Claims

A Quick Guide on the Importance and Process of Handling Claims and Encounter Submissions

AmeriHealth Caritas
VIP Care

Claims — Benefits of Using Electronic Claims and Payment Options

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- Electronic claim submission has been proven to significantly reduce costs. Claims are processed faster, so payments arrive faster.
- Electronic funds transfer (EFT) or Virtual Credit Card (VCC):

  - ✓ Cash flow advantages knowing payments will be made automatically on specific dates.
  - ✓ Eliminates lost, stolen, or delayed checks sent in the mail.
  - ✓ Decreases administrative costs and increases convenience with no trips to the bank to make deposits during office hours.
  - ✓ EFT allows you to keep your preferred banking partner.
  - ✓ Safe and secure.
  - ✓ Reduces paper.
  - ✓ It’s FREE.

Claims — How to Sign Up for Electronic Claim Processing

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AmeriHealth Caritas VIP Care partners with Optum/Change Healthcare and Availity to provide electronic claims submission.

- Claims can be submitted electronically through Optum/Change Healthcare, Availity, or another clearinghouse.
- Contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic claim submissions to AmeriHealth Caritas VIP Care.
- Providers are not required to enroll with Optum/Change Healthcare or Availity to submit electronic claims if they are already using another EDI vendor to submit claims electronically.
- AmeriHealth Caritas VIP Care payer ID is **90689**.
    - Optum/Change Healthcare's Provider Support Line, available via online chat or by calling 1-800-527-8133, option 2, Monday - Friday, 7am to 5:30pm CST.
    - Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday - Friday, 8am to 8pm EST.

Submission of Electronic Attachments to Claims (275 Transactions)

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The 275-transaction functionality expands the options for providers to include supplemental documents providing additional patient medical information that cannot be accommodated within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries, and operative reports to support health care claims adjudication.

The following 275 claims attachment report codes are available for use. When submitting an attachment, use the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04.

Attachment Type	Claim assignment attachment report code
Itemized Bill	03
Medical Records for Hospital Acquired Conditions (HAC) Review	M1
Single Case Agreement (SCA)/Letter of Agreement (LOA)	04
Advanced Beneficiary Notice (ABN)	05
Consent Form	CK
Manufacturer Suggested Retail Price/Invoice	06
EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter	EB
Ambulance Trip Notes/Run Sheet	AM

SNIP Level 4

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AmeriHealth Caritas VIP Care uses a SNIP Level 4 claims editing process to meet industry compliance standards. This will increase auto adjudication and reduce pending claims. **Claims filed with the Plan are subject to the following procedures:**

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification of electronic claims against 837 edits at Change Healthcare™.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- ***All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider Legacy, Commercial, State ID, UPIN and Location Numbers).***

Claims — Direct Entry Claims Submissions

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If you do not have another clearinghouse/vendor, you can submit your claims electronically directly through Optum/Change Healthcare's ConnectCenter or PCH Global.

ConnectCenter:

- Go to ConnectCenter. Sign Up to create your new account. Use vendor code: 214629.
- Electronic claims will need to be submitted to Optum/Change Healthcare using the plan's 4-digit ConnectCenter Payor Identifiers (CPIDs): Professional – 3701 or Institutional - 9023
- ConnectCenter will automatically edit and validate claims for HIPAA compliance and will forward them directly to the appropriate plan.
- For User guides and tutorials on how to navigate ConnectCenter, visit our plan's website.

PCH Global:

- Go to PCH Global at https://pchhealth.global/ and click the ***Sign-Up*** link in the upper right-hand corner.
- Complete the registration process and log into your account.
- For a detailed walk-through of the registration process, refer to the PCH Global Registration manual (PDF), found on the PCH Global website in the Resource Menu.
- When you are ready to submit claims, use our Payer ID 90689.

Common Errors on Claim Submissions

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For the most up to date information on common errors on claim submissions for both the CMS 1500 and the UB04, please reference the link below:

Common Errors on Claim Submissions

Electronic Payment Options

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Optum/Change Healthcare is partnering with ECHO Health Inc. (ECHO Health), a leading innovator in electronic payment solutions, to offer more electronic payment options to our health care providers. You can select the payment method that best suits your accounts receivable workflow:

- **Virtual Credit Card (VCC)** - ECHO Health offers virtual credit cards as an optional payment method. Virtual credit cards are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. VCC payments have a number of advantages for providers:
  - ✓ You do not have to enroll or fill out multiple forms in order to receive VCC.
  - ✓ We will never request personal information, such as practice bank account information.
  - ✓ You can access your payment the day you receive the VCC.
  - ✓ Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction, an instruction page for processing, and a detailed Explanation of Payment/Remittance Advice (EOP/RA).

