

CLAIMS

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In this chapter you will find EmblemHealth's policies and procedures for submitting your claims. Information includes recent managed care laws, electronic claims submission and where to file claims or documentation for plan members.

CLAIMS SUBMISSION

Electronic claims should be submitted to us by using the Payor IDs indicated in the **Claims Contacts** chart in the **Directory** chapter. Paper claims (CMS 1500 forms) may be sent to the addresses indicated, unless otherwise noted on the member's ID card.

ELECTRONIC CLAIMS SUBMISSION

Today, thousands of health care practitioners have eliminated paper claims and are submitting electronic claims to EmblemHealth in HIPAA-compliant professional provider (837P), institutional provider (837I) and dental provider (837D) EDI claims transaction formats.

Helpful Tips For Proper Setup of Electronic Billing Systems

- When billing electronically, please allow a reasonable amount of time to complete your account receivable reconciliation process. Ensure that your billing system is not set up to automatically re-bill every 30 days.
- Many times the payment for the original claim was applied to the copay or the service was denied for medical necessity, eligibility or another reason. Please make sure that your automated billing system accurately posts patient responsibility data and claims settlement messages.
- Ensure that your billing system does not automatically generate a paper claim. This duplicate billing practice is costly and delays processing.

Some Advantages of Electronic Claim Submission

- Quicker claims submission, which means faster reimbursement to you
- No paper claims to stock and complete
- Simplified record keeping by eliminating lost claims paperwork
- Reduced clerical time and the costs to process and mail paper claims

Pathways For Electronic Claim Submission To EmblemHealth

Providers, both institutional and professional, may use practice management system vendors, billing services or clearinghouses to submit claims and other EDI transactions to EmblemHealth.

Note: Practice management system vendors and billing services offer a variety of EDI solutions to the health care community and charge fees and/or transaction costs for their services. EmblemHealth does not specifically recommend or endorse any vendor or billing service.

Clean non-Medicare claims submitted electronically will be processed within 30 days; paper or facsimile clean non-Medicare claims will be processed within 45 days in accordance with the New York State law for prompt payment of claims. All claims submissions must include the TIN

and NPI of the rendering and billing provider(s).

IMPORTANT REQUIREMENT FOR ELECTRONIC CLAIMS SUBMISSION

National Provider Identifier

Please contact your practice management system vendor to ensure your software is capturing and correctly populating your National Provider Identifier (NPI) in your electronic claims or your claims will be rejected by EmblemHealth. Please note the following NPI requirements for electronic health care claim submissions:

Professional Provider Claim (837P) NPI Requirements

- **Billing Provider 2010AA:** An NPI is required for health care providers in the United States or its territories.
- **Pay-To Address 2010AB:** There is no NPI in the Pay-To Address loop. The purpose of Loop ID-2010AB has changed from previous versions. Loop ID-2010AB only contains address information when different from the Billing Provider Address.
- **Rendering Provider 2310B:** Only required when the Rendering Provider information is different from the information carried in Billing Provider Loop 2010AA. If this loop is sent, an NPI is required.
- **Rendering Provider 2420A:** Only required when the Rendering Provider information is different from the information carried in the 2310B or 2010AA loops. If this loop is sent, an NPI is required.

Institutional Claim (837I) NPI Requirements

- **Billing Provider 2010AA:** An NPI is required for health care providers in the United States or its territories.
- **Pay-To Address 2010AB:** There is no NPI in the Pay-To Address loop. The purpose of Loop ID-2010AB has changed from previous versions. Loop ID-2010AB only contains address information when different from the Billing Provider Address.

Dental Provider Claim (837D) NPI Requirements

- **Billing Provider 2010AA:** An NPI is required for health care providers in the United States or its territories.
- **Pay-To Address 2010AB:** There is no NPI in the Pay-To Address loop. The purpose of Loop ID-2010AB has changed from previous versions. Loop ID-2010AB only contains address information when different from the Billing Provider Address.
- **Rendering Provider 2310B:** Only required when the Rendering Provider information is different from the information carried in Billing Provider Loop 2010AA. If this loop is sent,

an NPI is required.

Payor ID Numbers

Plan	Payer ID
GHI HMO	25531
GHI PPO	13551
HIP	55247
Vytra	22264
CCI VIP Medicare Advantage	78375

Avoiding Duplicate Claims Submissions

When duplicate claims are submitted, you potentially delay claims processing and create confusion for the member. You may read more about how to avoid **duplicate claims submissions** at **Claims Corner** on www.emblemhealth.com.

