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Overview

The Claims department partners with the Provider Relations, Health Services and Customer Service departments to assist providers with any claims-related questions. The focus of the Claims department is to process claims timely, investigate the basis for any issues and correct their root causes.

Clean Claim

A claim that can be processed without obtaining additional information from the provider of the service or its designated representative. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Prompt Payment

The Plan shall ensure that clean claims are paid within 30 days of the date of receipt by the Plan. The Plan and the provider may, however, agree to an alternative payment schedule, provided the alternative payment schedule is reviewed and approved by the state of Hawai'i Department of Health Services (DHS). The Plan shall pay interest (according to the interest rate provided by the DHS) for all clean claims that are not paid within these required time frames.

Timely Claims Submission

Timely filing is 180 days from the date of service to the primary payers and 90 days to secondary payers other than claims for dual-eligible Medicaid/Medicare members. Claims for Medicaid recipients who also have Medicare coverage must be received within 180 days (six months). Refer to the Quick Reference Guide for the appropriate mailing address.

Claim Submission Format

Claims may be submitted to the Plan in one of the following formats:

- Electronic Claims Submission (EDI)
- CMS 1500 form
- UB-04 form

All providers are required to use the standard codes for ICD9, CPT and HCPCS, regardless of the type of



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submission.

The largest driver of payment turn-around time is the accuracy of the data on the claim, regardless of whether it is an electronic or paper claim submission. To assist providers in submitting the correct data in the correct fields on a claim, the Plan has prepared claim submission guidelines. These guidelines identify key fields the Plan requires to be filled for claims processing as well as the data source to complete the field.

Provider ID and NPI Requirements

The Plan requires the use of the National Provider Identifier (NPI) on all claim submissions except for providers exempt from NPI requirement, both electronic and paper.

- If submitting claims electronically, there is a required field in the file format for the referring, rendering or facility NPI numbers. Providers are encouraged to verify that their software management tool or clearinghouse is placing it in the correct field.
- Providers submitting paper claims should include their NPI on both CMS 1500 and UB-04 forms.

National Provider Identifiers Standard transactions such as claims submitted electronically to the Plan must include the referring, rendering or attending, billing and facility provider's NPI, per requirements put forth in HIPAA's NPI Final Rule Administrative Simplification.

The NPI and tax ID must be included with electronic and paper claim submissions for proper adjudication. More information about NPI is available on the CMS Web site <http://www.cms.gov/>.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires health care payers such as 'Ohana, as well as providers engaging in one or more of the identified transactions, to have the capability



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to send and receive all standard electronic transactions using the HIPAA designated content and format.

Specific 'Ohana requirements for claims and encounter transactions, code sets, and SNIP validation are described as follows. *To promote consistency and efficiency for all claims and encounter submissions to the Plan, it is 'Ohana's policy that these requirements also apply to all paper and direct data entry (DDE) transactions.*

Standard Guides

Available online or by calling Customer Service, providers may obtain the Plan's recommended transaction guidelines. These are:

- Electronic Data Interchange Transaction Set Implementation Guides
- Institutional Claims/Encounter Companion Guide
- Professional Claims/Encounter Companion Guide

Standard Transactions

Transactions, as defined by HIPAA, are activities involving the transfer of health care information for specific purposes, including claims and encounter information, payment and remittance advice, and claim status and inquiry. All providers who submit encounters and electronic claims to the Plan must do so in the formats established by HIPAA.

The following standard HIPAA electronic claim/encounter transactions must be submitted in the *ANSI ASC X12N format, version 4010A:

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response
- 276/277–Health Care Claim Status Request & Response



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- 278–Health Care Services Review – Request for Review and Response
- 835–Health Care Claim Payment/Advice
- 837–Health Care Claims

Standard Code Sets

Standard Code Sets as required by HIPAA are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. All providers are required to submit claims and encounters using current HIPAA compliant codes, which include the standard CMS codes for ICD9, CPT, HCPCS, NDC and CDT, as appropriate.

