

2026 Provider Guide

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How to search this guide: Press CTRL + F and enter in your keyword in the search bar that appears. Pressing enter will locate all keyword(s) throughout the document.

Read or don't read. this provider guide is meant to benefit the provider - not your biller.

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Last Revised 04/27/2024

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Contact Information and Business Hours

Business hours are **Mondays - Thursday 10am - 4pm AKST** with the exclusion of federal and state holidays that may affect the general operations and nature of the business (insurance call centers, state medicaid assistance offices, etc)

My office number is also my personal cell phone number. I do not publish or distribute my phone number unless absolutely necessary. Please respect applicable HIPAA laws regarding PHI when using this line for voicemail and text messaging. Email and fax are preferred. My phone number is (920)912-5060. Please make an appointment before calling.

The Billing Process

The standard billing process is as follows:

STEP 1. Prior to the first appointment, the patient completes the electronic **Patient Registration Form**.

STEP 2. Your biller sends the provider a **Verification of Benefits**.

STEP 3. (optional) **Prior Authorization, Pre-Determinations & Network Exceptions** are the patient's responsibility. Most insurances do not require a prior authorization for routine maternity and delivery care for outpatient deliveries UNLESS the patient is seeing a non-network provider, is delivering in the hospital and is admitted for longer than the 48/96 hour standard. Network benefit exceptions are the *responsibility and benefit of the patient*. We may file on behalf of the patient if a form/process is available but most insurances require contact from the patient. This will be marked on the VOB.

STEP 4. Submit a **Superbill** within 1 week of the encounter. Quick billing = quick payments. Delay your billing and your payments may be denied for not meeting timely filing requirements. Your biller can not and will not create a superbill for you. Please make sure your charting is complete and the level of coding is justified in your medical record.

STEP 5. The provider may receive an **Explanation of Payment** or EOP with payments and/or notices from insurances and payments from patients.. The provider is responsible for forwarding a copy of ALL EOPs, checks, notices, letters and payments to the biller by fax or email ***by the next business day***. The biller will apply these payments within CollaborateMD and work any denials, requests for information from insurance, etc on a claim-by-claim basis.

STEP 6. Gelida Medical Billing Will then bill the provider account on the 1st of the month (or next business day) for services provided in the previous calendar month.

(ex: Aug. 1 - 31st is billed Sept. 1st) and provide key reports on account activity. Please review your reports.

LAST STEP. Patient statements are automatically billed by the clearinghouse at **5am EST on the 10th of each month**. Providers are given a delay to review the monthly reports and notify the biller of any adjustments before statements are mailed.

Patient Registration (PRF)

Patient Registration is free to patients and available online through our website at www.GelidaBilling.com/patients. Patient registration forms found to be missing, incomplete or illegible will result in incomplete claims. Incomplete claims are susceptible to expire or fall out of timely filing and result in missed billing. Each insurance payer has different timely filing requirements so gathering these on or before services are rendered is essential. *Please DO NOT email an insurance card copy or ID to Emily unless it's accompanied by a complete Patient Registration Form.*

How to register. Patient Registration forms are completed online through MedForward Forms. Providers will have access to these forms through their secure login after hours.

When to register. Prior to the start of the first patient encounter.¹ This includes patients who are transferring to another midwifery provider/practice utilizing Gelida Medical Billing as their medical billing agency. Each provider/practice has a unique billing process and consent-to-pay forms that inform the patient as to the provider's network participation, insurance policies, payment policies, and financial agreements. Gelida Medical Billing can not disclose identifying information without consent from the patient/family- which is provided in the appropriate patient registration forms.

Patient Handouts

SCS CSHB 123(HSS): "An Act relating to disclosure of health care services and price information; relating to health care insurers; and providing for an effective date."

It is required by the Alaska state legislature that healthcare providers supply quality handouts to all patients (and post visibly in all office/facility settings) detailing the financial obligations for your services as a participating or non-participating provider, etc. Please become independently familiar with this price transparency law.