Electronic Claim Attachments

Attachments cannot be submitted electronically at this time. However, most claims should be submitted electronically. If supporting documentation is required for the settlement of your claim, we will request it. One common request is for the **Unlisted Procedure or Service Code Form**.

Note: We will be enhancing our technology to support an electronic attachment capability for professional practitioners. We will notify you when we are ready to accept attachments electronically.

Claims Submission for Unlisted Procedure or Service Codes

In accordance with American Medical Association Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) reporting guidelines, please use the Unlisted Procedure or Service Code Form available at www.emblemhealth.com to submit claims for unpublished procedure or service codes. This information will be used to determine appropriate payment and claim adjudication in conjunction with the member's benefit plan.

Electronic Coordination of Benefits Claims

At this time, commercial electronic coordination of benefits claims are not accepted electronically. We are currently enhancing our technology to support this functionality. We anticipate that commercial COB claim acceptance/processing will be available late fourth quarter 2014. We will notify you when it's available.

EmblemHealth PPO and HMO participate in the National Coordination of Benefits Agreement (COBA) program for the receipt and processing of Medicare Part A and Part B supplemental crossover claims.

Electronic Funds Transfer and Electronic Remittance Advice for EmblemHealth Claims

EmblemHealth offers **PNC Remittance Advantage**, a no-cost online payment solution that helps your office reduce payment processing expenses and improve cash flow.

With PNC Remittance Advantage, you can receive direct deposits to your bank accounts (electronic funds transfer) and view or download your remittances online (electronic remittance advice). Electronic transactions are fast, convenient and reduce the risk of lost or stolen payments. Electronic funds transfer and electronic remittance advice are the standards for receiving EmblemHealth payments and remittance advice.

The registration process is simple and secure and takes just moments to complete:

- **Step 1:** Have available a recent EmblemHealth Explanation of Benefits (EOB) and either a voided check or a letter from your bank listing the account name, account number, account type and bank routing number for each of your practice's bank accounts used to receive electronic payments.
- **Step 2:** Go to PNC Remittance Advantage at <https://rad.pnc.com>.
- **Step 3:** Select the "Register for Portal and Online Payment Services" link on the upper left side of your screen.
- **Step 4:** Register for the website with your email address, your practice's tax identification number and your Provider ID, found on your EmblemHealth EOB.
- **Step 5:** For larger practices, add all of your practice's payees and organize them according to bank account, location, personnel or whatever is appropriate for your practice.
- **Step 6:** Enter your bank account information and upload a scanned image of your voided check or bank letter.
- **Step 7:** Associate each payee group with a bank account, and then submit your enrollment form online.
- **Step 8:** Allow two weeks to validate the bank account information before receiving electronic payments and remittance advices.

If you need help with the registration process, please call the PNC Remittance Advantage Help Line at **1-877-597-5489**, option 1, Monday through Friday, from 8:30 am to 8:30 pm (ET).

Real Time Eligibility Benefit Inquiry and Response (270-271)

The ASCX12N 270/271 health care eligibility benefit inquiry and response transaction function is available for use. This functionality is designed as a secure electronic tool to verify member health coverage, benefits and member responsibilities such as deductibles, coinsurance and copays. Transactions work for both single members and for batches of members.

Enrolling to use the 270/271 eligibility benefit inquiry and response transaction is easy. Simply contact your billing vendor or clearinghouse. Inform them you would like to use the CAQH HIPAA-compliant 270/271 eligibility benefit inquiry and response transaction.

Health Care Claim Status Request and Response (276-277)

You may use the ASC X12N 276/277 (005010X212E2) health care claim status request and response transaction function. This functionality is designed as a secure electronic tool to look up the claim status for a single member or for batches of members.

Enrolling to use the EDI HIPAA/CAQH 276/277 health care claim status request and response is easy. Simply contact your vendor or clearinghouse. Inform them you would like to begin receiving the CAQH HIPAA-compliant 276/277 health care claim status request and response transaction.

EDI-Related Help Desk Support

Please call **1-212-615-4362**, Monday through Friday, from 9 am to 5 pm for EDI-related Help Desk Support or questions about HIPAA EDI transactions.

