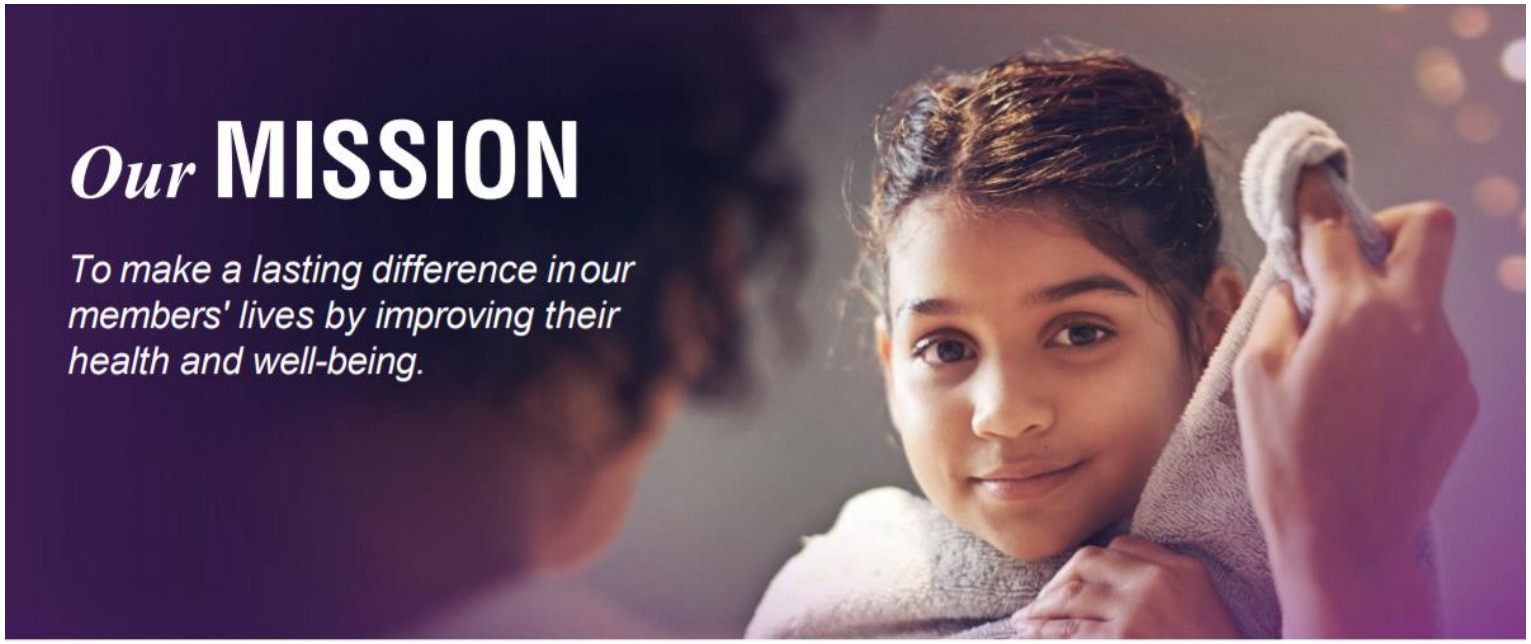
2021 IHCP Works
Annual Seminar

Claims 101: CMS-1500 & UB-04

Agenda

- About CareSource
- Member Eligibility and Credentialing
- Claim Submission
- Provider Payment Processing: ECHO Health, Payment Options
- Claim Concerns: Disputes/Appeals
- Top Denial Reasons: Top 8 Reasons, Resolution, Code Sets
- 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

