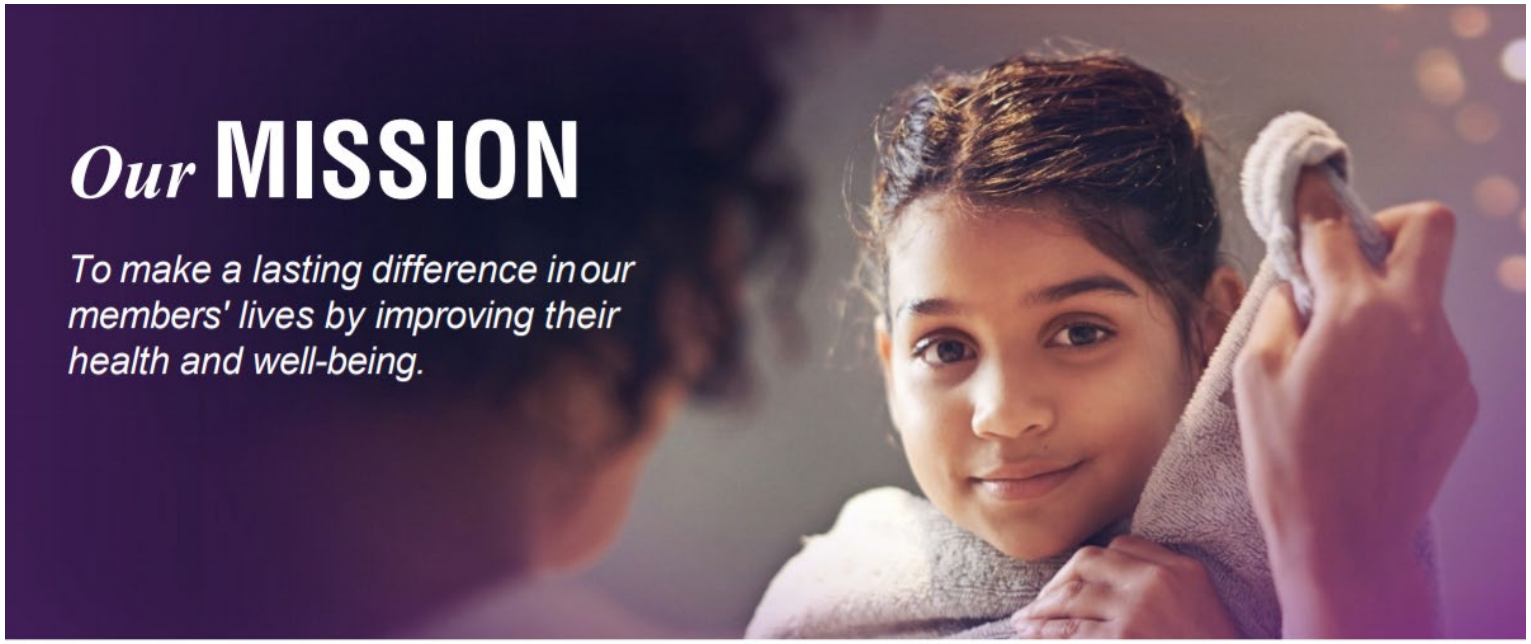
Claims: CMS-1500

2022 IHCP Works
Annual Seminar

Agenda

- About CareSource
- Professional Claim Submission
- Submitting Dental & Vision Claims
- Claim Reminders
- Top Denials & Resolutions
- Provider Payment Process
- How to Resolve a Claim Concern
- Important Updates/Reminders
- CareSource Health Partner Contacts

About CareSource



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

Professional Claim Submission

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

Terms to Know

- Electronic Data Interchange (EDI)
- Payer ID
- 837 file/loop and segment/raw data

Electronic Claims Submission

CareSource payer ID, **INCS1**

Availity's Client Services
1-800-282-4548

- Claim is transmitted to an EDI transaction
- EDI transaction sent to CareSource through Availity
- Received as the 837 file (also known as loop and segment or raw data)