Handouts included in the Patient Registration Forms include: Adding Your Baby to Insurance & Provider Fee Schedules.

Patient Payments

By default, all provider accounts are created with a 6 statement minimum for all patients with a balance. Providers may request to alter the number and frequency of the statements. Providers may still send alternate statements and electronic payment requests. Final Demand notices are also available to providers after their maximum number of statements have been mailed. To forgive or adjust patient balances for families in need, please email me using the template below:

¹ PRFs that are not received by the biller prior to the first appointment could be offset when an authorization for services is requested. For insurances that require pre-authorization for services, if an authorization for non-covered services is not obtained prior to services rendered and a retro-authorization is unavailable, the provider is required to write-off any amounts due to the patient and can not bill the patient for that balance.

EMAIL SUBJECT: [PATIENT FIRST AND LAST NAME] | ACCOUNT WRITE OFF

EMAIL BODY: [Your intentions to write off their balance and for whatever reason you want to include in the notes.] Please include the Financial Hardship Write Off handout on our website.

Network Exceptions

Most insurance plans and carriers have specific criteria that they will take into consideration when reviewing an exception request. This may include:

- The distance to the nearest hospital for emergency care
- The proximity of the nearest network provider who can provide the specified type of care (maternity, wellness, etc) Ex: 50 miles
- If the nearest network provider is currently accepting new patients, and more.

It is important that the directions to complete and file such requests are followed closely.

TRICARE / VA / CHAMPVA / TriWest

TRICARE West Region (Alaska) active duty or reserves, VA Health Care - previously known as CHAMPVA, will only cover services provided by a recognized health care provider specialty listed on the [authorizing provider list application](#)- excluding Alaska state licensed midwives, CPMs or birthing centers that are not CABC licensed. . Regardless of other insurance coverage, TRICARE/VA insured patients may not be accepted due to coordination of benefits. State licensed midwives are not able to obtain a prior authorization for Tricare/VA patients and therefore claims will be denied by Medicaid for official reason code **“9536 EOB States Provider Did Not Attempt To Pre-Authorize Service; Medicaid Cannot Pay.”** Medicaid will only cover services as a secondary insurance if authorization was attempted for the primary insurance policies. Claims will be denied and the patient can not be billed for services that would have been covered with an authorized provider and prior-authorization was attempted/obtained with all insurance policies. Additionally, TriWest may not respond with an accepted denial letter to file a secondary claim to the subsequent payer within the timely filing timeframe.

Medicaid Billing

Alaska Medicaid providers are responsible for reading, understanding and abiding by the [Alaska Medicaid Provider Billing Manuals](#) and General Program Information associated with their provider type before 1) accepting a Medicaid eligible person as a patient, 2) submitting a claim for reimbursement.

Alaska Medicaid patients do not require a verification of benefits or estimates since maternity, postpartum and newborn care is covered at 100% for eligible dependents and non-maternity related services are covered with a \$3.00 patient copay and 7% facility coinsurance. Patients should still complete a Patient Registration form and indicate “Medicaid” for DKC or Alaska Medicaid coverage. Patients applying but not yet covered by Alaska Medicaid are considered un-insured until approved. Alaska Medicaid is a month-by-month eligible program and breaks in

coverage will be processed as an uninsured patient. Newborns born to Medicaid mothers will require a full name and date of birth as shown on the birth certificate to be located within the Alaska Medicaid eligibility system. Until the patient/newborn is located in the Medicaid system as a covered recipient for the dates of service in question, the patient is uninsured. Newborn claims should be submitted as they are performed and the biller will follow-up and search for the recipient regularly until the patient is found. If a patient/newborn is not found in the Medicaid eligibility system within 60 days of the date of service (or as specified in the provider's debt collection policy), the patient will be sent a statement for the dates of service in question.

