EmblemHealth

Provider Manual

Chapter 30: Claims

We partner with different organizations in managing our members' care. In order for our provider partners to be paid correctly and quickly, this chapter provides guidance on best practices for claims submissions, payments, and finding information on claims submitted to EmblemHealth for processing.

EmblemHealth partners with ECHO Health, Inc. for all claims payment. Providers will continue to have access to their accounts to access their Explanations of Payment (EOPs) and their 835 transactions through our former partner, PNC Bank, which ran our Remittance Advantage EFT/ERA Program. This change will have no impact on claims submission protocol.

Claims Corner is an online claims information resource and an extension of the EmblemHealth Provider Manual. This is where notifications of claims policy changes are posted. It provides useful information on claims coding and benefit changes that impact billable services. There are also tips to aid in submitting clean claims for speedy processing. .

Please see the following page for our Claim Submission for Unlisted Procedure or Service Code Special Report form .

We encourage our providers to eliminate paper claims and to submit electronic claims to EmblemHealth in HIPAA-compliant professional provider (837P), institutional provider (837I), and dental provider (837D) EDI (electronic data interchange) claims transaction formats. See EmblemHealth's Guide for Electronic Claims Submission .

UB04 and CMS-1500 Forms

To obtain UB04 and CMS-1500 forms, sign in to Health Forms and Systems, Inc. or the Centers for Medicare & Medicaid Services. UB04 and CMS-1500 forms are also available in Claims Corner.

Hard-copy forms can be requested by calling the U.S. Government Publishing Office at **800-869-6590** or **202-512-1800**. If a claim must be submitted on paper, please see Claim Tips for Paper Submissions.

See our **NPI & Taxonomy Code Guide**.

Participating Providers:

- Claims must be received **within 120 days post-date-of-service** unless otherwise specified by the applicable participation agreement.
- Claims where EmblemHealth is the secondary payer must be received **within 120 days from the primary carrier's EOB voucher date** unless otherwise specified by the applicable participation agreement.
- **Corrected claims must also be submitted within 120 days post-date-of-service unless otherwise specified by the applicable participation agreement.**

Non-Participating Providers:

- Commercial products: claims must be received within 18 months, post-date-of-service.
- Medicaid, and Child Health Plus (CHPlus): claims must be received within 15 months, post-date-of-service.
- Medicare: claims must be received within 365 days, post-date-of-service.

Providers who wish to appeal a claim denied for late submission should follow the provider grievance process in the Dispute Resolution chapters for the line of business:

- Commercial/CHPlus
- Medicaid
- Medicare

Reimbursement may be reduced by up to 25% for timely filing claims denials that are overturned upon successful appeal. Participating practitioners may not bill the patient for services that EmblemHealth has denied because of late submission.

Clean non-Medicare claims submitted electronically are processed within 30 days; paper or facsimile clean non-Medicare claims are processed within 45 days in accordance with the New York State law for prompt payment of claims. All claim submissions must include the tax identification number (TIN), NPI, and applicable taxomomy of the rendering and billing provider(s).

For all Medicare claims, EmblemHealth adheres to the Centers for Medicare & Medicaid Services (CMS) rules and regulations for prompt claims payment: 95% of clean claims are processed within 30 days, and all other claims are processed within 60 days. For clean claims not processed within 30 days, interest is paid at the prevailing rate under Medicare regulations.

Do not submit duplicate claims. Duplicate claims delay claims processing and create confusion for the member. Providers may check the status of a prior claim submission by signing in to **emblemhealth.com/providers** and using the Claim Search drop-down under the Claims tab, or calling a **Provider Customer Service representative**. You may read more about how to avoid duplicate claims submissions at Claims Corner on emblemhealth.com.

All providers who are part of an EmblemHealth-contracted medical group – and individually credentialed providers who have a non-contracted provider as part of their group and share a TIN, NPI, or specialty/taxonomy code – are considered contracted providers for the purposes of claim payments and are considered “Substitute Practitioners.” Claims for Substitute Practitioner services should be billed by the medical group or by the regular participating practitioner and are reimbursed at the regular participating practitioner’s contracted fee schedule.

