SECTION XII: Billing, Claims And Encounters

CLAIM SUBMISSION

ELECTRONIC DATA INTERCHANGE (EDI)

ONECare encourages you to submit your medical claims electronically.

Advantages include:

- decreased submission costs
- faster processing and reimbursement
- allows for documentation of timely filing

EDI is for primary claims only with the exception of claims when a member's primary insurance is ONECare and their secondary insurance is Care1st as our system automatically coordinates processing for these services submitted. Any other claims that require secondary payments submit on paper with a copy of the primary remittance advice attached.

Medical (CMS 1500) Claims

ONECare works with CHANGE Healthcare fka Emdeon (WebMD) 800.215.4730 for acceptance of EDI CMS 1500 claims. Our CHANGE Healthcare (WebMD) Payer I.D. is **57116**.

Claims may be submitted electronically directly to CHANGE Healthcare (WebMD) or from your clearinghouse to CHANGE Healthcare (WebMD). If you experience problems with your EDI submission, first contact your software vendor to validate the claim submissions and upon verification of successful submission, contact CHANGE Healthcare directly at 800.215.4730.

Medical (UB-04) Claims

We work with SSI for acceptance of EDI UB-04 claims. Questions may be directed to SSI Help Desk at 800.880.3032.

Dental (J430D) Claims

The submission of dental claims electronically may be sent one of four ways:

- Providers can also submit claims, check eligibility and confirm benefits through Advantica's online provider portal. To register, go to www.advanticabenefits.com/providers and click on "Dental Provider Registration".

- Directly to CHANGE Healthcare or from your clearinghouse to CHANGE Healthcare. Advantica works with CHANGE Healthcare. Advantica's CHANGE Healthcare Payer I.D is 43168. To enroll, go to https://www.emdeondental.com/ and enter Advantica Payer ID 43168. If you are already enrolled, be sure to link

your CHANGE Healthcare account with the Advantica Payer ID. **EHG – EDI Health Group, Inc. – DentalXChange**. To enroll go to: http://www.dentalxchange.com/partners/WebClaim and click on Services > Provider Services > Claims Connect > Get Started or call 800.576.6412 ext. 455. Advantica Payer ID 43168

Tesia. To enroll contact call 800.724.7240 or e-mail sales@TesiaSupport.com. Visit the Tesia website at www.tesia.com. Advantica Payer ID 43168.

Attachments such as x-rays (submitted as a TIF or JPG document) or reports may be submitted electronically to www.nea-fast.com. You will receive an assigned NEA number to reference on the electronic claim submission.

To register with NEA simply go to www.nea-fast.com and click on "REGISTER NOW". Choose "Dental Online Registration". Or you may register by phone at 800-782-5150 (Select Option 2).

ELECTRONIC FUNDS TRANSFER (EFT)

EFT allows payments to be electronically deposited directly into a designated bank account without the need to wait for the mail and then make a trip to the bank to deposit your check!

Providers also have the ability to view remits online; allowing no delay between receipt of dollars and the ability to post payment.

Medical Claims

The EFT form is available on our website under the Forms section of the Provider menu. If you do not have internet access, contact Provider Network Operations and we will provide you with the form.

Dental Claims

Advantica selected CHANGE Healthcare fka Emdeon as its electronic (EFT) payment and electronic remittance advice (ERA) reporting partner. There is no cost to you to use these services and enrollment is free! To enroll in CHANGE Healthcare ePayment, visit www.emdeondental.com to create a Dental Provider Services (DPS) account. If you have questions about the enrollment process, please call CHANGE Healthcare at 888.255.7293.

HIPAA 5010 TRANSACTIONS

ONECare is compliant with the CMS implementation timeline for all 5010 transactions. Trading partners are required to begin sending electronic transactions in the 5010 format. We encourage you to reach out to your respective clearinghouse to obtain specific instructions to ensure you understand how the changes with 5010 may impact your submissions and receipt of data. Some of the major changes with the 5010 claims submission process are listed below:

- Service and billing address: The service and billing address must be the physical address associated with the NPI and can no longer be a post office box or lock box. The pay to address may still contain a post office box or lock box.

- State and Postal Codes: State and zip codes are required when the address is in the US or Canada only. Postal codes must be a 9-digit code for billing and service location addresses.

- Rendering tax identification number: The rendering provider tax identification number requirement has been removed. The only primary identification number allowed is the NPI. Secondary identification numbers are only for atypical providers (such as non-emergent transportation) and we recommend you use the G2 qualifier. The billing tax ID is still required.

- Number of diagnosis codes on a claim: For electronic submissions, it is a requirement that diagnoses are reported with a maximum of 12 diagnosis codes per claim under the 5010 format and paper CMS 1500 submissions contain a maximum of 12 diagnosis codes per claim.

ICD-10 IMPLEMENTATION REMINDER

ICD-10 replaced ICD-9 coding for the classification of disease or health condition, symptoms, and causes, used by hospitals, providers, and others, and is required to be implemented for *outpatient dates of service on or after October 1, 2015 and inpatient dates of discharge on or after October 1, 2015.*

Provider Information

- Provider resources are available from CMS to help with the transition of ICD-9 to ICD-10. The CMS link is http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.
- ICD-10 is used for:
  - Diagnosis codes (ICD-10-CM) for all providers
  - Inpatient hospital procedures (ICD-10-PCS)
- Provider documentation:
  - Codes must be supported by medical documentation and because ICD-10 codes are more specific, more documentation may be necessary
  - Revenue may be impacted by specificity

Claim Submissions

- Claims for dates of service or dates of discharge on or before September 30, 2015 are submitted with ICD-9 codes.
- Claims for dates of service or dates of discharge on or after October 1, 2015 are submitted with ICD-10 codes.

