MHS UB 04 2018

Tips and Billing Guidelines

0418.PR.P.PP 5/18

Agenda

Claim Process

- Claim Process
- Common Claim Rejections
- Common Claim Denials
- Claim Adjustments
- Claims Dispute Resolution
- Prior Authorization
- Claim Submission
- Reviewing Payments
- Home Health Billing
- Ambetter Claims Process
- Allwell Billing Overview

MHS Website/Portal

- Provider Portal

Claim Process

Claim Process

- **Electronic submission through EDI vendor**
  - Payer ID 68069
  - MHS accepts TPL information via EDI
  - It is the responsibility of the provider to review the error reports received
    - from the Clearinghouse (Payer Reject Report)

- **Online submission through the MHS Secure Provider Portal at: mhsindiana.com/login**
  - Provides immediate confirmation of received claims and acceptance
  - Professional and Facility claims accepted
  - Attachments accepted via MHS Secure Portal
  - Claim Adjustments and TPL accepted

Claim Process

Paper Claims

- Managed Health Services
  PO Box 3002
  Farmington, MO 63640-3802

Claim Inquiries

- Check status online with the MHS Secure Provider Portal:
- mhsindiana.com/login.
- Call Provider Services at:
  - 1-877-647-4848
  - IVR

Claim Process – Billing with Ease

CONTRACTED PROVIDERS – Claims must be received within 90 calendar days of the date of service.

- Exceptions:
  - Newborns (30 days of life or less) – Claims must be received within 365 days from the date of service. Claim must be filed with the newborn's RID number
  - Third party Liability (TPL)- Claims with primary insurance must be received within 365 days of the date of service with a copy of the primary EOB. If primary EOB is received after the 365 days, providers have **60 days** from date of primary EOB to file claim to MHS

Claim Process

Claim Rejection

- A rejection is an unclean claim that contains invalid or missing data elements required for acceptance of the claim in the claim process system. The provider will receive a letter or a rejection report from their EDI vendor if the claim was submitted electronically

Claim Denial

- A denial is a claim that has passed edits and is entered into the system but has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason

Claim Rejections

Claim Rejections

EDI rejections require the provider to contact their clearinghouse and obtain a payer rejection report

- Paper to electronic mapping is available on mhsindiana.com/provider-guides

Claim Rejection Tips

Member Information

- Member's information needs to match what is on file with Indiana Medicaid
- Newborn's RID number is required for payment
- Verify Members eligibility via web portal

TPL or Secondary Claims

- Accepted electronically from vendors or via the MHS Secure Provider Portal
- COB verification can be requested via portal message option

Claim Rejections (Paper)

- **The provider identification and the tax identification numbers are missing or not on file with the health plan.**
  - Verify that the provider's NPI is entered on the claim in box 56
  - Verify that the address located in box 1 is the provider's service location address with the complete zip code
  - Verify that the group taxonomy is in box 81CC with the B3 qualifier

Claim Denials

Common Claim Denials

- **Time Limit For Filing Has Expired (EX 29)**
  - Claims must be received within 90 calendar days of the date of service (contracted providers)
    - Exceptions
      - Newborn and Third Party Liability
- **Bill Primary Insurer 1st (EX L6)**
  - Verify other insurance (TPL). Medicaid is the payer of last resort

Common Claim Denials

NDC information missing or invalid

- Services requiring NDC numbers must be billed with valid NDC numbers in the correct format:

  - Enter the NDC qualifier of N4
  - Enter the NDC 11 digit numeric code
  - Enter the drug description
  - Enter the NCD unit qualifier of F2 for international unit, GR for gram, ML for Milliliter and UN units
  - Enter the NDC quantity (administered/billed amount) in the formation of 9999.99

Common Claim Denials

- **Coverage Not In Effect When Service Provided (EX 28)**
  - Check eligibility at each visit prior to submitting claims to ensure you are billing the correct carrier

- **Please Resubmit To Cenpatico For Consideration (EX 54)**
  - Behavioral Health Services for MHS members are covered by Cenpatico

- **Missing or Invalid POA (EX VV)**
  - Required for inpatient admissions unless exempt diagnosis

Common Claim Denials

- **Authorization Not On File (EX A1)**
  - Prior authorization should occur at least two (2) business days prior to the date of service
  - All urgent and emergent services must be called in to MHS within two (2) business days after service/admit

- **Claim and Auth Service Provider Not Matching (EX HP)**
  - Provider of service does not match service billed on authorization

- **Denied By Medical Services (EX HL)**
  - Claim and authorization locations do not match

Claim Adjustments

Claim Adjustments

- Claim adjustments requests must be submitted within 67 days of the date of the MHS EOP. *Claims will not be reconsidered after day 67*

- Adjustments can also be processed via paper submissions. The MHS claim adjustment form

  – Attach an MHS claim adjustment form along with documentation, including EOP (if available) explaining reason for resubmission. Please indicate original claim number Example: (N123INE00987)

Dispute Resolution
(2 STEP PROCESS)

Dispute Resolution

Level One Appeal

- Should be made in writing by using the MHS informal claim dispute or objection form, available at mhsindiana.com/provider-forms
- Submit all documentation supporting your objection
- Send to MHS within **67 calendar days** of receipt of the MHS EOP. Please reference the original claim number. Requests received after day 67 will not be considered

Managed Health Services
Attn: Appeals
P.O. Box 3000
Farmington, MO 63640-3800

- MHS will acknowledge your appeal within 5 business days
- Provider will receive notice of determination within 45 calendar days of the receipt of the appeal
- A call to MHS Provider Services **does not** reserve appeal rights

Dispute Resolution

Level Two Appeal (Administrative)

- Submit the Informal Claims Dispute/Objection Form with all supporting documentation to the MHS appeals address:

Managed Health Services
Attn: Appeals
P.O. Box 3000
Farmington, MO 63640-3800

- MHS will acknowledge your appeal within 5 business days

- Provider will receive notice of determination within 45 calendar days of the receipt of the appeal

Prior Authorization

Prior Authorization

Is Prior Authorization Needed?

- MHS website mhsindiana.com
  - PA tool
- Quick reference guide

Prior Authorization

- **Some Services that require prior authorization regardless of contract status (not inclusive) are:**
  - All elective hospital admissions
  - All urgent and emergent hospital admissions (including NICU) require notice to MHS following the admission
  - Transition to hospice
  - Newborn deliveries (following delivery)
  - Rehabilitation facility admissions
  - Skilled nursing facility admissions
  - Transition of care
  - Transplants, including evaluations
- **Reference QRG for a more detailed listing**

Authorization Considerations

- **Need to know what requires Authorization?**
  - Reference QRG
  - Pre-Auth Tool

- **How to obtain Authorization?**
  - Online (excluding Home Health and Hospice requests)
  - Phone
  - Fax

- **Authorizations are not a guarantee of payment**

Prior Authorization

Information Needed to Complete All PAs:

- Member's Name, RID, and Date of Birth
- Type of service needed (e.g. office visit, outpatient surgery, DME, inpatient admission, testing, physical therapy, occupational therapy, speech therapy etc.)
- Date(s) of service
- Ordering Physician with NPI number
- Servicing Physician with NPI number
- HCPCS/CPT codes requested for approval
- Diagnosis code
- Contact person, including phone and fax numbers
- Clinical information to support medical necessity

  Including current (within three months) clinical that is pertinent to the requested service, history of symptoms, previous treatment and results, physician rationale for ordering treatments and/or testing (MD exam notes)

Providers must request updates to prior authorizations within 30 days from the original date of service before claim submission

Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by Envolve Vision
Dental services need to be verified by Envolve Dental
Ambulance and Transportation services need to be verified by LCP Transportation
Behavioral Health/Substance Abuse services need to be verified by Cenpatico

Are services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

Yes No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?		
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?		

Are services being performed in the Emergency Department or Urgent Care Center or are these family planning services billed with a contraceptive management diagnosis?

☐ Yes ☑ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	◉
Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	◉
Are anesthesia services being rendered for pain management?	○	◉
Are services for infertility?	○	◉
Is the member receiving dialysis?	○	◉

Enter the code of the service you would like to check:

99394 Check

N
No

99394 - PREV VISIT EST AGE 12-17
No Pre-authorization required for all providers.

Therapy Services - (Speech, Occupational, Physical Therapy)

- **10/1/17 authorization is no longer required**
  - Benefit limitations are applicable
- **Must follow billing guidelines (GP, GN, GO modifiers)**
- **National Imaging Associates, Inc. (NIA) will conduct retrospective review to evaluate medical necessity**
  - If requested, medical records can be uploaded to RadMD.com or faxed to NIA at 800-784-6864
  - Medical necessity appeals will be conducted by NIA
    - » Follow steps outlined in denial notification
    - » NIA Customer Care Associates are available to assist providers at 800-424-5391