Substitute Practitioners are not required to enroll with the health plan and should not bill the health plan directly. Note the following to ensure your claims for the Substitute Practitioner’s services are documented correctly:

- Claims for services provided by a Substitute Practitioner must include the credentialed provider’s billing name, address, and NPI in Block 33 of the claim form.
- The name and mailing address of the Substitute Practitioner must be documented in Block 19, not Block 33.
- When billing for a service provided by a Substitute Practitioner physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the Substitute Practitioner.

EmblemHealth does not immediately process claims from a network hospital as out-of-network solely based on a health care provider who is not participating with EmblemHealth.

EmblemHealth does not process claims from network health care providers as out-of-network solely because the hospital is not participating with EmblemHealth.

EmblemHealth does not deny a claim, in whole or in part, based on coordinating benefits unless we have a reasonable basis to believe the member has other health insurance coverage that is primary for the claimed benefit. If EmblemHealth requests and does not receive information regarding other coverage from the member within 45 days, we adjudicate the claim. See claim submission guides – Electronic and Paper Claims – for COB billing instructions.

Network providers are required to accept EmblemHealth's reimbursement schedule for services rendered. Network providers must not bill or seek payment from the member for any additional expenses (except for applicable copayments, coinsurance, or permitted deductibles) including, but not limited to:

- The difference between the charge amount and the EmblemHealth fee schedule, or the difference between the member's copay amount and fee schedule if the copay amount is greater than the fee schedule.
- Reimbursement for any claim denied for late submission, inaccurate coding or unauthorized service, or deemed not medically necessary.
- Reimbursement for any claim pending review.

Any provider attempting to collect such payment from the member has breached their obligations under their contract with EmblemHealth.

The provider is responsible for collecting members' copayments at the time of service (not to exceed the fee schedule amount). Copayments may not be charged for preventive care services as indicated in the Member Policies and Rights chapter.

A member's out-of-pocket payment responsibility is shown on the Explanation of Benefits (EOB) sent to the member and the Explanation of Payment (EOP) or 835 transaction for an electronic remittance advice (remit) sent to the provider. (See How do I receive payment, sign up for EFT/ERA and find my EOPs/Remits and 835/ERAs? for instructions for finding EOPs and 835/Remits online.) If any coinsurance or deductible remains, you can then bill your patient directly for the balance.

EmblemHealth is not responsible for payment of noncovered services. Before delivering a noncovered service, the network provider must notify the member in writing that the service is not covered by our plan, notify the member of the cost of the service, and receive the member's written consent to receive the service. Only then may the provider

collect payment for the noncovered service(s) directly from the member.

The member may sign an agreement with a provider in which the member accepts responsibility for payment for noncovered services only.

To determine Medicare member liability for services typically not covered, but could be covered under specific conditions, the member, or the provider acting on behalf of the member, must request a preauthorization organization determination. If EmblemHealth denies the service, we will issue a standardized denial notice with appeal rights. Only then may the provider collect payment for the noncovered service(s) directly from the Medicare member. An organization determination is not required to collect payment from a member where the Evidence of Coverage (EOC) or other related material is clear that a service or item is not covered.

Medicare Dual Eligible Members

Individuals with both Medicare and Medicaid coverage are called “dual-eligibles.” Depending on their category of Medicaid coverage, a dual eligible may receive Medicaid plan assistance to cover their Medicare Part B premium, Medicare Parts A and B cost-share, and certain benefits not covered by Medicare.

Centers for Medicare & Medicaid Services (CMS) guidelines stipulate dual-eligibles who qualify to have their Medicare Parts A and B cost-share covered by their state Medicaid plan are not responsible for paying their Medicare Advantage plan cost-shares for covered services. Providers may not balance bill for these amounts.

To comply with this CMS requirement, providers treating dual-eligibles enrolled in an EmblemHealth Medicare Advantage plan must do the following for these members:

- Bill the Managing Entity as the primary payor, and the state Medicaid plan as the secondary payor.
- Accept the Medicaid payment as payment in full and not collect any cost-share from the member if the provider participates with their state Medicaid program.
- Prior to providing services, notify the member if they do not accept the state Medicaid payment in full.

For more information, visit the CMS website.