  - For example:
    - UB04 claims with dates of service than span across 10/1 are submitted with ICD-10 codes.(recurring outpatient services, such as physical therapy, chemotherapy, etc, must be split for ongoing treatment that spans 10/01/15.
    - CMS1500 claims must be split to submit services with dates of service 9/30/15 and prior with ICD-9 codes and services with dates of service 10/1/15 and after with ICD-10.
- Claims for dates of service 10/1/15 and after may be billed with an ICD-10 code and can be processed without issue even if the authorization was obtained prior to 10/1/15 with an ICD-9 code(s).

Prior Auth Submissions

- Authorization requests submitted on or before September 30, 2015 are submitted with ICD-9 codes.
- Authorization requests submitted on or after October 1, 2015 are submitted with ICD-10 codes.
  - Please follow the guidelines above. Requests with incorrect coding will be pended for more information and delay the processing of your request and your request may be voided as incomplete if we are unable to obtain the proper coding information from your office.

CLAIM ADDRESSES

Medical Claims:

Direct CMS 1500 and UB-04 claim forms (initial submissions and resubmissions) and medical records to:

Attn: Claims Department
2355 East Camelback Rd #300
Phoenix, AZ 85016

Dental Claims:

Direct dental claim forms (initial submissions and resubmissions) and dental records to:

Advantica Administrative Services, Inc.
PO Box 8510
St. Louis, MO 63126

CLAIMS CUSTOMER SERVICE

Medical Claims (CMS 1500 and UB-04 Claim Types):

Claim status can be checked 24 hours a day, seven days a week online at www.care1st.com/az.

Our Claims Customer Service Team is also available to assist you during the business hours listed below:

Monday – Friday 8:00 AM - 12:00 PM & 1:00 PM - 4:30 PM
Ph. 602.778.8345/877.778.1855 (options in order 5, 4)

Dental Claims:
Advantica manages the dental benefits provided to ONECare members on behalf of Care1st.

Claim status can be checked 24 hours a day, seven days a week online at Advantica's website, www.advanticabenefits.com.

For questions on dental claim submissions, contact Advantica directly at the following:
Monday – Friday 8:30 AM – 4:30 PM
Ph: 800.429.0495

CLAIM LIAISON
Our *Claim Liaison* is an excellent resource and is available to assist your office via phone or in person with questions regarding claim submission and processing. The Claim Liaison can be contacted directly at 602.778.1800 x1877.

REQUIRED ID NUMBERS

FEDERAL TAX ID
The Provider must also report the Federal Tax Identification Number (TIN) under which they will be paid. The Federal TIN (Employer Identification Number, EIN) must also be billed on the CMS 1500 form in Field 25.

NATIONAL PROVIDER IDENTIFICATION (NPI)
ONECare requires all providers to submit the rendering/servicing provider's NPI on every claim. ONECare requires that when applicable, the prescribing, referring, attending and operating provider NPI(s) also be present on claim submissions. Claims without the required NPI(s) will be developed for the NPI.

Please work with your billing team to ensure that NPI(s) are submitted appropriately with each claim submission and call us if you have any questions or need assistance.

- To apply for your Individual NPI and/or Organizational NPI online, go to www.nppes.cms.hhs.gov or contact National Provider Identifier Enumerator Call Center 800.465.3203 to request a paper application.

- If you have not yet notified ONECare of your NPI(s), please fax a copy of your NPI(s) confirmation to Provider Network Operations at 602.778.1875.

SECTION XII: Billing, Claims And Encounters

BILLING FOR SERVICES RENDERED

CLAIM FORMS

The Centers for Medicare and Medicaid Services (CMS) now requires providers to submit all claims on the newest version of each claim form.

- Practitioners – CMS 1500 (version 02/12)
- Facilities – UB-04
- Dental – J430D

Claims submitted on the old claim form will be developed to resubmit on the appropriate claim form.

Services can be billed on one of three forms: the CMS 1500 (version 02/12) claim form for professional services, the UB-04 for inpatient and outpatient facility services, dialysis, nursing home and hospice services or the J430D for dental services. All providers must submit claim forms as documentation of services rendered, even if the provider has a capitated agreement with the health plan for the service.

TIMELY FILING GUIDELINES

When ONECare is primary, the initial claim submission must be received within six months from the date of service for contracted providers. For non-contracted providers, the initial claim submission must be received within twelve months from the date of service.

Secondary claim submissions must include a copy of the primary payer's remittance advice and be received within 60 days of the date of the primary payer's remittance advice or twelve months from the date of service, whichever is greater.