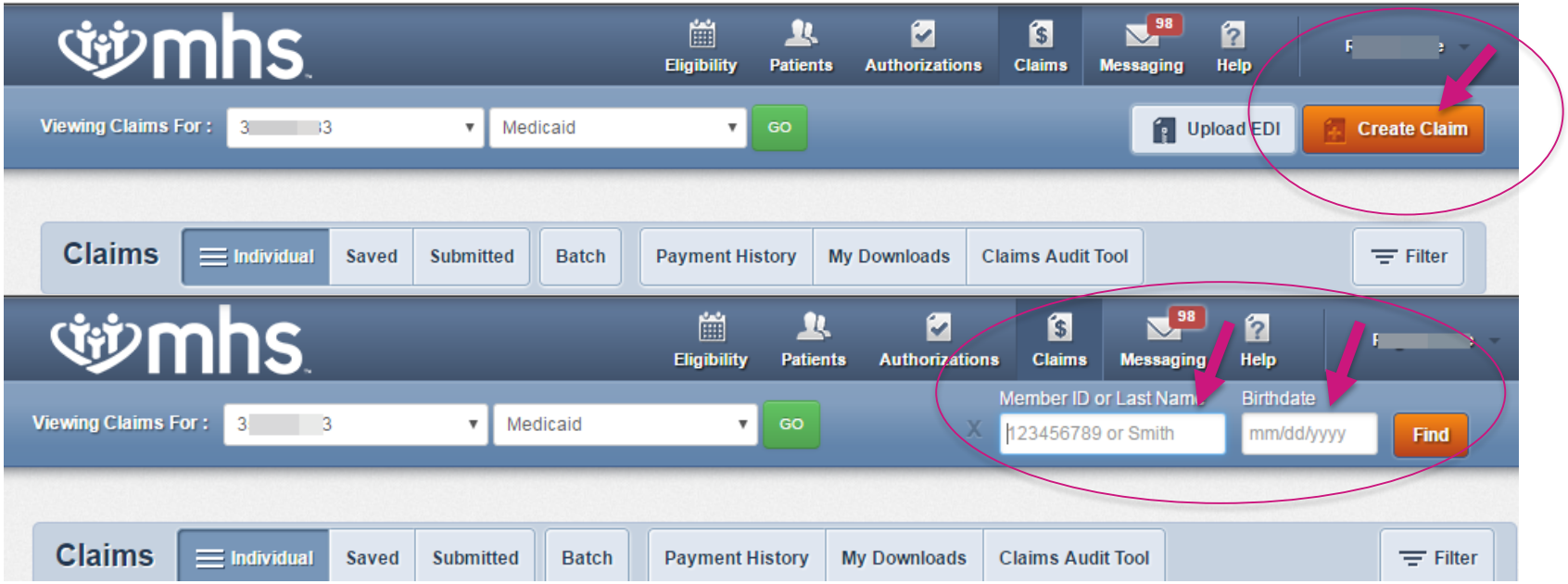
Outpatient Radiology PA Requests

- **MHS partners with NIA for outpatient Radiology PA Process**
- **PA requests can be submitted**
  - NIA Web site at RadMD.com
  - 1-866-904-5096
  - Not applicable for ER and Observation requests

Claim Submission

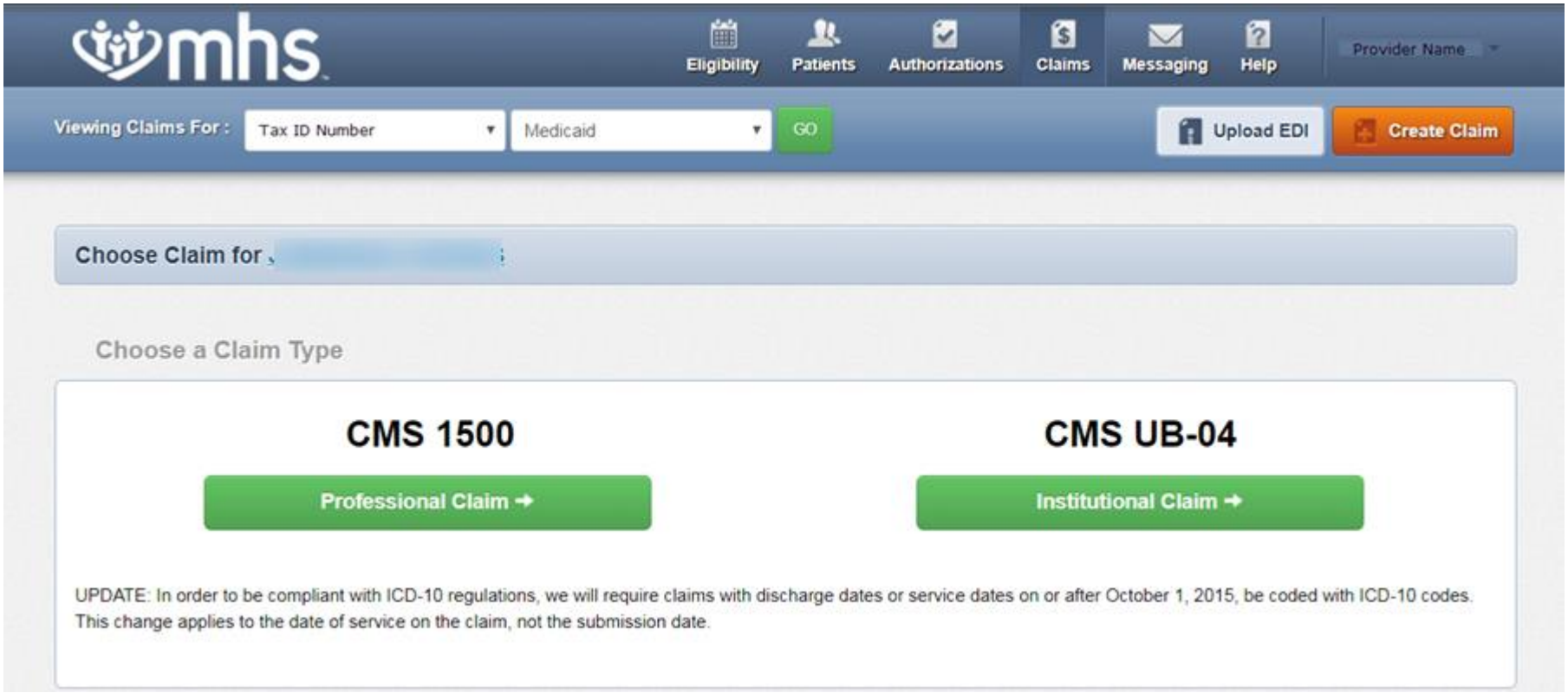
Claim Submission

- Providers are able to use the portal to review claims on file for a patient, submit new claims, correct claims, and view payment history.
- Claims Submission
- Correct a Claim
- Payment History
- Review Claims on File for a patient
- **Submit a New Claim**