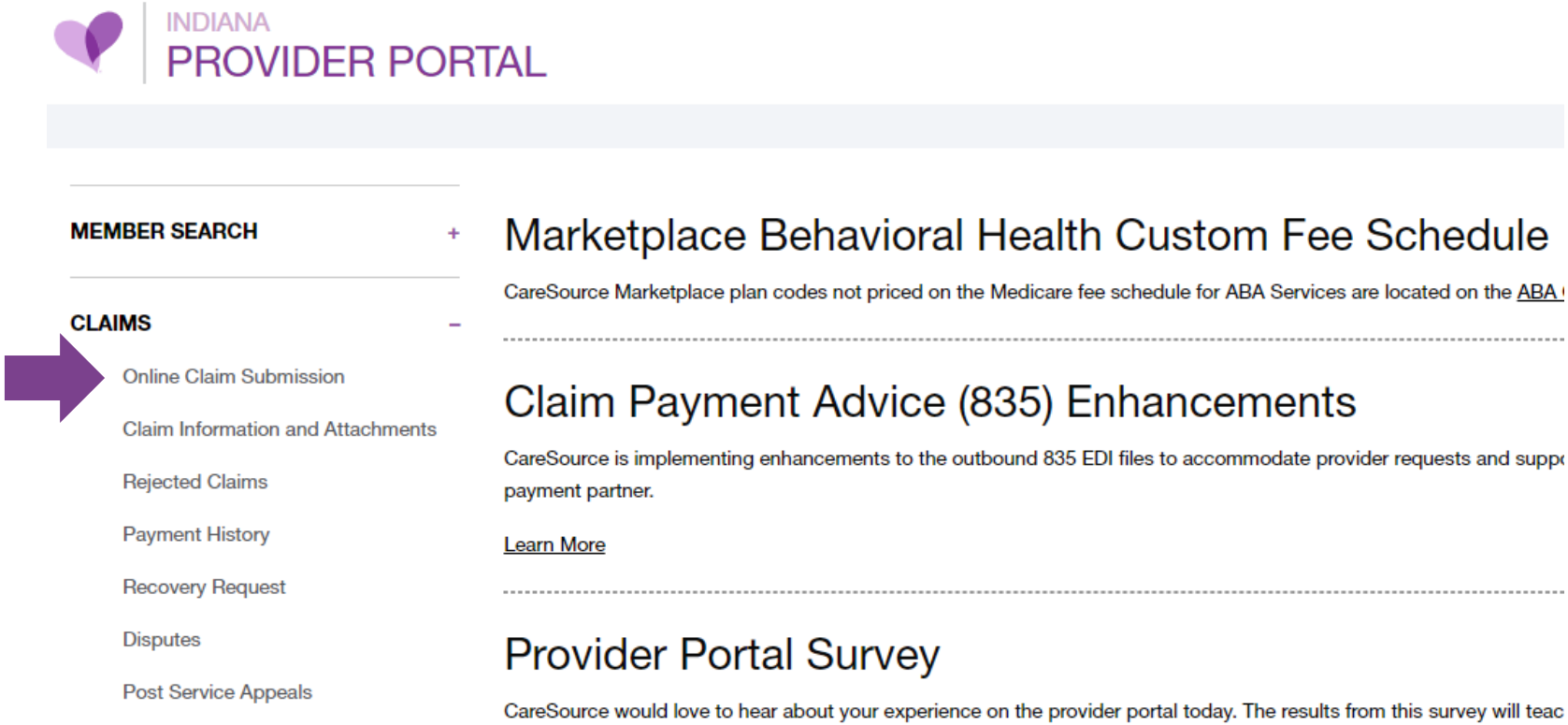
Example of the 837 File

CLM*18434718T0*150.00***11:B:1*Y*A*Y*Y~
DTP*431*D8*20170720~
REF*G1*123456~
HI*ABK:M24532*ABF:M21332~

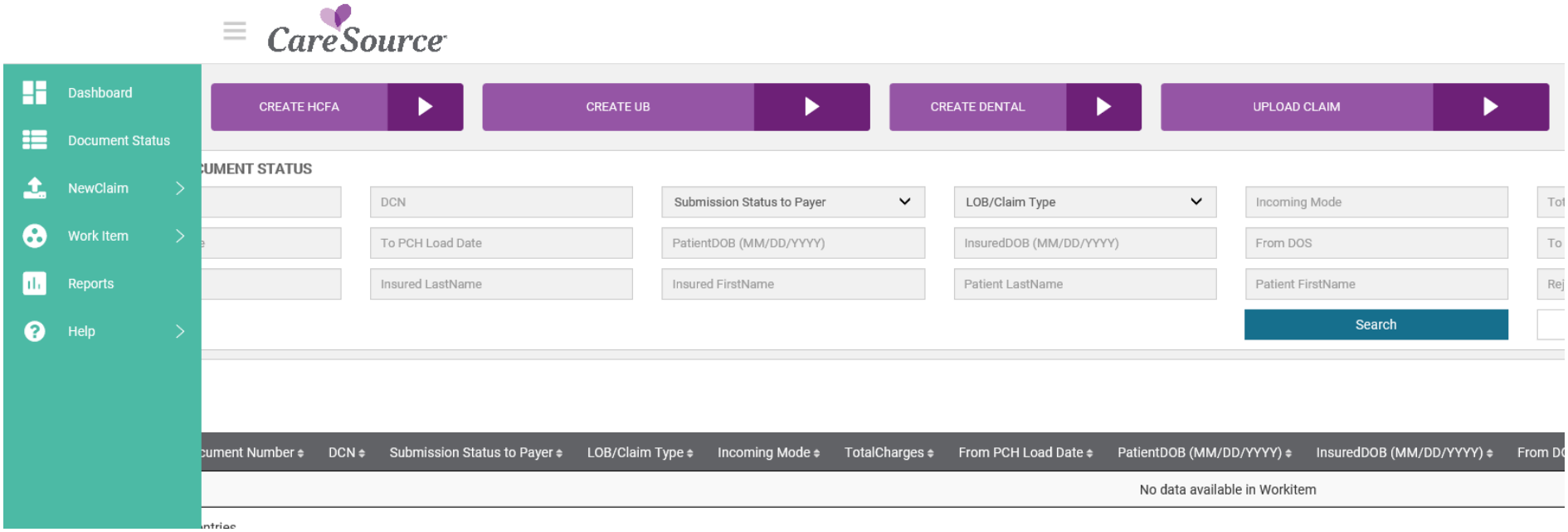
[How to Read an EDI (837) File - Overview – Therabill (zendesk.com)]

Online Claim Submission

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



Online Claim Submission



Online Claim Submission

25. FEDERAL TAX ID NUMBER

611764853 SSN ◯ EIN ◯

26. PATIENT'S ACCOUNT NO.

PATIENT ACCOUNT NO

27. ACCEPT ASSIGNMENT?

Yes ◯ No ◯

28. TOTAL CHARGE $ | **29.** AMOUNT PAID $ | **30.** BALANCE DUE $

$ 0.00 | $ 0.00 | $ 0.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS *(I certify that the statements on the reverse apply to this bill and are made a part thereof.)*

LAST NAME | FIRST NAME | MIDDLE INITIA | SUFFIX

CREDENTIAL | MMDDCCYY | Y

32. SERVICE FACILITY LOCATION INFORMATION ☐ Ambulance