Normal transaction fees apply based on your merchant acquirer relationship. If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health at 1-888-492-5579.

Electronic Payment Options - Continued

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- **Electronic funds transfers (EFT)** allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be available on the ECHO provider portal (http://www.providerpayments.com). If you are new to EFT, you will need to enroll with ECHO Health for EFT from AmeriHealth Caritas VIP Care.
  - ✓ To sign up to receive EFT from AmeriHealth Caritas VIP Care, visit: https://enrollments.ECHOhealthinc.com/efteradirect/enroll. **There is no fee for this service**.
  - ✓ To sign up to receive EFT from all of your payers that process payments on the Settlement Advocate platform, visit https://enrollments.ECHOhealthinc.com. **A fee for this service may be required.**
  - ✓ Please note: Payment will appear on your bank statement from PNC Bank and ECHO as “PNC - ECHO.”

Claims — How to Submit Paper Claims

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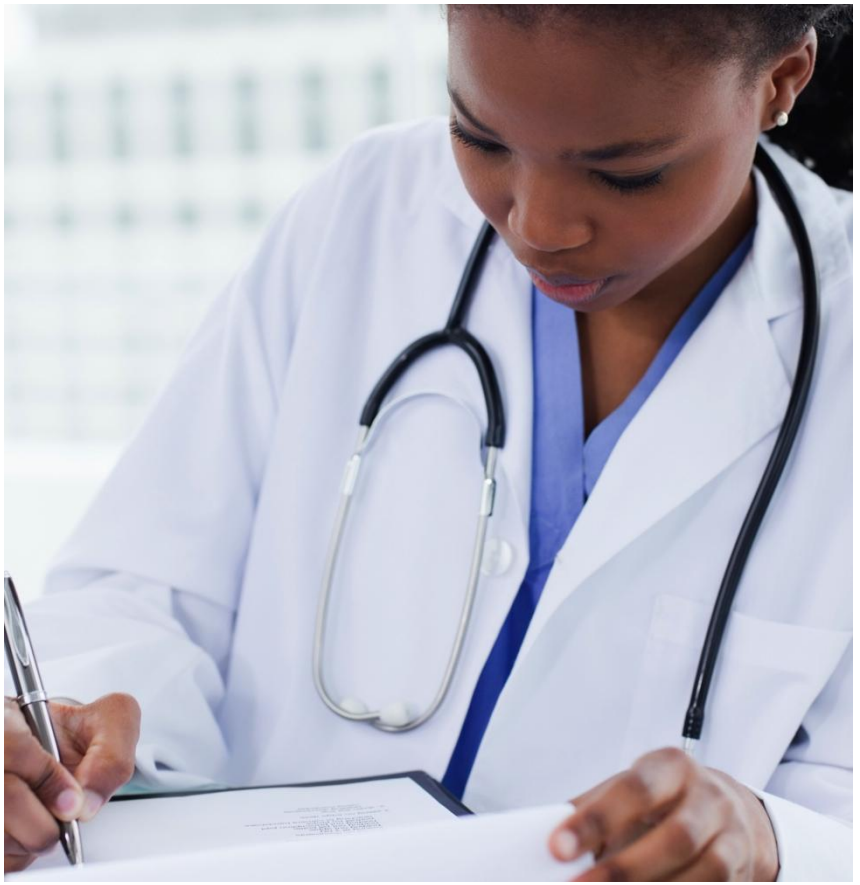
Provider may submit new and corrected paper claims to:

AmeriHealth Caritas VIP Care
Claims Processing Department
P.O. Box 7074
London, KY 40742-7074



How to File a Claim

- Please submit only one claim for both the Medicare and Medicaid covered services; file it as you would to Medicare, using Medicare billing guidelines.
- For Medicaid-only covered services, file the claim as you would file it to Medicaid, using MDHHS billing guidelines.
- We will process the Medicare benefit and automatically crossover the claim to process under the Medicaid benefit.
- You will have 365 days from the date of service to submit claims.
- Your office will receive one remittance advice and one payment for both benefits.

What Type of Claim is Resubmitted as a Corrected Claim?

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Rejected Claims - NO

- Those claims are returned to the provider without being processed or adjudicated due to a billing issue.
- It is as if the claim never existed and does not appear on any remittance advice, therefore rebilling of a previously rejected claim should be done as an ***original claim and not a corrected claim***.
- ***Note:*** Rejected claims are assigned a document control number (DCN); however, a DCN is not the same as an AmeriHealth Caritas VIP Care claim number.