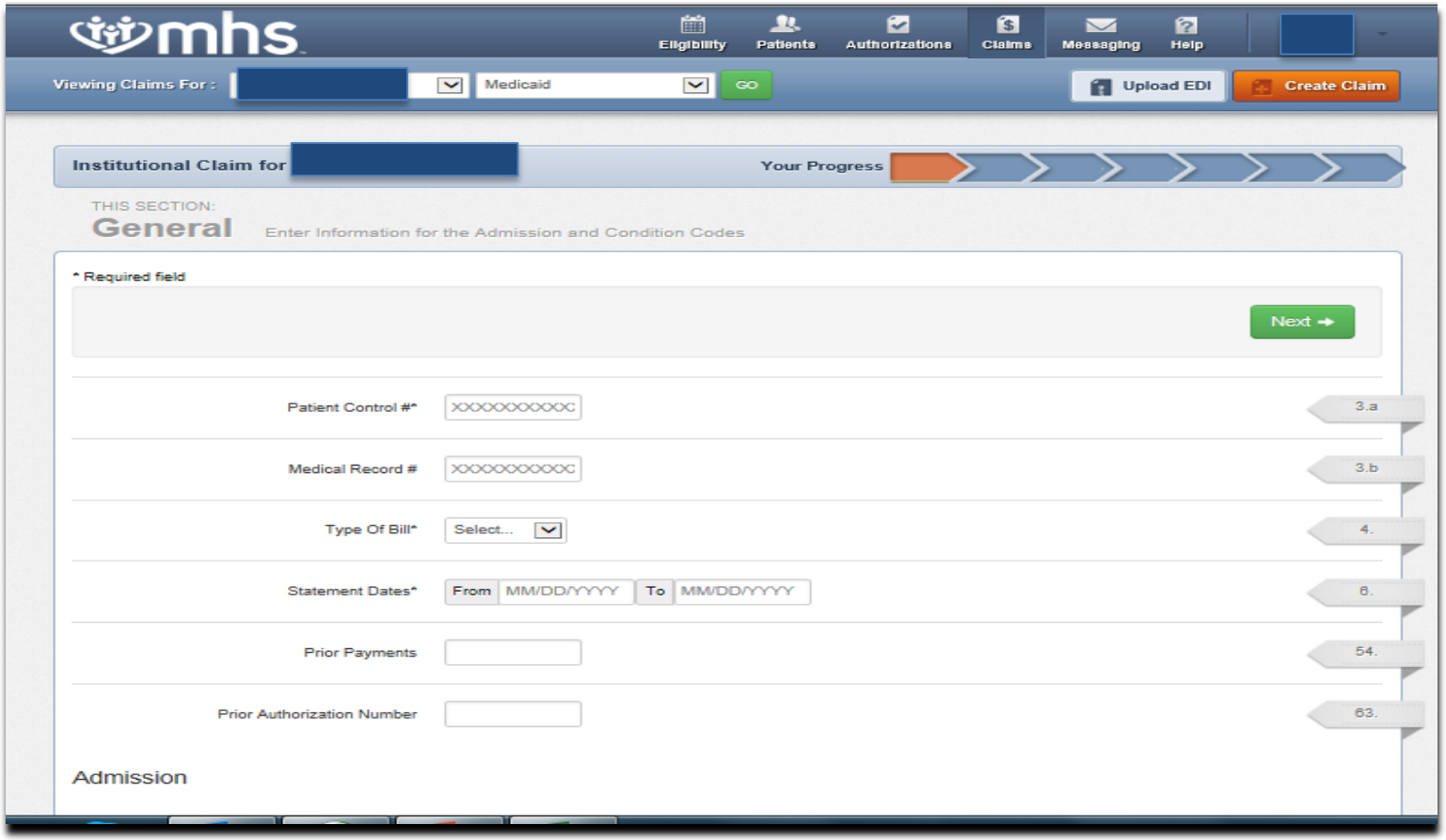


Claim Submission

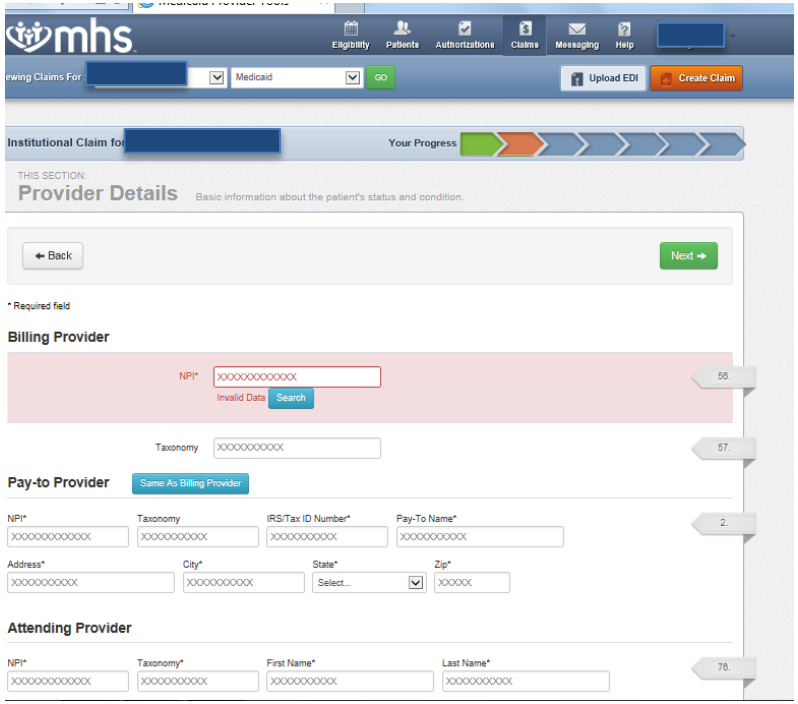
- Choose the **Claim Type**
  - **Professional** or **Institutional** claim submission



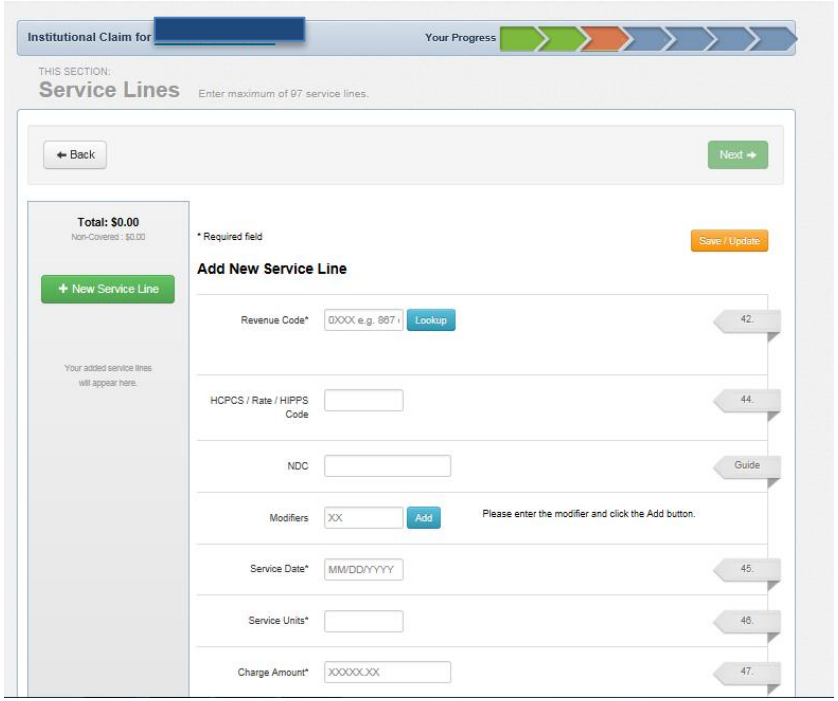
- In the **General Info** section, populate the **Patient's Account Number** and other information related to the patient's condition by typing into the appropriate fields. Click **Next**.



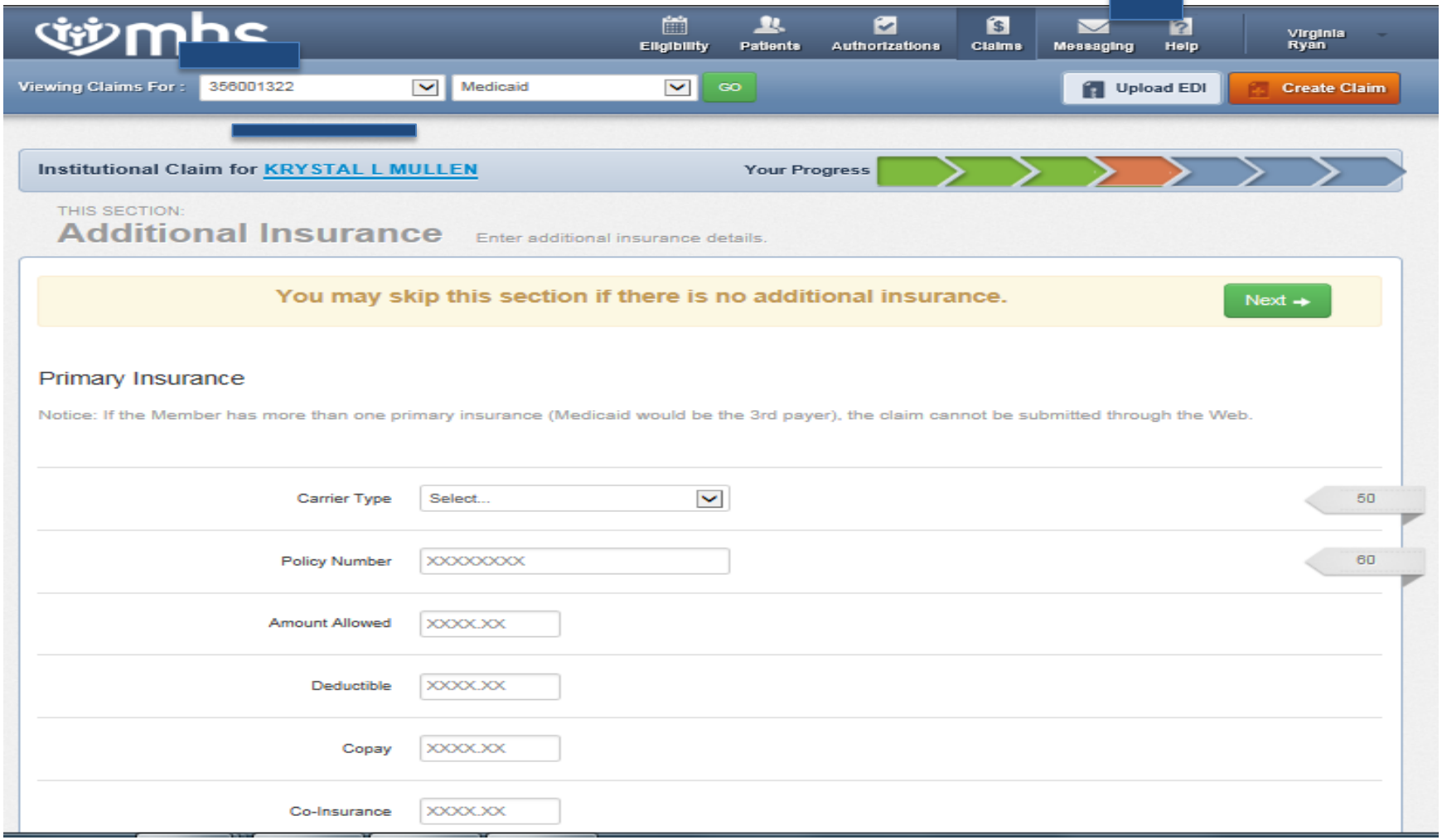
- Add the **provider information.** Click save and continue to go to next section.



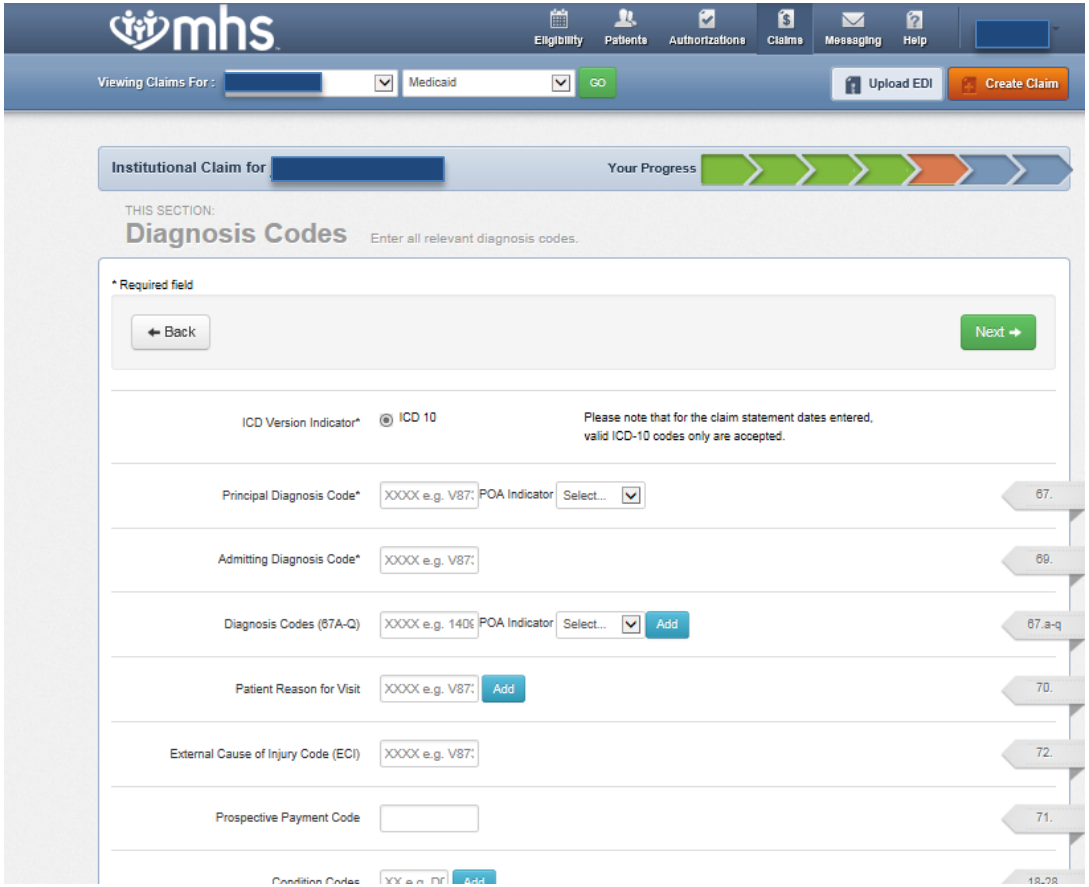
- Click **Add new service line** and enter the service lines information.