FACILITY NAME

FACILITY ADDRESS 1

FACILITY ADDRESS 2

FACILITY CITY

FACILITY STATE

FACILITY ZIP CODE | EXT

NPI: FACILITY NPI | Qualifier: FACILITY QUAL | PIN: FACILITY PIN

33. BILLING PROVIDER INFO & PH #

LAST NAME | FIRST NAME | MIDDLE NAME | SUFFIX

CREDENTIAL

(Or)

RHN CLARK MEMORIAL PHYSICIAN PRACTICES LLC

2205 GREENTREE N

PROVIDER ADDRESS 2

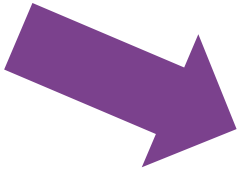
CLARKSVILLE

IN

47129 | 8957

PROVIDER TELEPHONE NUMBER

NPI: 1063896637 | Qualifier: QUAL | PIN: PIN



33. BILLING PROVIDER INFO & PH #

LAST NAME | FIRST NAME

Paper Claim Submission

To ensure optimal claims processing timelines:

- Use only original claim forms; do not submit claim forms 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

Paper Claim Notes

Detailed instructions for completing the CMS-1500 are available at Indiana Medicaid > Providers > IHCP Provider Reference Modules.