- Acceptable proof of timely filing documentation must establish that ONECare or its agent has <u>received</u> a claim or claim related correspondence
    - Acceptable examples of proof of timely filing include:
        - Signed courier routing form documenting the specific documents contained
        - Certified mail receipt that can be specifically tied to a claim or related correspondence
        - Successful fax transmittal confirmation sheet documenting the specific documents faxed
        - Acceptable confirmation report from CHANGE Healthcare fka Emdeon (our sole electronic clearinghouse) documenting successful transmittal

- Unacceptable examples of proof of timely filing include:
  - Provider billing history
  - Any form or receipt that cannot be specifically tied to a claim or related correspondence
  - Acceptance confirmation report from any electronic clearinghouse other than CHANGE Healthcare

DUPLICATE CLAIMS

ONECare receives a large number of duplicate claim submissions as a result of claims being frequently resubmitted within 30 days from the date of initial submission.

To avoid duplicate claims, we recommend validating claims status after 14 days following submission and allowing 60 days prior to resubmission of a claim. The 60 days allows us to meet our goal of paying claims within 30 days from the date of receipt and also allows enough time for billing staff to post payments. Resubmission of claims prior to 60 days causes slower payment turnaround times.

Verify claim status prior to resubmitting a claim. Your claim status can be verified 24-hours a day, seven days a week on our website. Minimizing duplicate submissions reduces your administrative costs.

SCANNING TIPS

All paper claims are input into our system using a process called data lifting.

1. Printing claims on a laser printer will create the best possible character quality
2. If a dot matrix printer must be used, please change the ribbon regularly
3. Courier 12 pitch non proportional font is best for clean scanning
4. Use black ink for all claim submissions
5. Always attempt to ensure that clean character formation occurs when printing paper claims *(i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number)*
6. Ensure that the claim form is lined up properly within the printer prior to printing
7. If a stamp is required, refrain from red ink as this may be removed during the scanning process
8. Make every effort to not place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc. *(characters on the claim from outside of the lined boxes have a tendency to "throw off" the registration of the characters within a box)*
9. Use an original claim form as opposed to a copied claim form as much as possible
10. Use a standard claim form as opposed to a form of your own creation *(individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly)*

SECTION XII: Billing, Claims And Encounters

REQUIRED CLAIM FIELDS

The "required" fields to be completed on a **CMS 1500** Claim Form* are as follows:

Field	Description
1a	Insurer's I.D. Number
2	Patient's Name (last, First, Middle Initial)
3	Patient's Birth Date/Sex
5	Patient's Address
9	Other Insurer's Name
9a	Other Insurer's Policy or Group Number
9b	Other Insurer's Date of Birth/Sex
9c	Employer's Name or School Name
9d	Insurance Plan Name or Program Name
10	Patient Condition Related to: a,b,c
12	Patient's or Authorized Person's Signature
13	Insurer's or Authorized Person's Signature
14	Date of Current Illness; Injury; Pregnancy
17	Name of Referring Physician or Other Source
17a	Other ID Number
17b	NPI Number (only required if box 17 is populated)
21	Diagnosis or Nature of Illness or Injury 1,2,3,4
23	Prior Authorization Number
24a	Date(s) of Service
24b	Place of Service
24d	Procedures, Service or Supplies
24f	Charges (usual and customary amount(s))
24g	Units
24j	Rendering Provider's NPI
25	Federal Tax ID Number or Social Security Number
28	Total Charge
31	Signature of Physician or Supplier and Provider Identification Number
32	Name and Address of Location Where Services were rendered – when the address in box 33 is not the address where services where rendered, box 32 must be populated with the service location. **Note:** For transportation claims, the complete pick up and drop off address is required. If the Pick-Up location is an area where there is no street address, enter a description of where the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80')
33	Provider's Facility Name, Supplier's Billing Name (as registered with the IRS), Address, Zip code, and Phone Number
33a	Provider's Organizational NPI

*Operative reports, consult notes, consent forms and/or any other documentation required in order to determine reimbursement status of a claim must also be attached.

SECTION XII: Billing, Claims And Encounters

The "required" fields to be completed on a **UB-04** Claim Form are as follows:

Field	Description
1	Provider Name, Address, and Phone Number
3b	Medical Record Number
4	Bill Type
5	Federal Tax Number
6	Statement Covers Period
9	Patient Name
9	Patient Address
10	Patient Date of Birth
11	Patient Sex
12	Admission Date
13	Admission Hour
14	Type of Admission
15	Source of Admission (Inpatient and observation only)
16	Discharge Hour (Inpatient and observation only)
17	Patient Status (Inpatient and observation only)
19-28	Condition Codes
42	Revenue Code
43	Revenue Code Description
44	HCPCS/ Rates
45	Service Date – Required for outpatient billings with more than 1 DOS in box 6
46	Service Units
47	Total Charges by Revenue Code
50	Payer
51	Health Plan ID Number
52	Release of Information
56	Rendering Provider's NPI (field required)
58	Insurer's Name
59	Patient's Relationship to Insured
60	Patient I.D. Number
61	Group Name
62	Insurance Group Number
63	Treatment Authorization Codes
65	Employer Name
66	Other Diagnosis Codes
69	Admitting Diagnosis Codes
74	Principal Procedure Code and Dates
74 a-e	Other Procedure Codes
76	Attending Physician Name (required for bill types 11x, 12x, 21x and 22x) and NPI Number (required if name field is populated)
77	Operating Physician Name and NPI Number (NPI Number only required if name field is populated)
78-79	Other Physician Names and NPI Numbers (NPI Number only required if name field is populated)

SECTION XII: Billing, Claims And Encounters

OTHER INSURANCE

ONECare follows Medicare guidelines for coordination of benefits. When the member has primary commercial coverage, the primary insurance carrier must be billed first. When a patient notifies the provider of other insurance, ONECare must be notified. Please note that the allowed amount shall be based upon the lesser of ONECare's or third party carrier's fee schedule, less the paid amount by the third party carrier(s) any remaining balance shall be paid by ONECare as coordination of benefits. Please refer to our Prior Authorization Guidelines for prior authorization requirements. Prior authorization is required for some services when ONECare is the secondary payer.