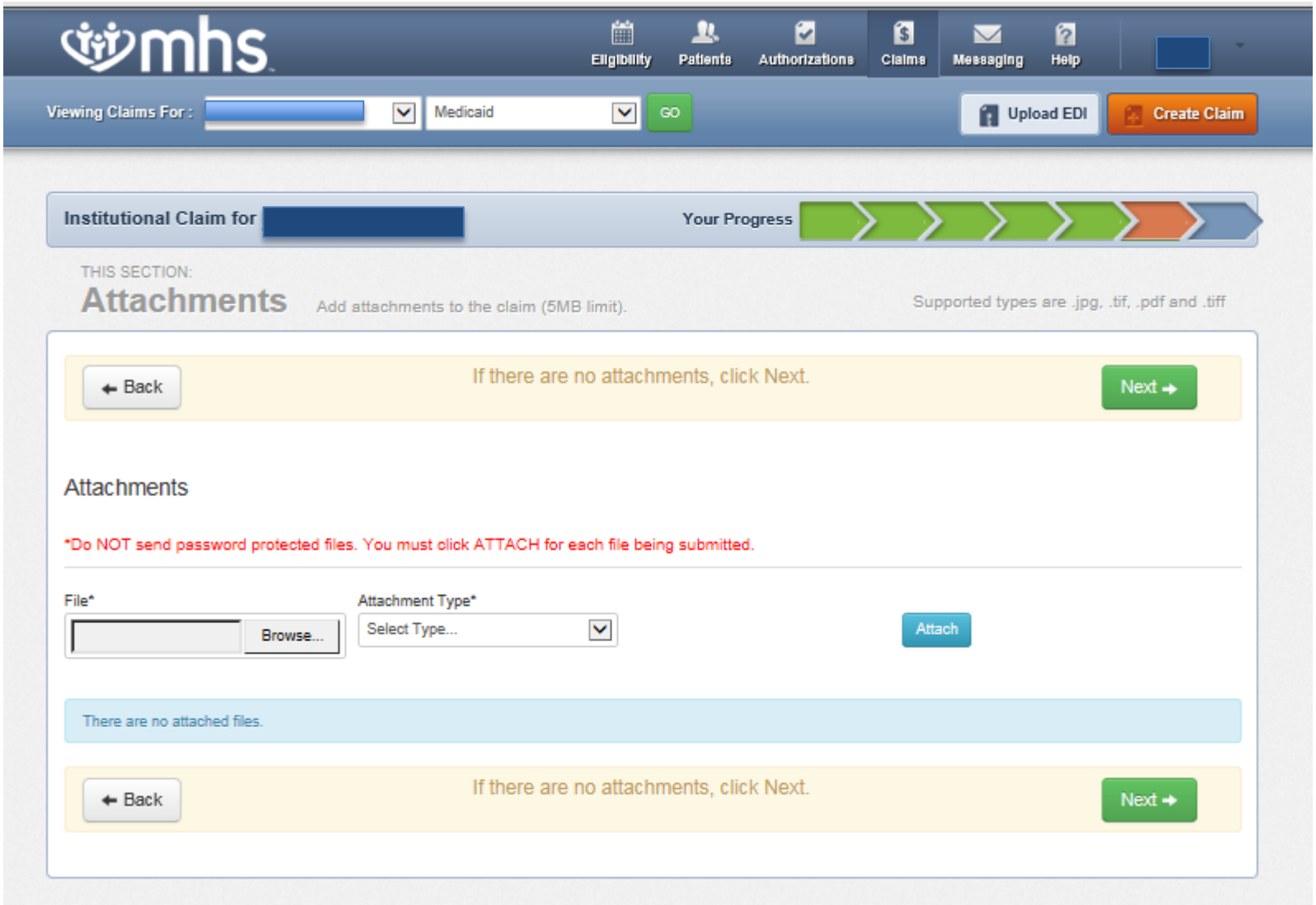
Enter additional insurance (if applicable)



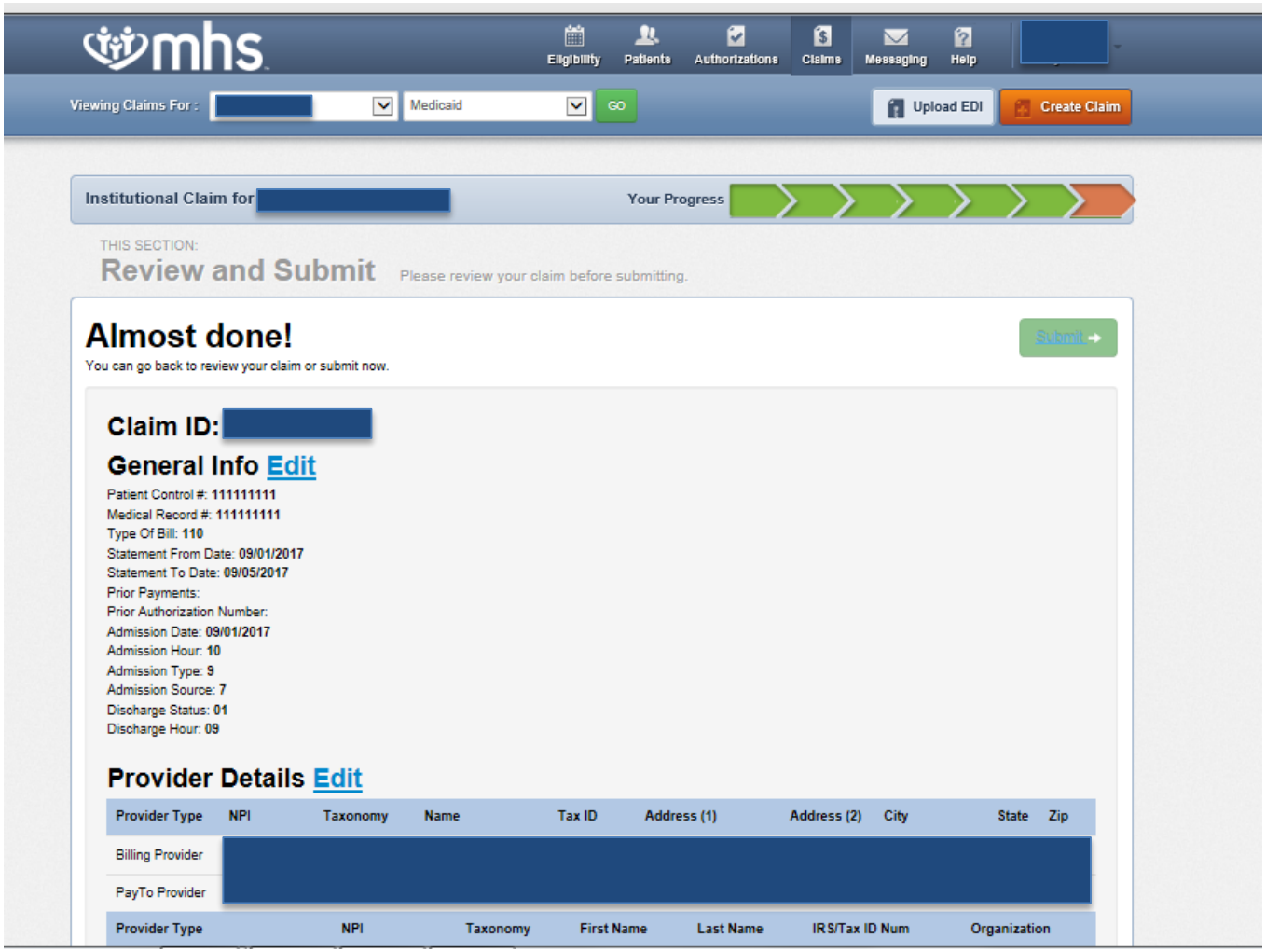
Enter diagnosis codes



Add attachments (if applicable)



Review claim and submit



Correcting Claims

1. Click **Correct Claim**
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information
5. Click **Submit**.

Tips to Remember

- Clicking on items (claim numbers, check numbers, dates) that are highlighted will reveal additional information.
- When filtering to find a claim or payment, only a 90 day date range can be used.
- Click on the Submitted Claims tab to view claims that have been submitted. The Filter tab can be utilized to see older dates.
- Click on the Saved Claims tab to view claims that have been created but not Submitted. Claims in this queue can be edited for submission or deleted from this tab.
- In order to utilize the Correct Claim feature, the claim needs to be in a Paid or Denied status.
- If you manage multiple tax id numbers you can choose another tax id and view the dashboard associated with that TIN from any screen.