Please note:

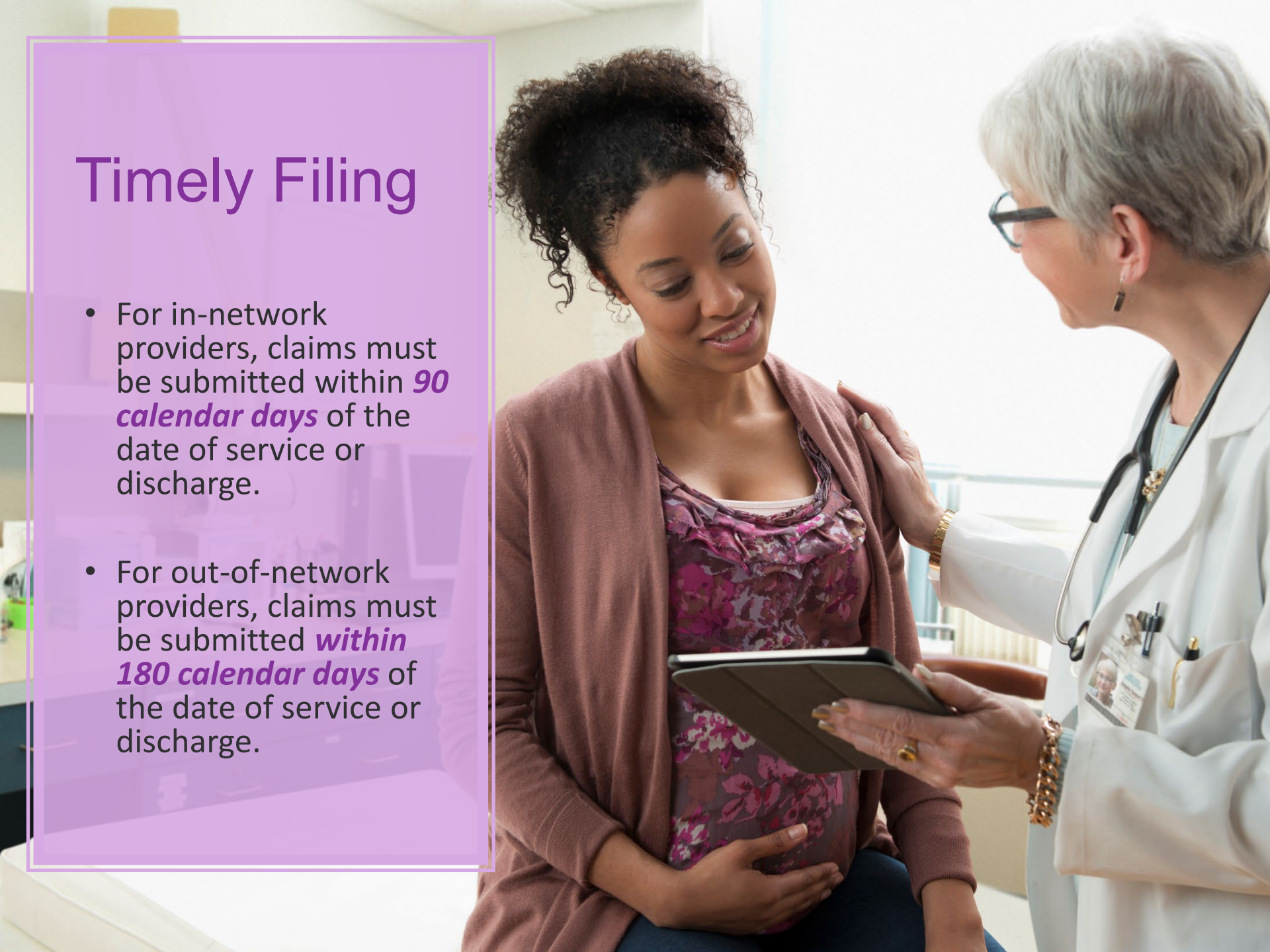
- Rendering NPI – Box 24J
- Billing Provider NPI – Box 33a
- Group Taxonomy – Box 33b

Claim Reminders

CareSource™

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.



