Claims: CMS-1500 & UB-04

2020 IHCP Works
Annual Seminar

Agenda

- About CareSource
- CareSource Claims
- Claim Submission: Electronic, Paper
- Member Eligibility and Credentialing
- Provider Payment Processing: ECHO Health, Payment Options
- Claim Concerns: Disputes/Appeals
- Top Denial Reasons: Top 8 Reasons, Resolution, Code Sets
- Important Updates/Reminders: HPV Vaccine Initiative, Prior/Retro Authorizations for Ancillary Providers, Member Billing, Updates & Announcements
- CareSource Health Partner Contacts

About CareSource

OUR MISSION:

To make a **lasting difference** in our members' lives by **transforming** their health and well-being

OUR PLEDGE:

- ✓ Make it easier for you to work with us
- ✓ Partner with providers to help members make healthy choices
- ✓ Direct communication
- ✓ Timely and low-hassle medical reviews
- ✓ Accurate and efficient claims payment

Submitting Claims

INSTITUTIONAL & PROFESSIONAL

CareSource™

CareSource Claims
Billing Methods

CareSource accepts claims in a variety of formats:

- Electronic claims submitted through a clearinghouse
- Claims data submitted directly via our provider portal
- Postal mail

We encourage health partners to ***submit claims electronically*** for faster processing, reduced administrative costs, decreased probability of error and faster feedback on claims status.

CareSource Claims
Timely Filing

- For in-network providers, claims must be submitted within ***90 calendar days*** of the date of service or discharge.
- For out-of-network providers, claims must be submitted ***within 180 calendar days*** of the date of service or discharge.

We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim.

Exceptions*:*

- ***Coordination of Benefits (COB):*** The claim and primary payer's explanation of payment (EOP) must be submitted to us within ***90 calendar days*** from the primary payer's EOP date. If a copy of the claim and EOP is not submitted within the required time frame, the claim will be denied for timely filing.

CareSource Claims

NPI Tax ID and Taxonomy

The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- UB-04 Claim – billing provider service location name, address and expanded ZIP Code + 4 in form field 1
- UB-04 Claim – 10 digit NPI for the billing provider in form field 56
- 1500 Claim – billing provider taxonomy code is required in 33b
- 1500 Claim – billing provider NPI is required in 33a

Please contact your Electronic Data Interchange (EDI) vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Rendering Provider Linkage

Health partners must be linked to all rendering locations in CoreMMIS. If not, claims will reject.

CareSource Claims

Box 33 of CMS-1500 Claim & form field 1 of the UB-04 **must** have the provider service location name, address and the ZIP code + 4 as listed on the IHCP provider enrollment profile.

PO Boxes ***will not*** be accepted in box 33. Please refer to IHCP Banner BR201820.

Electronic Claims Submission

To submit claims electronically, health partners must work with an electronic claims clearinghouse. Please provide the clearinghouse with the CareSource payer ID number **INCS1.**

Availity

As part of our ongoing efforts for continuous improvement, CareSource will be consolidating Electronic Data Interchange (EDI) Clearinghouses into a single gateway. As of June 1, 2020, our preferred partner will be Availity.

We are focused on continuity of service for your EDI transactions. This consolidation should not impact you if your clearinghouse can send transactions to Availity. You can find a list of EDI vendors who transmit EDI transactions to Availity EDI Gateway for CareSource transactions by using this link www.availity.com/caresourceedivendors. **If your current or desired clearinghouse is not on this list**, please contact them to confirm continuity of support for CareSource transactions.

Availity's Client Services can be reached at 1-800-Availity (1-800-282-4548).

Billing Provider NPI – CMS-1500

On 837P professional claims, the billing provider NPI should be in the following location:

2010AA Loop – Billing Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing Provider NPI

2310B Loop – Rendering Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Rendering Provider NPI

The billing provider Tax Identification Number (TIN) must be submitted as the secondary provider identifier using a REF segment which is either the EIN for the organization or the SSN for individuals:

- Reference Identification Qualifier – REF01 = E1 (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the Member ID number is entered:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Name

Billing Provider NPI – UB-04

On 837I Institutional claims, the billing provider NPI should be in the following location:

2010AA Loop – Billing Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing Provider NPI

2310B Loop – Rendering Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Rendering Provider NPI