Reviewing Payments

EFTs and ERAs

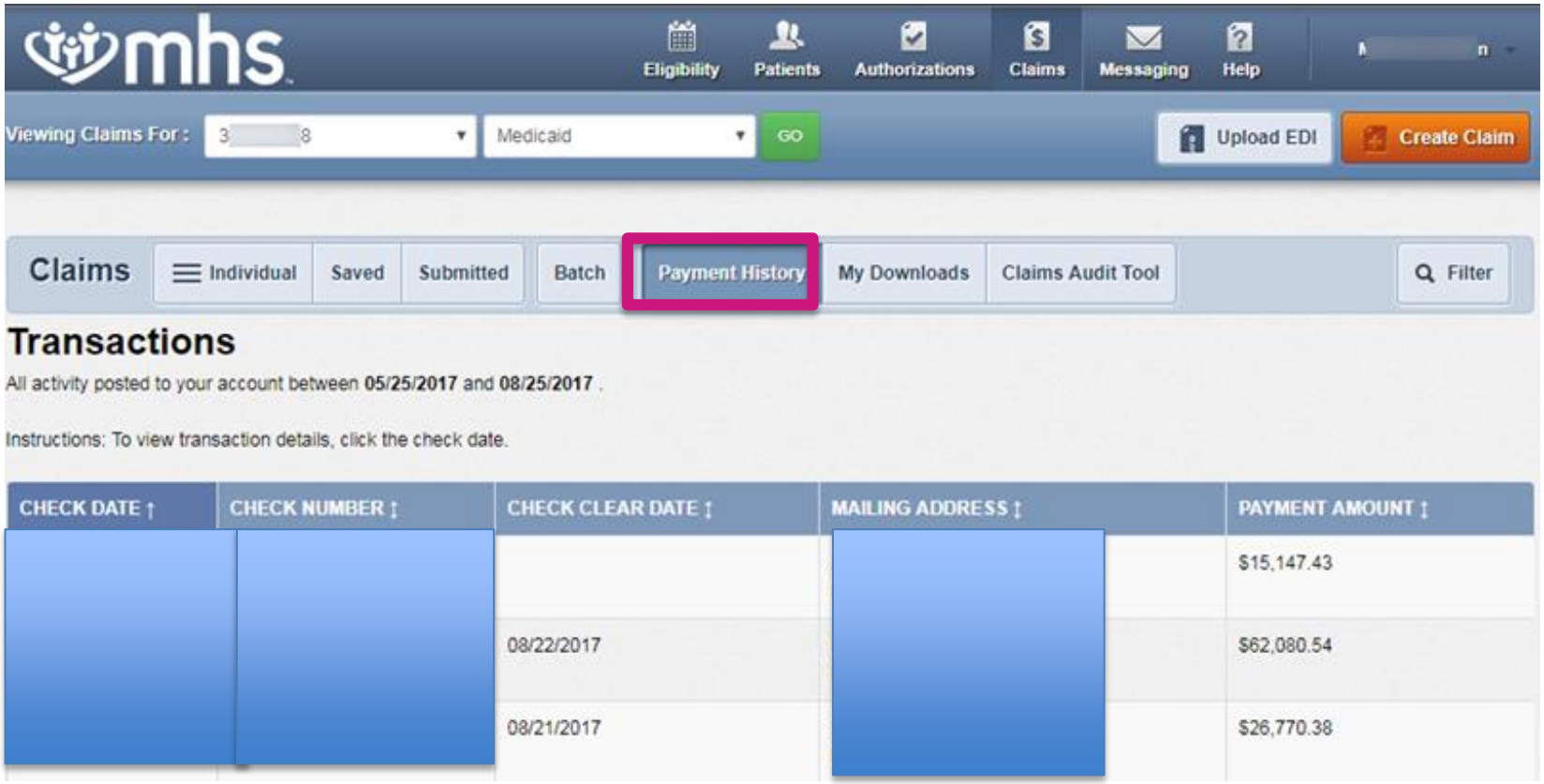
PaySpan Health

- Web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs)
- One year retrieval of remittance advice
- Provided at no cost to providers and allows online enrollment
- Register at payspanhealth.com
  - For questions call 1-877-331-7154 or email providersupport@payspanhealth.com

Payment History

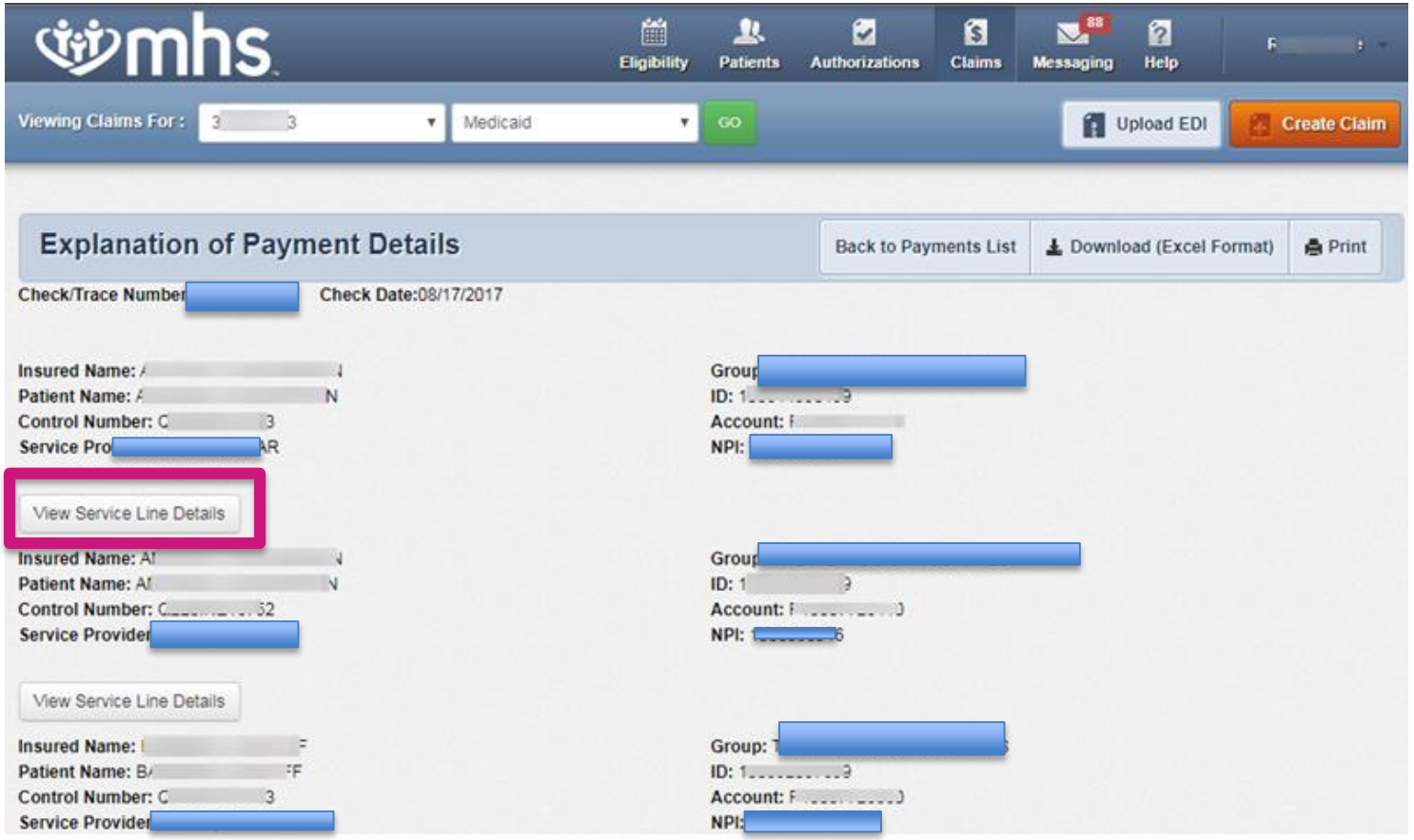
Click on **Payment History** to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount.