BALANCE BILLING

ONECare members are eligible for both Medicare and Medicaid. Providers shall not hold ONECare members liable for Medicare Part A and B cost sharing when the AHCCCS is responsible for paying such amounts. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will (a) accept the ONECare payment as payment in full, or (b) bill the appropriate AHCCCS Plan.

BALANCE DUE CLAIMS

When submitting a claim for balance due, the provider must include a complete copy of the claim along with the other insurance carrier's Explanation of Benefits (EOB) or Remittance Advice (RA), include the remark code/remittance comments section of the RA. ONECare must receive any balance due claim within 60 days of the receipt of the primary carrier's EOB or RA or 180 days from the date of service, whichever is greater.

When a member is ONECare primary and Care1st secondary our system automatically coordinates processing for these services and submission of the primary remittance advice along with another claim is not necessary. This is only when the member is both ONECare and Care1st. Please contact our Claims Customer Service Team if you have not received a remittance advice for both lines of business within 90 days.

CLAIMS RESUBMISSION POLICY

Resubmissions/reconsiderations must be received within the following time frames:

- 12 months from date of service
- 60 days of the date of recoupment or last adverse action, if greater than 12 months from the date of service
- 60 days from the date on the primary payer's remittance advice, if greater that 12 months from the date of service

Note: ONECare will re-adjudicate claims re-submitted by providers if an initial claim was filed within the original prescribed submission deadline.

SECTION XII: Billing, Claims And Encounters

RESUBMISSIONS/CORRECTED CLAIMS

When submitting a corrected claim, please include an attachment indicating the reason for resubmission along with the corrected claim/resubmission and the original claim number to expedite handling. If you feel that you have identified a billing issue that may result in a larger volume of resubmissions, please work directly with your Provider Network Representative or our Claims Liaison.

DUPLICATE OR ERRONEOUS PAYMENTS

Providers will refund promptly to ONECare any payment incorrectly collected from ONECare for services for which another carrier or entity has or should have primary responsibility. In the event of any overpayment, erroneous payment, duplicate payments or other payment of an amount in excess of which the provider is entitled, ONECare may, in addition to any other remedy, recover the same by offsetting the amount overpaid against current and future reimbursements due to the Provider.

EXPLANATION OF REMITTANCE ADVICE

The Remittance Advice (RA) is an explanation of the payment arrangements that is sent out with the claims payment to the provider. The report identifies key payment information. If you have any questions regarding a RA, please contact Claims Customer Service or Provider Network Operations.

REMITTANCE ADVICE REPORT COLUMNS AND DESCRIPTIONS

The following are the report columns and descriptions included in the RA:

Company	Number, name, address, and telephone number of the company defined in the general ledger on the Company Name and Address Maintenance screen and assigned to the LOB on the Enter/Update Line-of-Business Codes screen.
Vendor/Subscriber	Name and address of either the vendor or subscriber, depending on who is being paid for the claim. The vendor is defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. The subscriber information is defined either on the Enroll Subscribers screen or the Enroll Additional Members screen.
Vendor No.	The code identifying the claim vendor defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. If the vendor has multiple addresses, "*An" displays to the right of the vendor number, where n represents the vendor's address number used.
Check No.	The check number pulled from the MASTER. CLAIM file.
Payment	The amount being paid by the check. The payment amount is pulled from the MASTER. CLAIM file.
Document Number	The claim document number defined either during claim entry on the Enter/Update General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Invoice Number	The claim invoice number taken from the CONSTANT file and entered on the Enter/Update General Claims screen.
Date Approved	The approval date of the general claim. The claim is approved on the Enter/Update General Claims screen and the date is stored in the MASTER.CLAIM file.
Member	The member's number and name defined either on the Enroll Subscribers screen or the Enroll Additional Members screen.
Procedure	The claim document number defined either during claim entry on the Enter/Update

	General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Qty	The number of times the procedure was performed between the From and thru dates. This information is entered on the Procedure Information screen.
Req. Amt	The requested amount for the procedure entered on the Procedure Information screen.
Elig. Amt	The eligible amount for the procedure. The eligible amount is The lesser of the requested amount or the maximum allowable amount, both of which are entered on the Procedure Information screen.
COB. Amt	The coordination of benefits amount entered on the Procedure Information screen.
W. Hold	The amount withheld by the health care organization from the payment amount. The amount withheld is based on the agreement made with the vendor, provider, or LOB and is entered on the Procedure Information screen.
Discount	The amount withheld by the health care organization for discounts. This is also based on the agreements made with the vendor, provider, or LOB. The discount is defined on the Regional Vendor Information screen and entered on the Procedure Information screen.
Copay	The amount the member paid for copayment defined on the Copay/Coinsurance Maintenance screen and entered on the Procedure Information screen.