CMS 1500 And UB04 Forms

To obtain UB04 and CMS 1500 forms, sign in to Health Forms and Systems, Inc. at www.healthforms.com or the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/CMSForms/CMSForms/list.asp. UB04 and CMS 1500 forms are also available in **Claims Corner** on www.emblemhealth.com.

Hard copy forms can be requested by calling the U.S. Government Printing Office at **1-800-869-6590** or **1-202-512-1800**.

TIMELY SUBMISSION

Appropriate Timely Submissions When GHI Is Primary Carrier:

- In-network claims: 365 days from date of service
- Out-of-network claims: 18 months from date of service

Appropriate Timely Submissions When GHI Is Secondary Carrier:

- 365 days from the primary carrier's EOB voucher date

Appropriate Timely Submissions When HIP Is Primary Carrier:

- In-network claims: 365 days from date of service
- Out-of-network claims: 365 days from date of service

Appropriate Timely Submissions When HIP Is Secondary Carrier:

- 365 days from the primary carrier's EOB voucher date
- **Note:** For Medicare Supplemental line of business, claims are exempt from the time limitation because of the length of time required for responses from primary payers.

CLAIMS PROCESSING AND PAYMENT

Clean non-Medicare claims submitted electronically will be processed within 30 days; paper or facsimile clean non-Medicare claims will be processed within 45 days in accordance with the New York State law for prompt payment of claims. All claims submissions must include the TIN and NPI 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. That is, 95 percent of clean claims will be processed within 30 days, and all other claims will be processed within 60 days. For clean claims that are not processed within 30 days, interest will be paid at the prevailing rate under Medicare regulations.

EmblemHealth will not reimburse any claim submitted more than 365 days after the service date. Providers who wish to contest a claim that was denied for untimely filing should follow the provider grievance process set out in the applicable Dispute Resolution chapters for **Commercial, Medicaid or Medicare**. The reimbursement paid on late claims submissions may be reduced by an amount up to 25 percent. Participating practitioners may not bill the patient for services that EmblemHealth has denied because of late claims submission.

Duplicate claims should not be submitted. Providers may check the status of a prior claim submission by going to the EmblemHealth website, www.emblemhealth.com/providers, or calling a **Provider Customer Care Advocate**.

Claims that include a substitute physician should be submitted by the regular EmblemHealth-contracted practitioner, as substitute physicians are not required to enroll with the health plan and should not bill the health plan directly. See the **Submitting Claims for Non-Credentialed Practitioner in a Group Arrangement or for a Non-Par Substitute Practitioner** section later for more information on how to submit claims for substitute/non-contracted physicians at a contracted medical group service location.

SUBMITTING CLAIMS FOR NON-CREDENTIALLED PRACTITIONER IN A GROUP ARRANGEMENT OR FOR A NON-CREDENTIALLED SUBSTITUTE PRACTITIONER

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, 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 will be 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.

Please note the following to ensure your claims for the Substitute Practitioner’s services are documented correctly:

- Claims that include services provided by a Substitute Practitioner or must include the credentialed provider’s billing name, address and national provider identifier (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.

CLAIMS FROM A NETWORK HOSPITAL ASSOCIATED WITH A NON-NETWORK HEALTH CARE PROVIDER

EmblemHealth will not summarily process claims from a network hospital as out of network solely on the basis that a health care provider who is not participating with EmblemHealth treated the member.

CLAIMS FROM A NETWORK HEALTH CARE PROVIDER ASSOCIATED WITH A NON-NETWORK HOSPITAL

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

COORDINATION OF BENEFITS

EmblemHealth will not deny a claim, in whole or in part, on the basis that it is coordinating benefits and the member has other health insurance coverage, unless we have a reasonable basis to believe that 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, then we will adjudicate the claim.

BILLING THE MEMBER OR SECONDARY PAYOR

Network providers, in agreeing to accept EmblemHealth's reimbursement schedule for services rendered, shall not bill or seek payment from the member for any additional expenses (except for applicable copayments, co-insurance 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, unauthorized service or as deemed not medically necessary.
- Reimbursement for any claim pending review.

Any provider attempting to collect such payment from the member does so in breach of the contractual provisions between the provider and 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 charge for preventive care services as indicated in the **Your Plan Members** chapter.