Strategic National Implementation Process (SNIP)

All claims and encounter transactions submitted via paper, direct data entry (DDE) or electronically will be validated for transaction integrity/syntax based on the Strategic National Implementation Process (SNIP) guidelines.

The SNIP validations used by the Plan to verify transaction integrity/syntax are available in the Forms section of this manual and on our Web site. The SNIP Validation Descriptions document may be a helpful resource to share with your billing agent or clearinghouse.

If your claim is rejected for lack of compliance to the Plan's claim and encounter submission requirements, please correct your claim and resubmit it to the Plan. For additional information, please contact your Provider Relations representative or the Customer Service department.

Electronic Claim Submissions

The Plan accepts electronic claim submissions through Electronic Data Interchange (EDI).

Advantages of EDI

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- Submitting claims electronically is less costly than billing with paper.
- In most instances, the Plan can process your electronic claim in half the time of a paper claim.
- Clearinghouses charge varying fees. The Plan has free options, including connectivity and software that are free. Contact the EDI department to see if you qualify for this service. You may also contact your clearinghouse or billing software vendor to see if they offer free options.

There are seven primary clearinghouses through which we receive EDI transactions. Those companies are:

- ACS EDI Gateway Inc.
- Availity
- Emdeon
- Legacy Consulting
- RelayHealth (McKesson)
- SSI Group Inc.
- ZirMed

Because most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, if different from those listed, to establish EDI with the Plan.

All files submitted to the Plan must be in the ANSI ASC X12N format, version 4010A. Implementation guides for HIPAA transaction sets are available at <http://www.wpc-edi.com>.

If you do not have a clearinghouse or have been unsuccessful in submitting claims through your clearinghouse, please contact our EDI team. The EDI team contact information can be found on the **Quick Reference Guide**.

Payer ID

There are unique Payer IDs that must be used to identify our Plan on electronic claim submissions. The



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appropriate Payer IDs for each of the seven clearinghouses through which 'Ohana claims may be submitted are listed as follow:

ACS* EDI Gateway

- 77004

Availity, Emdeon , Legacy Consulting, SSI, ZirMed and RelayHealth (McKesson)

- 14163

Paper Claim Submission Guidelines

Paper claims must be completed in full and include:

- The Plan member's name and his or her relationship to the subscriber;
- The subscriber's name, address and Social Security number;
- The subscriber's employer group name and number (when applicable);
- Information on other insurance or coverage for the Plan member;
- The name, signature, place of service address, billing address and telephone number of the physician or provider performing the service;
- The tax ID number; and

Qualifiers

Each form of identification should be accompanied by a qualifier which will correctly allocate the information when transferred into our databases. Proper qualifiers for identification numbers submitted to the Plan are:

ID	Qualifier
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Tax ID	24
NPI	XX
Taxonomy	ZZ

Notice that some form fields will include a box to submit the identification number's qualifier. In others, however, the box will not be available and the qualifier should be included by preceding the identification number with a hyphen (Ex. XX-XXXXXXXXXX).

- Appropriate ICD-9 codes;
- Standard CMS procedure or service codes (e.g., CPT-4 procedure codes and HCPC-I,II codes with appropriate modifiers, revenue codes);
- Number of service units rendered;
- Billed charges;
- Referring physician's name and NPI number;
- Date(s) of service;
- Place(s) of service and facility NPI (where applicable);
- Authorization Number (if applicable);
- NDC for drug therapy (if applicable); and
- Job related, auto or other accident information.

CMS 1500 Paper Claim Submissions

The Plan accepts the revised CMS 1500 forms printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS 1500 form can be downloaded from the CMS Web site, copies of the form cannot be used for submission of claims and will be rejected because your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).



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This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. OCR technology allows the Plan to record and process paper claims faster.