CLAIM PAYMENT DETAIL

Provider/ Member	The provider code, or the member number and name of the person who should receive the corresponding payment amount. Provider codes are defined on the Enter/Update Provider Codes screen and entered on the Enter/Update General Claims screen. Member numbers are defined either on the Enroll Subscribers screen or the Enroll Additional Members screen and entered on the Enter/Update General Claims screen.
Payment	The payment amount due to the provider or member. This amount is entered on the Enter/Update General Claims screen.

OTHER A/P TRANSACTIONS

Invoice No.	Invoice number (defined on the Enter Invoices screen) or memo number (defined on the Debit and Credit Memo Entry screen).
Type	The batch source of the invoice or memo. The type is defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Date Approved	The invoice or memo approval date defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Description	The invoice or memo description defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen. If the invoice was for a capitation payment, the comment will be "*Capitation Payment*."
Amount	The invoice or memo total amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Payment	The invoice or memo payment amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Less Discount	The total discount amount of the invoices and memos.
Total Transactions	The total payment amount of A/P invoices and memos that affect the amount of the check for the vendor or family.

REMITTANCE ADVICES AVAILABLE ON WEBSITE

Medical

For your convenience, remittance advices are available for reviewing and printing on our website minimizing delay between receipt of dollars and the ability to post payment. Contact Provider Network Operations to obtain a login or confirm your login status.

SECTION XII: Billing, Claims And Encounters

Dental
Advantica selected CHANGE Healthcare fka Emdeon as its electronic remittance advice (ERA) reporting partner. There is no cost to you to use these services and enrollment is free! To enroll in CHANGE Healthcare ePayment, visit www.emdeondental.com to create a Dental Provider Services (DPS) account. If you have questions about the enrollment process, please call CHANGE Healthcare at 888.255.7293.

IMPORTANT NOTES

- When box 31 on the CMS 1500 form has "Signature on File," this is acceptable as long as the processor can determine the servicing provider. When only the group name appears in Box 33 and the processor is unable to determine the servicing provider, the claim will be developed for a corrected claim. Box 33 should always indicate the facility name as provided to the IRS and CMS.

- If the same service is performed on the same day and by the same provider, the claim must be submitted with the applicable modifier and supporting documentation attached.

- If a claim is received with dates of service that fall after the received date the entire claim will be developed for a corrected claim.

- Diagnosis codes that require a 4th or 5th digit will be developed for a corrected claim if not submitted with appropriate code. ONECare never changes or alters a diagnosis code.

MODIFIERS

Valid modifiers should be used when submitting claims to ONECare. Claims that are submitted with an inappropriate or missing modifier will be developed for a corrected claim. The following are a few commonly used modifiers and tips on appropriate usage:

***MODIFIER 50* (bilateral procedure)**
Modifier 50 is required for all bilateral procedures. Please refer to the current coding guidelines for a listing of appropriate bilateral procedures.

Bilateral procedures are billed on one line with 1 unit and the 50 modifier:

EXAMPLE:
Line 1: 69436, with "50" modifier, full dollar amount, 1 unit
Total payment: 150% of fee schedule

***MODIFIER 59* (distinct procedural service)**
Modifier 59 is required to identify a truly distinct and separate service and should not be used if the procedure is performed on the same site. When an already established

modifier is appropriate, it should be used instead of modifier 59 (example modifier 91 for repeat clinical procedures). ONECare applies NCCI (National Correct Coding Initiative) bundling edits to claims. Claims submitted with modifier 59 are subject to medical review and office notes/operative reports are required with the claim submission for consideration. As a reminder, it is not appropriate to use this modifier with the following CPT ranges: 77421-77427 or 99201-99499. Effective 01/01/15 four new HCPCS modifiers to define subsets of the modifier 59, used to define a "Distinct Procedural Service", are available for use:

- XE: Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS: Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP: Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Similar to modifier 59, records to support the use of these modifiers are required for codes within the following ranges:

CPT Code	Brief Description
36600	Blood Draw/Arterial Catherization
43210 - 43239	Upper Gastrointestinal - Diagnostic
45380 - 45398	Colonoscopy - Diagnostic
45900 - 45999	Rectal/Colon - Diagnostic
46600 - 46615	Anoscopy - Rectal/Colon - Diagnostic
49560 - 49568	Hernia Repair
51600 - 51720	Bladder - Diagnostic
51725 - 51798	Cysometrogram – Bladder - Diagnostic
52000 - 52318	Cystourethroscopy – Bladder - Diagnostic
58100 - 58120	Endometrial Biopsy - Diagnostic
62310 - 64640	Lumbar and Sacral Pain Management
69100 - 69999	Ear Procedures
94640 billed with 94060 on same date of service	
96372 when billed with pain management procedures	

***MODIFIER 76* (repeat procedure by same physician)**

Modifier 76 is required to identify repeat procedures performed by the same physician. When multiple procedures are performed by the same provider, both services are submitted on the same claim. Claims submitted with modifier 76 are subject to medical review and records are required with the claim submission in order to be considered.

***MODIFIER* 77 (repeat procedure by a different physician)**

Modifier 77 is required to identify repeat procedures performed by different physicians. Claims submitted with modifier 77 are subject to medical review and records are required with the claim submission in order to be considered.