New York State (NYS) Medicaid does not reimburse partial Medicare Part B coinsurance amounts when the Medicare payment exceeds the Medicaid fee or rate for a service. If the Medicare payment is greater than the Medicaid fee, no additional Medicaid payment is made.

NYS Medicaid does not pay the full copayment or coinsurance amounts for Medicare Part C claims. Medicaid reimburses at the rate of 85% of the Medicare Part C copayment or coinsurance amount.

This also applies to pharmacy claims for medications and supplies but does not apply to Medicare Part B coinsurance or Part C copayment/coinsurance for ambulance providers, psychologists, or Federally Qualified Health Centers (FQHCs). These providers are paid the full Medicare Part B coinsurance and Part C copayment/coinsurance amounts.

As of Jan. 1, 2020, EmblemHealth no longer pays the full cost of Part B drugs. Please bill New York State Medicaid for our dual eligible members’ cost-share.

Claims Payment

Once we adjudicate a claim, we notify our banking partner, ECHO Health, Inc. (ECHO), and they process payments on our behalf. EmblemHealth pays its providers electronically by electronic funds transfer (EFT) or by vCard.

- Registration is required for EFT.
- If no EFT registration is on file, payments will default to a Virtual Card (vCard). vCard is a virtual Visa debit transaction.
- Please contact ECHO Provider Support at **888-492-0032** if your practice cannot process EFT or vCard payments so an accommodation may be made.

Explanations of Payment (EOPs) & Remittances

Explanations of payment (EOPs), also known as remittances (remits), for all payments are posted on EmblemHealth's secure provider portal under the Claims tab in the Search EOP drop-down.

An electronic remittance advice (ERA) will be sent to those receiving payments by EFT as an 835 transaction. 835 ERAs will be housed on 835/ERAs that are available through providerpayments.com.

Remits for vCards payments will be faxed along with the vCard.

835/ERAs and EOPs for claims processed before Aug. 19, 2020 for EmblemHealth Plan, Inc. (formerly Group Health Incorporated (GHI)), and before Sept. 2, 2020 for Health Insurance Plan of Greater New York (HIP) and EmblemHealth Insurance Company (formerly HIP Insurance Company of New York (HIPIC)), may still be found on PNC.com.

vCards

A vCard is a debit/credit card-like payment sent to providers via fax. You must have a credit card terminal in your office to use this payment method. The QuicRemit payment statement includes all of the information needed to key-in to the credit card machine to receive funds. The process used is the same as any other credit card payment processed without the use of a physical credit card.

For more details, see How do I receive payment, sign up for EFT/ERA and find my EOPs/Remits and 835/ERAs?.

Applies to all plans.

To ensure fair and accurate claims payment, EmblemHealth conducts audits of previously processed claims. The period for these audits is referred to as the “look-back period.” Claims may be audited based on the settlement or paid/check date, not the date(s) of service. The date range for each audit is primarily determined by regulatory requirements and varies with the member’s plan type. The look-back periods and plan requirements are summarized in Claims Corner.

EmblemHealth denies or adjusts Medicare and Medicaid claims submitted for never events: surgical or other invasive procedures performed in error by a practitioner or group of practitioners.

Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are cut into, or an instrument is introduced through a natural body orifice. Procedures range from minimally invasive to major surgeries. This applies to all procedures found in the surgery section of the Current Procedural Terminology (CPT®) coding standard. It does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

In general, never event errors are any procedure not consistent with the correctly documented informed consent for the patient. These include, but are not limited to:

- **Performing a different procedure than intended**
- **Performing the correct procedure on the wrong body part**

This includes surgery on the appropriate body part, but in the wrong place (for example, operating on the left arm versus the right or on the left kidney not the right, or at the wrong level (spine).

- **Performing the correct procedure on the wrong patient**

All related services provided during the same hospitalization in which the error occurred are not covered. Medicare also does not cover other services related to these noncovered procedures as defined in the Medicare Benefit Policy Manual (BPM):

- All services provided in the operating room when such an error occurs
- Services rendered by all practitioners in the operating room when the error takes place who could normally bill individually for their services

Performance of the correct procedure after the never event has occurred is not considered a related service.

Note: Emergent situations that change the plan during surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under the CMS ruling. This also includes the discovery of new pathologies near the surgery site, if the risk of a second surgery outweighs the benefit of patient consultation, or the discovery of an unusual physical configuration (e.g., adhesions, extra vertebrae, etc.).