Member Eligibility & Credentialing

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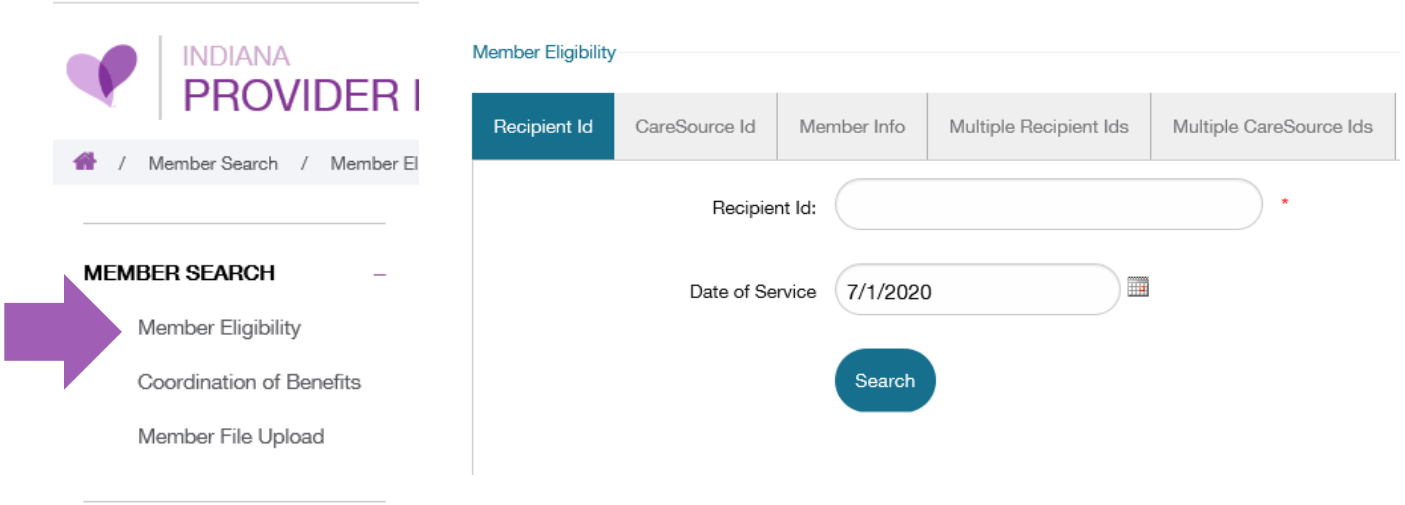
Member Eligibility

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.