MODIFIER 91 (repeat clinical diagnostic laboratory test)
Modifier 91 is required to identify repeat procedures performed by the same physician. When multiple procedures are performed by the same provider, both services are submitted on the same claim. Claims submitted with modifier 91 are subject to medical review and records are required with the claim submission in order to be considered

MODIFIER **SG (Ambulatory Surgical Center facility service)**
Modifier SG is not required on surgical procedures to identify the facility billing and is not used for professional services; however it is recommended to clearly indicate facility billings.

MODIFIERS AD, QK, QX & QY **(Anesthesia with CRNA oversight)**
When anesthesia services are provided by a CRNA with oversight from a physician, the appropriate modifier is required (AD, QK, QX, or QY).

Services are reimbursed to each provider (CRNA and supervising physician) at 50%.

ADDITIONAL MODIFIER CRITERIA

- When a complete laboratory service is performed (both professional and technical component), the service should be billed on a single service line with no modifier.

- Modifiers are required for all DME, Prosthetics and Orthotics and Ambulance services.

- When both the technical and professional component are performed by the same provider of service, the service code(s) should be billed on a single service line without a modifier, and not billed on two separate lines with the TC and 26 modifiers.

OPERATIVE REPORT

An operative report is required for the following surgical procedures:

- Multiple procedures with a total allowed amount greater than $5000.00
- Any surgical procedure billed with modifier(s) 59, 62, 66, 76, 77, or 78
- Any unlisted procedures
- Any surgical procedure billed for a higher level of care than originally prior authorized

SECTION XII: Billing, Claims And Encounters

REFUNDS

When submitting a refund, please include a copy of the remittance advice, a letter or memo explaining why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable).

If multiple claims are impacted, submit a copy of the applicable portion of the remittance advice for each claim and note the claim in question on the copy. When a refund is the result of a corrected claim, please submit the corrected claim with the refund check.

Refunds are mailed to ONECare, Attention: Finance, 2355 E Camelback Rd, Suite 300, Phoenix, AZ 85016.

ANESTHESIA

Notes are required for all timed procedures and authorization are subject to medical review. The specific anesthesia start and end time must be submitted on the CMS-1500 form. The total number of minutes is required in the unit field (25G).

- Consultations of other evaluation and management code on the same day as an anesthesia administration are not payable. Consultations provided the day before anesthesia services are payable separately when prior authorization is obtained.

- Daily pain management following surgery is not a covered expense.

When services are provided by a CRNA and oversight is provided by a supervision physician, the applicable modifier must be submitted on each claim. The QX modifier is billed with the CRNA service when medical direction is provided by a physician. The QY modifier is billed by the supervising physician to indicate medical direction was provided to the CRNA. Either AD or QK modifiers are billed by the supervising physician to indicate that medical direction was provided to multiple concurrent anesthesia procedures.

As a reminder, the anesthesia record is required anytime the anesthesia starts and stops during a procedure.

ASSISTANT SURGEONS

Assistant surgeon bills are submitted with a modifier -80 or -81. These charges are reimbursed at 10% of the reimbursement rate of the assistant surgeon. Assistant surgeon charges submitted for a physician assistant, nurse practitioner, or clinical nurse specialist should be submitted with modifier AS.

DENTAL PROVIDERS

All dental providers must submit claims on the current ADA Dental Form. ADA dental codes, as published in the most current CDT manual, should be used for claims

submission. Please include the information below on each claim to avoid delay in payment:

1. Member's name
2. Member's Medicaid number
3. Member's date of birth
4. Rendering dentist's name
5. Rendering dentist's office location
6. Rendering dentist's TIN
7. Rendering dentist's NPI
8. Billed Amount
9. Date of service for each line submitted
10. Other Insurance Information
11. Quadrants, arches, tooth numbers and surfaces for dental codes that require identification.

Please refer to Section VI Covered Services for detailed information regarding covered services.

DIALYSIS

- For facility billings, the type of bill must be 72x and the appropriate modifiers must be billed for the specific dialysis services.

- Physicians do not require their own authorization. They may use facility authorization.

DURABLE MEDICAL EQUIPMENT

- Canes, crutches, standard walkers, standard wheelchairs and supplies do not require an authorization when provided by a contracted provider.

- Valid modifiers must be submitted with DME services to indicate NU (new) or RR (rental rate). Claims submitted without one of these modifiers will be developed for a corrected claim.

EMERGENCY TRANSPORTATION PROVIDERS

Claims for emergent transportation, including transport transfer services to a higher level of care (such as member transfer from Skilled Nursing Facility to Hospital), must indicate Emergency in Box 24C. Emergent services do not require prior authorization; however non-emergent services must be authorized accordingly. Inter-facility transports require authorization.

The appropriate modifier for ambulance services must also be billed.

The full pick up address address (or location if an address is not available) and drop off address are required in box 32 for ambulance services. If the pick up location is an area where there is no street address, enter a description of where the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80'). Claims that do not contain this information will be developed for a corrected claim.

For electronic claims, the pick up location must be billed in loop 2310E and the drop off location must be billed in loop 2310F. No trip ticket is required if these fields are populated correctly.

For paper claims, a trip ticket is required on each claim. Pick-up and drop-off requirements are as follows:

1. Pickup and/or drop off location = facility, i.e. hospital, SNF
   - Facility name, city, state, zip OR street address, city, state, zip required in box 32
2. Pick up and/or drop off location ≠ facility
   - Street address, city, state, zip required in box 32
3. Pick up location = area where there is NO street address

Description of where service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80') required in box 32

Supplies provided during emergency transportation are to be billed by the ambulance service and not the supply company. Supplies are included in the reimbursement for the ambulance transport and not paid separately.