Out of State Medicaid Plans

Since Medicaid is a state assistance program and not every state recognizes Alaska State licensing for midwives or “CDMs” and/or homebirth services as a legal or medically appropriate service, please check with that state’s Medicaid laws and regulations before accepting out-of-state Medicaid patients. Gelida Medical Billing will attempt to assist in contacting the appropriate Medicaid provider service department prior to the patient receiving care, but can not and will not accept responsibility for the provider/patient care plan if the patient and provider enter into a care plan before benefits and eligibility determination are made.

Medicare

Medicare part A (facility and hospital coverage) and Medicare part B (professional services) is at the time of this update, only available to senior citizens and disabled individuals. Gelida Medical Billing does not currently bill for Medicare patients and advises all providers in contract with Gelida Medical Billing to consider this when accepting patients. If Medicare is to expand to all income eligible individuals (not Marketplace plans), Medicare rates, navigation of additional federal laws and regulations, increased prior authorizations, and increased overhead will be considered as a separately reimbursable service from Alaska Medicaid and Commercial insurance reimbursement rates. Please contact your biller before accepting a Medicare patient for a contract amendment if your practice would like to start accepting Medicare patients.

Benefits and Eligibility

Please become independently familiar with the most common terminology for health insurance benefits and how they apply to real life applications. The next 4 pages are courtesy of Regence Blue Cross and help providers and patients alike understand insurance terminology and how it applies to care.

The purpose of a benefits check is **NOT** intended to determine if the client can or can not be seen by the provider. It is ultimately the ***patient’s responsibility and benefit*** to contact their insurance prior to choosing a healthcare provider to determine the provider’s network status and their financial responsibility.

Final coverage or non-coverage determination is made by the insurance after receipt and final processing of the claim(s). Proper coding and establishment of benefits and coverage can only help avoid denials and inflated financial responsibilities. It is the providers responsibility to determine if patients qualify for financial hardship and establish practice policies for adjustments, discounts and prepayments collected in office at the time services are rendered.

No Guarantees or Warranties.

It has never been guaranteed to the Provider/Customer by Gelida Medical Billing or by any other person, expressly or by implication, that your services will be covered or paid in full by any insurance or patient by utilizing our services. Gelida Medical Billing does not create or manage insurance rates, reimbursement, benefits, payment

policies, etc.

