes mellitus
E15 – E16	Other disorders of glucose regulation and pancreatic internal secretion
E65 – E68	Obesity and other hyper alimentation
E70 – E89	Metabolic disorders
F01 – F99	Mental, Behavioral and Neurodevelopmental Disorders
F10.1	Alcohol Abuse
F11.1	Opioid Abuse
F20	Schizophrenia
F31	Bipolar Disorder
F32.3	Major depressive disorder, single episode, severe with psychotic feature
F33.1 – F33.3	Major depressive disorder, recurrent
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.5	Asperger's Syndrome
G00 – 99	Diseases of the Nervous System
G00	Bacterial meningitis
G04	Encephalitis myelitis and encephalomyelitis
G06 – G07	Intracranial and intraspinal abscess and granuloma
G12.21	Amyotrophic Lateral Sclerosis
G35	Multiple sclerosis
G36	Other acute disseminated demyelination
G37	Other demyelinating disease of central nervous system
G82.5	Quadriplegia



683.4 Cauda Equina Syndrome 692 Toxic encephalopathy 693.1 Anoxic brain injury 100 - 199 Diseases of the Circulatory System 120 Angina pectoris 121.09 - 122 Acute mycoardial infarction 124 Acute and subacute ischemic heart disease 125 Chronic ischemic heart disease 126 Pulmonary embolism 127 Other pulmonary heart disease 128 Other diseases of pulmonary vessels 133 Acute & subacute endocardits 134 - 138 Heart valve disorders 142 - 143 Cardiomyopathy 144 - 145 Conduction disorders 146 Cardiac arrest 147 - 149 Cardiac dysrhythmias 150 Heart failure 160 - 161 Subarachnoid hemorrhage/intercerebral enteries 163 Cerebral infarction 165.8 - 166 Occlusion of precerebral/cerebral arteries 167 Atherosclerosis/aortic aneurysm 140 - 148 Chronic Obstructive Pulmonary Disease (COPD) 141 - 198.4		.,
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124	120	Angina pectoris
125	I21.09 – I22	Acute myocardial infarction
126	124	Acute and subacute ischemic heart disease
127	I25	Chronic ischemic heart disease
Description Cardionary Description D	I26	Pulmonary embolism
I33	127	Other pulmonary heart disease
134 - 138	128	Other diseases of pulmonary vessels
I42 - I43 Cardiomyopathy I44 - I45 Conduction disorders I46 Cardiac arrest I47 - I49 Cardiac dysrhythmias I50 Heart failure I60 - 161 Subarachnoid hemorrhage/intercerebral hemorrhage I63 Cerebral infarction I65.8 - I66 Occlusion of precerebral/cerebral arteries I67 Other cerebrovascular disease I70 Atherosclerosis/aortic aneurysm J40 - J44 Chronic Obstructive Pulmonary Disease (COPD) J84.10 - J84.89 Postinflammatory Pulmonary Fibrosis J98.11 - J98.4 Pulmonary collapse/respiratory failure K00 - K95 Diseases of the Digestive System K22 Esophageal obstruction K25 - K28 Ulcers K31 Other diseases of stomach & duodenum K50 Crohn's disease K51 Ulcerative colitis K55 - K64 Diseases of peritoneum & retroperitoneum K65 - K68 Diseases of peritoneum & retroperitoneum K70 - K77 Diseases of piliary tract K83 Diseases of pancreatitis K90 - K95 Other diseases of digestive system/complications of bariatric procedures M00 - M99 Diseases of the Musculoskeletal System & Connective Tissue M34 Systemic Iupus erythematosus M34 Systemic sclerosis M41 Scoliosis	133	Acute & subacute endocarditis
