Care1st Health Plan Arizona – October 2017

News you can use!

Billers' Corner

Provider Tips

Top 5 Denial Reasons and Reminders to Reduce Denials:

1. **Duplicates:**
   - 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. **Primary Insurance Coverage:**
   - Verify coverage at each appointment
   - Use AHCCCS online to verify other coverage
3. **Provider Not Contracted – Authorization Required**
   - Refer all laboratory services to Sonora Quest (our exclusive lab)
   - Refer to the Prior Authorization Guidelines on the website
4. **Patient Not Eligible on Date of Service**
   - Confirm eligibility on AHCCCS online prior to claims submission
5. **Exceeds Timely Filing Guidelines**
   - Submit initial claims within 6-months of date of service
   - Submit resubmissions within 12-months of the date of service
   - Contact customer service for questions

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Member Billing - Medicaid

Be sure to verify the member's AHCCCS ID at the time of each appointment. The ID number can be confirmed on the member's AHCCCS ID card or by using AHCCCS online or our secure web portal. When Medicaid (AHCCCS) is primary, , it is important to bill the accurate AHCCCS ID on the appropriate claim form: CMS-1500, UB-04, or J430D form. Many clearinghouses reject claims when the member ID, name and birth date do not match the enrollment system.

Dual-Eligible Member Billing

Dual-eligibility refers to those members that are enrolled with both Medicare and Medicaid (AHCCCS). When a member has dual coverage, Medicare must be billed first. Secondary billing is then submitted to the AHCCCS plan such as Care1st under the member's AHCCCS ID. When a member is enrolled with both our Medicare plan (ONECare) and our AHCCCS plan (Care1st), the ONECare ID number should be billed on the claim to ensure the Medicare benefits are adjudicated as primary to avoid delays in processing.

Benefits – When a member has both ONECare and Care1st we take care of the coordination and secondary handling for professional claims that have member cost-share applied by automatically creating the secondary claim to process the member cost share under the secondary plan, Care1st. This is referred to as the Cross-Over Process. The Cross-Over Process creates a new claim number that is ONECare claim number with an M added at the end. This prevents the need for you to submit a new claim to Care1st with the ONECare EOB attached and expedites the secondary payment process.

There are exceptions to this process such as those claims where billing requirements differ, i.e. different quantity, CPT , or modifier requirements.

Billing Requirements – To avoid processing delays, it's important to bill claims to the primary insurer with the primary insurance member ID

- For dual-eligible members covered by ONECare and Care1st, this is the ONECare ID.
- When the member is ONECare and Care1st, ONECare processes the claim as the primary payer and makes every attempt to use the Cross-Over Process to cross the claim over to Care1st for processing as the secondary payer so you can avoid submitting the claim twice. However, because there are exception situations when the Cross-Over Process can't be employed, *if the Care1st remittance advice is not received within 90 days of submission of the ONECare claim*, please submit the secondary claim to Care1st within normal timely filing guidelines (6 months from date of service or within 60-days of primary remittance advice).
- For dual-eligible members covered by a Medicare payer other than ONECare that have Care1st as their secondary, please submit the secondary claim to Care1st with the AHCCCS ID and make sure to include the Medicare Remittance Advice.