Because member liability is determined *after* a claim is processed, the EOB will clearly state the member's payment responsibility. 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 rendering 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 such service. Only then may the provider collect payment for the noncovered service(s) directly from the members.

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

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 state 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 that 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 EmblemHealth as primary payor and the state Medicaid plan as secondary payor
- Accept the Medicaid payment as payment in full and not collect any cost-share from the member if they participate with their state Medicaid program
- Prior to providing services, notify the member if they do not accept the state Medicaid as payment in full

Effective January 1, 2016, Medicaid will no longer reimburse partial Medicare Part B coinsurance amounts when the Medicare payment exceeds the Medicaid fee or rate for that service. If the Medicare payment is greater than the Medicaid fee, no additional Medicaid payment will be made.

Effective July 1, 2016, Medicaid will no longer pay the full copayment or coinsurance amounts for Medicare Part C claims. Medicaid will reimburse at the rate of 85 percent of the Medicare Part C copayment or coinsurance amount.

These changes also apply to pharmacy claims for medications and supplies. There is no change to the current reimbursement methodology of Medicare Part B coinsurance or Part C copayment/coinsurance for ambulance providers, psychologists, or Federally Qualified Health Centers (FQHCs). These providers will continue to be paid the full Medicare Part B coinsurance and Part C copayment/coinsurance amounts.

LOOK BACK PERIODS TO RECONCILE OVERPAYMENTS

Applies to all plans

To ensure fair and accurate claims payment, EmblemHealth conducts audits of previously adjudicated claims. The time 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 are summarized in the table below (and may be modified as needed to reflect statutory, regulatory changes and exceptions).

Plans	Look Back Period
Commercial Plans	2 years
FEHB Plans and Medicaid Reclamation Claims	3 years
Medicare Advantage Plans	<p>Pre-American Taxpayer Relief Act of 2012 Within one year for any reason and 3 years after the year in which payment was made for good cause (new and material evidence has come to light)</p> <p>Post-American Taxpayer Relief Act of 2012 Within one year for any reason and 5 years after the year in which payment was made for good cause (new and material evidence has come to light)</p>
Medicaid, Child Health Plus and Veterans Administration (VA) Facilities Claims*	6 years

*No unilateral offset permitted. If an overpayment is identified, notices and requests for repayment will be sent to the provider. The notices will provide a detailed explanation of the erroneous payment, as well as instructions for repayment options and how to dispute the repayment request. The provider may challenge an overpayment recovery by following the Provider Grievance process set out in the applicable Dispute Resolution chapter of the Provider Manual: **Commercial/CHP, Medicaid or Medicare**. If the overpayment is not returned within the requested time frame or the dispute of overpayment is not submitted in a timely manner, EmblemHealth will withhold funds from future payment(s) to the provider up to the amount of the identified overpayment.

Note: These time frame limitations do not apply to:

- Claims that fall under the False Claims Act
- Duplicate claims
- Fraudulent or abusive billing claims
- Claims of self-funded members
- Claims of members enrolled in coverage provided by the state or a municipality to its employees
- Claims subject to specifically negotiated contract terms between an EmblemHealth company and a provider (contractual time frames will apply)

Also important to note:

Commercial Plans

- Section 3224-b of the Insurance Law limits recovery of overpayments to 24 months.
- Notice must be sent to provider specifying the patient name, service date, payment amount, proposed adjustment and a reasonably specific explanation of the proposed adjustment.
- The 24-month limitation does not apply to: (i) claims that are fraudulent or abusive billing; (ii) claims of self-funded plan members; (iii) claims of members enrolled in a state or federal government program; or (iv) claims of members enrolled in coverage provided by the state or a municipality to its employees.

FEHB Plans

- 30/60/90-day interval notices must be sent to provider; offset may occur if debt remains unpaid and undisputed for 120 days after first provider notice.
- The 3-year look back limitation does not apply to False Claims Act claims.
- Provider Notice must provide: (a) an explanation of when and how the erroneous payment occurred; (b) the appropriate contractual benefit provision (if applicable); (c) the exact identifying information (i.e., dollar amount paid erroneously, date paid, check number, etc.); (d) a request for payment of the debt in full; (e) an explanation of what may occur should the debt not be paid, including possible offset to future benefits; (f) offer installment options; and (g) provide the provider with an opportunity to dispute the existence and amount of the debt.