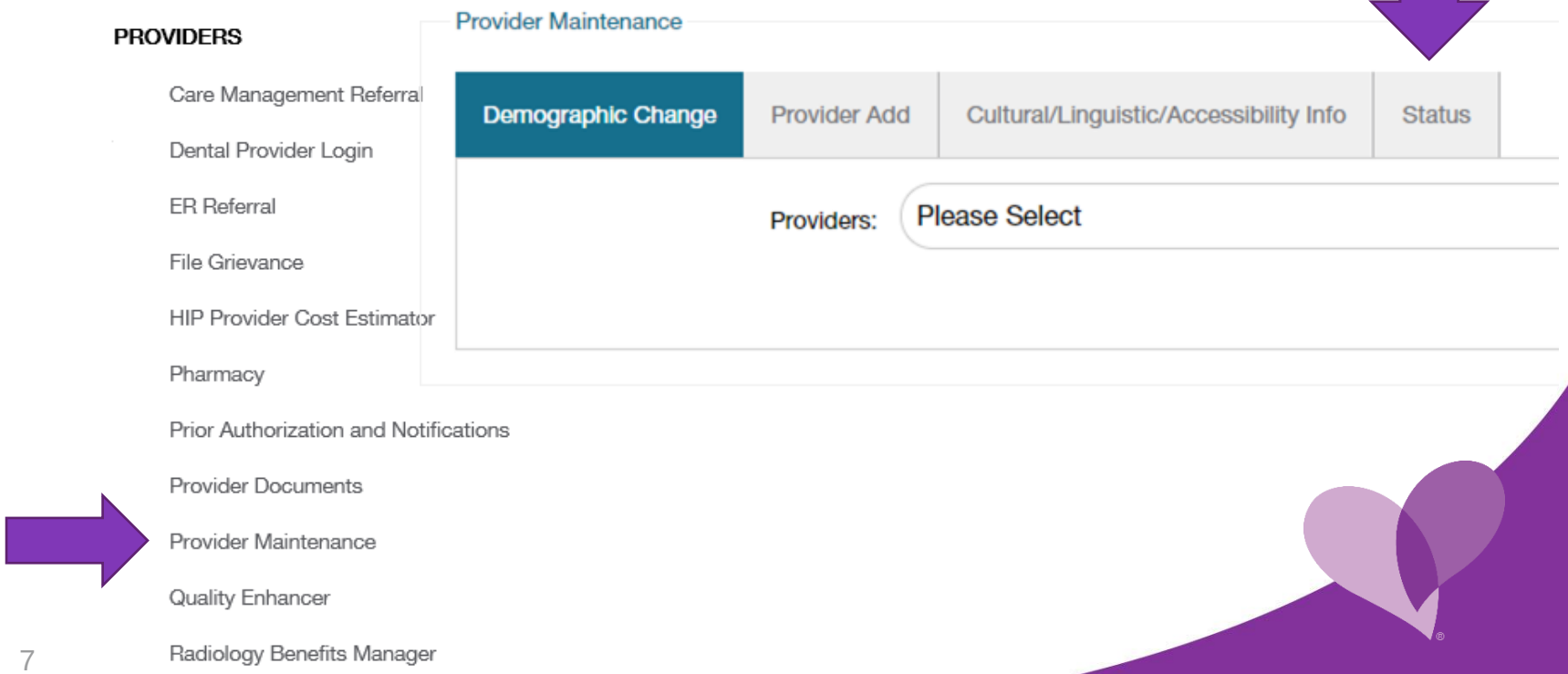
Credentialing

- Credentialing with CareSource (including Contracting, Credentialing and Provider Loading) takes approximately 30-45 days
- The preferred method for submission is via the Provider Portal
- We now load all provider types individually in our system
  - See: https://www.caresource.com/documents/in-med-p-279473-enhanced-credentialing-process-may-2021/
- Reach out to your Health Partner Engagement Specialist with questions

Credentialing
Maintenance in the Provider Portal

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

New Enhancement



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										

Submitting Claims

INSTITUTIONAL & PROFESSIONAL

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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

Claims

- 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.

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
- CMS 1500 Claim – billing provider taxonomy code is required in 33b
- CMS 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.

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

Electronic Claims Submission

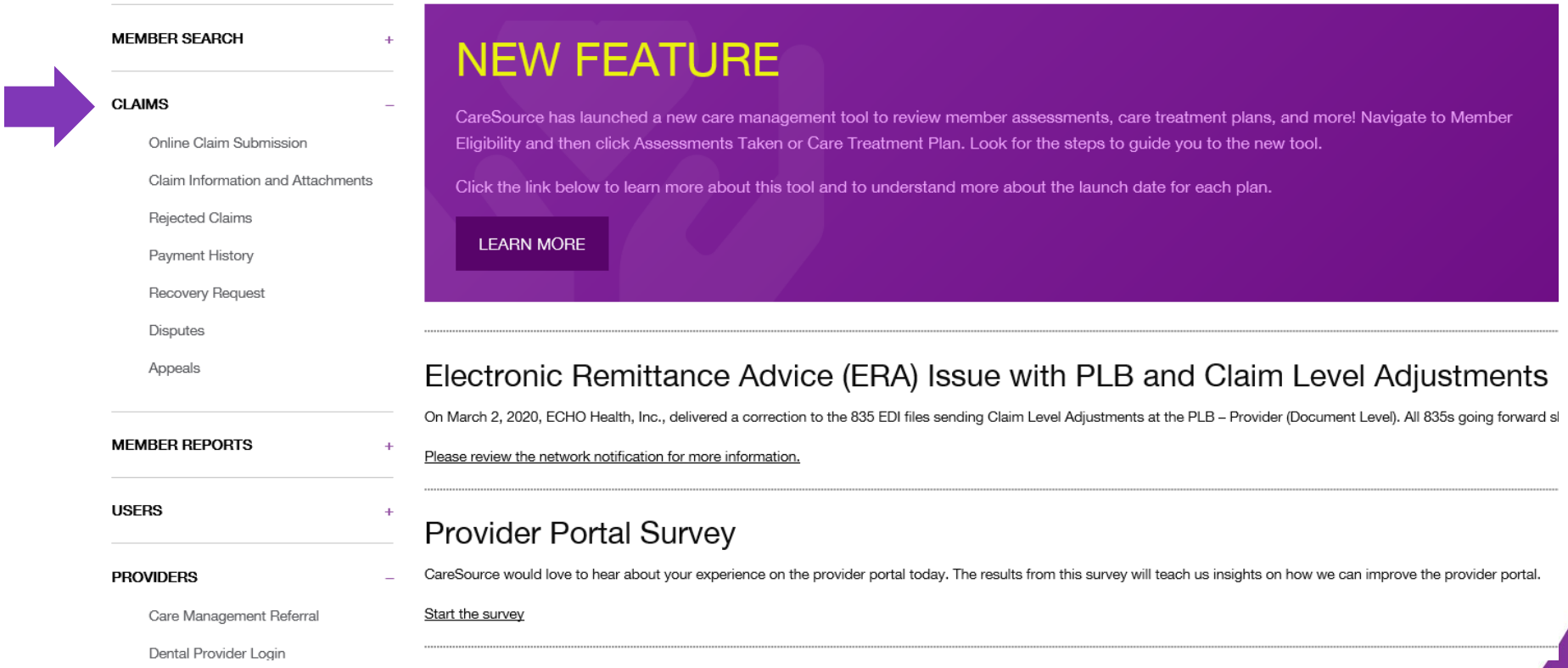
To submit claims electronically, health partners must work with an electronic claims clearinghouse. Please provide the clearinghouse with the CareSource payer ID number **INCS1.**