Coordination of Benefits

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 are not submitted within the required time frame, the claim will be denied for timely filing.

Updating COB

- Who can update the COB information?
- How should the COB information be updated?

Updating COB Answers

- Providers or members can submit the COB updates.
- Updates are done by contacting the state or by utilizing the state's Portal's Secure Correspondence link.

Corrected Claims

- 60 calendar days from the date of EOP
- Number of claim that needs to be corrected
- Resubmission code 7

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.

Professional Claims – Top Denials & Resolutions

CareSource™

Timely Filing Denials

Top Denial #1

- Submitted after Provider's Filing Limit

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.

Timely Filing Denials - Resolution

To Resolve

- **Dispute** (60 calendar days from date of EOP)
- **Appeal** (after a dispute, within 60 days of date of resolution of dispute)
- **Reach out** to Health Partner (HP) Engagement Specialist
- Include proof of timely filing on all requests

Invalid Rendering Provider NPI

Top Denial #2

- KNP Incomplete, Invalid Rendering Provider NPI
  - Typically, these claims were rejected at clearinghouse level
  - Several submission errors can cause rejection/denial

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:

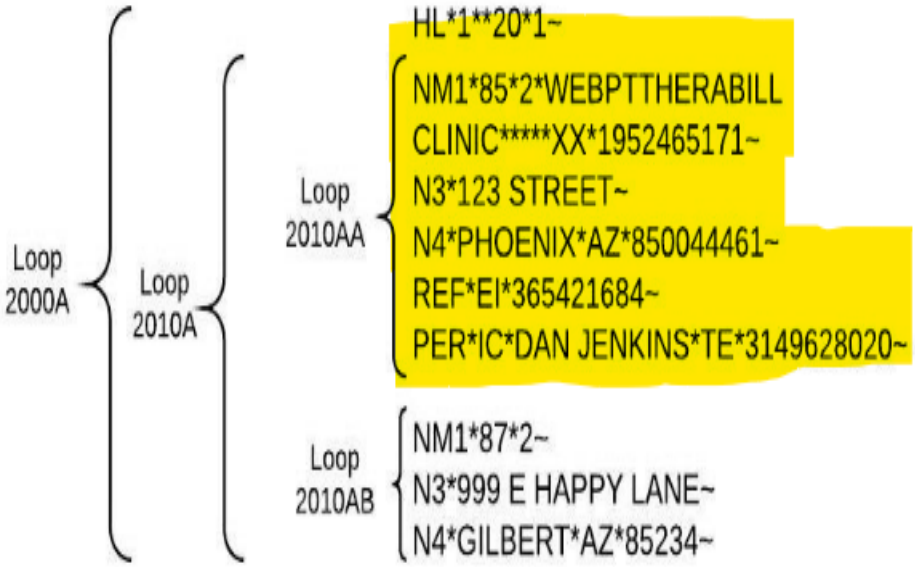
- Reference Identification Qualifier – REF01 = E1 (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

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

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

Billing Provider NPI – 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

Keep In Mind

Health partners must be linked to the service locations in CoreMMIS. If not, claims will be rejected.

If the provider treats a member prior to their effective date of the service location, claims will be denied as out-of-network.

Invalid Rendering Provider NPI - Resolution

- To resolve
  - Is there a PO Box in Box 33?
    - If so, update to a service address and resubmit as an original

- Professional claims – The actual physical service location address must be entered in Field 33 of the *CMS-1500* claim form or the equivalent field of an electronic transaction. Note: For IHCP claims, Field 32 of the *CMS-1500* form, or its electronic equivalent, is optional. It is not used for claim processing.

  In most instances, the service location address is the actual physical location where a service was rendered. However, for professional claims, if the member is seen at a hospital, nursing facility, the member's home, or other non-office-based location, the specific service location address to which the rendering provider is linked should be used.