Medicaid Reclamation Claims

- NYS has the right to recoup payments from EmblemHealth that Medicaid fee-for-service paid on behalf of a patient who has commercial insurance.

Medicaid and Child Health Plus

- Required by Model Contract with SDOH.

CLAIMS CORNER

EmblemHealth has developed **Claims Corner**, an online claims information resource, in order to provide useful information to aid in submitting clean claims for speedy processing. More information can be found in the Provider section of our Web site.

ADOLESCENT MENTAL HEALTH CHECKUP REIMBURSEMENT

Providers will be reimbursed for administering a mental health checkup during a well-child exam or a routine office visit by using the codes noted in the chart below. The codes must indicate that a separately identifiable evaluation and management service was performed.

REIMBURSEMENT CODES* FOR ALL EMBLEMHEALTH NETWORKS AND PLANS
Well-Child Visit Reimbursement Codes for Mental Health Screening

CPT Codes for Well-Child Visit		CPT Codes (E/M Codes Based on Time)		Modifier	Developmental Screening Code	ICD Codes
99393	5-11 est. patient	99211	5 minutes, est. patient	25 Note - Modifier 25 should append the E/M codes and not the developmental screening code.	96110	V20.2 - well-child/preventive health visits V79.8 - special screening exam for mental disorders and developmental handicaps (negative screening) V40.0 - mental and behavioral health problems (positive screening)
99394	12-17 est. patient	99212	10 minutes, est. patient			
99395	18 + est. patient	99213	15 minutes, est. patient			
99383	5-11 new patient	99214	25 minutes, est. patient			
99384	12-17 new patient	99215	40 minutes, est. patient			
99385	18 + new patient	99201	10 minutes, new patient			
These well-child codes may be used in conjunction with mental health screenings.		99202	20 minutes, new patient			
		99203	30 minutes, new patient			
		99204	45 minutes, new patient			
		99205	60 minutes, new patient			

*Providers must refer to their provider contract for office visit reimbursement rates.

COVERAGE DENIED FOR NEVER EVENTS

Beginning January 1, 2010, EmblemHealth will deny or adjust Medicare and Medicaid claims submitted for never events (defined as 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 the minimally invasive to major surgeries. This applies to all procedures found in the surgery section of the Current Procedural Terminology (CPT) coding. 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 include, but are not limited to:

- **Performing a different procedure altogether**

Any procedure that is not consistent with the correctly documented informed consent for the patient.

- **Performing the correct procedure on the wrong body part**

Any procedure that is not consistent with the correctly documented informed consent for the patient. 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**

Any procedure that is not consistent with the correctly documented informed consent for that patient.

All related services provided during the same hospitalization in which the error occurred are not covered. Medicare will also 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 any and all practitioners in the operating room when the error takes place who could 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 in the course of 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 at www.cms.gov.

Medicaid Never Events

The 13 avoidable hospital conditions that 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, 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 will continually review this list, which will be 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 will follow a two-step process for billing the admission:

1. The hospital will *first* submit 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.). That claim will be processed in the normal manner and the provider will receive full payment for the case.
2. Once remittance for the initial claim is received, it will be 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:
 - 2591 (DRG with serious adverse events), or
 - 2592 (Per Diem with serious adverse events)

All claims identified as never events will be reviewed on a case by case basis.

FACILITY CLAIMS REQUIREMENTS

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 the New York State-mandated payment methodology for most Medicaid outpatient services. APGs will be paid for outpatient clinic, ambulatory surgery and emergency department services when the service is reimbursed at the Medicaid rate. APGs will not be used for services that are carved out of Medicaid managed care.

To facilitate APG claims processing, please:

- 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 will be returned to you for correction prior to adjudication.

More information on APGs can be found at the New York State Department of Health's website at www.health.state.ny.us/health_care/medicaid/rates/apg/, as well as the DOH's Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual at www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_provider_manual.

For documentation on known APG issues and HIPAA APG requirements, go to eMedNY's website at www.emedny.org/apg_known_issues.pdf and at www.emedny.org/HIPAA/index.html.

"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."