There are key fields that will properly identify and adjudicate claims information on a paper CMS 1500 form when submitted to the Plan. Below are guidelines identifying those fields to ensure timely and accurate processing of your claim.

CMS 1500 Guidelines for Paper Claims

- Block 17b: The referring provider's NPI number. Please ensure the 10-digit NPI number is accurate.
- Block 24j (lines 1-6): The rendering provider's NPI.
- Block 25: The 9-digit federal tax ID number (TIN). The provider's tax ID must be included or the claim will be denied.
- Block 31 – Rendering Provider Name
- Block 32: Facility contact information (name, address and telephone number). Include when applicable.
- Block 32a: Facility's NPI number. Please ensure the 10-digit NPI number is accurate.
- Block 33: Billing provider's (or billing vendor's) contact information.
- Block 33a: Billing provider's NPI number. Please ensure the 10-digit NPI number is accurate.

UB-04 Paper Claim

The Plan accepts UB-04 forms printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the form can be downloaded from the CMS website, copies

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of the form cannot be used for submission of claims and will be rejected since your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).

This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. Photocopies cannot be scanned and therefore are not accepted.

There are key fields to properly identify and adjudicate claim information on a paper UB-04 form when submitted to our Plan. Below are guidelines identifying these fields to ensure timely and accurate processing of your claim submission.

UB-04 Guidelines for Paper Claims

- Block 56: Billing provider's NPI number is entered here.
- Block 71 PPS Code: Enter DRG code, if applicable.
- Blocks 76-79 NPI: Include the attending, operating or other physician's NPI number.
- Block 81CC: Enter the taxonomy codes corresponding to providers listed in fields 76-79.

Other Claims Submissions

Providers who render non-traditional home and community based services (HCBS) or related services, (i.e. chore services or home modification) to our members may submit their claims to the Plan by invoice. Invoices must be mailed, faxed, or emailed to Plan Provider Relations Department. For more information on submitting claims via methods other than electronic or CMS1500 or UB-04 forms, contact your local Provider Relations Representative or call the Provider Hotline. Please refer to the Quick Reference Guide for contact information.



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Encounter Data Submissions

If a provider's payment method is on a capitation basis, claims still must be submitted to the Plan. This requirement is mandated to meet the reporting requirements of the Plan as well as those established by regulatory agencies and the Balanced Budget Act. Claims submitted under a capitation contract are usually referred to as encounter data. Encounter data can be submitted on CMS 1500 or UB-04 forms or through EDI following the same rules as standard claim submissions.

The Plan currently utilizes the seven clearinghouses listed below to process the 837 Health Care Claims transactions. The encounter payer ID for all clearinghouses is **59354**.

- ACS EDI Gateway Inc.
- Availity
- Emdeon
- Legacy Consulting
- RelayHealth (McKesson)
- SSI Group Inc.
- ZirMed

The Plan will record all encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

Encounter Data reporting requirements are defined within the provider agreement. Any capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Services

We have partnered with Payformance Corporation to offer you free Electronic Funds Transfer (EFT) and online Electronic Remittance Advice (ERA, also known as electronic payment voucher or 835) services, by registering with PaySpan Health®.

The benefits of enrolling for EFT/ERA through PaySpan

Health[®] include:

- A secure, self-service Web site;
- Absolutely no cost for participating;
- Improved cash flow through automated deposits;
- You determine who has access to payment information;
- Convenient access to print or view remittance records online at any time;
- Reporting mechanisms to access adjudicated claims information; and
- Ability to import payment data directly into your Practice Management or Patient Account System.

Online registration is simple and fast. PaySpan Health[®] will mail a registration letter to network providers containing a unique registration code and PIN number. Using the information contained in the registration letter, providers will proceed through an easy registration process that includes these steps:

- Log on to PaySpan Health[®] using the registration and pin number provided in the letter;
- Enter Tax ID number (for security purposes);
- Enter banking information and set up account administrators and users;
- Select payment and remittance advice preferences; and
- Confirm receipt of fund transfer into provider bank account.