- Click on **Check Date** to view Explanation of Payment



Payment History

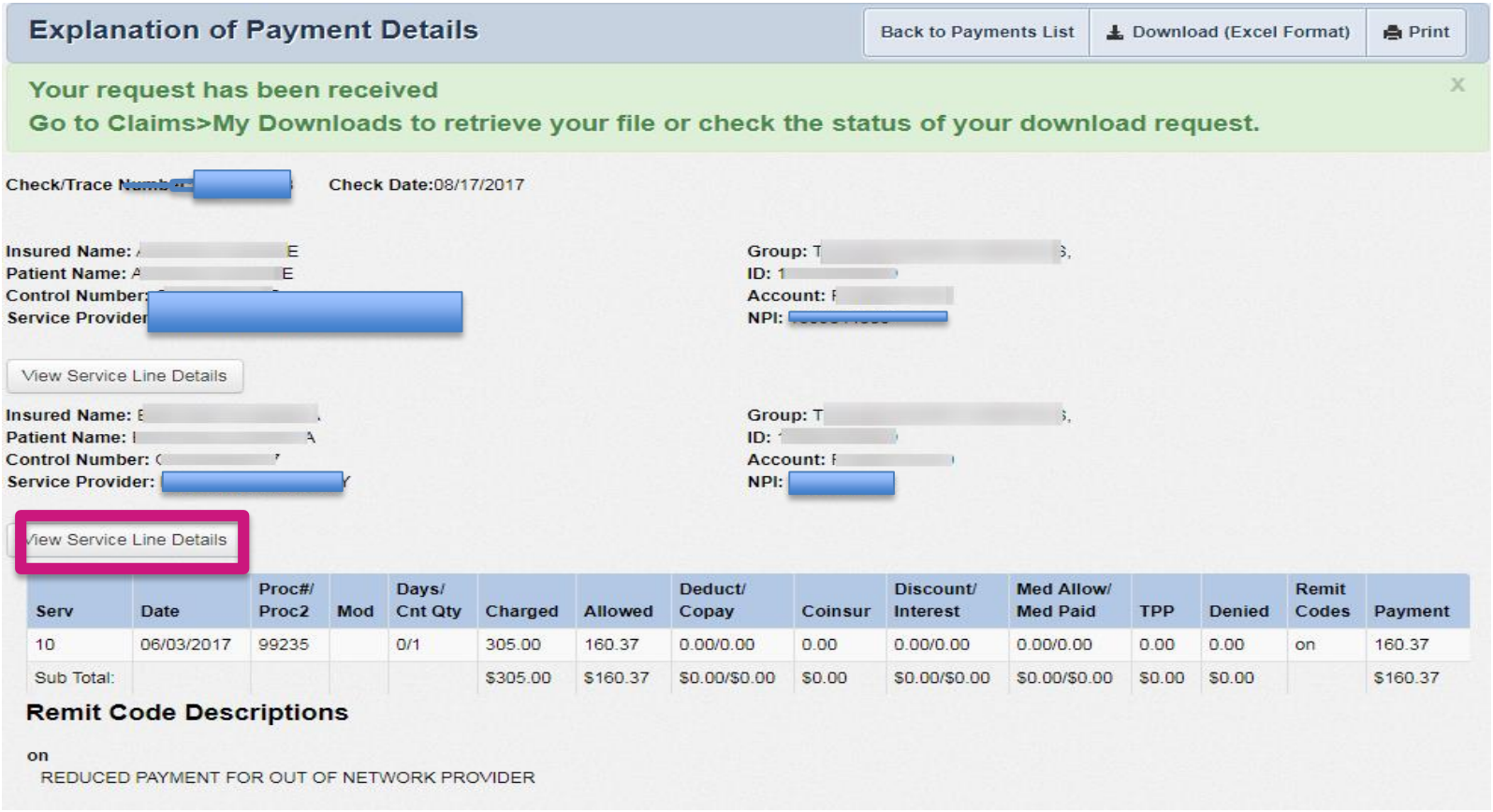
Click on **View Service Line Details**



Payment History

View Service Line Details

- The explanation of payment details displays the date and check number
- This view shows each patient payment by service line detail made on the check



Home Health Billing

Home Health Billing

Revenue and Healthcare Common Procedure Coding System (HCPCS) codes

- **42X**
  - G0151 – Physical therapy in home health setting
  - 97001 –Physical Therapy Evaluations
- **43X**
  - G0152 – Occupational therapy in home health setting
  - 97003 – Occupational Therapy Evaluations
- **44X**
  - G0153 – Speech therapy in home health setting
  - 92521–92524 – Speech Evaluations
- **552 – 99600**

  – Skilled nursing home health visit (modifier TD for RN and TE for LPN or licensed vocational nurse (LVN))
- **572 - 99600**

  – Home health aide home health visit
- (modifier TD for RN and TE for LPN or licensed vocational nurse (LVN))

Home Health Billing

Overhead:

- Home health providers receive an overhead rate for administrative costs for each visit to the members home.

- Providers can only receive one overhead rate per member per date of service.

- Overhead can be billed as a span date if the dates of service are consecutive.

Home Health Billing

Overhead:

There are two occurrence codes that can be used to submit the overhead

- **Occurrence code 61**
  - used for individual days as well as span dates.
- **Occurrence code 50**
  - Used only within 30 days of hospital discharge.

Ambetter Claims Process

Claims

Clean Claim

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Exceptions

- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible

Claim Submission

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Claims may be submitted in 3 ways:

1. **The secure web portal located at ambetter.mhsindiana.com**

2. **Electronic Clearinghouse**
   - Payor ID 68069
   - Clearinghouses currently utilized by ambetter.mhsindiana.com will continue to be utilized
   - For a listing our the Clearinghouses, please visit out website at ambetter.mhsindiana.com

3. **Paper claims may be submitted to PO Box 5010 Farmington, MO 64640-5010**

Claim Submission

Claim Reconsiderations

- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 180 days of the Explanation of Payment.
- Claim Reconsiderations may be mailed to PO Box 5010 – Farmington, MO 63640-5010

Claim Disputes

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at ambetter.mhsindiana.com
- The completed Claim Dispute form may be mailed to PO Box 5000 – Farmington, MO 63640-5000

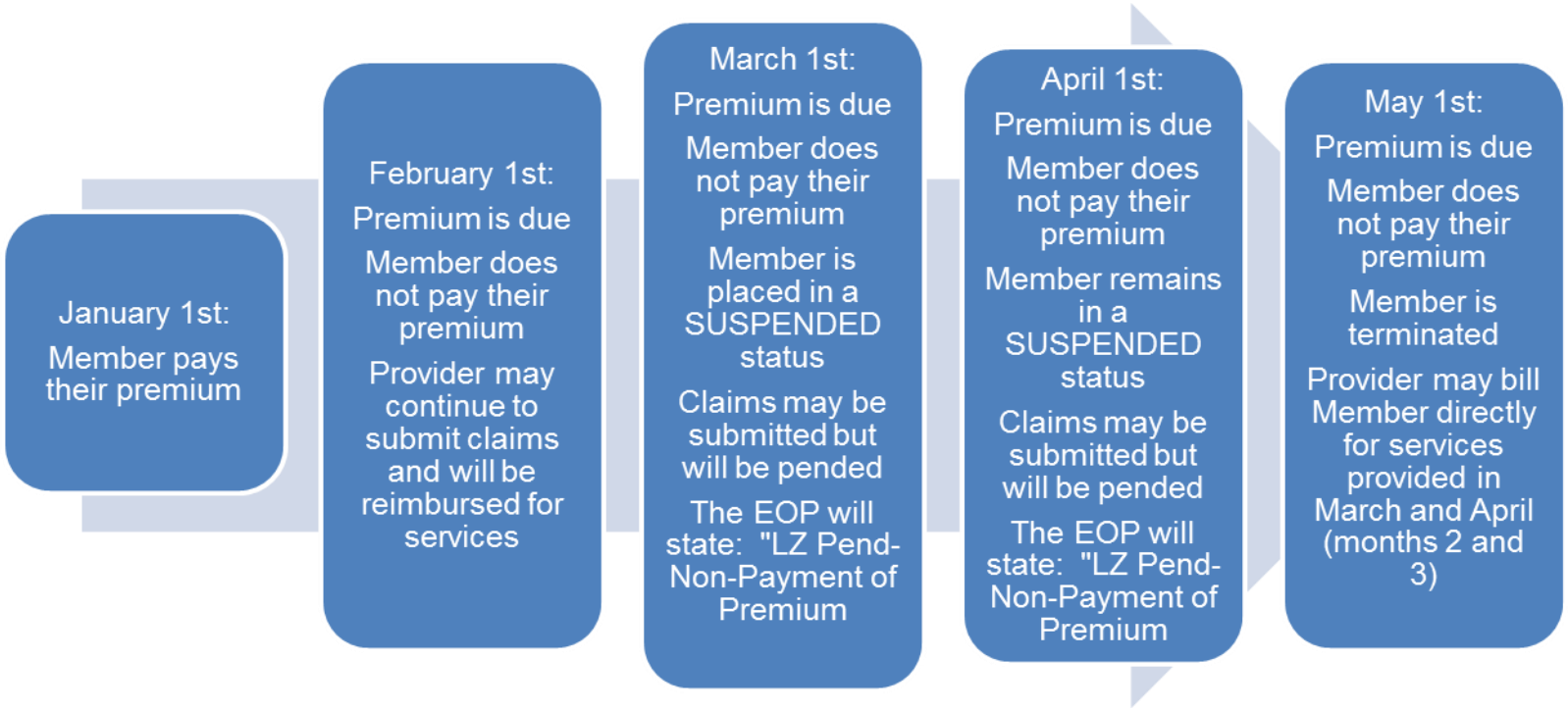
Claim Submission

Member in Suspended Status

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- While the member is in a suspended status, claims will be pended.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services.

Claim Submission

Member in Suspended Status



Claims for members in a suspended status are not considered “clean claims”.

** Note: When checking Eligibility, the Secure Portal will indicate that the member is in a suspended status.*

Claim Submission

Other helpful information:

Rendering Taxonomy Code

- Claims must be submitted with the rendering provider's taxonomy code
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim

Claim Payment

PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer
- If you currently utilize PaySpan, you will auto-enrolled in PaySpan for the Ambetter product
- **If you do not currently utilize PaySpan: To register** call 1-877-331-7154 or visit payspanhealth.com

Allwell Billing Overview

Electronic Claims Transmission

- **Six clearinghouses for Electronic Data Interchange (EDI) submission**
- **Faster processing turn around time than paper submission**
  - Emdeon – Payer ID 68069
  - Gateway
  - Availity/THIN
  - SSI
  - Medavant
  - Smart Data Solution

EDI Support

Companion guides for EDI billing requirements plus loop segments can be found on the following website:
mhsindiana.com/providers/resources/electronic-transactions

For more information, contact:
Allwell from MHS c/o Centene EDI Department
1-800-225-2573, extension 25525
e-mail: EDIBA@centene.com

Claims Filing Timelines

- **Medicare Advantage Claims are to be mailed to the following billing address:**

Allwell from MHS
P.O. Box 3060
Farmington, MO 63640-3822

- **Participating providers have 180 days from the date of service to submit a timely claim**

- **All requests for reconsideration or claim disputes must be received within 180 days from the original date of notification of payment or denial**

Claims Payment

- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim
- Providers may NOT bill members for services when the provider fails to obtain authorization and the claim is denied
- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments
- Providers may not balance bill members for any differential