Ambulance wait time is not a covered benefit.

HOME HEALTH

- Nursing supplies are not considered routine. All supplies require prior authorization to be reimbursed.

HOSPICE SERVICES

- When a member elects hospice, hospice services are reimbursed by traditional Medicare and not ONECare.

IMMUNIZATIONS/INJECTABLES

COVERED IMMUNIZATIONS

- A complete list of covered immunizations and additional quick reference information can be located at the following link: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf

OTHER INJECTABLES

- Vitamin B-12 injections (J3420) are payable for diagnosis codes 266.x, 281.0 and 579.8 only and must be billed with the applicable NDC.

- J3490 (unclassified drug code) requires description & dosage and should only be used if there is no other appropriate code. A description of the specific drug is required along with the applicable NDC.

DRUG BILLING/NATIONAL DRUG CODE (NDC)

Since all ONECare members are dual-eligible, ONECare follows AHCCCS guidelines regarding requirements for NDC billing. AHCCCS implemented new billing requirements for drugs administered in outpatient clinical settings in accordance with Federal Deficit Reduction Act of 2005. All paper and electronic UB-04 and CMS 1500 claims must include the appropriate National Drug Code (NDC) number on claims for payments for drugs administered in an outpatient setting.

NDC is billed with an N4 qualifier when submitted electronically and must be billed in the following format: With 11 digits for the NDC, the unit of measure (F2, GR, ML, or UN) and the quantity (examples: N411111111111 F210 for electronic submission or 11111111111 F210 for paper submission)

Claim lines billed without the NDC code are developed for a corrected claim.

For more information, please visit:

- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1234.pdf

LABORATORY

PCPs and Specialists may bill in office labs based on the Clinical Laboratory Improvement Amendments (CLIA) test complexity categorization provisions utilized by CMS. In order for a lab to be payable, the lab must be allowed to be performed in POS 11. Practices with CLIA certifications must ensure that each CLIA certification is on. All other laboratory services must be performed by Sonora Quest.

Sonora Quest patient service locations are available at www.sonoraquest.com by clicking on the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24 hours per day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

SECTION XII: Billing, Claims And Encounters

MATERNITY SERVICES

When submitting prenatal care and delivery claims, the following guidelines and coding procedures will apply:

ONECare reimburses obstetrical care as a total OB (TOB) package. To qualify for a TOB package, a minimum of 5 ante partum visits must be rendered in addition to the delivery. To confirm this requirement was satisfied, the appropriate delivery CPT procedure code is billed in addition to the ante partum visits. Ante partum and post partum visits are billed with the appropriate E&M CPT code (99211-99215) on individual service lines with 1 in the 'units' field for each date of service.

ONECare collects all dates of service for obstetrical care. This does not impact policies related to global billing, however it requires that all dates of service be reported on the claim. Consequently, each ante partum date of service must be billed individually. Claims received ***November 1, 2014 and later*** that are not billed in this format will be denied.

Total OB Example:

OB physician performs 6 ante partum visits between January 1 and April 30 and delivery occurs May 5.

- Line 1: Appropriate total OB care delivery CPT code
- *Line 2: 1st Ante partum visit billed with the date of service and E&M CPT code
- *Line 3: 2nd Ante partum visit billed with the date of service and E&M CPT code
- *Line 4: 3rd Ante partum visit billed with the date of service and E&M CPT code
- *Line 5: 4th Ante partum visit billed with the date of service and E&M CPT code
- *Line 6: 5th Ante partum visit billed with the date of service and E&M CPT code
- *Line 7: 6th Ante partum visit billed with the date of service and E&M CPT code
- *Line 8: Post partum visit billed with the date of service and E&M CPT code. *Claims for the total OB package can be billed prior to the post partum visit being rendered. Please be sure to submit the post partum visit once it is completed.*

*****Each visit must be billed on a separate line with the specific date of service and a unit of 1.

All services included in the TOB package are billed with the delivery. Reimbursement is made on the total OB care delivery CPT code.

To report services related to maternity care, use the appropriate CPT-4 office visit codes and the appropriate ICD-9-CM pregnancy diagnosis codes.

Prenatal care can be billed as fee-for-service if patient transfers to a high risk OB doctor or patient terminates from ONECare.

CPT Procedure Codes, Vaginal Delivery

59400 Package Routine obstetric care including antepartum care (a minimum of five visits), vaginal delivery (with or without episiotomy and/or forceps) and postpartum care. Total OB package should be billed after delivery.

59409 Vaginal delivery only (with or without episiotomy), forceps or breech delivery. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59410 Vaginal delivery only (with or without episiotomy), forceps or breech delivery including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.

CPT PROCEDURE CODES, CESAREAN DELIVERY

59510 Package Routine obstetric care including antepartum care (a minimum of five visits), cesarean delivery, and postpartum care. Total OB care should be billed after delivery.

59514 Cesarean delivery only with no postpartum or antepartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59515 Cesarean delivery only including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59525 Subtotal or total hysterectomy after cesarean delivery.

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

*Multiple births should be paid using the total OB code for the first birth and the delivery only code with a 51 modifier for subsequent births.