Availity

- As of June 1, 2020, our exclusive partner is Availity.
- This consolidation should not impact you if your clearinghouse can send transactions to Availity.
- For 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.

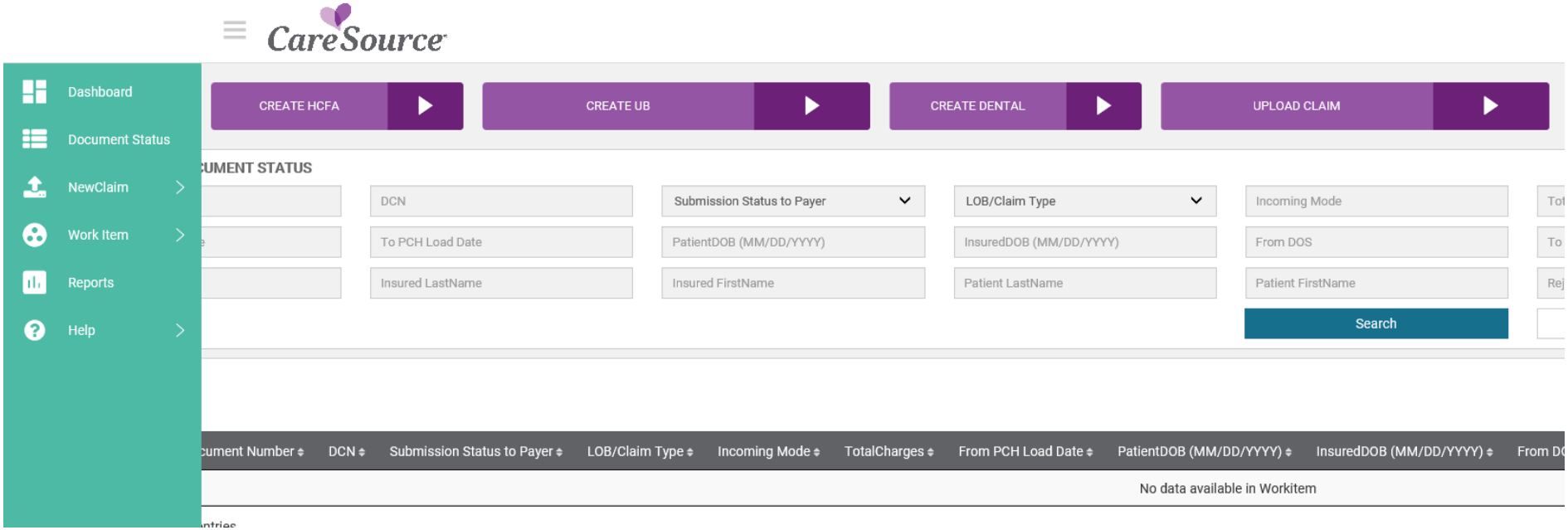
Availity's Client Services can be reached at 1-800-Availity (1-800-282-4548).