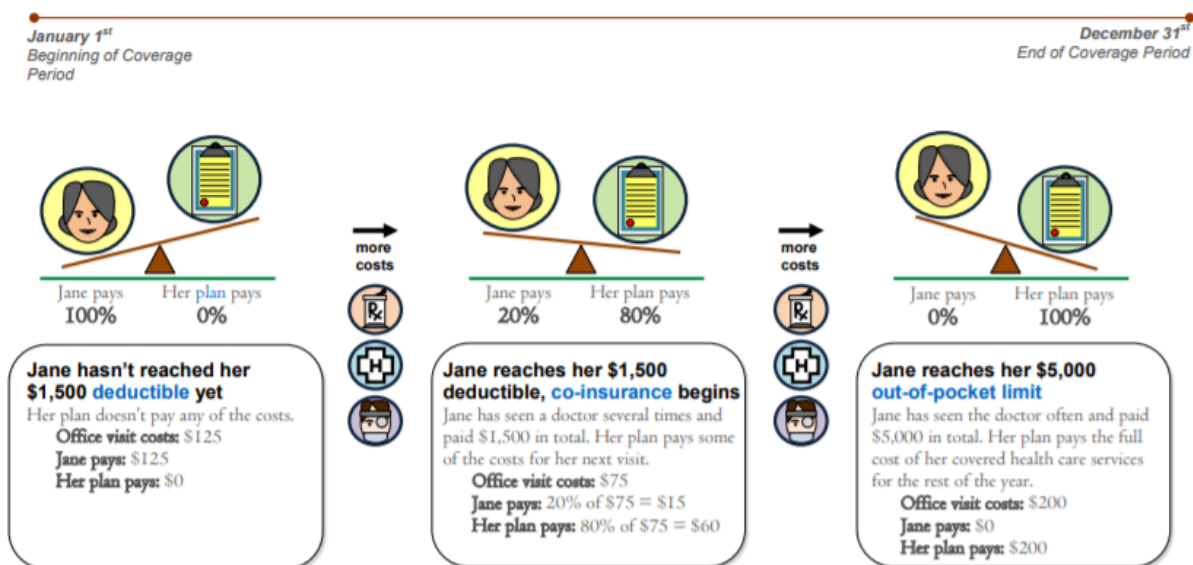
Patient Financial Estimates

Patient financial estimates are **ESTIMATES ONLY** based on the information disclosed by the insurance carrier and anticipated based on the provider's fee schedule. It is the insurance's responsibility to provide the patient with a detailed explanation of benefits and inform the patient of coverage changes. The electronic Verification of Benefit Forms should not be mistaken for a guarantee of patient coverage, benefits, payment or otherwise.

Additionally, if providers wish to receive prepayment for services not yet rendered or billed to insurance, it is the provider's responsibility to establish an in-house payment plan and report payments as a credit to the account. Prepayment for care not yet rendered is not HSA or VEBA reimbursable if they require a Coordination of Benefits from the insurance. These payments should only be taken after the claims have been processed for a detailed receipt (Date of service, CPT, ICD-10, etc).

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Co-insurance: 20% Out-of-Pocket Limit: \$5,000



Glossary of Health Insurance Terminology

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

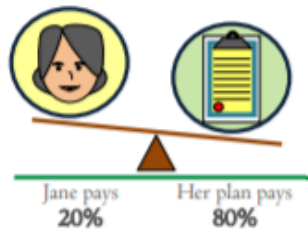
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



Complications of Pregnancy

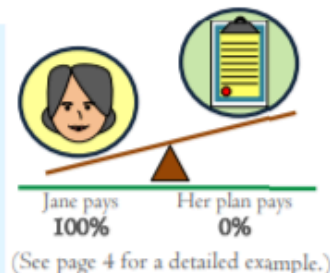
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance

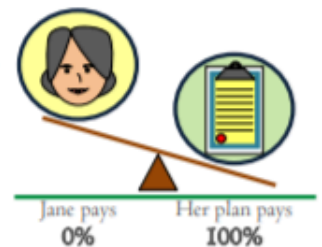
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or **plan** doesn't cover. Some health insurance or **plans** don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

Superbills

Superbills are provided through MedForward forms to ensure all patient information is secure. Superbills should be completed in full in order for your biller to create clean claims and avoid insurance denials.

*Electronic signatures are accepted.

*To remain HIPAA compliant, a biller that is not operating as a coder for that practice should only review medical records on an as needed basis. If Gelida Medical Billing does not receive a superbill, a claim will not be billed for the service.

*Please consult a certified medical coder or enroll in the AAPC Codify tool for correct coding consultation.

* **Only one patient can be identified per superbill. The Mother and the Newborn can not be the same patient.**

Explanation of Payment/ Explanation of Benefits

An explanation of payment otherwise known as EOP or EOB is issued with insurance payments and explains

- Why the insurance paid the amount they did
- How much was allowed by the plan for the service or contract
- Any error codes or requests for additional information
- Patient Responsibility

It is important that all EOPs and payment receipts are forwarded to the biller by email or fax as soon as they are received. The original documents must remain in the care and possession of the provider for a length of time designated by the state or as long as the medical record must be maintained. EOP copies are not stored by the biller for any guaranteed length of time and are therefore not released upon account closure as complete or original records.

Insurance notices and/or requests for additional information that are not provided to the payer before the designated response period ends, will delay payment further and possibly result in missed payment of services.

Reporting

Gelida Medical Billing will send key reports about the provider's account on the 1st of every month - holidays and weekends not included.

The provider also has 24/7 access to the account and all reports within CollaborateMD through their secure login.