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147 - 149 Cardiac dysrhythmias 150	I44 – I45	Conduction disorders
ISO	I46	Cardiac arrest
Subarachnoid hemorrhage/intercerebral hemorrhage	l47 – l49	Cardiac dysrhythmias
I63	I50	Heart failure
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M34 Systemic sclerosis M41 Scoliosis	M15 – M19	Osteoarthritis
M41 Scoliosis	M32	Systemic lupus erythematosus
	M34	Systemic sclerosis
M43 Spondylolysis	M41	Scoliosis
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M50	Cervical disc disorders							
M51								
	Thoracic, thoracolumbar & lumbosacral intervertebral disc disorders							
M72.6 M86	Necrotizing fasciitis Octoomyolitis							
N00 – N99	Osteomyelitis Discourse of the Conitouring System							
	Diseases of the Genitourinary System							
N00 – N01	Acute and rapidly progressive Nephritic Syndrome							
N03	Chronic Nephritic Syndrome							
N04	Nephrotic Syndrome							
N05 – N07	Nephritis and nephropathy Glomerular disorders classified elsewhere							
N08								
N17	Acute Kidney Failure							
N18	Chronic Kidney Disease (CKD)							
N19	Renal failure, unspecified							
O00 – O9A	Pregnancy, Childbirth, and the Puerperium							
O09	High Risk Pregnancy							
011	Pre–existing hypertension with pre–eclampsia							
O14 – O15	Pre–eclampsia and eclampsia							
O30	Multiple gestation							
O31	Other complications specific to multiple gestations							
P00 – P96	Certain Conditions Originating in the Prenatal Period							
P07	Disorders of newborn related to short gestation and low birth weight							
P10 – P15	Birth trauma							
P19	Fetal distress							
P23 – P28	Other respiratory conditions of newborn							
P29	Cardiovascular disorders originating in the perinatal period							
P36	Bacterial sepsis of newborn							
P52 – P53	Intracranial hemorrhage of newborn							
P77	Necrotizing enterocolitis of newborn							
P91	Other disturbances of cerebral status newborn							
Q00 – Q99	Congenital Malformations, Deformations, and Chromosomal Abnormalities							
Q00 – Q07 Q20 – Q26	Congenital malformations of the nervous system							
	Congenital cardiac malformations							
Q41 – Q45	Congenital anomalies of digestive system							
Q85	Phakomatoses, not classified elsewhere							
Q87 Q89	Congenital malformation syndromes affecting multiple systems							
	Other congenital malformations							
R00 – R99	Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, not elsewhere classified							
R07.1 – R07.9	Chest pain							
R40 – R40.236	Coma							
R57 – R58	Shock, hemorrhage							
R65.2 – R65.21	Severe sepsis							
S00 - T88	Injury, Poisoning, and Certain Other Consequences of External Causes							
S02	Fracture of skull and facial bones							
S06	Intracranial injury							