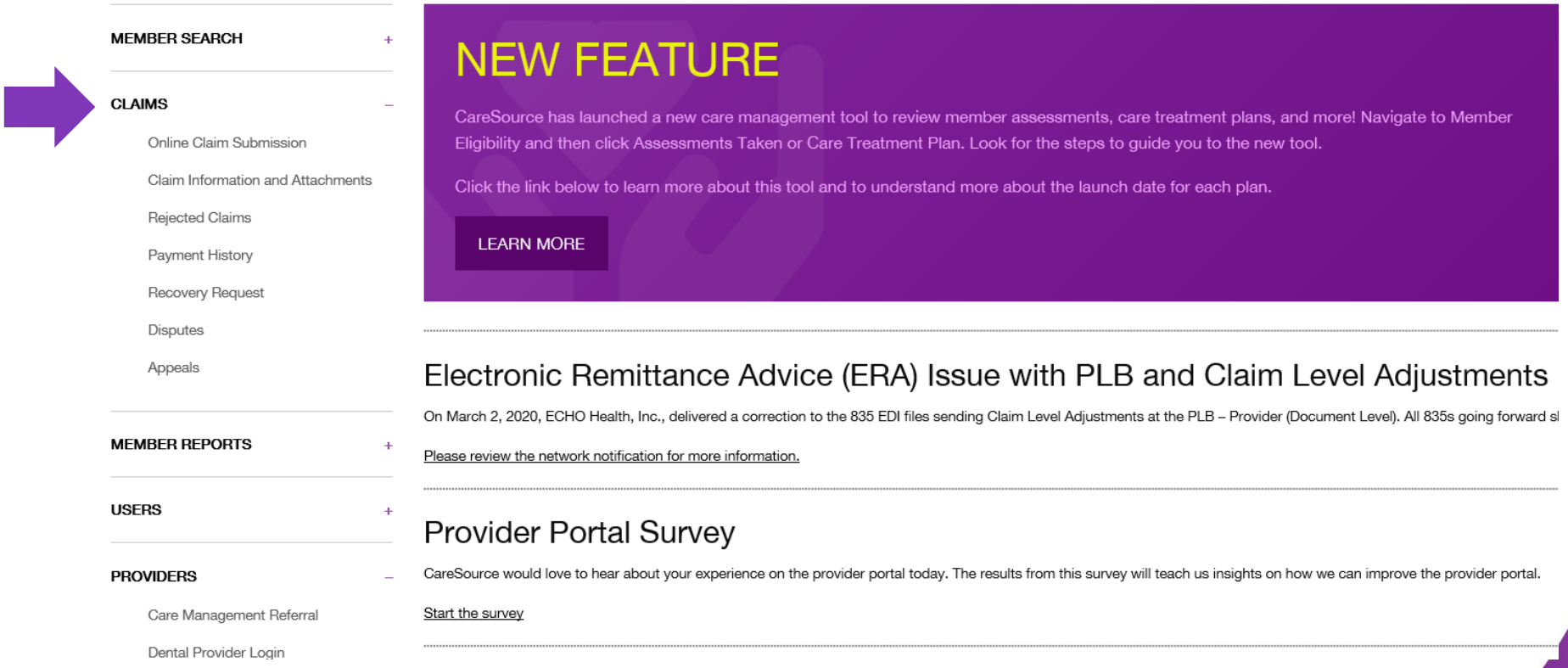
The billing health partner TIN must be submitted as the secondary provider identifier using a REF segment which is either the EIN for the organization or the SSN for individuals:

- Reference Identification Qualifier – REF01 = E1 (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the Member ID number should go on:

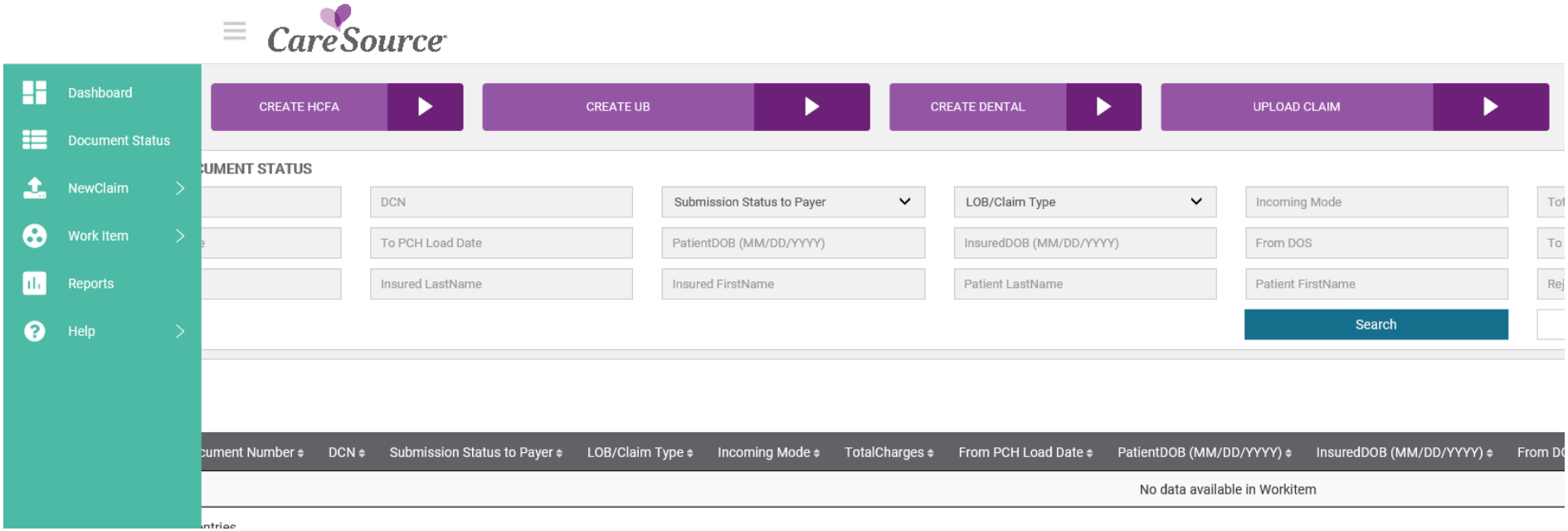
- 2010BA Loop – Subscriber Name
- NM109 = Member ID Name