Coding Auditing & Editing

- **Allwell from MHS** uses code editing software based on a variety of edits:
  - American Medical Association (AMA)
  - Specialty society guidance
  - Clinical consultants
  - Centers for Medicare & Medicaid Services (CMS)
  - National Correct Coding Initiative (NCCI)
- Software audits for coding inaccuracies such as:
  - Unbundling
  - Upcoding
  - Invalid codes

Claims Reconsideration & Disputes

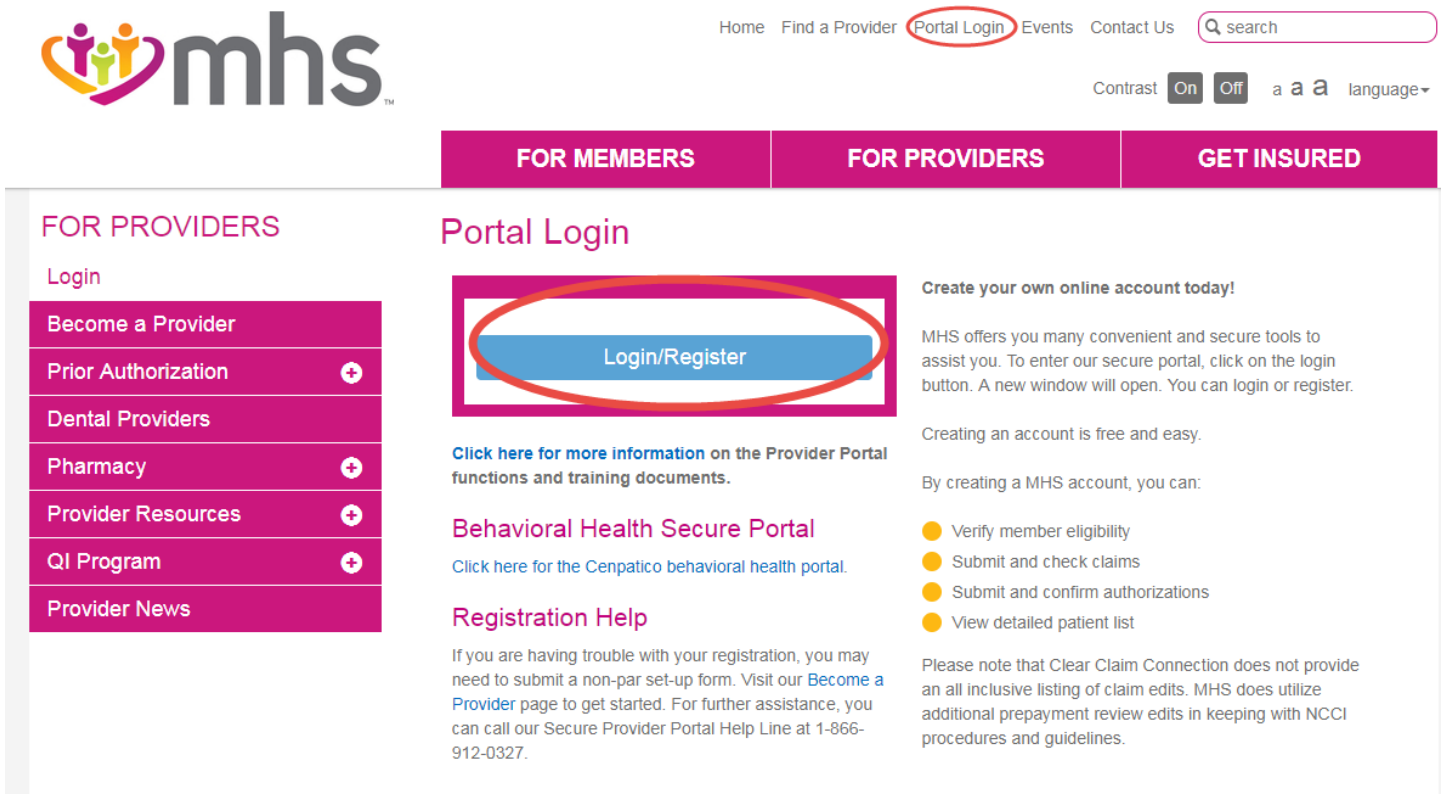
- **A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration**
- **Submit reconsiderations or disputes to:**

  Allwell from MHS

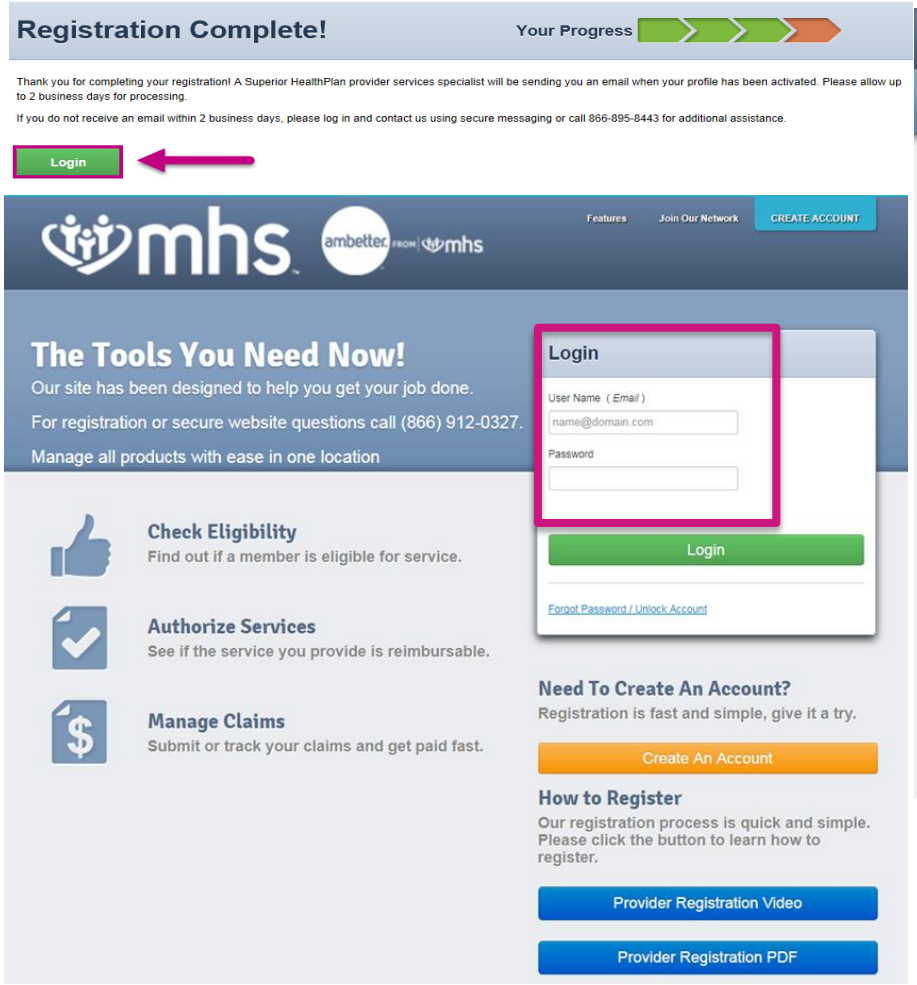
  Attn: Reconsiderations
  P. O. Box 4000
  Farmington, MO 63640-4000

