11 BILLING AND REIMBURSEMENT

11.1 *GENERAL PAYMENT GUIDELINES*

When adjudicating claims SHP applies all applicable federal and state statutes, regulations and agency guidelines, including but not limited to those payment rules set forth in Title 10 of the New York Code of Rules and Regulations.

11.2 *CAPITATION*

SHP generally pays PCPs a monthly capitation fee for each SHP member on their panel. PCPs are expected to file a claim each time a member is seen in their office. Claims should be submitted in the approved CMS1500 or UB04 format, dependent on your practice type. Claims can also be submitted electronically using submitting ID# 11325 in the HIPPA compliant 837P or 837I format. These claims serve as encounter data, which is used by SHP to evaluate quality, identify utilization trends, satisfy New York managed care quality reporting requirements (QARR), and assess primary care practitioner performance.

11.3 *FEE-FOR-SERVICE CLAIMS*

All specialists and ancillary providers are paid on a fee-for service basis. Reimbursement by SHP for covered services provided to SHP members is considered payment in full. As such, Providers may not bill SHP members for the difference between the SHP claims payment and your charges (balance billing) except for any applicable co-payments, coinsurance or deductibles.

11.4 *CLAIMS SUBMISSION*

All claims and encounter forms must be submitted on a CMS1500 or UB04 form to:

SHP
PO Box 6008
Hauppauge, NY 11788 – 9007

All claims and primary care encounters must be submitted within 90 days of the date of service due to New York State Department of Health reporting requirements. Claims submitted beyond the 90-day limit will be denied.

It is expected that SHP Providers will submit “clean claims”. A “clean claim” is defined as one that can be processed without obtaining any additional information from the provider who rendered the service or a third party. Clean

claims, in essence, have no defect, impropriety (including lack of substantiating documentation), or circumstance requiring special handling that might impact or prevent timely remittance of payment.

Providers must include their National Provider Identifier (NPI) on each claim submission. If you have not obtained a NPI, you can apply through a web-based application process. The web address to the National Plan and Provider Enumeration System (NPPES) is https://nppes.cms.hhs.gov.

Providers should submit original claim forms. Submission of black and white copies delays claim-processing time and may be returned as not able to process.

Claim inquiries or appeals of claim denials must occur within 60 days of the original claim payment or appeal.

If your office does not have electronic capability, you may fax Referral forms to 1-888-892-6130 prior to claim submission.

11.5 *ELECTRONIC CLAIM SUBMISSION*

Suffolk Health Plan is encouraging all providers to submit their claims electronically. We accept claims from **any** clearinghouse that can submit to (Emdeon formerly known as WebMD).

TAKE ADVANTAGE OF THE MANY BENEFITS OF ELECTRONIC CLAIM SUBMISSIONS:

- Services submitted electronically process more quickly
- Reduced administrative costs
- Reduce volume of paper in your office
- Reduce timely filing denials
- Optimize reimbursement turnaround time

Emdeon currently accepts claims for Suffolk Health Plan with Submitter ID# 11325.

****For information regarding Emdeon and initial set up, contact Emdeon Client Solutions Support Line at 1-800-845-6592.**

UB04 Submitters

Please submit your 837I file with your NPI numbers in the appropriate locations:
NPI Qualifier: XX
Billing Provider NPI: Loop 2010AA, Segment NM1, Data Element 09
Rendering Provider NPI: Loop 2310B, Segment NM1, Data Element 09

CMS1500 Submitters

Please submit your 837P file with your NPI numbers in the appropriate locations:
NPI Qualifier: XX
Billing Provider NPI: Loop 2010AA, Segment NM1, Data Element 09
Rendering Provider NPI: Loop 2310B, Segment NM1, Data Element 09

Please do not include the provider's title or middle initial in the "Last Name Field". There is an element available for it in the Rendering Provider Name segment (loop 2310B, position 250) – NM107 (Name Suffix).

If you are not sure if you are submitting the correct NPI number or you have any additional questions pertaining to electronic claims submission, please contact **Provider Services** at 1-877-747-6789..

For services requiring a referral authorization, please use the online electronic referral at www.suffolkhealthplan.com or fax a copy of the paper referral to 1-888-892-6130 prior to submitting claims to Emdeon to minimize denials for lack of authorization.

11.6 *PAPER CLAIM FILING*

Suffolk Health Plan utilizes Optical Character Recognition (OCR) equipment to process CMS1500 and UB04 paper claim forms. Using this type of equipment reduces the processing time of claims. However, only legible, red-ink, current versions of these claim forms can be scanned into the OCR equipment.

