Care1st Health Plan Arizona – December 2020

News you can use!

Billers' Corner

Provider Tips

Top 5 Denial Reasons and Reminders to Reduce Denials:

1. **Primary Insurance on file-Bill Primary Insurance:**
   - Verify coverage at each appointment
   - Use AHCCCS online to verify other coverage
2. **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
3. **Patient Not Eligible on Date of Service:**
   - Confirm eligibility on AHCCCS online or Care1st Member Services prior to claims submission
4. **Provider Not Contracted – Auth Required:**
   - Refer all laboratory services to Sonora Quest (our exclusive lab)
   - Refer to the Prior Authorization Guidelines on the website
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

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Maternity Service Claims

As we continue to focus on identifying ways to improve our customer service, to get your initial claims processed and to reduce duplicate billing, Care1st has implemented the following changes to streamline the handling of maternity service claims.

- **Authorization**
  - Contact Care1st Prior Auth to advise of a member pregnancy to establish a Maternity authorization
  - Updates to the number of visits are no longer required should they change from the initial authorization
    Note: *Specific services that require a separate prior auth (e.g., more than 2-D ultrasounds, 3-D ultrasounds, MRIs, etc.) will still require separate authorization*

- **Prenatal Service Billing**
  - Care1st now processes all prenatal services as fee for service until the final delivery claim is received. These services are no longer be denied pending receipt of the delivery claim.
  - As a result, prenatal visits can be billed as services are rendered:
    - Billed charges should be at the provider's contracted rate (or higher), as reimbursement is limited to the lesser of the allowable rate or billed charges
    - Prenatal visits do not need to be reported with the delivery OB claim if previously billed
    - Prenatal visits should no longer be billed with a $0.00 or $0.01 when a TOB package is rendered
    - Each prenatal visit should continue to be billed separately with one date of service and 1 unit per line

- **Delivery Billing**
  - If you are the delivery provider, bill using the appropriate delivery code based the type of delivery and the number of prenatal visits performed:
    - TOB delivery codes are used when the provider performs the delivery and provides 5 or more prenatal visits
    - FFS delivery codes are used when the provider performs the delivery and provides 4 or less prenatal visits
  - If you are not the delivery provider, submit any additional prenatal visit claims that were not previously submitted
  - When the delivery claim is received, Care1st will perform a reconciliation on all prenatal visits paid
  - If TOB delivery requirements are satisfied, services that are part of the TOB package will be adjusted at the time the delivery is paid. The adjustments and TOB payment will be processed on the same remittance advice, providing clear communication of claims handling.

- **Post-Partum Visit Billing**
  - As a reminder, post-partum visits should continue to be billed (even if you are reimbursed for the TOB package)

Please reach out to Claims Customer Service, your Network Management Representative, or our Claims Educators if you have any questions.