Adjudicated Claims - YES

- Claims which were accepted, processed, and a remittances advice is received by the provider.
- Claim will have a claim number assigned to it.
- This is the type of claim that ***a corrected (replacement) claim can be submitted***.
- There are various reasons that a provider may submit a corrected claim, including but not limited to, the provider wants to update or correct submitted charges, procedural codes, number of units, etc.

How to Submit a Corrected Claim

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- Corrected/replacement and voided claims may be sent electronically or on paper ***after the original claim has finalized***.
  - If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '7' for the Replacement (correction) of a prior claim or '8' for the Void of a prior claim. The value '6' should no longer be used.
  - In addition, you must also provide the original claim number in Payer Claim Control Number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a unique requirement of the Plan but rather a requirement of the mandated HIPAA Version 5010 Implementation Guide.
  - If the corrected claim is submitted on paper, the claim must have the following in order to be processed:
    - ✓ On a Professional CMS 1500 Claim, the resubmission code of "7" or "8" and the Plan's original claim number must be in Field 22.
    - ✓ On an Institutional UB04 Claim, bill type should end in "7" or "8" in Form Locator 4 and the Plan's original claim number must be in Form Locator 64A Document Control Number.

Claims — Claims Processing Time Frames

- AmeriHealth Caritas VIP Care processes both electronic claims and paper claims in thirty (30) calendar days.
- Providers have 365 days from the date of service to submit claims.
- Real-time claim status is available via NaviNet or by calling Provider Services at 1-844-964-4767.

Claim Inquiries

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If an AmeriHealth Caritas VIP Care provider has an inquiry, such as claim status, or a dispute regarding the way a claim was processed or adjudicated, the provider should do one of the following:

- Call Provider Services to make a verbal inquiry and/or dispute.
- Utilize NaviNet to make an inquiry or submit a claim investigation.
- Complete the Claim Dispute form located on the AmeriHealth Caritas VIP Care Plan website under Provider > Resources > Claims and Billing.
- Send a written request instead of the Claim Dispute form and include the following:

  - ✓ Submitter contact information (name, phone number)
  - ✓ Provider information (name, phone number, NPI number, Tax ID number)
  - ✓ Member information (name, DOB, member ID number)
  - ✓ Claim information (claim number, DOS, total billed amount)
  - ✓ Reason for dispute
  - ✓ Any documentation which supports your position that the plan's reimbursement is not correct.

- Mailed disputes must be postmarked within **180 calendar days** of the initial remittance advice to:

  AmeriHealth Caritas VIP Care
  Claims Processing Department
  P.O. Box 7074
  London, KY 40742-7074

Claim Disputes

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A claim dispute is a request from a provider for AmeriHealth Caritas VIP Care to review and reconsider a payment amount made by AmeriHealth Caritas VIP Care. Providers may dispute full or partial payments made by AmeriHealth Caritas VIP Care if the provider disagrees with AmeriHealth Caritas VIP Care's payment amount. Examples of circumstances that may give rise to a provider dispute are:

- Where the amount allowed for a Medicare-covered service is less than the amount that would have been paid under Original Medicare.
- Where AmeriHealth Caritas VIP Care paid for a different service or more appropriate code than what was billed.

If you believe the payment amount you received for treating our member is less than the expected payment, you have the right to dispute that payment. Requests for a claims dispute must be submitted ***within one hundred eighty (180) calendar days of the date of the initial remittance advice*** by calling Provider Services at 1-844-964-4767, or in writing to the claim's P.O. Box using the Provider Claims Dispute form which is available on our website. Mailed disputes must be postmarked ***within one hundred eight (180) calendar days of the date of the initial remittance advice*.**

Please note, contracted providers do not have rights to appeal payment of denied claims. Denied claims for any reason, including lack of authorization, may only be reviewed through the claim's ***dispute*** process.