Online Claim Submission

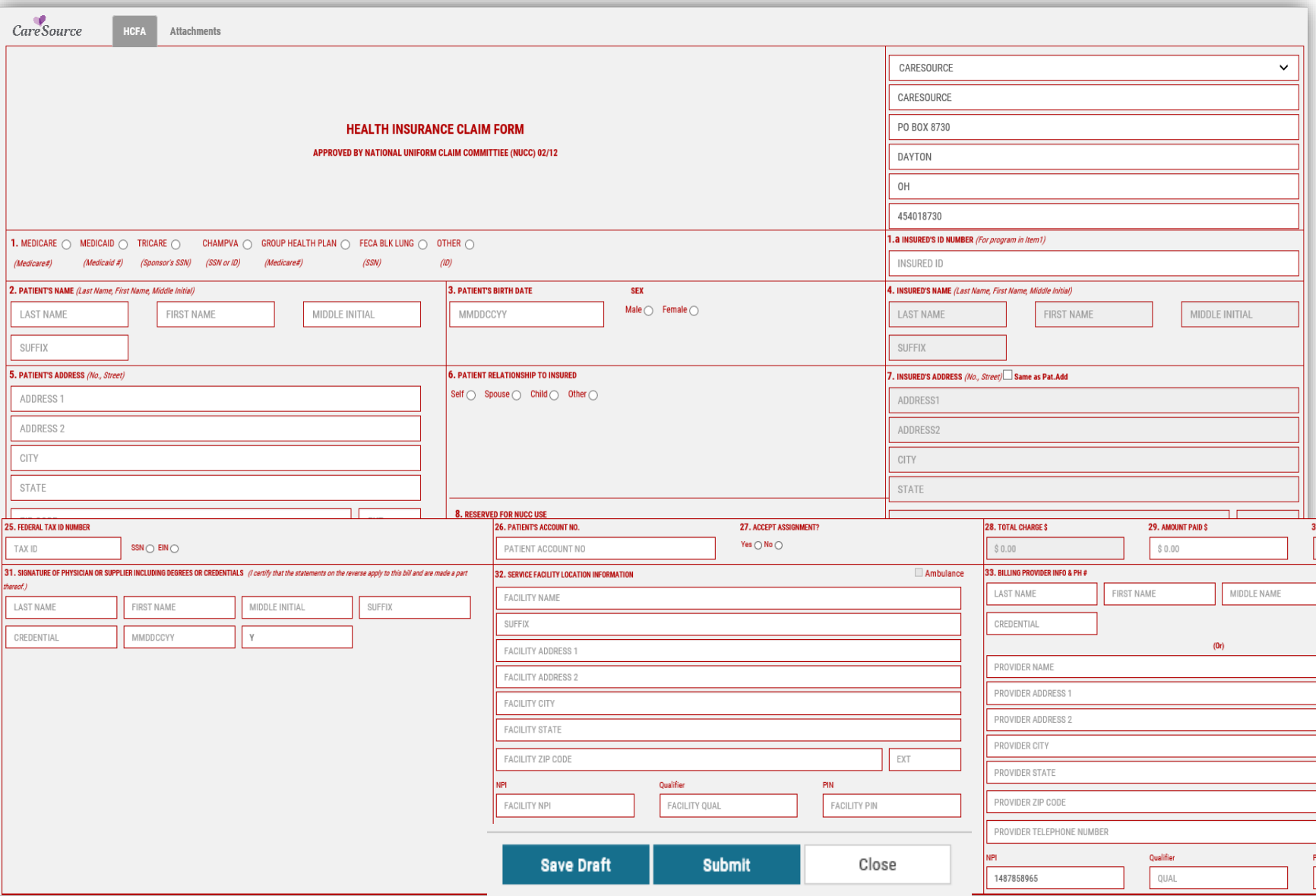


Under Claims, click on **Online Claim Submission**.