Following these simple instructions will facilitate the processing of your claims:

- Submit original red-ink, current versions of CMS1500 and UB04 claim forms
- Avoid submitting black and white copies
- Report only six lines of service on a single CMS1500 claim form
- Avoid handwriting claims
- Print data within the allotted field size
- Include your National Provider Identifier (NPI)

You can order CMS1500 claim forms by calling the U.S. Government Printing Office at (202)512-1800 or for smaller quantities you may contact your local office supply vendor that provides the red dropout ink version of the form.

If you use the service of an external agency or vendor for the preparation of your claim forms, please ensure that these instructions are available to them.

11.7 *SUBMITTING DUPLICATE CLAIMS*

Submitting duplicate claims increases processing costs, processing times and potential for errors.

We ask for your cooperation in contacting our Provider Services Department at 1-877-747-6789 to obtain claim status of a submission prior to resubmitting a claim.

If you would like a reconsideration of a claim payment or denial, please send a written inquiry outlining the reason for the review to:

Suffolk Health Providers
PO Box 6008
Hauppauge, NY 11788.

Remember, claim status can be obtained via our IVR (interactive voice recognition) 24 hours a day/7 days a week.

11.8 *30-DAY DENIAL LETTER*

In order to comply with New York State Prompt Payment Legislation, Suffolk Health Plan sends 30-Day Notices for any claim that may potentially be denied within 30 days from receipt. These notices **DO NOT** require a response and will be sent in addition to the Statement of Remittance.

The Statement of Remittance will reflect the final determination of your claims.

For the providers' convenience, SHP's 30-Day Notices will display the following reasons for possible denial:

- Verification of Eligibility
- Utilization Management/Authorization Review
- Provider Review / Fee Schedule Update
- Possible Duplicate Claim Investigation
- Plan Benefit Review
- Possible Coordination of Benefits / Other Coverage

11.9 *ANESTHESIA BILLING FREQUENTLY ASKED QUESTIONS*

Many anesthesia providers have asked us the following questions regarding the appropriate way to bill SHP for the provision of anesthesia services.

1. **Do you limit reimbursement for obstetrical anesthesia?**

   Yes. There is a 240- minute cap on labor-and-delivery related epidurals. Medical documentation can be submitted to consider reimbursement for time in which the anesthesiologist was in personal attendance beyond 240-minutes (4 hours).

   CPT codes 01967 and 01968 should be billed when a vaginal delivery results in a C-section.

When billing anesthesia services for epidurals during labor, the date of service is the delivery date.

2. **What time interval is used to determine time units?**

   15-minute time intervals are used to determine an anesthesia time unit (i.e. 60 minutes = 4 time units)

   Anesthesia time for which the anesthesiologist was in personal attendance will be considered for reimbursement.

3. **Do you reimburse base units in addition to time and if so, should the base units be identified on the claim submission?**

   Anesthesia procedures (CPT 00100-01999) are reimbursed as base plus time units.

   Base units are maintained in the claims processing system and should not be included on your claim submission.

4. **Do you additionally reimburse for the patient's physical status?**

   No additional payment is made for physical status modifiers P1 through P6.

5. **Do you separately reimburse for CPT codes 99100 or 99140?**

   No. Procedure codes 99100 (special anesthesia service) and 99140 (emergency anesthesia) are not separately reimbursed.

6. **What calculation is used to reimburse general anesthesia services?**

   The total minutes billed are converted into time units and added to the base unit. This sum is then multiplied by the contracted conversion factor to determine the appropriate reimbursement.

   Time in minutes ÷ 15-minutes per time unit = Time Units Sum*

   (Time Units Sum + Base units) x Per Unit Conversion Factor

   * Rounded to the nearest whole value. For example:

   70 minutes ÷ 15 = 4.6 time units (rounded up to 5).

   If submit 1-7 minutes time unit value = 0 (round down to nearest whole value).

   If submit 8 minutes time value = 1 (round up to nearest whole value).

7. **What procedure codes should be utilized?**

   Bill general anesthesia services using the ASA/CPT codes (00100-01999).

   DO NOT bill general anesthesia using surgical CPT codes with anesthesia modifiers. Claims submitted in this manner will be denied to resubmit using anesthesia CPT codes.

   All other services (i.e. injections) should be billed with the appropriate CPT code.

8. **Should minutes or time units be billed?**

   Please bill the total time in minutes using qualifier MJ.

   Do NOT utilize qualifier UN. Claims submitted using qualifier UN will be interpreted as total minutes and therefore underpaid.

   Only the total minutes are to be reported as the days/units (box 24g of CMS-1500) when billing general anesthesia services.

   For example:

   If anesthesia was administered between 9 a.m. and 10 a.m., box 24g should reflect 60 minutes.

   If anesthesia was administered between 12 noon and 2:12 p.m., box 24g should reflect 132 minutes.

9. **Where should the start and stop time be placed?**

   This information can be submitted but is not required for claims processing via EDI.