Online Claim Submission

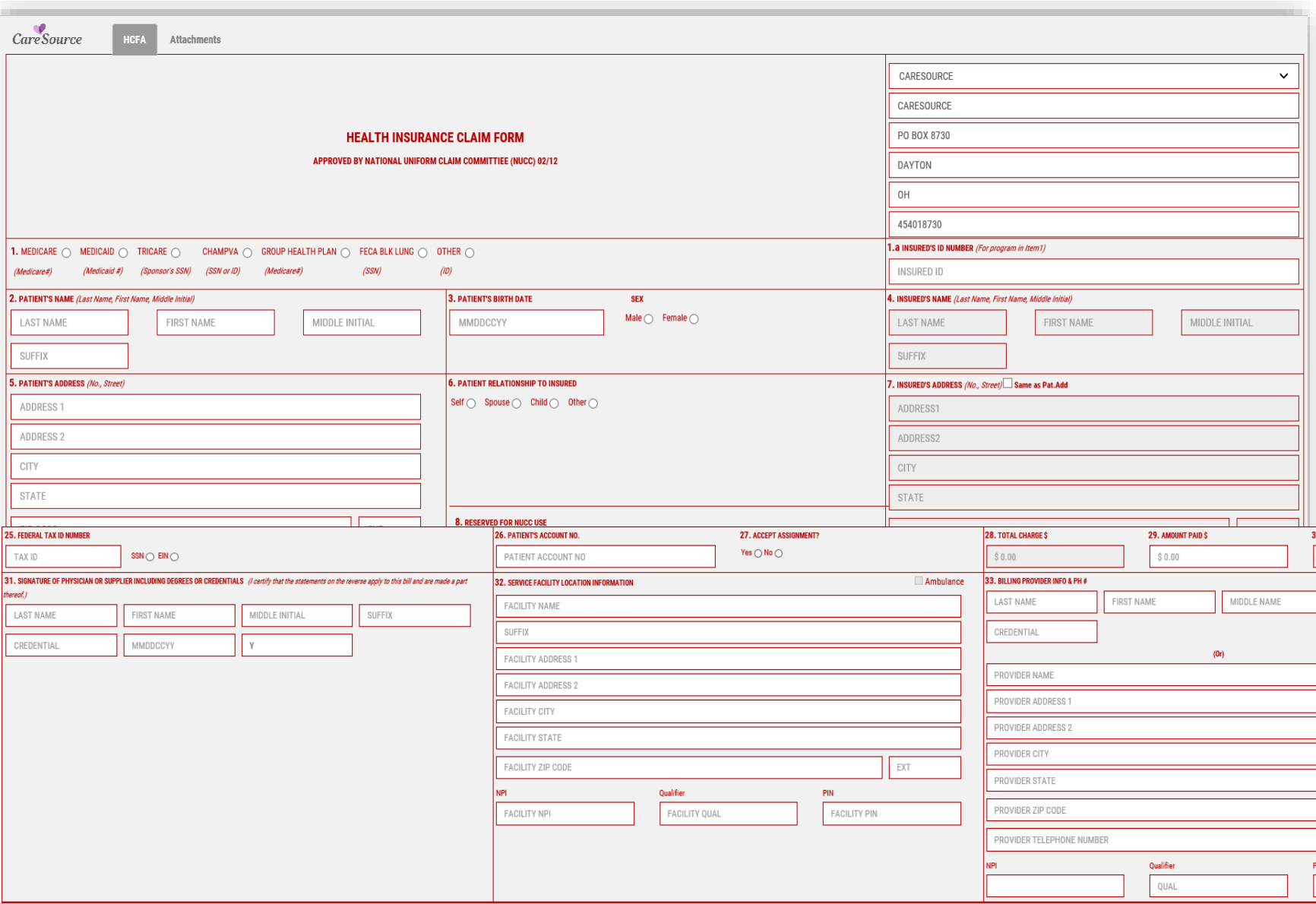


Under Claims, click on **Online Claim Submission**.

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 provider's 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

Provider Payment Process

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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 payments.

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

You will need:

- Your CareSource Provider ID
- Your 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.

- Fees
- Additional fees are not charged

- A unique credit card number
- Processing

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

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Claim Concerns
Claim Status

Claim status is updated daily on the CareSource Provider Portal. You can check 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
- 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:

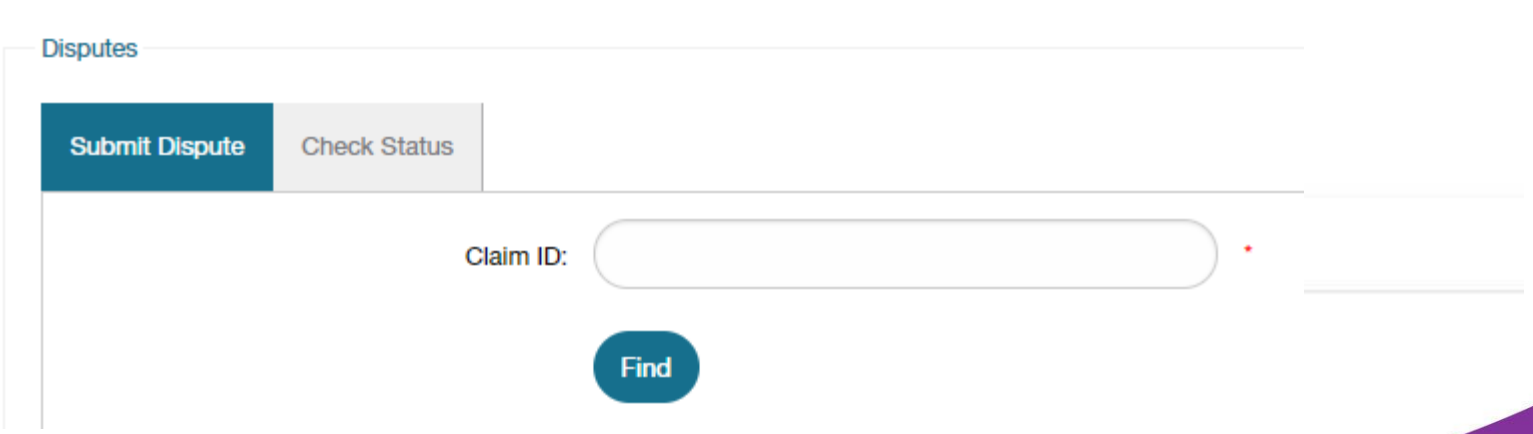
If you are responding to a denied authorization that requires medical necessity review, please submit an appeal.

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:



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

Claim Concerns

Claim Appeals – Provider Portal

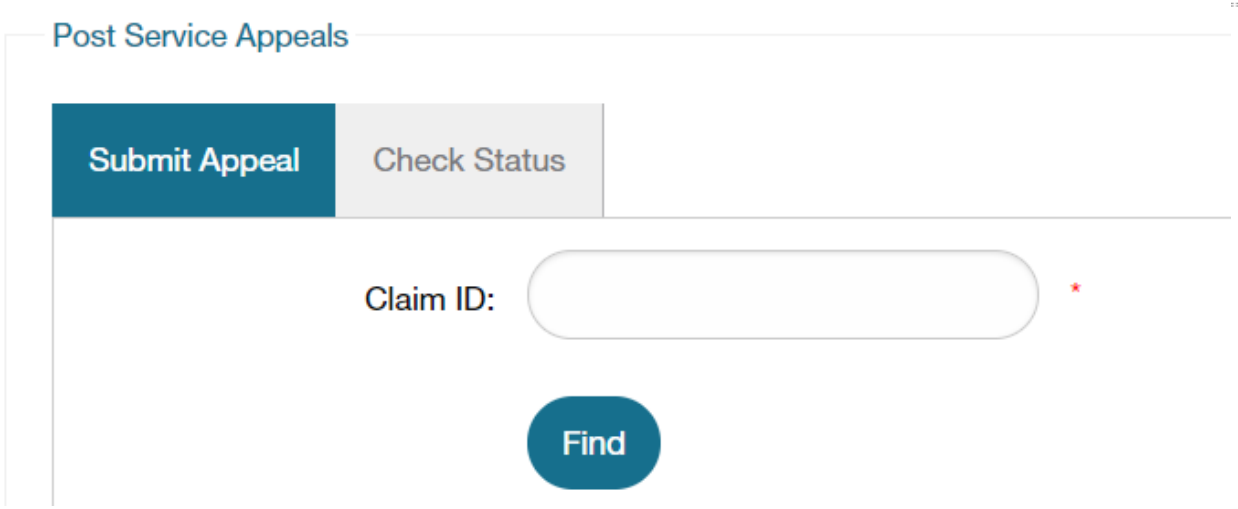
Post Service Appeals

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

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Top 8 Denial Reasons

Denial Reason	Resolution
Service not payable for provider	Provider needs to ensure their specialty is allowed to bill for this code & code is payable per IHCP fee schedules. File a dispute
Code does not have a contracted fee	CareSource recommends filing a dispute and reaching out to health partner engagement specialist, if code billed is valid & payable for provider's type.
Services disallowed by UM/ Units exceed UM 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 & prior auth was obtained. File a dispute
Invalid diagnosis code/not a primary diagnosis code	Visit Indiana Medicaid website & code sets. File a dispute.