Online Claim Submission



Online Claim Submission



Paper Claim Submission
UB-04 or CMS-1500 Paper Claims

- Submission must be done using the most current form version as designated by CMS.

  CareSource does not accept handwritten claims, black and white claim forms or SuperBills.

- Detailed instructions for completing the UB-04 are available at https://www.in.gov/medicaid/providers/469.htm
- **Please note:** On paper UB-04 claims, the billing providers NPI number should be placed in Box 56.
- Detailed instructions for completing the CMS-1500 are available at https://www.in.gov/medicaid/providers/469.htm

  Please note: On paper CMS-1500 claims, the rendering NPI number should be placed in Box 24J and the billing provider NPI number in Box 33a and Group Taxonomy in 33b.

Paper Claim Submission

To ensure optimal claims processing timelines:

- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Font should be 10-14 point with printing in ***black ink.***
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, TIN and taxonomy are required for all claim submissions.

Send all paper claim forms to CareSource at:

CareSource

Attn: Claims Department

P.O. Box 3607

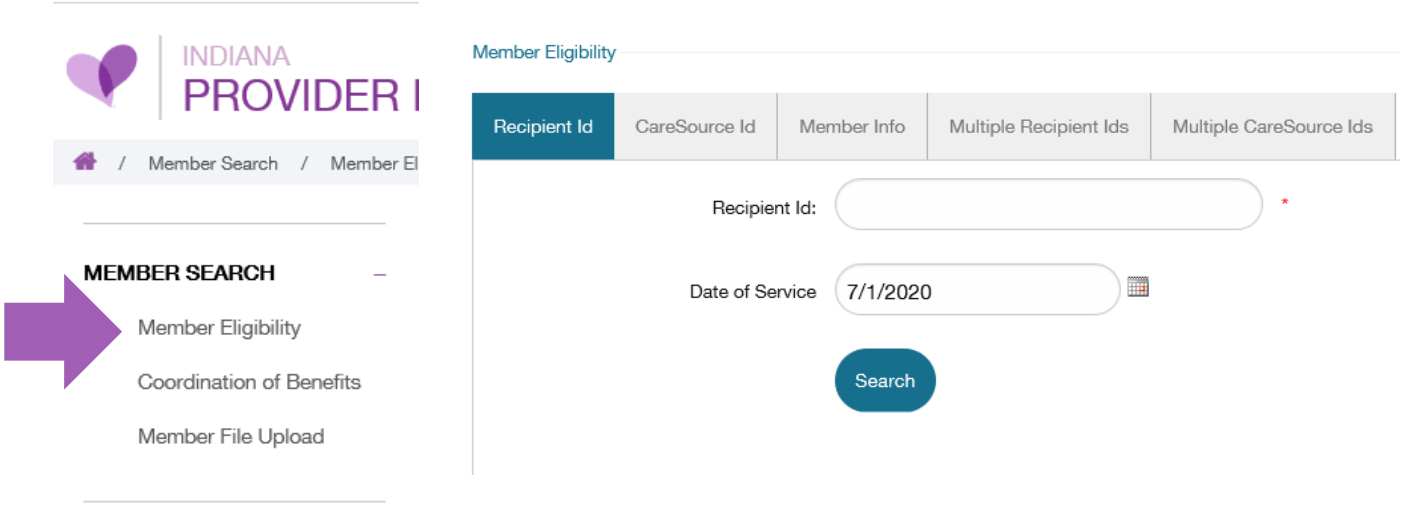
Dayton, OH 45401

Member Eligibility & Credentialing

CareSource™

Member Eligibility

Verification in the Provider Portal



Upon logging into the Provider Portal, health partners will be able to view member eligibility:

24 months of history

Member span information

Multiple member look-up (up to 50)