*Payments not reported to the billing service will result in inaccurate aging reports, outstanding balances, and patients may receive inaccurate statements requesting payment.

It is essential that all providers and practice managers/owners take part in auditing all monthly reports before the 10th of each month. These monthly reports also serve as monthly audit opportunities for missing claims, missing patient and insurance payments, incomplete patients and claims, etc. While additional, "off-cycle" reporting and auditing is always available, they should never replace monthly audits and account "hygiene" essential to avoiding billing errors.

Timely Filing Deadlines and Claim Dismissals

There are scenarios where claims must be resubmitted or adjusted within the 12 months following the date of service. Delayed superbills, delayed EOB reporting, delayed recoupment reporting, or delays in claims processing in general can push a claim past the timely filing deadline and can not be the patient's responsibility if the provider failed to meet the timely filing requirements. This stresses the importance of super billing immediately after services are rendered, emailing a copy of all insurance correspondence within 1 week of receiving the correspondence to your billing and ultimately acting as soon as possible to expedite claim handling to meet these timely filing requirements. Timely filing deadlines are different for each payer and dependent on the providers contract stipulations for network providers. If timely filing requirements are not met and a claim ages out for any reason, Gelida Medical Billing will adjust the claim balance to -o- in CollaborateMD.

Incomplete Claims

Incomplete claims are claims that are missing vital information about the patient or the patient's insurance policy that result in missed billing. A Customer with incomplete claims will receive a report on the first of each month as part of the monthly reporting email. Customers are expected to review all reports thoroughly each month.

Incomplete claims without action can fall outside of timely filing resulting in no payment. Gelida Medical Billing may send the patient a statement for the incomplete claims amount if a mailing address is on file. The statement should include a note requesting more information from the patient as well as the biller's email address and mailable form to return to the provider with the requested information. This can help expedite the process in the event no corrective action is taken by the provider after one or more reporting periods have passed.

Newborns born to Medicaid eligible mothers

Newborns born to Medicaid eligible mothers that do not have a Medicaid ID number within 90 days of birth will be sent statements for outstanding claims/balances. Once the newborn's Medicaid information is received, the claims will be sent to Medicaid immediately for processing. Until the newborn's Medicaid benefits are available, the newborn is considered uninsured.

Phone Etiquette

Patients are not provided with our biller's phone contact information. Patients are encouraged to contact our billers via email with any questions or concerns they may have. The most common patient questions can be answered by;

1. Contacting your insurance
Coverage, benefits, exceptions, predetermination, finding an in-network provider, cost estimates, newborn coverage, claims determination and patient liability pleas can all be answered by a phone call to the insurance plan directly at the member services number on the back of the member ID card.
2. Ask your provider
How much certain services cost, whether or not the provider will be charging the insurance for a service, if the provider has any recommendations or referrals for specialists in the area, if the provider accepts their insurance, etc. are easily answered by the provider's office.

Gelida Medical Billing is a contracted medical billing service that does not meet face-to-face with patients nor provide medical care, treatment, supplies, medications, equipment, advice or medical opinion to anyone.

We will not provide estimates over the phone to any patient.

Medical Records

Gelida Medical Billing will require a secure user access to Electronic Medical Records to be able to confirm patient demographics, super bill accuracy, newborn information, etc.

Balance Billing

Providers retain the right to collect copayments, deductibles, coinsurance, and other patient-responsible amounts as determined by the payer and permitted under applicable law and network agreements. Balance billing—charging a patient the difference between the billed charge and the payer’s allowed amount—is governed by contractual obligations and federal and state law, including the Federal No Surprises Act where applicable. Participating (in-network) providers must comply with contractual limitations on balance billing. Non-participating (out-of-network) providers are responsible for ensuring compliance with all disclosure and consent requirements prior to billing patients beyond payer reimbursement. Nothing in this guide restricts the provider’s lawful right to pursue unpaid patient balances, provided such actions comply with applicable regulations.