A POA indicator is not needed for Medicare member claims in the following hospitals:

- Critical access hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities
- Maryland waiver hospitals
- Long term care hospitals
- Cancer hospitals
- Children's hospitals
- Hospitals paid under any type of prospective payment system (PPS) other than the acute care hospital PPS

A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *ICD-9-CM Official Guidelines for Coding and Reporting*, by the Centers for Medicare & Medicaid Services [CMS] and the National Center for Health Statistics [DHHS]) and the external cause of injury. CMS does not require a POA indicator for the external cause of injury unless it is being reported as an "other" diagnosis.

If a condition would not be coded and reported based on *Uniform Hospital Discharge Data Set* definitions and current official coding guidelines, then the POA indicator would not be reported.

PRESENT ON ADMISSION (POA) INDICATOR LIST	
Code	Description

Y	Yes. The condition was present at the time of inpatient admission.
N	No. The condition was not present at the time of inpatient admission.
U	Unknown. The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
1	Unreported/not used, exempt from POA reporting. This code is the equivalent code of a blank on the UB-04. However, it was determined that blanks were undesirable when submitting this data via the 4010A.

Issues related to inconsistent, missing, conflicting or unclear documentation must be resolved by the practitioner.

More information and coding instructions, including the POA Fact Sheet, can be found on the CMS website at www.cms.gov/MLN MattersArticles/downloads/MM5499.pdf and at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/wPOAFactSheet.pdf.

CLAIMS REVIEW SOFTWARE

EmblemHealth uses multiple types of commercially available claims review software to support the correct coding of claims that result 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**. 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 were rendered to the patient.

In addition to the above, EmblemHealth utilizes the services of several organizations for claim editing services as indicated below:

EmblemHealth Claims Review



<p>IHEALTH TECHNOLOGIES, INC.</p>	
<p>The iHealth Technologies, Inc. Payment Policy Management software provides EmblemHealth with correct coding and payment policy for EmblemHealth to administer and pay claims in a manner consistent with relevant policy sources. Policy sources include, but are not limited to, the requirements of CMS, AMA and other specialty academies' policies and procedures. Examples of claims editing software rule recommendations include, but are not limited to: A) Implementation of industry standard and vendor recommended updates; B) Systematic revisions to ensure correct administration of EmblemHealth benefit plans; C) Correction of diagnoses and procedure inconsistencies, procedure and setting inconsistencies and incorrect/coding of multiple services.</p>	
<p>MCKESSON HEALTH SOLUTIONS CLAIMSXTEN</p>	
<p>ClaimsXten is an ICD-9- and ICD-10-compliant software solution that assesses claims information, including CPT/HCPCS procedure codes, to detect coding irregularities and conflicts or errors, and makes recommendations for correction for both professional and facility claims¹. ClaimsXten coding rules come preconfigured in Knowledge Packs and are based on a compilation of guidance from AMA and CPT publications, CMS, specialty societies, and McKesson's clinical physician teams. The auditing logic evaluates modifiers in a correct, hierarchical fashion when multiple modifiers are reported per claim line. All rules, codes, edits sources and edit clarification are updated quarterly. Preconfigured ClaimsXten clinical rules may be revised by Senior EmblemHealth Medical Directors to align with EmblemHealth clinical policies. Additional Knowledge Packs will be phased in after EmblemHealth review.</p>	

¹The Planned effective date for facility claim assessments is 4Q2015.

Montefiore CMO Claims Review Software

Montefiore CMO (the management services organization for Montefiore IPA) uses a series of claims rules that encompass CMS National Correct Coding Initiative edits, specialty edits, commercial edits and unique, code-specific edits. For Montefiore CMO claims inquiries, contact **1-877-447-6888**.

TRIZETTO® QNXT (VERSION 3.0.200.0)

QNXT is a comprehensive payer solution developed by Trizetto to administer all lines of medical business and efficiently manage all relationships between HIP, members and practitioners. QNXT manages complex reimbursement capabilities, flexible benefit plan design functions and complex contract modeling capabilities.

HealthCare Partners Claims Review Software

HCPIPA claims follow EmblemHealth, CPT, AMA and ASA claims processing guidelines and apply CMS coding initiative guidelines. For HCPIPA claims inquiries, contact **1-800-877-7587** or use the **EZ-Net system** on the HCPIPA website at **www.hcpipa.com**. A valid username and password are required.

VIRTUAL AUTH TECH (VERSION 3.11.2)

VAT allows EmblemHealth to review specific CPT codes and diagnoses prior to issuing approval. Claims auditors and processors use VAT during the adjudication process to apply Medicare Carrier Manual (MCM) rules, correct coding and AMA guidelines and to confirm pricing.