Once the fund transfer is confirmed, all payments will be sent via EFT. Should a provider elect not to receive



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payments or vouchers electronically, they will continue to receive paper checks generated at the Payformance payment processing center. For questions related to this service, please visit the PaySpan Health® Web site at <http://www.payspanhealth.com> or call the Plan's Provider Hotline (refer to the Quick Reference Guide for contact information).

The remittance advice, related to the Plan's payments to providers will contain, at minimum:

- An adequate description of all denials and adjustments;
- The reasons for such denials and adjustments;
- The amount billed;
- The amount paid;
- Application of coordination of benefits (COB) and subrogation of claims (SOC); and
- Provider rights and claim disputes.

Coordination of Benefits

Coordination of Benefits (COB) is the procedure used to process health care payments when a person is covered by one or more insurers including members eligible for both Medicare and Medicaid (dual eligible). Prior to submitting a claim to the Plan, providers must identify if any other payer has primary responsibility for payment of a claim.

If determination is made that another payer is primary:

- The primary payer should be billed prior to billing the Plan;
- Any balance due after receipt of payment from the primary payer should be submitted to the Plan for consideration; and
- The claim must include information verifying the payment amount received from the primary plan as well as a copy of their Explanation of Payment (EOP) statement with the name of the primary payer and the member's primary subscribed ID

number.

Upon receipt of the claim, the Plan will review the claim using the COB processing guidelines as established below.

Provider Cost Sharing Responsibilities

Some providers have an agreement with the Plan that requires them to collect member cost share amounts. An example is when a member is a resident in a long-term-care facility and the State has determined that the member must share in the cost of their health insurance premium.

The collection of the cost sharing amount will be delegated to the provider. Member's cost share is available on the DHS eligibility site or by contacting Plan's customer service department. The provider will immediately collect the amount from the member and remit the full amount due to 'Ohana Health Plan. The remittance is due to 'Ohana by the end of the statement month.

Prohibition on Billing Plan Members

Your agreement with the Plan requires providers to accept payment directly from the Plan. Payment from the Plan constitutes payment in full, with the exception of applicable deductibles, co-insurance and any other amounts listed as member responsibility on the Explanation of Payment/Provider Remittance Advice.

Providers may not bill Plan members for:

- The difference between actual charges and the contracted reimbursement amount;
- Services denied because of timely filing requirements;
- Services denied due to failure to follow Plan procedures;
- Covered services for which a claim has been returned and denied for lack of information;

- Remaining or denied charges for those services where a contracted provider fails to notify the plan of a service that required prior authorization; payment for that service will be denied; and
- Covered services that were not medically necessary, in the judgment of the Plan, unless prior to rendering the service, the provider obtains the member's informed written consent and the member receives information that they would be financially responsible for the specific services.
- Sales tax or GET on services rendered

Non-Covered Services

Plan members may be billed for non-covered services like cosmetic procedures and items of convenience (i.e., televisions), services received from unauthorized non-plan providers, in addition to instances when a member self-refers to a specialist or other provider within the network without following Plan procedures (e.g. without obtaining prior authorization) and the Plans denies payment to the provider.

If a provider bills a member for non-covered services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service.

Professional and Technical Component Payment

The Plan covers the professional and technical components of global CPT procedures. Therefore, the appropriate professional component modifiers and technical component modifiers should be used on the claim form.

Explanation of Payment

The Explanation of Payment (EOP) is a document used to communicate to the provider of a claim determination. The determination may indicate a payment, denial or a request for additional information. An EOP may be accompanied by a check.



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Delegated Entities

All participating providers or entities delegated for claims processing are to use the same standards as defined in this section. Formal audits are conducted annually. Refer to the Quick Reference Guide for a listing of delegated entities.