Avulsion and traumatic amputation of part of head S12 – S13 Fracture and injuries of cervical vertebra and other parts of neck S14.0 – S14.15 S22.0 Fracture of thoracic vertebra S24 Injury of nerves and spinal cord at thorax level S25 Injury of blood vessels of thorax S26 Injury of blood vessels of thorax S27 Fracture of skull and facial bones S32.0 – S32.2 Fracture of lumbar vertebra S34 Injury of lumbar and sacral spinal cord and nerves S35 Injury of blood vessels at abdomen, lower back and pelvis S36 – S37 Injury of intra – abdominal organs S48 Traumatic amputation of shoulder and upper arm S58 Traumatic amputation of elbow and forearm S68.4 Traumatic amputation of hand at wrist level S78 Traumatic amputation of hip and thigh S88 Traumatic amputation of lower leg S98 Traumatic amputation of ankle and foot T30 – T32 Burns and corrosions of multiple body regions T81.11 – T81.12 Postprocedural cardiogenic and septic shock Complications of cardiac and vascular prosthetic devices, implants and grafts T86 Complications of prosthetic devices, implants and grafts T86 Complications of transplanted organs and tissue Complications to reattachment and amputation Multiple births Z38.3 – Z38.8 Multiple births Z48.248.98 Encounter for aftercare following organ transplant Z90 Presence of cardiac and vascular implants and grafts Transplanted organ and tissue status Presence of cardiac and vascular implants and grafts Transplanted organ removal status Dependence on respirator Dependence on lailysis	S07	Crush injury to head
S12 - S13 Fracture and injuries of cervical vertebra and other parts of neck S14.0 - S14.15 S22.0 Fracture of thoracic vertebra S24 Injury of nerves and spinal cord at thorax level S25 Injury of blood vessels of thorax S26 Injury of heart S02 Fracture of skull and facial bones S32.0 - S32.2 Fracture of lumbar vertebra S34 Injury of lumbar and sacral spinal cord and nerves S35 Injury of lumbar and sacral spinal cord and nerves S35 Injury of intra - abdominal organs S48 Traumatic amputation of shoulder and upper arm S58 Traumatic amputation of shoulder and upper arm S68.4 - S68.7 Traumatic amputation of hand at wrist level S78 Traumatic amputation of hand at wrist level S78 Traumatic amputation of lower leg S98 Traumatic amputation of multiple body regions S81.11 - T81.12 Postprocedural cardiogenic and septic shock T82 Complications of cardiac and vascular prosthetic devices, implants and grafts T83 - T85 Complications of prosthetic devices, implants and grafts T84 Complications of transplanted organs and tissue T80		
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S25		
S26 Injury of heart S02 Fracture of skull and facial bones S32.0 – S32.2 Fracture of lumbar vertebra S34 Injury of lumbar and sacral spinal cord and nerves S35 Injury of blood vessels at abdomen, lower back and pelvis S36 – S37 Injury of intra – abdominal organs S48 Traumatic amputation of shoulder and upper arm S58 Traumatic amputation of elbow and forearm S68.4 – S68.7 Traumatic amputation of hip and thigh S78 Traumatic amputation of lower leg S98 Traumatic amputation of lower leg S98 Traumatic amputation of ankle and foot T30 – T32 Burns and corrosions of multiple body regions T81.11 – T81.12 Postprocedural cardiogenic and septic shock T82 Complications of cardiac and vascular prosthetic devices, implants and grafts T83 – T85 Complications of prosthetic devices, implants and grafts T86 Complications of transplanted organs and tissue T87 Complications to reattachment and amputation Z00 – Z99 Factors Influencing Health Status and Contact with Health Services Z37.5 – Z37.6 Multiple births Z48 – Z48.298 Encounter for aftercare following organ transplant Z99 Fresence of cardiac and vascular implants and grafts Transplanted organ and tissue status Presence of cardiac and vascular implants and grafts Tansplanted organ removal status Dependence on respirator		
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Z99.1 Dependence on respirator	Z95	Presence of cardiac and vascular implants and grafts
	Z98.85	Transplanted organ removal status
Z99.2 Dependence on dialysis	Z99.1	Dependence on respirator
	Z99.2	Dependence on dialysis