VIRTUAL EXAMINER (VERSION 3.8.14)

Virtual Examiner reviews claims to identify potential fraud and abuse, duplicate payments, bundled services or other problematic claims. The program applies correct coding, CPT and AMA guidelines and produces reports that help auditors identify and prevent payment errors.

EZCAP (VERSION 4.6)

EZCAP collects and stores provider profiles, health plan benefit and member eligibility data, specialist treatment authorizations, procedure and diagnosis codes, case management and customer service information. EZCAP also stores and processes professional and facility claims and calculates member months and capitation payments.

Palladian Muscular Skeletal Health Claims Review Software

Palladian's claim review utilizes the principles of correct coding as outlined in the CMS guidelines including benefits relative to physical therapy, occupational therapy and chiropractic care.

QICLINK SYSTEM (VERSION 3.30.60.00)

The QicLink System is a suite of applications providing claims payment, member eligibility and utilization management, provider credentialing, repricing and internal and external

reporting services. Claims and authorizations are subject to member eligibility and practitioner contractual agreements before being paid or authorized. This system also integrates with other software programs such as ProviderNet, PUMA and DataPiccion.

TAXONOMY CODES: DEFINITION AND CLAIMS USE

Taxonomy codes are administrative codes set for identifying the practitioner type and area of specialization for health care practitioners. Each taxonomy code is a unique ten character alphanumeric code that enables practitioners to identify their specialty at the claim level. Taxonomy codes are assigned at both the individual practitioner and organizational practitioner level.

Taxonomy codes have three distinct levels: Level I is the practitioner type, Level II is Classification, and Level III is the Area of Specialization. A complete list of taxonomy codes can be found within the Health Insurance Portability and Accountability Act (HIPAA).

Taxonomy codes are self-reported, both by registering with the **National Plan and Provider Enumeration System** (NPPES) and by electronic and paper claims submission.

Taxonomy Codes registered with NPPES at the time of NPI application are reflected on the confirmation notice document received from NPPES with the provider's assigned NPI number. Current taxonomy codes registered, including any subsequent changes, may be obtained on an inquiry basis by visiting the **NPI Registry website**.

A practitioner can have more than one taxonomy code, due to training, board certifications etc. It is critical to register all applicable taxonomy codes with NPPES and **to use the correct taxonomy code to represent the specific specialty when filing claims**. This will assist EmblemHealth in more accurate and timely processing of claims.

Please provide Taxonomy codes **on all EmblemHealth claims**, the absence of these codes may result in incorrect payment.

Taxonomy codes on electronic claim submissions with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level and segment PRV03 and loop 2420A for the rendering level. For paper CMS-1500 professional claims, the taxonomy code should be identified with the qualifier "ZZ" in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the "ZZ" qualifier for the billing level.

UNLISTED PROCEDURE OR SERVICE CODE FORM

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



CLAIM SUBMISSION FOR UNLISTED PROCEDURE OR SERVICE CODE SPECIAL REPORT

In accordance with American Medical Association Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) reporting guidelines, please complete the following form to support the use of an unlisted procedure or service code. This information will be used to determine appropriate payment and claim adjudication in conjunction with the member's benefit plan.

Member Name:	
Member ID #:	Member Date of Birth:
Member Address (Street, City, State, ZIP):	
Date of Service:	
Submitting Provider Name:	
License #:	Specialty Type:

Indicate the unlisted procedure or service code number: _____

Indicate the specific CPT/HCPCS code that is most closely related to this service: _____

Describe the unlisted service or procedure and explain why the service does not meet the definition of the standard defined CPT/HCPCS code listed above. Please be certain to include an adequate definition or description of the nature, extent and need for the unlisted procedure and the time, effort and equipment necessary to provide the service. Additional items, which may be included, are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic/therapeutic procedures, concurrent problems and follow-up care.

Description: _____

Please attach a copy of this form to the paper claim and indicate the name of the individual who may be contacted should there be questions regarding this form.

Name: _____ Telephone: _____

Mailing Instructions:

HIP Claims

HIP Health Plan of New York
 PO Box 2803
 New York, NY 10116-2803

GHI Claims

Prepayment Review Department
 PO Box 3235
 New York, NY 10116-3235

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