LABOR AND DELIVERY

Providers should use ASA code:

00857 Continuous epidural analgesia for labor and cesarean section

00955 Continuous epidural analgesia for labor and vaginal delivery

00850 Base (7) + time for cesarean section-8 total time units max

00946 Base (5) + time for vaginal delivery-8 total time units max

01960 Anesthesia for vaginal delivery only-8 total time units max

01961 Cesarean delivery only-8 total time units max

01967 Neuraxial labor analgesia/anesthesia for planned vaginal delivery-8 total time units max

01968 Cesarean delivery following neuraxial labor analgesia/anesthesia-8 total time units max

01969 Cesarean hysterectomy following-8 total time units max

OB anesthesia does not require documentation. Providers should not bill 01996 with anesthesia for delivery.

ADDITIONAL OB INFORMATION

- If a provider different from the provider with the total OB authorization performs the delivery only, the provider with the total OB authorization shall be reimbursed for all prenatal visits on a fee-for-service basis. The prenatal visits should be submitted indicating each individual date of service and separate charges for each visit. Should provider change facility affiliation, ONECare must be notified regarding disposition of members. The authorization may follow the physician but final billings must be initiated by each facility and each facility must indicate the dates of service and charges that apply. The physician's facility that provides the delivery will be eligible for total OB reimbursement if the authorization is on file and the minimum numbers of visits have taken place.

- A total OB authorization includes all prenatal visits and postpartum care. When a patient transfers care to another provider, a new OB auth must be obtained.

- Any additional surgical procedures performed during the delivery admission must also be reported along with appropriate diagnosis. If a postpartum tubal ligation is performed, the signed consent form must be submitted with the claim.

- No prior authorization is required for assistant surgeon services on cesareans. Assistant surgeon services are not covered for vaginal deliveries, **only** for cesareans.

- OB claims need a minimum of five visits in order to qualify and be paid for a total OB package rate. If no prenatal visits are billed with total OB package codes 59400, 59510, 59610, or 59618 the claim will be developed for a corrected claim.

- If a claim indicates pregnancy terminated, patient transferred care, or patient moved out of state, the provider(s), total OB authorization will still cover all charges incurred up to that point to be paid fee-for-service. The reason for discontinuation of care should be indicated on the CMS 1500 form.

- The operative report, prior authorization and the Federal consent form are required for sterilization services. Consent form must be signed 30 days prior to sterilization. Total Hysterectomies do not require an authorization if performed on an emergency basis and they never require a federal consent form.

- 2D OB ultrasounds (3 or more) require prior authorization

MID-LEVEL PROFESSIONALS (NP'S & PA'S)

NPs and PAs are reimbursed at the ONECare Midlevel Fee Schedule.

RADIOLOGY

Providers must bill with either a 26 (professional) or TC (technical) modifier for correct reimbursement. When billed with no modifier, provider is indicating they provided both the technical and professional services. All services performed for a specific service date or date span must be billed on a single claim.

SKILLED NURSING FACILITY (SNF)

- The type of bill for facility billings must be 21x
- Revenue codes for room & board for SNFs is 190-194 and 199
- *SNF providers cannot bill with overlapping months

SURGERY PROVIDERS

- An operative report is required for the following surgical procedures:
  1. Multiple procedures with a total allowed amount greater than $5000.00
  2. Any surgical procedure billed with modifier(s) 59, 62, 66, 76, 77, or 78
  3. Any unlisted procedures
  4. Any surgical procedure billed for a higher level of care than originally prior authorized

- Multiple procedures are paid at 100% of the applicable fee schedule for the first, and 50% of the applicable fee schedule for the next five procedures. When an operative report is required and not submitted, the claim will be developed for the operative report. Office procedures require office note's if

an OP report is not available. In order to eliminate any delay in payment, submit an OP Report with a surgery claim.

- Planned surgeries require their own prior authorizations. Surgical trays (A4550) are not reimbursable.

MEDICAL CLAIMS REVIEW

The Medical Management (MM) Department has assigned the medical claims analysis responsibility to the medical claims analysts who are responsible for reviewing and analyzing all claims deemed appropriate for retrospective review. The MM Department uses the following guidelines, criteria, and coding indexes to review a claim:

- International Classification of Diseases-Tenth Edition (ICD-10)
- Current Procedural Terminology (CPT)
- CMS Common Procedure Coding System (HCPCS)
- Medicare Guidelines
- Milliman Care Guidelines®
- National Correct Coding Guide: Correct Coding Initiatives (CCI)
- UB Editor
- McKesson Claim Check

The following types of claims are reviewed by MM on a regular basis. Please note that this is not an all-inclusive list and is subject to change at any time.

- All Level-V Emergency Medicine Physician charges
- Inpatient claims that are set to pay at the inpatient outlier rate
- Multiple and Bilateral Surgeries over $500.00
- Observation over 24-hours
- Critical care
- Prolonged services
- Anesthesia unusual services
- Unlisted/ By report procedures

As needed, the results of the MM analysis are forwarded to the CMO for review and decision. All identified claims that do not meet the criteria may be subject to denial or reduction of reimbursement and are reviewed by the CMO or designee. All cases of potential fraud or abuse are referred to CMS in accordance with ONECare's Fraud and Abuse policy.

The outcomes and aggregate adjustments are compiled, tabulated and presented monthly to the MM Committee by the CMO.

If appropriate, members will be referred to MM for monitoring and assistance with continuity of the member's care.