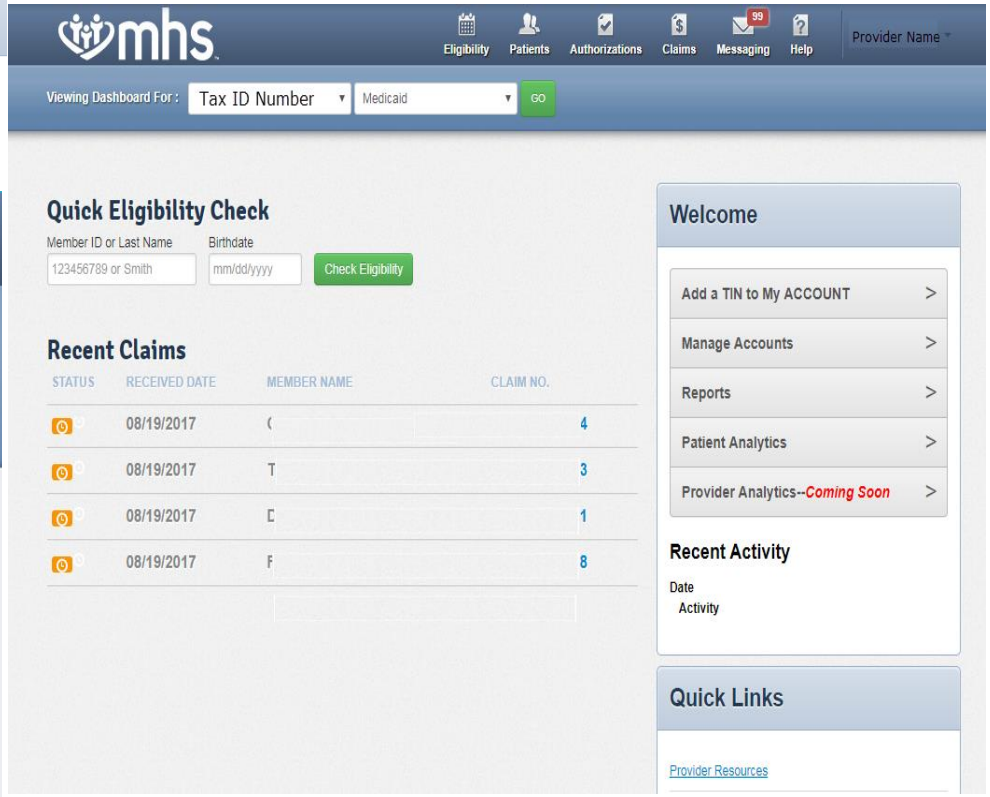
Provider Portal

Secure Portal Registration or Login



Registration



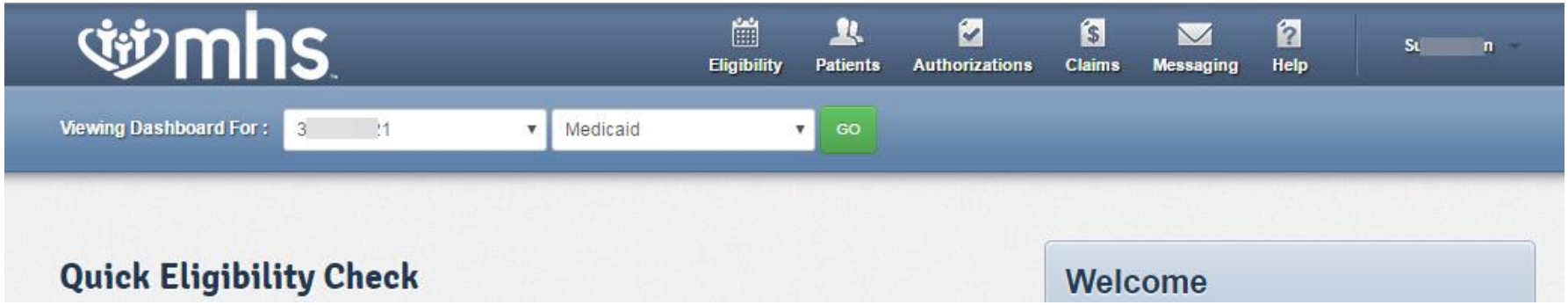


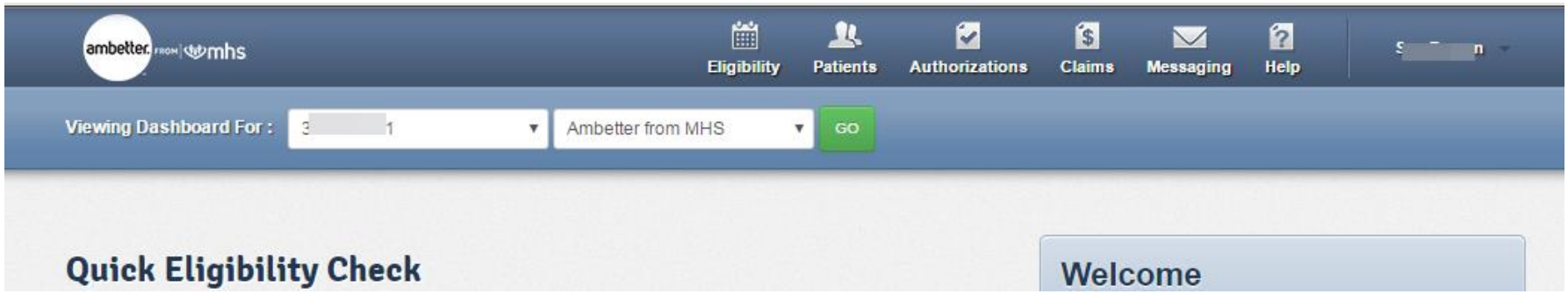
The Registration is complete and the Secure Portal homepage will be visible!

Please allow 24-48 hours for your account to be verified. An email will be sent once access to the portal tools have been granted to the respective account.

Dashboard Change

- Provider has the ability to change between **Tax IDs** along with **Medicaid** and **Ambetter and Allwell** at anytime.





MHS Provider Relations Team

Candace Ervin	Envolve Dental Indiana Provider Relations	1-877-647-4848 ext. 20187	Candace.Ervin@envolvehealth.com
Chad Pratt	Provider Relations Specialist – Northeast Region	1-877-647-4848 ext. 20454	ripratt@mhsindiana.com
Tawanna Danzie	Provider Relations Specialist – Northwest Region	1-877-647-4848 ext. 20022	tdanzie@mhsindiana.com
Jennifer Garner	Provider Relations Specialist – Southeast Region	1-877-647-4848 ext. 20149	jgarner@mhsindiana.com
Taneya Wagaman	Provider Relations Specialist – Central Region	1-877-647-4848 ext. 20202	twagaman@mhsindiana.com
Katherine Gibson	Provider Relations Specialist – North Central Region	1-877-647-4848 ext. 20959	kagibson@mhsindiana.com
Esther Cervantes	Provider Relations Specialist – South West Region	1-877-647-4848 ext. 20947	Estherling.A.PimentelCervantes@mhsindiana.com
Mary Schermer	Behavioral Health Provider Relations Specialist - West Region	1-877-647-4848 ext. 20269	mary.schermer@mhsindiana.com
LaKisha Browder	Behavioral Health Provider Relations Specialist - East Region	1-877-647-4848 ext. 20224	lakisha.browder@mhsindiana.com

Provider Network Territories

Physical Health

PROVIDER NETWORK TERRITORIES

TAWANNA DANZIE
Provider Performance Associate
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com
Exception to map: Franciscan Alliance

CHAD PRATT
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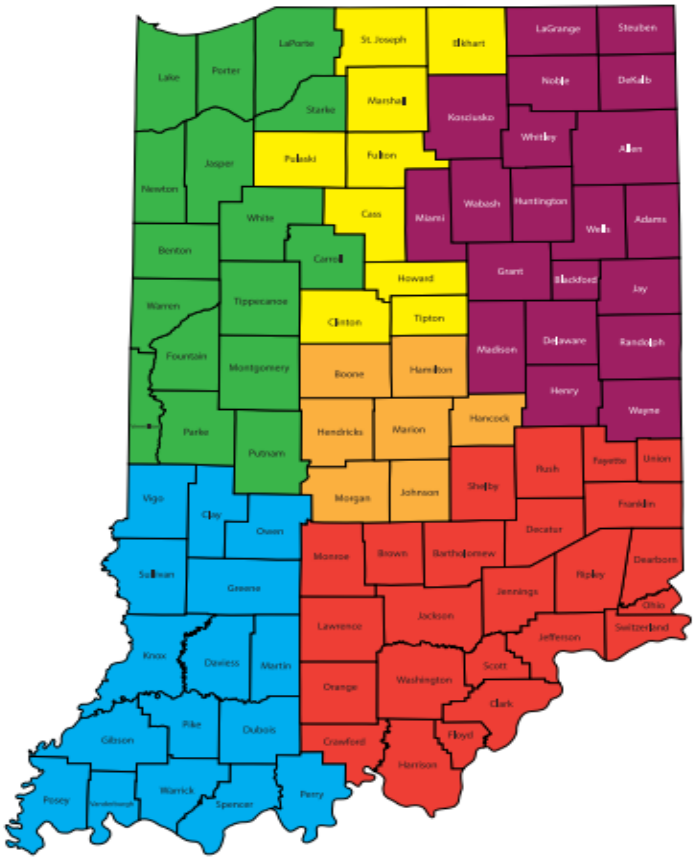
Exception to map: IU Health, Eskenazi Health



Behavioral Health Provider Network Territories

WEST TERRITORY

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EAST TERRITORY

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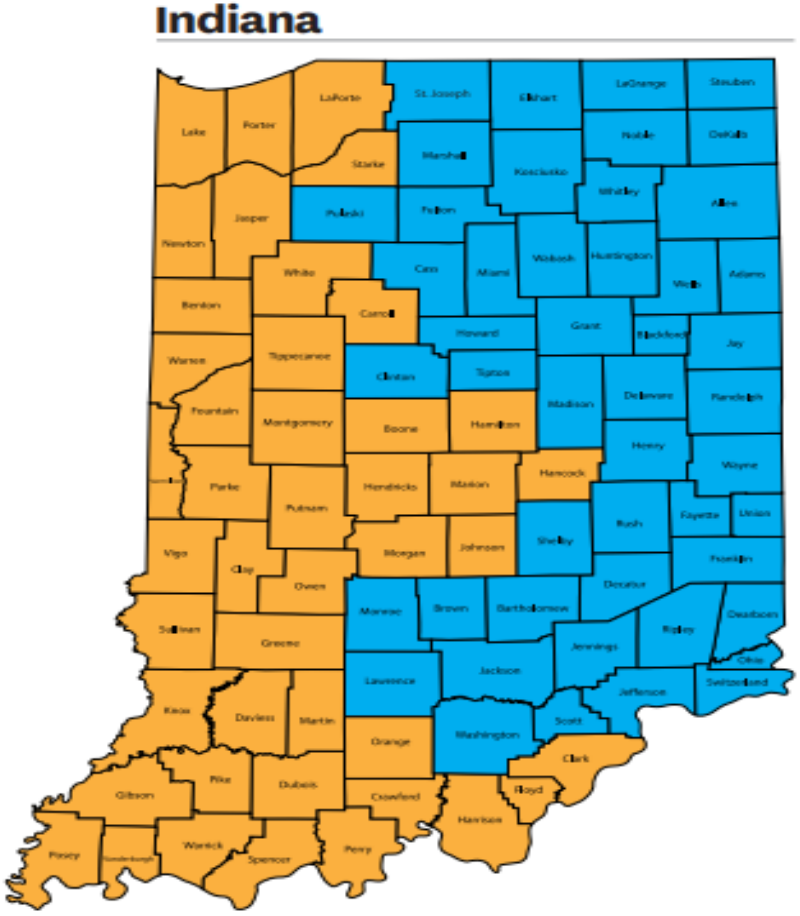

What You Learned Today

- The difference between a claim rejection and claim denials
- Common denials and resolution process
- How to submit and correct claims via the Web Portal
- How to contact your Provider Network representative
- Ambetter Claim Process
- How to bill claims for Allwell

Questions?