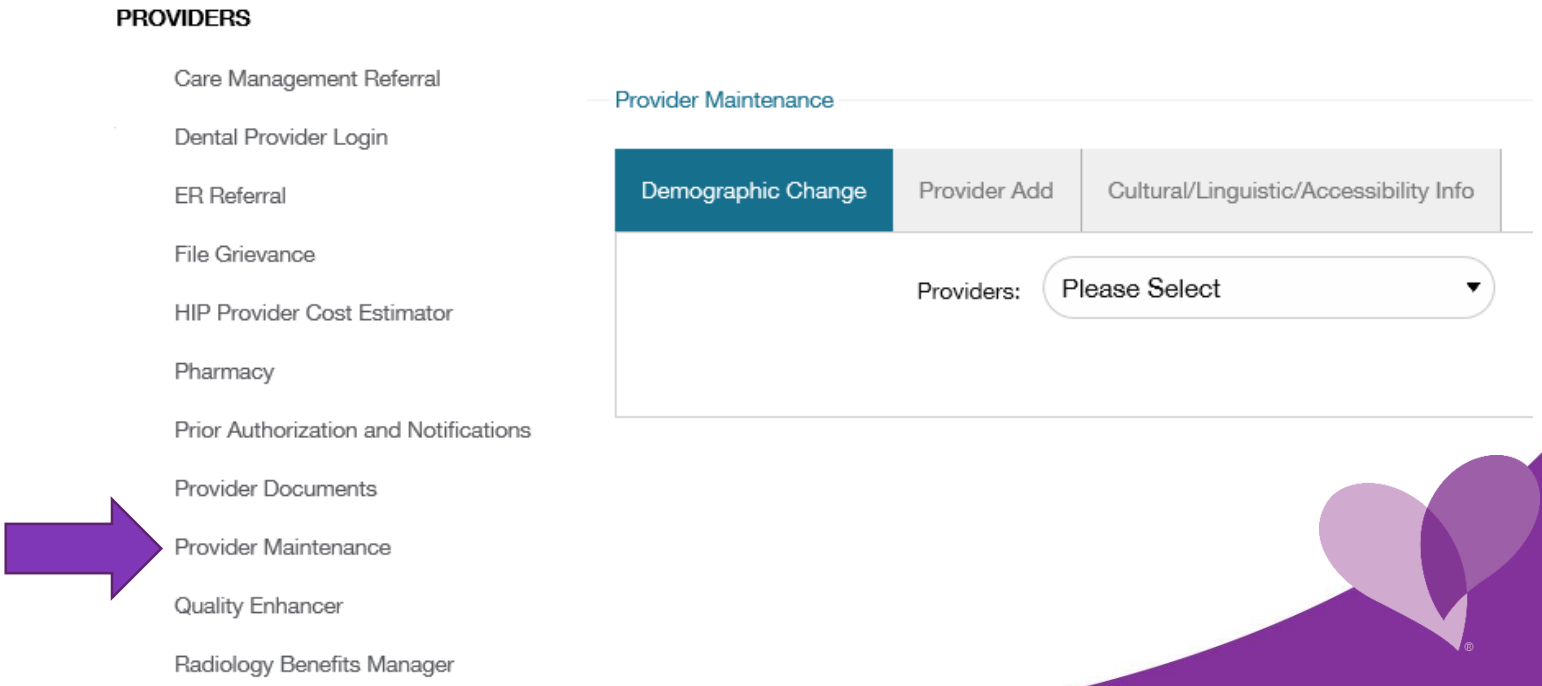
Verify eligibility at every visit prior to rendering services.

Credentialing

- Credentialing with CareSource (including Contracting, Credentialing and Provider Loading) takes approximately 30-45 days
- The preferred method for submission of Provider Maintenance (adding a provider to an existing contract, changing demographic information) requests, is via the Provider Portal
- Group level credentialing includes the following provider types:
  - Radiologists
  - Anesthesiologists
  - Pathology
  - Hospitalists
  - Emergency Medicine
  - Laboratory

Credentialing
Maintenance in the Provider Portal

- From the **Provider Tab**
- Click on **Provider Maintenance**
- Follow the steps



Credentialing

Submitting Requests via E-mail

- Submit a Hierarchy Form (HIE) and W9 to providermaintenance@caresource.com
- For large group updates providers can fill out page 1 of the HIE form and attach a roster (see below for pertinent information).

Provider		Deg.											
John Doe (SAMPLE)		MD											
Address		City/County		State		Zip							
123 Main St		Anytown		Indiana		99999							
Phone	Fax	NPI #	CAQH#			Medicaid/IHCP #						Medicare #	
317-555-1212	317-555-1213	1234567890	123456			1234567A						1234567	
Specialty		PCP? Y/N	HHW Capacity? (Min. 50)		HIP Capacity? (Min 50)			Cultural Compentency (Y/N)				Compentency Training Name	
Family Practice		Y	100		100			Yes				Cultural Comptency Training Name	
Age Restrictions? (18 yrs & older)		Race/Ethnicity	Gender Restrictions	Office Hours									
				Mon	Tues	Wed	Thur	Fri	Sat	Sun			
N		See below	N										

Provider Payment Process

CareSource™

Provider Payment Processing

Payment methods offered by ECHO Health, Inc.:

- Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)
- Virtual Card Payment
- Paper Check

Provider Payment Processing

Electronic Funds Transfer & Electronic Remittance Advice

EFT & ERA are the preferred methods of payment for CareSource.

