Overview

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

The Plan has established toll-free telephone numbers for providers to access a representative in our Customer Service department. Please refer to the state-specific **Quick Reference Guide** for contact information.

Timely Claims Submission

Timely filing is six months from the date of service to the primary payers and 90 days to the secondary payers.

Refer to the state-specific **Quick Reference Guide** for the appropriate mailing address.

Clean Claim

Providers are required to submit clean claims. A clean claim is one that can be processed without obtaining additional information from the provider who provided the service or from a third party.

Prompt Payment

Clean claims must be paid within the number of days specified in the contractual payment agreement between the provider and health carrier. Interest is to be paid to the provider based on the number of days that have elapsed between the date payments are due based on the contractual payment arrangement entered into and the date payment is made.

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

Claims should be submitted to the Plan according to the following standards. Failure to comply with these

standards may result in delay of payment or the rejection (returned to provider as unprocessed) of the claim.

- Claims must contain the National Provider Identifier (NPI) for all primary and secondary provider fields on all electronic and paper claims (UB-04 and CMS-1500) submissions.
    - The NPI is a unique identification number for all health care providers mandated by the Health Insurance Portability and Accountability Act (HIPAA). This number is a 10-position, intelligence-free numeric identifier (10-digit number).
    - Information for obtaining a NPI is available by:
        - Telephone: (800) 465-3203
or TTY: (800) 692-2326
        - E-Mail:
customerservice@npienumerator.com
        - Mail: NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

      Answers to frequently asked questions regarding NPI are available on www.cms.gov.
- Claims must contain the Federal Tax ID (Employer Identification Number or Social Security number) for the provider of service or supplier.
- All data fields are to be completed.
- Claims should not be handwritten or altered.
- Only current standard procedural terminology is acceptable for reimbursement per the following coding manuals:

- Current Procedural Terminology (CPT) for physician procedural terminology.
- International Classification of Diseases (ICD9-CM) for diagnostic coding.
- Health Care Procedure Coding System (HCPC).

- CMS-1500 paper claim submissions must be submitted on form OMB-0938-0999(08-05) as noted on the document's footer.

- The Plan accepts the revised CMS-1500 and UB-04 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 as the 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. OCR technology allows the Plan to record and process paper claims faster.

- For EDI submissions, providers should follow the HIPAA transaction and code set requirements as found in the National Electronic Data Interchange Transaction Set Implementation Guides and the Companion Guide when provided by the Plan. HIPAA requires compliance with the Electronic Data Interchange (EDI) standards.
  - The National Electronic Data Interchange Transaction Set Implementation Guides for HIPAA transaction sets are available at www.wpc-edi.com.

- All files submitted to the Plan must be in the ANSI ASC X12N format, version 4010A.

- For further instructions for both paper and EDI claim submission including access to Plan EDI Companion Guides, visit www.ohanahealthplan.com.

- Refer to the state-specific **Quick Reference Guide** for claim mailing addresses.

The largest driver of payment turnaround 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. These guidelines can be found on the Plan's Web site at www.ohanahealthplan.com.

Tax ID and NPI Requirements

The Plan requires the use of the payer-issued tax ID and NPI on all claim submissions, both electronic and paper.

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 National Provider Identifier (NPI), per requirements put forth in HIPAA's NPI Final Rule Administrative Simplification.

The NPI and tax ID must be included with electronic claim submissions for proper adjudication. More information about NPI is available on the CMS Web site.

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 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 4010A1:

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response

- 276/277–Health Care Claim Status Request & Response
- 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

- 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 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 other than 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 state-specific **Quick Reference Guide**.

Payer ID

There are unique Payer IDs that must be used to identify our Plan on electronic claim submissions. The appropriate Payer IDs for each of the seven clearinghouses through which claims may be submitted are listed as follow:

ACS* EDI Gateway

- 77004

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

- 14163

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 services (ERA, also known as electronic payment voucher) 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;
- Convenient access to view remittance records online, at any time;
- Reporting mechanisms to access adjudicated claims information; and
- Ability to import payment data directly into your

[*] *Subject to change*

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 Personal Identification Number (PIN). Using the information contained in the registration letter, providers will proceed through an easy registration process that includes the following steps:

- Log on to PaySpan Health® using the registration and PIN number provided in the letter;
- Enter banking information and set up account administrators;
- Select payment and remittance advice preferences; and
- Confirm receipt of fund transfer into provider bank account.

Should a provider elect not to receive 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 www.payspanhealth.com or call the Plan's Provider Hotline. Refer to the state-specific **Quick Reference Guide** for contact information.

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
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-XXXXXXXXX).

- 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.

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.

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.

Coordination of Benefits

Coordination of Benefits (COB) is the procedure used to process health care payments when a member has coverage with more than one insurer.

Prior to submitting a claim to the Plan, providers must identify if another 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.

Upon receipt of the claim, the Plan will review using the COB rule or other, as applicable.

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 co-payments, deductibles, co-insurance and any other amounts listed as member responsibility on the Explanation of Payment/Provider Remittance Advice.

Providers <u>may not bill Plan members for</u>:

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

  Remaining or denied charges for those services

where the 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.

Non-Covered Services

Plan members may be billed for non-covered services like cosmetic procedures and items of convenience (i.e., televisions).

'Ohana Health Plan
A plan offered by WellCare Health Insurance of Arizona, Inc.