Care1st Health Plan Arizona – August 2021

News you can use!

Billers' Corner

Provider Tips

Top 5 Denial Reasons and Reminders to Reduce Denials:

1. **Duplicate Billing:**
   - Use the Care1st Web portal to confirm claim status at any time
   - Allow 45-60 days from the initial claim submission prior to resubmitting
   - Contact Claims Customer Service to assist with questions prior to submitting duplicates
2. **Provider Not Contracted – Auth Required:**
   - Refer all laboratory services to Sonora Quest (our exclusive lab)
   - Refer to the Prior Authorization Guidelines on the website
3. **Primary Insurance on File-Bill Primary Insurance:**
   - Verify coverage at each appointment
   - Use AHCCCS online to verify other coverage
4. **Patient Not Eligible on Date of Service:**
   - Confirm eligibility on AHCCCS online or Care1st Member Services prior to claims submission
5. **Exceeds Timely Filing Guidelines:**
   - Initial claim submission must be received no later than 6 months from the date of service, or eligibility posting date, whichever is greater
     - Care1st secondary claims must be received within 6 months from the date of service/eligibility posting date, or within 60 days of the primary carrier's processing date as indicated on the EOB, whichever is greater
   - Resubmissions must be received within 12 months of the date of service, or eligibility posting date, whichever is greater

Care1st Health Plan Arizona
1870 W Rio Salado Parkway
Tempe, AZ 85281
Phone: 602.778.1800
Toll Free: (866).560.4042

Bilateral Billing / Pathology Claims: CLIA Reminders & Repeat Service Billing

We have two topics we wanted to discuss with you today, based on an increase in denials that have been going out. As always, our goal is to help you get your claim paid correctly the first time and to avoid resubmissions.

- **Bilateral Billing Requirements**
  - Please be sure that when you are billing a bilateral service, you are using the correct modifiers required by AHCCCS.
    - If a CPT code is valid for use with modifier 50, the service must be billed with a quantity of 1 and modifier 50 to indicate bilateral billing in order to be processed for payment under AHCCCS
    - If a primary carrier does not require modifier 50, we can still coordinate with the primary EOB. However, the claim you submit to Care1st must use the correct modifier.
    - Remember that finger, toe, eyelid, and eyelash services may also be bilateral services
      - If the service qualifies for modifier 50, you must bill modifier 50 with a quantify of 1. Then add the additional modifiers to indicate the locations where the service(s) were performed.
      - If the service does not qualify for modifier 50, please bill each modifier on a separate line to ensure that services are priced correctly.

- **Pathology**
  - CLIA Labs – Many lab services require CLIA certification (Examples: U0003 and U0004 for COVID-19 testing).
    - Labs, FQHCs, and individual providers that are CLIA certified must recertify as required and must send the recertification to AHCCCS to ensure the claim will process to pay the CLIA service on the first submission.
    - Individuals that are sending specimens to outside labs do not required CLIA certification, but should ensure they are billing appropriate CPT/HCPC codes for the specimen collection
  - Repeat Lab Service – If performing a repeat lab service where the CPT/HCPC code is billed on separate lines of the claim, or on separate claims, the provider must bill modifier 91 to indicate a repeat lab service
    - This is required anytime the provider/vendor is the same, even if the lab is performed at a different location
    - The provider may still bill modifiers XE, XS, XU, or 59 to indicate a unique service, however, if the same code is billed twice, it must also include modifier 91 on each additional line

As always, you can reach out to Network Management or the Provider Claims Liaisons at the location listed to the left if you have questions or concerns.