Trigger Treatment and Services

99374-99380	Home Health Care
S9126	Hospice
V57.9	Inpatient Rehabilitation
G0128	Skilled Nursing Facility
43800-43999	Gastric Bypass
J9000-J9999	Chemotherapy
77427-77499	Radiation
81.9	Joint Replacement
S9001	Home Uterine Monitoring
S9364-S9368	Home TPN or IV Therapy
80400-80440	Expensive injections, such as Growth Hormones
V56/90945-90999	Dialysis
89	Transplant Evaluation

Large Case Management

We expect that claims with the potential for savings through management be assessed for large case management. If a TPA is unable to or the case refuses, we will handle the assessment and monitor the claim. Please contact our office in this case.

If large case management is placed, please furnish case management reports to our office. Fees are reimbursable under the excess stop-loss coverage once the claim exceeds the specific deductible. However, we must have a report for the period being billed.

Monthly Paid Claims

The paid claims for each group you have with IAT should be submitted by the 10th of each month for the month just completed. Reports, which are later, are requested via email from our claims staff.

Also, we request that you submit a report identifying any claimants who have claims paid in excess of 50% of the Group's specific deductible. This report should include diagnosis codes for all claimants listed.



MONTHLY PAID CLAIMS SUMMARY

Case Name:					
Effective Date:					
Month Reporting:/		<i>I</i>	_ to		
PLEASE MAKE SURE TH			HLY PAID CLA L MONTHS	AIMS ARE RE	EPORTED
If reporting a 12/15 or 15/12 po	licy, p	olease speci	fy if run-in clair	ns are includ	ed in this total.
GROSS PAID CLAIMS					
Medical:	\$				
Dental:	\$			<u></u>	
Weekly Indemnity:	\$				
Rx Drug Card:	\$				
TOTAL GROSS PAID CLAIMS:	\$			_	
Less Claims Not Covered by Excess:	\$				
Net Paid Claims:	\$				
Additional Comments:					
Third-Party Administrator:	· · · · · · · · · · · · · · · · · · ·				
Date:		E	mail:		

Directions For Advanced Funding

IAT provides Advanced Funding to all cases. The plan's check(s) must be issued and the check data provided along with the specific reimbursement request. The request for reimbursement will be processed as all others.

The availability of advanced funding in the final month of the contract is dependent on the definition of PAID in the stop-loss policy. Please refer to that definition for your specific request.

Aggregated Specific Claims

Specific claims for cases with an Aggregated Specific amount should be submitted as usual. An audit will be performed and the TPA will be notified of any needed information. The amount reimbursable will be applied to the group's aggregated specific. This application will be noted on the EOB.

Out-of-Network Claims

We request that out-of-network bills be emailed to our office for discounting through secondary PPO networks or direct negotiating.

Hospital Bill Audits

We discourage the practice of auditing hospital bills due to the lack of savings experienced. However, there are certain situations where audits may be recommended or ordered by our office.

Reimbursement of Discounting Fees

Fees charged by the primary PPO are considered administrative and not reimbursable. Fees for secondary PPOs are reimbursable but not in excess of 25% of the savings, with a \$50,000.00 plan year cap per claimant. Shared fees payable to the TPA are considered administrative and not reimbursable. Shared savings fees payable to an LCM/UR vendor are also considered administrative and not reimbursable.

Initial Specific Claim Reimbursement Request

Initial reimbursement requests should include:

- Completed specific claim form.
- Enrollment card/applicable change card. If the enrollment card does not reflect the claimant's
 original effective date on the Plan or if the name of the employer is omitted,
 a statement will be required from the employer verifying this information.
- COBRA election form and payment documentation (if applicable).
- Copy of Medicare card (if applicable).
- Copies of all bills that are included in this claim request.
- Check data date of issue, amount, payee, check number.
- EOBs or report reflecting deductible, coinsurance, ineligible amount and explanation, discounts, co-pays and net paid amount.
- Itemization of hospital bills is required if the PAID amount is \$350,000 or more.
- Pre-certs
- Copy of creditable coverage certificate (if applicable).
- Copy of signed subrogation agreement, police report, accident details, auto insurance information (if applicable).
- Large Case Management reports.
- Proof of deductible and coinsurance satisfied prior to this claim (if applicable).
- Completed Eligibility/Work Status form.

Omitted information on the Specific Claim Form or necessary documentation reflected above will delay reimbursement.



SPECIFIC STOP-LOSS CLAIMS

Initial (Claim	Supplemental Claim
Case:		
Policy Terms:		Policy Period:
Claimant Name:		DOB:
EE Name:		EE SSN:
Relationship:		Original Effective Date on the Plan:
Date Coverage Terminated or Last Date tha	at EE Worked:	
Diagnosis/ICD9:		Prognosis:
Case Management? ☐ Yes ☐ No		
Case Manager's Name:		Case Manager's Phone:
Total Eligible Benefits This Submission:	\$	
Less Specific Deductible:	\$	
Reimbursement Requested:	\$	
REIMBURSEMENT. COPIES OF: All charges that are part of the check copies or registers; itemized hosp proof; in-patient certifications; student subrogation/accident details/police report I CERTIFY THAT THE ABOVE INFORMAT ACCORDANCE WITH THE PLAN DOCUMENT.	this claim; enro pital bills if PAID tatus; pre-exist rt; Medicare cai FION IS CORRE IENT.	CT AND THAT THE CLAIMS HAVE BEEN PAID IN
Submitted by:		
		
Phone:	Ext.:	Email:
Authorized Signature:		Date:

Subsequent Specific Claim Reimbursement Request

- Subsequent specific reimbursement requests should include:
- Completed specific claim form.
- COBRA election form and payment documentation (if applicable).
- Copies of bills that are included in this claim request.
- Check data date of issue, amount, payee, check number.
- EOBs or report reflecting deductible, coinsurance, ineligible amount and explanation, discounts, copays and net paid amount.
- Itemization of hospital bills is required if the PAID amount is \$350,000 or more.
- Pre-certs
- Large Case Management reports.