32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
Optional - not used by the IHCP for claims processing.	*Required - enter the group/billing provider's address/service location on file with the IHCP.*

Invalid Rendering Provider NPI - Resolution

To resolve:

- Review address in Box 33
  - Does the service address in Box 33 match what is on the IHCP Enrollment Profile?
  - Does the zip + 4 match IHCP?
  - Is the provider enrolled with IHCP at that service address?

Invalid Rendering Provider NPI - Resolution

Per IHCP, NPIs are required on professional claims for all applicable providers.

Rendering NPI must be entered in field 24j of the CMS-1500

24J Top Half – Shaded Area	**RENDERING PROVIDER ID. #** – Enter the IHCP Provider ID or taxonomy code of the provider that rendered the service. **Required, if applicable.** • **Provider ID** – Atypical providers (for example, certain transportation and waiver service providers) are required to submit their IHCP Provider ID. If billing for case management, the case manager's Provider ID must be entered here. (Provider ID is indicated by qualifier G2 in field 24I.) • **Taxonomy** – The taxonomy code includes 10 alphanumeric characters. The taxonomy code is optional unless required for a one-to-one match. (Taxonomy is indicated by qualifier ZZ or PXC in field 24I.)
24J Bottom Half	**RENDERING PROVIDER ID. # – NPI** – Enter the NPI of the provider that rendered the service. **Required, if applicable.**

https://www.in.gov/medicaid/providers/files/claim-submission-and-processing.pdf

Service Requires Authorization

Top Denial #3

- Service Requires Authorization
  - Denial occurs when authorization was not present on claim or authorization was not requested
  - When claim details do not match what was requested on the authorization

Service Requires Authorization - Resolution

To resolve:

- Is the authorization number in Box 23?
- Is the authorization number correct?
- Do the units match what was requested?
- Does the Current Procedural Terminology (CPT) codes and diagnosis codes match what was submitted on authorization request?

Coordination of Benefits (COB)

Top Denial # 4

- COB information not received
  - Member has primary insurance
  - EOP from primary was not included/attached to claim
  - Eligibility Verification prior to appointment can avoid COB denials

Coordination of Benefits (COB) - Resolution

To resolve:

- Verify if member has a primary insurance
- Submit claim to primary insurance
- Resubmit claim with Explanation of Payment (EOP) to CareSource as a corrected claim within 90 days of receipt of EOP
- Submit a Third-Party Liability update to Indiana Medicaid
- Update COB information in CareSource Provider Portal, if incorrect

Duplicate Claim

Top Denial # 5

- Duplicate Claim
  - Denial occurs when claim was submitted after same claim was already processed
  - Denial occurs when a corrected claim is missing an original claim number

Duplicate Claim - Resolution

To resolve:

- Has the claim already been processed/paid?
- Does the corrected claim have a resubmission code 7 and original claim number in Box 22 (most recent)?
- Were the line denials for duplicate verified against other processed claims?

Submitting Vision & Dental Claims

CareSource™

Vision Claims

Routine vision claims need to be submitted to Superior Vision.

Medical vision claims are processed by CareSource.

Dental Claims

SkyGen manages:

- Claims payment
- Prior Authorization
- Electronic Funds Transfer (EFT)
- Portal issues

CareSource manages:

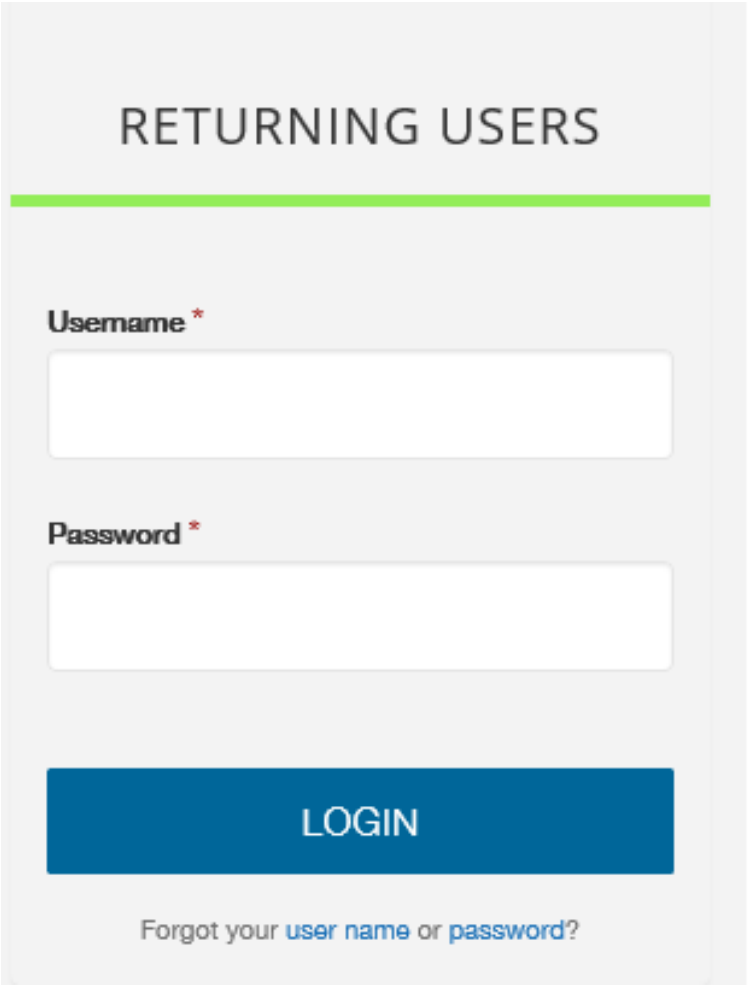
- Member-related concerns such as claim issues, covered services, and patient eligibility
- Contracting with dental providers

Dental Claim Submission

Online:
https://pwp.sciondental.com/PWP/Landing

Electronic Data Interchange (EDI) Payer ID: INCS1

Paper:
CareSource
Attn: Claims Department
P.O. Box 3607
Dayton, OH 45401-3607



The filing limit for participating providers is 90 days.

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

Electronic Funds Transfer & Electronic Remittance Advice

EFT & ERA are the preferred methods of payments.

To register, please visit https://enrollments.echohealthinc.com/

You will need:

- Your CareSource Provider ID.
- Your practice's bank routing number and bank account number.

If already registered with ECHO, you will need:

- ECHO provider portal credentials or Tax Identification Number (TIN).
- An ECHO draft number and draft amount.

Provider Payment Processing Virtual Card Payment

- Standard credit card processing & transaction fees apply.
- A unique credit card number will be assigned.
- Processing fees are based on your credit card processor’s fees.

Provider Payment Processing

Paper Check Payment

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

How to Resolve a Claim Concern

CareSource™

Claim Status

Claim status is updated daily on the CareSource Provider Portal. You can view claims that were submitted for the previous 36 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
- View status of claim disputes or appeals

Corrected Claim

- Providers have 60 calendar days from the date of EOP to submit a corrected claim
- CMS-1500 claims – resubmission code 7 and Box 22 (needs original claim number)

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 Disputes

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.

Dental Claim Disputes

- The health partner must complete a claim dispute prior to requesting an appeal. The claim dispute form can be located within the *Dental Health Partner Manual* at **CareSource.com**.
- The dispute must be submitted within **60 days** after the health partner's receipt of the written determination of the claim.

Claim Concerns

Claim Appeals

- Paper appeal form can be found at CareSource.com
- May only submit appeal ***after*** completing dispute process
- Must be submitted within **60 days** of the resolution of the dispute
- 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.*****

Dental Claim Appeals

Health partners may only submit appeals after completing the claim dispute process as previously outlined.

Appeals must be submitted within **60 days** of the dispute decision

- CareSource must issue a written decision within **45 days** of receipt of the written request for appeal.
- If the appeal is not resolved within the **45-day** time frame, the appeal will be determined as an approval.

Important Updates & Reminders

CareSource™

Notification of Pregnancy (NOP)

Indiana Health Coverage Programs (IHCP) recognizes that timely identification of risk factors improves birth outcomes.

The Notification of Pregnancy (NOP) form pinpoints risk factors in the earliest stages of pregnancy for women enrolled in HIP and HHW.