Federal No Surprises Act 2022

Patient Verification of Benefits in 2022 will start to note whether or not the patient will require a waiver for their care plan and provide a copy of the appropriate federal waiver form for the provider to complete and provide to the patient within 10 days of registering for care and at least 3 hours prior to any services rendered.

Complete information about the federal law at <https://www.cms.gov/nosurprises>

Collections

Gelida Medical Billing is NOT a collections agency. Gelida Medical Billing does not call or directly contact patients with outstanding patient debt to demand payment. If a provider would like to hire a third party collections agency for these services, Gelida Medical Billing will cooperate and assist in transferring records of debt to the designated collections agency at the provider’s expense.

What is a Collection Agency?

Basically, collection agencies provide their services to business owners looking to collect money due from providers. Almost every company in existence has experienced providing their services or products to multiple non-paying customers over the years. Customers such as these are especially frustrating and downgrading for a company, not to mention potentially dangerous to a business’s success. This is where a collection agency comes in.

Medical Collections Agencies that may be able to assist...

1. [Accounts Receivable](#)
2. [TSI](#)

Patients with “Past Due” Balances

Accounts that have received the maximum number of statements and/or Final Demand Notices for severely past due balances will be moved to "Collections". This does not actually send the patient's account to a collections agency unless the provider has hired an agency and linked their account for me to forward patient information. What this will do is better communicate to providers where patients are no longer receiving printed statements and make a decision on how best to handle these delinquent accounts.

Coding

Internal Audits

Gelida Medical Billing performs periodic pre- and post-claim internal reviews to support billing accuracy, compliance, and operational efficiency. Reviews may include payer reimbursements, denied claims, code set updates, fee schedule updates upon request, remittance advice review, aged accounts, claim form accuracy, communication workflow, records management, and related billing operations.

Coding Responsibility

Gelida Medical Billing is not a certified coding service unless otherwise stated in writing. The provider is solely responsible for the accuracy and compliance of all codes submitted via medical records or superbills. Any coding guidance provided is general in nature and does not replace consultation with a certified professional coder. Gelida Medical Billing is not liable for improper or unsupported coding.

Exclusive Billing & Compliance

During the term of the agreement, the provider designates Gelida Medical Billing as the exclusive billing service for covered claims. The provider agrees not to engage additional billing services or implement alternative billing practices that conflict with the established billing structure. Unauthorized adjustments, undisclosed payment arrangements, or improper billing practices are not permitted under this agreement.

National Correct Coding Initiative (NCCI) - Medicaid Edits

To quote a summary, “The Affordable Care Act of 2010 required CMS to notify states by September 1, 2010, of the NCCI methodologies that were compatible with Medicaid. [State Medicaid Director Letter \(PDF 133.63 KB\)](#) notified states that all five Medicare NCCI methodologies were compatible with Medicaid. The Affordable Care Act required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010.”

For more information on NCCI for Medicaid programs, visit medicaid.gov

NCCI Edits help prevent improper payments or overpayments when incorrect code combinations are reported. This can also be called “unbundling”. For more information about NCCI edits with your state Medicaid program, please consult with a certified coding specialist.

Insurance Fraud and Abuse

Federal departments and regulations regarding fraud and abuse reported expected investigative recoveries of over \$2.04 billion for the first half of 2017. Commercial health plans are also recouping money and many have their own fraud and abuse departments.

Centers for Medicare and Medicaid Services (CMS) defines fraud as making false statements or misrepresenting

facts to obtain an undeserved benefit or payment from a federal healthcare program. CMS defines abuse as an action that results in unnecessary costs to a federal healthcare program, either directly or indirectly.