Omitted information on the Specific Claim Form or necessary documentation reflected above will delay reimbursement.

Aggregate Claim Reimbursement Request

Submit the completed request form along with:

- A census which includes for each insured covered at any point during the policy period: name, date of hire, relationship to employee, date of birth, effective date of coverage, termination date of coverage. This information should also be provided for any covered dependents.
- A paid claims report, subtotaled by claimant, which displays for each EOB claim line the provider name, inclusive dates of service, ICD-9 code, CPT code, amount charged, PPO/negotiated discount, deductible/coinsurance/co-pay applied, and amount paid.
- If a run-in dollar limitation is indicated, a detailed report for the period.
- Detailed Rx billings, (if Rx plan covered under the aggregate).
- Detailed listing of all Rx rebates
- Copies of check registers from the beginning of the policy period through the last month for which
 the aggregate claim is being filed. These copies are not needed if check numbers and dates are
 reflected on the paid claims report.
- A copy of the checking account bank statement for the entire policy period <u>as well as a copy of the statement for the following month.</u>
- Documentation of any voids and/or overpayments received or outstanding.
- Claim specific details regarding any extra-contractual payments made.
- Subrogation details regarding closed as well as outstanding files.
- Individual Specific Analysis.

After the initial review of the claim, additional documentation may be requested or an on-site audit may be required.



AGGREGATE CLAIM REIMBURSEMENT REQUEST

Case:		Policy Year:			
Policy Number:		Policy Terms:			
			I		
(A) Total Single Units	X	Factor			=
(B) Total Family Units	X	Factor	•		=
(C) Total EE + SP Units	Χ	Factor			=
(D) Total EE + CH Units	X	Factor			=
		Total (A)) + (B)	+ (C) + (D) = (E)	=
		Minimum	Attac	chment Point (F)	=
Total Paid Claims:	\$				
Less Ineligible Claims Paid:	\$				_
Less Specific Claims:	\$				
Less the Greater of (E) or (F) above:	\$				
Less Previously Reimbursed:	\$				
Reimbursement Requested:	\$				
TPA/Company Name:					
TPA/Company Name:					
Address: E					
Authorized Signature:					
Date:					

Monthly Accommodation Claims

To request reimbursement of a monthly accommodation aggregate claim, please complete an IAT request form and submit it to our office by the 10th of the month along with the following:

- A detailed report of claims paid and incurred according to the terms of the policy.
- An explanation of the ineligible amounts
- · An accounting of all administrative fees.
- If a run-in dollar limitation is indicated, a detailed report for that period.
- If there are lasered individuals in the group, please provide a total paid claim report for each lasered individual.
- Check Register for the policy period.
- Eligibility and actively-at-work status for all individuals in excess of 75% of the pooling point/specific deductible.
- Detail report of all Rx Rebates



MONTHLY ACCOMMODATION BENEFIT

Case:			Polic	cy Year:		
Policy Number:			Polic	y Terms:		
(A) Total Single Units	X	Factor			=	
(B) Total Family Units	Χ	Factor			=	
(C) Total EE + SP Units	Χ	Factor			=	
(D) Total EE + CH Units	X	Factor			=	
		Total (A) + (B)) + (C) + (D) = (E)	=	
		Minimum	n Atta	chment Point (F)	=	
Total Paid Claims:	\$				_	
Less Ineligible Claims Paid:	\$					
Less Specific Claims:	\$					
Less the Greater of (E) or (F) above:	\$					
Less Previously Reimbursed:	\$					
Reimbursement Requested:	\$				_	
TPA/Company Name:						
Address:						
Phone:						
Authorized Signature:						· · · · · · · · · · · · · · · · · · ·
Date:						