More information regarding Medicare never events and the latest rulings may be found on the CMS website.

Medicaid Never Events

The 13 avoidable hospital conditions the New York State Department of Health has identified as non-reimbursable are:

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure performed on a patient
4. Patient disability associated with a medication error
5. Patient disability associated with use of contaminated drugs, devices, or biologics provided by a health care facility
6. Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
7. Patient disability associated with an electric shock while being cared for in a health care facility
8. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance
9. Patient disability associated with a burn incurred from any source while being cared for in a health care facility
10. Patient disability associated with the use of restraints or bedrails while being cared for in a health care facility
11. Retention of a foreign object in a patient after surgery or other procedure
12. Patient disability associated with a reaction to administration of ABO-incompatible blood or blood products
13. Patient disability associated with intravascular air embolism that occurs while being cared for in a health care facility

The Department of Health continually reviews this list, which is modified and expanded over time.

For those Medicaid cases where a serious adverse event occurs, and the hospital anticipates at least partial payment for the admission, the hospital follows a two-step process for billing the admission:

1. The hospital **first** submits their claim for the entire stay in the usual manner, using the appropriate rate code (i.e., rate code 2946 for DRG claims or the appropriate exempt unit per diem rate code such as 2852 for psychiatric care, etc.). The claim is processed in the normal manner and the provider receives full payment for the case.
2. Once remittance for the initial claim is received, it is necessary for the hospital to then submit an adjustment transaction to the original paid claim using one of the following two new rate codes associated with identification of claims with serious adverse events:
    1. 2591 (DRG with serious adverse events), or
    2. 2592 (Per Diem with serious adverse events)

All claims identified as never events are reviewed on a case-by-case basis.

Ambulatory Patient Group (APG) Rate Codes

EmblemHealth pays claims billed with ambulatory patient group (APG) rate codes (and their corresponding CPT codes)

for services covered by APG reimbursement. The APG system is theNew York State-mandated payment methodology for most Medicaid outpatient services. APGs are paid for outpatient clinic, ambulatory surgery, and emergency department services when the service is reimbursed at the Medicaid rate. APGs are not used for services carved out of Medicaid managed care.

To facilitate APG claims processing:

- Submit APG and non-APG services on separate claims.
- Report a value code of 24 and an appropriate rate code.
- Report CPT codes for all revenue lines.

Claims without proper coding are returned to the provider for correction prior to adjudication.

More information on APGs can be found at the New York State Department of Health (DOH) website as well as the DOH's Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual. For documentation on HIPAA APG requirements, go to the eMedNY website.

Present on Admission Indicator for Hospitals

The Deficit Reduction Act of 2005 requires hospitals to report the secondary diagnoses (if present) for Medicare and Medicaid patients. To comply with this government program, EmblemHealth requires a "present on admission" (POA) indicator for the following claims:

- Acute care hospital admissions for Medicare members
- All medical inpatient services
- Substance abuse treatment
- Mental health admissions

Note: Patients considered exempt by Medicare must also have POA indicators noted. If the diagnosis is exempt, enter a value of "1."

Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the practitioner. More information about exempt hospitals, reporting requirements, and coding instructions can be found on the CMS website.

Health Home claims should be submitted using electronic formats. For more information, see the Guide to Billing Health Home Claims.

29-I Health Facilities will submit claims to EmblemHealth for services provided to Medicaid members according to the 29-I Billing Guidance. The 29-I Health Facility Billing tool is an interactive UB-04 form that walks through the components required to submit a clean claim for Core Limited Health Related Services and Other Limited Health Related Services.

EmblemHealth uses multiple, commercially available claims review software to support the correct coding of claims that results in fair, widely recognized, and transparent payment policies.

To avoid any payment adjustments, we recommend you carefully document each service provided, according to CMS guidelines: Documentation Guidelines for Evaluation and Management (PDF download). Complete medical record documentation is the foundation of every patient's health record and can significantly affect claims coding and adjudication. Accurate coding translates clinical documentation into uniform diagnostic and procedural data sets and provides the evidence that the services billed are rendered to the patient.