CMS examples of fraud:

- Billing for services and/or supplies that you know were not furnished or provided
- Altering claim forms and/or receipts to receive a higher payment amount
- Billing a Medicaid patient above the allowed amount for services
- Billing for services at a higher level than provided or necessary
- Misrepresenting the diagnosis to justify payment
- Falsifying documentation* (*This includes listing a provider as the rendering provider for the sole purpose of reimbursement or higher payment when the provider was in no way associated with the services provided.*)

CMS examples of abuse:

- Misusing codes on a claim
- Charging excessively for services or supplies
- Billing for services that were not medically necessary
- Failure to maintain adequate medical or financial records
- Improper billing practices
- Billing Medicaid patients a higher fee schedule than non-Medicaid patients

False Claims Act (FCA)

Relative to healthcare services, examples of fraud or misconduct subject to the False Claims Act include:

- Falsifying a medical chart notation
- Submitting claims for services not performed, not requested, or unnecessary
- Submitting claims for expired drugs
- Upcoding and/or unbundling services
- Submitting claims for physician services performed by a non-physician provider (NPP) without regard to Incident-to guidelines

The FCA is violated by submitting a false claim with knowledge that it is false; however, the Act states that a violation may occur even if there is no intent to defraud.

*** Providers found to be in violation of the FCA or suspected to be committing insurance fraud and abuse will be terminated as a customer effective immediately and reported appropriately***

Failure to Return Overpayments

Section (a.1.G) of the FCA provides liability where a person acts improperly to avoid paying money owed to the government. In the FCA (31 USC §3729 (b) (3) (2010)), obligation is defined as “an established duty, whether fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.”

Helpful Coding Resources

- Evaluation and Management Coding visit, cms.gov
- What is inclusive to global maternity care? Visit, aapc.com

Policies of Operation

Gelida Medical Billing reserves the right to revise this manual at its discretion at any time. Business Associates will be notified in writing of material changes.

Gelida Medical Billing is committed to equal opportunity and non-discrimination in all business practices, including contracting, consultation, credentialing, and commission-based compensation, in accordance with applicable federal and state laws. Discrimination or unlawful harassment of any kind is strictly prohibited.

Business Associates are responsible for reviewing this manual, seeking clarification when needed, and complying with all company policies during the term of their agreement. An acknowledgment of receipt is required. Associate agreements and provider contracts will be reviewed and updated annually as necessary to maintain quality service.

Customer Property and Account Closure

All superbills, patient demographics, registration forms, and account records related to the provider remain the property of the provider. Upon termination and account closure, such information will be relinquished in the form of exported reports or spreadsheets. The CollaborateMD account will be inactivated (not deleted) until the provider either requests a data transfer, confirms no further data is needed, or three (3) months have passed from the termination date.

Data transfers through CollaborateMD are subject to applicable platform fees and must be paid in full prior to release. If a direct transfer is not requested, Gelida Medical Billing will provide account reports and summaries, and the provider must acknowledge receipt in writing.

After termination, Gelida Medical Billing will not perform claim follow-up or ongoing services previously covered under contract. Any post-termination assistance will be billed at an hourly consulting rate with a one-hour minimum per calendar day. The provider remains solely responsible for coding accuracy. Gelida Medical Billing does not provide certified coding services and assumes no liability for coding-related claim outcomes.

Business Associates are encouraged to participate in an exit interview. Commissions are calculated on the first day following each billing cycle and are due the following week unless otherwise announced due to holidays or schedule adjustments.

Overpayments and Account Credits

If a provider receives notice of a payer recoupment, the biller must be notified immediately. Any commission previously charged on recouped payments will be credited to the provider's account and applied to future invoices. Recoupment credits may offset up to 50% of monthly charges and may be applied across multiple billing cycles until fully reconciled.

Communication and Accountability

Communication with Gelida Medical Billing should occur via email or another written format to ensure proper documentation. All correspondence from a @GelidaBilling.com address is considered important and may contain time-sensitive instructions requiring prompt review and response. Failure to respond to or act on requests may result in delays, denials, or other consequences for which Gelida Medical Billing is not responsible. If additional work is required due to lack of response or failure to follow instructions, corrective services may be billed at \$35 per hour with a one-hour minimum.