Top 8 Denial Reasons

Denial Reason	Resolution
Claim returned to provider for corrections/services not payable as billed	Check for correct coding: NCCI edits, modifiers, primary codes, etc. File a dispute
Incomplete, invalid rendering provider NPI	Evaluate box 33 on CMS 1500 to ensure appropriate information is entered. File a dispute
Procedure has an unbundled relationship	Verify appropriate NCCI edits, correct coding practices & CCI edits. File a dispute
NDC invalid or missing	Verify NDC billed is valid, on the claim, and appropriate units of measurement included. File a dispute

General Billing Codes

- Emergency Department Autopay List
- Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient DRG
- Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance
- Procedure Code Modifiers for Professional Claims
- Procedure Codes That Require Attachments
- Procedure Codes That Require NDCs
- Revenue Codes
- Revenue Codes with Special Procedure Code Linkages
- Service Codes That Require Electronic Visit Verification

Service- and Provider-Specific Codes

- Anesthesia Services Codes
- Chiropractic Services Codes
- Dental Services Codes
- Durable and Home Medical Equipment and Supplies Codes
- Family Planning Services Codes
- Hearing Services Codes
- Hospice Services Codes
- Injections, Vaccines, and Other Physician-Administered Drugs Codes
- Inpatient Hospital Services Codes
- Long-Term Care Codes
- Mental Health and Addiction Services Codes
- Obstetrical and Gynecological Services Codes
- Podiatry Services Codes
- Renal Dialysis Services Codes
- Surgical Services Codes
- Telehealth Services Codes
- Therapy Services Codes
- Transportation Services Codes
- Vision Services Codes

Program- and Benefit-Specific Codes

- Adult Mental Health Habilitation Codes
- Behavioral and Primary Healthcare Coordination Codes
- Family Planning Eligibility Program Codes
- Medicaid Rehabilitation Option Services Codes
- Medical Review Team Codes
- Presumptive Eligibility for Pregnant Women Codes
- Preventive Care Services Excluded from Copayment for HIP and PE Adult

Code Sets

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

- Necessary Codes
- Billable codes ("code sets")
- Codes related to specific coverage

https://www.in.gov/medicaid/providers/business-transactions/billing-and-remittance/

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 five 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 1st trimester

Enhanced Credentialing

CareSource now loads all provider specialties into our directory, including ancillary provider types:

- Radiology
- Anesthesiology
- Pathology
- Hospitalist services
- Emergency medicine
- PT/OT/ST

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 after

- December 17th 2 pm – 4 pm
- Save the Date will be published on our Updates & Announcements Page

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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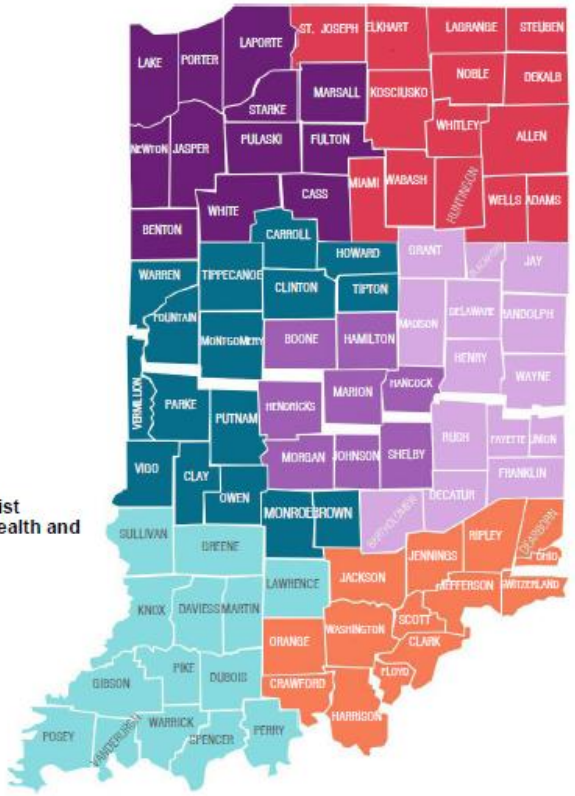

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CareSource