To register, please visit
http://view.echohealthinc.com/eftera/EFTERAInvitation.aspx?tp=MDAxODk=

You will need:

- Your CareSource Provider ID (available via the Provider Portal or by calling Provider Services at (1-844-607-2831)
- Your bank routing number and bank account number

If already registered with ECHO, please have the following available to expedite registration:

- ECHO provider portal credentials or Tax Idenitification Number (TIN)
- An ECHO draft number and draft amount (you may use **any** ECHO draft number and corresponding draft amount issued to you by ECHO) to authenticate your registration

*When signing up without a previous payment from ECHO, select “Enroll using Enrollment Code.” Enter your CareSource Provider ID as your Enrollment Code.

Provider Payment Processing

Virtual Card Payment

Standard credit card processing & transaction fees apply. Fees are based on your credit card processor's fees and your current banking rates. ECHO does not charge any additional fee for processing.

- For each payment transaction, a credit card number unique to that payment transaction is sent either by secure fax, or by mail.
- Processing these payments is similar to accepting and entering patient payments via credit card into your payment system.

Provider Payment Processing

Paper Check Payment

If your office would prefer to receive check payments, please call ECHO Support at 1-888-485-6233.

*******Please note, for the security of your personal information, **CareSource cannot convert your banking information from InstaMed to ECHO.** If you do not proactively register with ECHO for EFT payments from CareSource, your payment method will default to QuicRemit Virtual Card Payment (VCP) or paper check.

How to Resolve a Claim Concern

CareSource™

Claim Concerns

Claim Status

Claim status is updated daily on the CareSource Provider Portal. You can check claims that were submitted for the previous 24 months.

Additional information on the portal:

- Determine reason for payment or denial
- Check numbers and dates
- Procedure/diagnosis
- Claim payment date
- View and print remittance advice
- Check status of claim disputes or appeals

Claim Concerns

Corrected Claims

- Providers have 60 calendar days from the date of EOP to submit a corrected claim
- UB-04 claims – Box 64
- CMS-1500 claims – resubmission code 7 and Box 22

Please note: If a corrected claim is submitted without this information, the claim will be processed as an original claim or rejected/denied as a duplicate.

Claim Concerns

Claim Disputes

Definition: A provider's first response when disagreeing with the adjudication of a claim.

- Available for participating and non-participating providers

All disputes must be:

- Submitted in writing via the CareSource Provider Portal or on paper
- Submitted within 60 days after receipt of the EOP
- Completed **prior** to requesting an appeal

If CareSource fails to render a determination for the dispute within **30 days** after receipt, an appeal may be submitted.

Claim Concerns

Claim Disputes – Provider Portal

Disputes

File a claim payment dispute for a claim underpayment, a partially or fully denied claim (*please see below for a few exceptions*), or for an adverse claim payment decision.

A claim number is required to submit your claim dispute through the Portal. Any supporting documentation should also be attached.

The following should not be submitted as a Dispute:

If you are responding to a denied authorization that requires medical necessity review, please submit an appeal.

If you are submitting a request due to overpayment, please submit a claim recovery request.

If your claim was denied due to a missing consent form, please upload the consent form.

If your hospital claim was denied due to missing medical records, please upload the medical records.

Notice:

CareSource is currently unable to receive dental appeals or disputes through the Portal. If you need to submit an appeal or dispute involving a dental claim, please mail your submission to:

CareSource
Attn: Grievance and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

You can also fax your submission to **937-531-2398**.

Claim Concerns

Claim Appeals

CareSource.com/documents/in-med-provider-clinicalclaim-appeal-form/

- May only submit appeal ***after*** completing dispute process
- Must be submitted within **60 days** of the resolution of the dispute determination OR if dispute was not responded to timely, appeal must be filed w/in **60 days** after the **30 day** dispute response window.
- CareSource must issue a written decision within **45 days** of receipt of the written request for appeal
- If CareSource does not resolve appeal within the **45 day** timeframe, the appeal will be determined to be in favor of the provider
- May submit via the CareSource Provider Portal, fax (937-531-2398), or by paper to:

  Claim Appeals Department
  P.O. Box 2008
  Dayton, OH 45401-2008

- Timely filing appeals must include proof of original receipt of the appeal by fax or EDI for reconsideration