Claim Dispute Form

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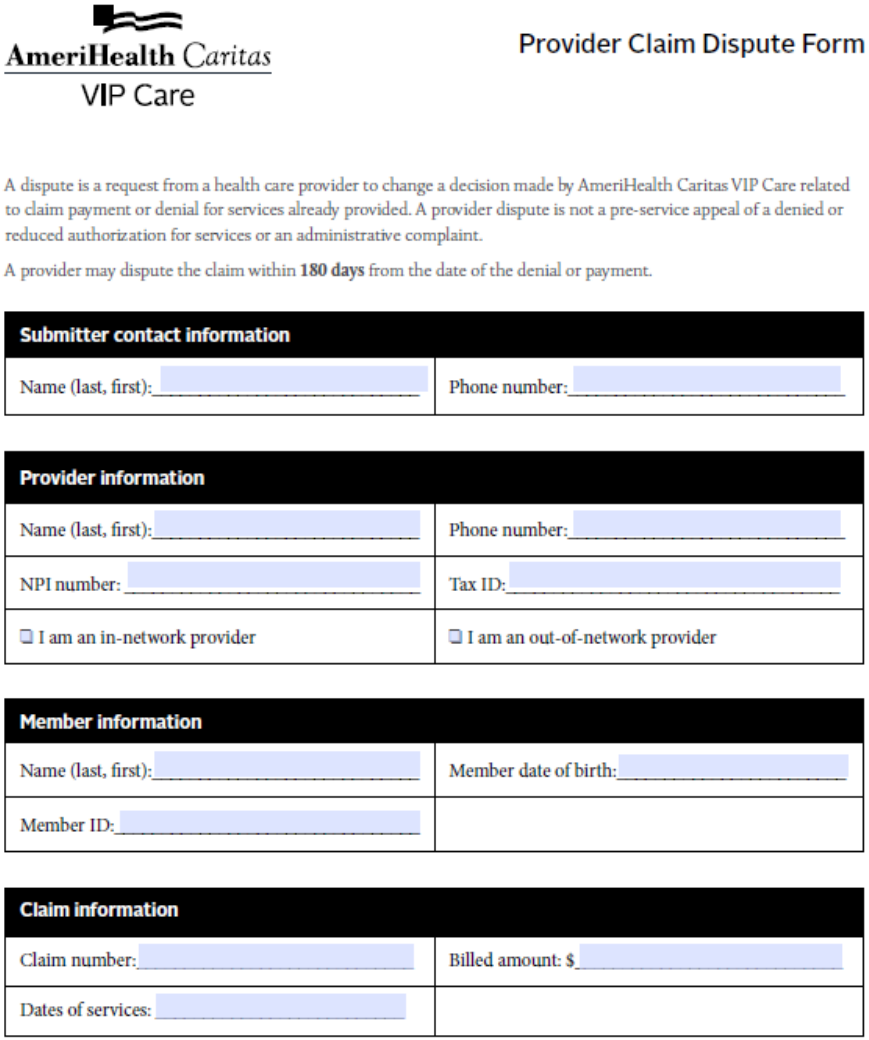

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Provider Claim Dispute Form

A dispute is a request from a health care provider to change a decision made by AmeriHealth Caritas VIP Care related to claim payment or denial for services already provided. A provider dispute is not a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

A provider may dispute the claim within **180 days** from the date of the denial or payment.

Submitter contact information	
Name (last, first):	Phone number:

Provider information	
Name (last, first):	Phone number:
NPI number:	Tax ID:
☐ I am an in-network provider	☐ I am an out-of-network provider

Member information	
Name (last, first):	Member date of birth:
Member ID:	

Claim information	
Claim number:	Billed amount: $
Dates of services:	

If the form is not used, you must include the following:

1. Submitter contact information (name, phone number)
2. Provider information (name, phone number, NPI number, Tax ID number)
3. Member information (name, DOB, member ID number)
4. Claim information (claim number, DOS, total billed amount)
5. Reason for dispute
6. Any documentation which supports your position that the plan's reimbursement is not correct

Claim Payment Example

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Scenario # 1:

Provider Charges $150.00

Medicare Allowable $100.00

Medicare Payable Amount: $80.00 (80%)

Medicaid Allowable $75.00

Medicaid Payable Amount: $0.00 (Medicare paid more than Medicaid allowed so no additional payment)

Insurance Payable Amount: $80.00

Provider Write Off Amount: $70.00

Member Liability: $0.00

Scenario # 2:

Provider Charges $150.00

Medicare Allowable $100.00

Medicare Payable Amount: $80.00 (80%)

Medicaid Allowable $95.00

Medicaid Payable Amount: $15.00 (Medicaid allowed more than Medicare)

Insurance Payable Amount: $95.00

Provider Write Off Amount: $55.00

Member Liability: $0.00

*Example only

NO BALANCE BILLING IN EITHER SCENARIO!

Payment — Balance Billing Requirements

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- Per Section 1902(n)(3)(B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997, Medicare providers cannot collect Medicare Parts A and B deductibles, coinsurance, or copays from members enrolled as a Qualified Medicare Beneficiary (QMB).
- AmeriHealth Caritas VIP Care **members** will have no out-of-pocket responsibility for all Medicare services. Some traditional Medicaid services may require copayments, as determined by the state. Providers must accept payment for these services as payment in full and ***may not balance-bill*** the AmeriHealth Caritas VIP Care member.
- AmeriHealth Caritas VIP Care **providers** will have deductibles and coinsurance applied to payments.
- Providers may also not bill for contractual disallowances and non-covered services (unless a prior written agreement was signed by the member and provider).
- All providers are encouraged to use the claims inquiry/disputes process to resolve any outstanding claims payment issues.
- For concerns regarding dispute resolution, providers should contact their Account Executive.