Harassment

Harassment of any employee, business associate, patient, or client by anyone representing Gelida Medical Billing is strictly prohibited. All complaints will be investigated, and appropriate disciplinary action will be taken when necessary.

Gelida Medical Billing maintains an open-door policy and encourages Business Associates to raise concerns or questions with management.

Due to the sensitive nature of protected health information and credentialing data, Gelida Medical Billing does not employ minors or individuals with known criminal backgrounds.

A provider file is maintained for each account and may include applications, credentials, agreements, and login information. Providers are responsible for notifying Gelida Medical Billing of any changes to keep records current.

Failure to comply with company policies may be considered a breach of contract and may result in mediation, suspension, or termination of services.

Services & Rates

Over the past several years, maternity reimbursement structures have shifted significantly, particularly with the transition away from global maternity billing toward individual claim billing models. These changes increase claim volume, payment posting complexity, statement processing, and secondary insurance coordination.

To ensure long-term sustainability, regulatory clarity, and fair alignment between administrative workload and compensation, I will be transitioning from a percentage-based billing model to an episode-based billing structure effective **April 1, 2026**.

This change allows compensation to reflect the actual administrative work required to manage maternity care, regardless of payer mix, deductible levels, coinsurance structures, or reimbursement timing.

Beginning **April 1, 2026**, compensation will be structured as follows:

Professional Services

- **Completed Maternity Episode (delivery billed by practice):**
\$450 per completed maternity episode
- **Incomplete Maternity Episode (≥ 4 prenatal visits, delivery not billed due to transfer):**
\$300 per incomplete episode
- **Early-Exit Prenatal (≤ 3 visits) and All Other Non-Maternity Encounters:**
\$30 per encounter billed

Birth Center Facility Billing

- **Completed Facility Birth:**
\$175 per facility delivery claim submitted

Monthly Administrative Minimum

- A **\$75 monthly minimum administrative fee** will apply to all accounts. Episode and encounter fees will be applied toward this minimum.

To ensure a smooth and fair transition:

1. **All percentage-based billing will conclude for payments received on or before March 31, 2026.**
2. A “Claims at Insurance” report will be generated as of March 31, 2026, identifying claims submitted but not yet reimbursed.
3. Claims submitted prior to April 1, 2026 but not yet paid will transition into the new episode model.
4. For clients currently mid-episode under individual billing:
Any commission already paid on individual claims will be credited toward the applicable episode fee.
Upon delivery or formal transfer, the episode fee will be reconciled accordingly.
5. For “global” clients not yet billed for a maternity case:
All cases delivered on or after April 1, 2026 will fall under the new episode model.

This approach ensures no duplication of billing and no loss of compensation for work already performed.


The transition to individual maternity billing significantly increases:

- Number of claims submitted
- Remittance processing
- Secondary insurance billing
- Patient statement cycles
- Administrative oversight

A percentage-based model tied solely to payments no longer accurately reflects the administrative workload required to manage maternity revenue cycles.

The episode-based model provides:

- Stability and predictability



Fair compensation for incomplete or transferred cases
Protection against reimbursement volatility
Alignment with evolving payer structures

Business Associate Agreement

This Business Associate Agreement (“Agreement”) is entered into between the Provider (“Covered Entity”) and Gelida Medical Billing (“Business Associate”), effective as of the date of contract (“Effective Date”). Covered Entity and Business Associate may be referred to collectively as the “Parties.”

Business Associate provides medical billing services to Covered Entity pursuant to a separate services agreement. In the course of providing such services, Business Associate may create, receive, maintain, or transmit Protected Health Information (“PHI”) and Electronic Protected Health Information (“ePHI”), including claim materials, as defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and applicable regulations issued by the U.S. Department of Health and Human Services (“HHS”).

The Parties agree to comply with all applicable HIPAA Privacy and Security Rule requirements and to safeguard PHI and ePHI in accordance with federal law.