Claim Concerns

Claim Appeals – Provider Portal

Appeals

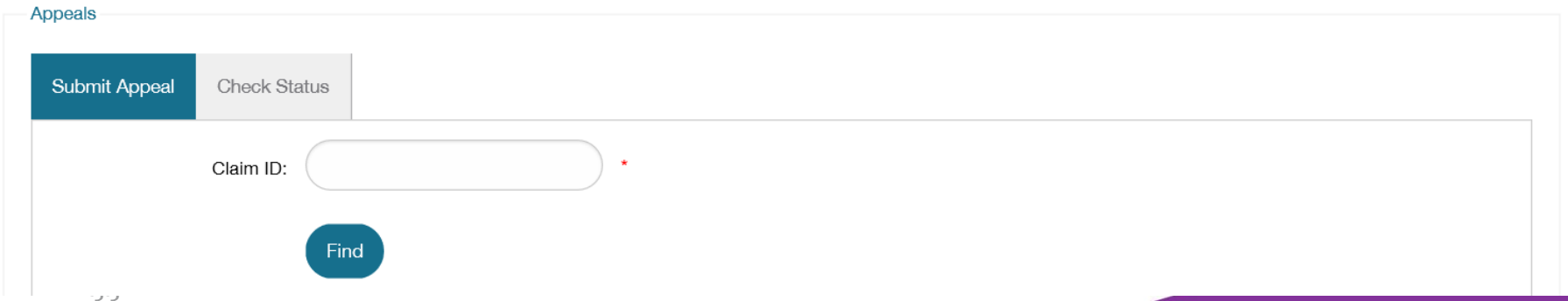
Prior to filing an appeal you must submit a claim dispute to CareSource. You have the right to appeal once you have received your claim dispute decision or 30 calendar days have passed since CareSource received your dispute.

Notice:

CareSource is currently unable to receive dental appeals or disputes through the provider portal. If you need to submit an appeal or dispute involving a dental claim, please mail your submission to:

CareSource
Attn: Grievance and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

You can also fax your submission to **937-531-2398**.



Top Denial Reasons

CareSource™

Top 8 Denial Reasons

July Resolution

Denial Reason	Resolution
Service not payable for provider	Provider needs to ensure their specialty is allowed to bill for this code
Incomplete, invalid rendering provider NPI	Evaluate Box 33 on CMS 1500 to ensure the appropriate information is entered. The National Provider Identifier (NPI) submitted on the claim must crosswalk to an Indiana Health Coverage Programs (IHCP) Provider ID, or the claim will be rejected or denied. Three data elements are used for the standard NPI crosswalk to establish a one-to-one match: billing NPI, billing taxonomy code, and billing provider service location zip code + 4 on file in Core MMIS. See Network Notification https://www.caresource.com/documents/in-p-0850-claims-submission-and-matching-logic-reminder/. Also, reference BT201768 and BR201820. Per BT201768, "A rendering provider must be linked to a group provider. The rendering provider NPI continues to be required on all FFS and managed care claims. If a rendering provider has multiple taxonomies for a service location, the taxonomy may be required for matching purposes." Providers need to submit a new claim, however, it needs to be submitted as an original claim.
Service requires authorization	Analyze claim form to confirm the prior authorization number is listed on the claim in Box 23 on CMS 1500 and Box 63 on UB04. If the prior authorization is on the form ensure that the number is correct. If it is believed the service does not require a prior authorization the appropriate action is to file a dispute first and then an appeal (if necessary). Providers can also reach out to Customer Service or the Provider Engagement Specialist for their area.

Top 8 Denial Reasons

July Resolution

Denial Reason	Resolution
Invalid or missing claim/ line data	Check for correct coding – NCCI edits, Modifier. Etc.
Invalid procedure code	Check the Indiana Medicaid website to ensure this procedure code is on the fee schedule. And, verify it is billable for the specialty. If the procedure code is valid and billable for the specialty type CareSource recommends filing a dispute and reach out to your Provider Specialist in your area.
Invalid diagnosis combination	Check the Indiana Medicaid website. However, there is a good possibility that it has not been configured correctly on CareSource side or not billable for specialty. CareSource recommends filing a dispute and reaching out to the Provider Specialist so we can check for a configuration error.
Code does not have a contracted fee schedule	CareSource recommends filing a dispute and to reach out to the Provider Specialist.
Procedure has an unbundled relationship	Verify appropriate NCCI edits, correct coding practices and CCI edits.

Code Sets

The Indiana Health Coverage Programs (IHCP) provides a number of code tables for provider reference, including:

- Codes necessary for billing and claim processing
- Codes billable for certain types of services and by certain provider types or specialties ("code sets")
- Codes related to specific coverage policies for certain members and programs

Important Updates & Reminders

CareSource™

HPV Vaccine Initiative

Indiana ranks 33rd in the country for vaccinating our adolescents against HPV. We need your help.

In partnership with the Indiana Immunization Coalition and the American Cancer Society, the Indiana State Department of Health and multiple community organizations, we are working to improve and enhance a prevention campaign with the goal of reducing the cancer burden in Indiana through increased prevention.