A qualified provider is eligible for a $60 reimbursement for one NOP per pregnancy

- Submit claim 99354-TH if you completed the NOP
- The NOP must be submitted via the Provider Portal no more than 5 calendar days from the date of the office visit on which the NOP is based
- The member's pregnancy must be less than 30 weeks' gestation at the time of the office visit on which the NOP is based
- CareSource will pay a $10 enhancement to this code if billed within the first trimester

Provider Resources

- Visit the CareSource.com Plan Resources page to access the following resources:

  - Printable health partner manual
  - Printable orientation slides
  - Newsletters & network notifications
  - Formularies
  - Covered benefits
  - Quick reference guides
  - And more

- **CareSource Provider Portal:**
- **https://providerportal.caresource.com/IN**

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.

Quarterly Friday Forums

- Revenue cycle, contracting, credentialing, clinical operations, quality, or administrative staff are welcome to attend.
- Brief presentation covering updates
- Live Q&A follows presentation
- **December 16th 2 – 4 p.m. Eastern Time (ET)**
- Save the Date will be published on our Updates & Announcements page
- Please reach out to your HP Engagement Specialist for any topics you want to hear about

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

Updates & Announcements | Indiana – Medicaid | CareSource

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)

Health Partner Engagement Specialists

HEALTH PARTNER ENGAGEMENT REPRESENTATIVES

Denise Cole, Director
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Denise.Cole@caresource.com
Amy Williams, Manager
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HEALTH PARTNER ENGAGEMENT SPECIALIST

Brian Grcevich – Ancillary, Dental, Skilled Nursing Facilities, Home Health and Hospice
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Brian.Grcevich@caresource.com

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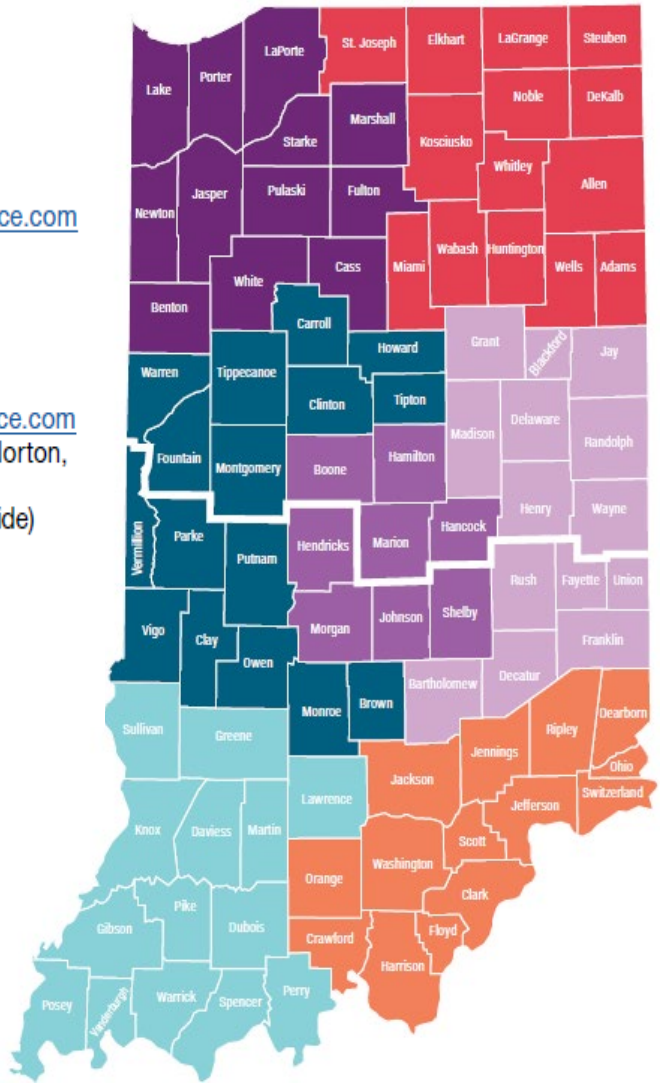

Contact Us | Indiana – Medicaid | CareSource

RR2022-IN-MED-P-1578011 Issue Date: 9/23/2022 OMPP Approved: 9/8/2022