Balance Billing FAQs

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What is Balance Billing? For members of a Medicare Advantage Dual Eligible Special Needs Plan, balance billing is billing the patient for any balances left after what Medicare and Medicaid pays for your services, such as remaining cost share balances or contractual disallowances. **Providers must accept payments from Medicare and Medicaid as payment in full.**

Why can't providers bill members of this Plan? Federal law bars Medicare providers from balance billing a Qualified Medicare Beneficiary (QMB) under any circumstances. QMB is a Medicaid program for Medicare beneficiaries that exempt them from paying any Medicare Part A or Part B cost-sharing for deductibles, coinsurance, and co-payments related to Medicare-covered services and prescription drugs. Most members enrolled in our plan are considered QMBs. Please note, providers who inappropriately balance bill are subject to sanctions.

Why are you providing this information? Despite Federal law, providers and suppliers continue to improperly bill individuals enrolled in our plan. Many members are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies or fear providers may deny services for non-payment.

Balance Billing FAQs Continued

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What can providers do to prevent balance billing? Learn which Medicare Advantage plans are considered DSNPs or what patients have both Medicare and Medicaid and if possible, suppress patient billing in your accounts receivable system for any patients with this type of plan. Remember to always bill the Medicaid payer for any balances after the Medicare payment.

What can be billed to members? Non-covered items and services, however, providers must give members advanced notice that such items or services will be non-covered and have a written agreement with the member for these non-covered items or services. If such notice is not given and the agreement is not in place, providers may not bill members for such items or services.

What if I have questions regarding balance billing or payment of a claim? Please contact your Account Executive or Provider Services. You may also use the claims inquiry/disputes process to resolve any outstanding claims payment issues. Additionally, for more information from the Centers for Medicare & Medicaid Services see the MLN Fact Sheet, “Prohibition on Billing Qualified Medicare Beneficiaries”.

Defining Fraud, Waste, and Abuse (FWA)

AmeriHealth Caritas VIP Care receives state and federal funding for payment of services provided to our members. In accepting claim payment from the plan, health care providers are receiving state and federal program funds and are, therefore, subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered fraud or abuse against the Medicare program. Providers are responsible for knowing and abiding by all applicable state and federal laws and regulations.

Fraud

Fraud is any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. Providers should be aware of applicable federal and state laws, which detail specific acts that constitute fraud.

Waste

Waste is an overutilization of services or other practices that directly or indirectly results in unnecessary costs. Waste is not considered to be caused by criminally negligent actions, but rather is the misuse of resources.

Abuse

Abuse is provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the federally funded programs, reimbursement for services that are not medically necessary, or provider practices that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the federally funded programs.

Examples of FWA

Provider fraud, waste, or abuse include but are not limited to:

- Billing for services not furnished
- Submitting false information to obtain authorization to furnish services or items to Medicare recipients
- Accepting kickbacks for patient referrals
- Violating physician self-referral prohibitions
- Billing for a more costly service than the one performed
- Providing, referring, or prescribing services or items that are not medically necessary
- Providing services that do not meet professionally recognized standards

Member fraud, waste, or abuse include but are not limited to:

- Fraudulent activities (forged/altered prescriptions or borrowed cards)
- Repetitive emergency room visits with little or no PCP intervention or follow-up
- Same/similar services or procedures in an outpatient setting within one year
- A member using someone else's insurance card to receive care
- Forging or altering prescriptions/medications, trafficking SNAP benefits, or taking advantage of the system in any way

Report Suspected Fraud, Waste or Abuse

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Providers who suspect that an AmeriHealth Caritas VIP Care provider, employee or member is committing fraud, waste or abuse should notify the AmeriHealth Caritas VIP Care Special Investigative Unit as follows:

- By phone: 1-866-833-9718
- By U.S. mail:

  AmeriHealth Caritas VIP Care Special Investigative Unit
  200 Stevens Drive
  Philadelphia, PA 19113

Reports may also be sent directly to the U.S. Department of Health and Human Services one of the following ways:

- By calling 1-877-7SAFERX (772-3379)
- Online at hhstips@oig.hhs.gov

Information may be left anonymously.

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Coverage by AmeriHealth First.