This initiative focuses on the human papilloma virus (HPV) and increasing the vaccination rate throughout the state of Indiana. HPV infection can cause cervical, vaginal, and vulvar cancers in women and penile cancer in men. HPV can also cause anal cancer, oropharyngeal cancer, and genital warts in men and women.

The HPV vaccine is cancer prevention, but vaccination rates continue to fall far below rates of other routinely recommended vaccines for adolescents across the state. Indiana is 15th in the country for vaccinating our adolescents with MenACWY but 33rd for vaccinating against HPV. That's why we need your help. As a provider, you are empowered to assist in cancer prevention efforts by talking to parents or guardians about the importance of the vaccine and reducing the risk of HPV related cancers.

Research consistently shows that a provider's recommendation to vaccinate is the single most influential factor in convincing parents to vaccinate their children. Studies show simply changing the wording used to introduce the HPV vaccine makes a tremendous difference in outcomes. Offer a Same Day, Same Way recommendation during the visit. For example, **"Your child needs three vaccines today: Tdap, HPV, and meningococcal."**

With your continued participation in this initiative, together we can reduce the burden of cancer in Indiana. Thank you for your time and attention to this important initiative!

Prior/Retro Authorization

For Ancillary Providers

Ancillary provider types:

- Radiology
- Anesthesiology
- Pathology
- Hospitalist services
- Labs
- Other professional services performed in an inpatient or outpatient setting

Member Billing

Not permitted:

- Balance billing a member for a Medicaid-covered service
- Billing a member in emergent situations

To charge a member for non-covered services, health partners must disclose in writing:

- Service to be rendered is not covered by Medicaid.
- Whether procedures or treatments that **are** covered by Medicaid are available in lieu of non-covered service.
- The health partner must offer, on a disclosure form, the member's willingness to accept the financial responsibility of the non-covered service, the amount to be charged for the non covered service and the specific date the service is to be performed.
- ***Documentation must be signed by member prior to rendering the specific non-covered service***.

Note: Medicaid covered services **cannot** be billed to the member.

Updates & Announcements

Visit the **Updates and Announcements page** located on our website for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

How to Reach Us

Provider Services	**1-844-607-2831**
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)
Member Services	1-844-607-2829
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)

CareSource

PARTNER with Purpose

CareSource Health Partner Engagement Representatives

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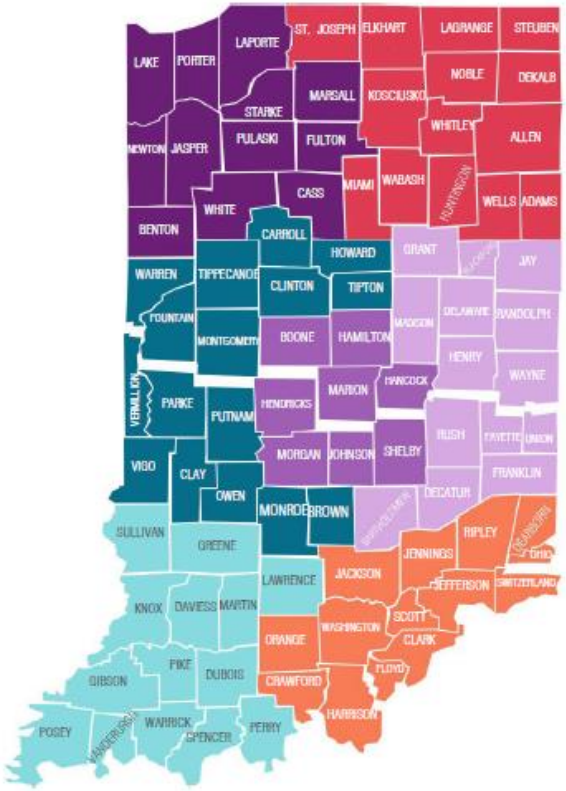

Regional Representatives

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IN-P-0190h
Date Issued: 08/04/2020
OMPP Approved: 07302020

Who is CareSource's EDI vendor as of 6/1/2020?

Change Healthcare	**EDI**
Availity	**Emdeon**

ECHO is CareSource's payment processing vendor.

True

False

What is the timely filing limit for in-network providers?

90 Days	**365 Days**
180 Days	**30 Days**

When a provider disagrees with a dispute decision the next action is to....

Dispute again	**File an Appeal**
Submit a Corrected Claim	**Call it a day**

A PO Box should be placed in Box 33

True

False

What is the #1 top denial reason?

Invalid NPI / Taxonomy	**Service requires authorization**
Procedure has an unbundled relationship	**Service not payable for provider**

How many days from the EOP date can a provider file a dispute?

365 Days	**60 Days**
90 Days	**120 Days**

It isn't permitted to balance bill a member for a Medicaid covered service.

True

False

IN-P-0799a Issued Date: 9/9/20

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OMPP Approved: 9/9/20