   It is recommended that this information be included on paper claim submissions but is not required.

   Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the physician is no longer in personal attendance.

   Personal attendance, or time in attendance, is time spent face-to-face with the patient.

   Documentation of time in attendance must always be recorded in the patient's record.

If you need additional assistance or have questions not covered above please contact Provider Services at 1-877-747-6789..

11.10 *VACCINATION FOR CHILDREN (VFC) PROGRAM*

As of August 1, 2006, the New York State Department of Health purchases and distributes vaccines for all **Child Health Plus (CHP)** enrollees using the same process that is used for vaccine for **Medicaid** enrolled children.

Providers who currently participate in the VFC program will be able to order vaccine for CHP patients using the same process currently used to order vaccine for Medicaid patients.

Providers who are NOT currently enrolled in the VFC program must now enroll in order to receive vaccine through this program.

Providers who do not participate in the VFC **will not** be able to access free vaccine.

If you require assistance in enrolling into the VFC program please contact Mr. Gary Rinaldi in the Department's Immunization Program at 518-474-4578.

Additionally, SHP is **not required** to pay providers for the cost of vaccine. Therefore, <u>claims submitted for members under age 19 and one of the immunization procedure codes listed in the following page will be denied with a message referencing the VFC program:</u>

VACCINE	FULL NAME OF VACCINE	MANUFACTURER	CPT CODE
DT***-not available until further notice**	Diptheria Tetanus Toxoid vaccine	SANOFI	90702
DTAP (Tripedia)	Diptheria, Tetanus Toxoid, Acellular Pertussis vaccine	SANOFI	90700
DTAP (Daptacel)	Diptheria, Tetanus Toxoid, Acellular Pertussis vaccine	SANOFI	90700
DTAP (Infanrix)	Diptheria, Tetanus Toxoid, Acellular Pertussis vaccine	GlaxoSmithKline	90700
DTaP- Hep B-IPV (Pediarix)	Diptheria, Tetanus Toxoid, Acellular Pertussis, Hepatitis B and Inactivated poliovirus vaccine	GlaxoSmithKline	90723
DTAP/HIB (Trihibit)-**not available until further notice**	Diptheria, Tetanus Toxoid, Acellular Pertussis and Haemophilus Influenza B vaccine	SANOFI	90721
e-IPV	Inactivated poliovirus vaccine	SANOFI	90713
HEPATITIS A PED (Vaqta) **not available until further notice**	Hepatitis A Pediatric vaccine	MERCK	90633
HEPATITIS A PED (Havrix)	Hepatitis A Pediatric vaccine	GlaxoSmithKline	90634
HEPATITIS B (PED/ADOL)	Hepatitis B pediatric/adolescnent vaccine (Engerix B)	GlaxoSmithKline	90744
HEPATITIS B (PED/ADOL)	Hepatitis B pediatric/adolescnent vaccine (Recombivax HB)	MERCK	90744
HEPATITIS B -2 dose (11-15 only)	Hepatitis B adult - 2 dose vaccine	MERCK	90743
HEPATITS A-HEPATITIS B	Hepatitis A and Hepatitis B combo vaccine (Twinrix)	GlaxoSmithKline	90636
HEP B HIB (Comvax) **not available until further notice**	Hepatitis B and Haemophilus Influenza B vaccine	MERCK	90748
HIB (Pedvax) **not available until further notice**	Haemophilus B conjugate vaccine	MERCK	90647
HIB (Acthib)	Haemophilus Influenza B vaccine	SANOFI	90648
HPV (Gardasil)	Human Papilloma Virus vaccine	MERCK	90649
INFLUENZA			
MENINGOCOCCAL CONJUGATE	Meningococcal Conjugate vaccine	SANOFI	90734
MMR	Measles, Mumps and Rubella vaccine	MERCK	90707
MMR-V (Proquad) **not available until further notice**	Measles, Mumps and Rubella and Varicella Vaccine	MERCK	90710
PNEUMOCOCCAL (Prevnar)	Pneumococcal conjugate vaccine	WYETH AYERST	90669
PNEUMOCOCCAL (2 yr and up)	Pneumococcal polysaccharide vaccine	MERCK	90732
TD (Decavac)	Tetanus Toxoid and Diphtheria vaccine	SANOFI	90718
TD	Tetanus Toxoid and Diphtheria vaccine	HENRY SCHEIN	90718
ROTAVIRUS (Rotateq)	Rotavirus vaccine	MERCK	90680
TDAP (Boostrix)	Tetanus Toxoid and Diphtheria and acellular pertussis vaccine	GlaxoSmithKline	90715
TDAP (Adacel)	Tetanus Toxoid and Diphtheria and acellular pertussis vaccine	SANOFI	90715
VARICELLA (Varivax)	Varicella virus vaccine	MERCK	90716

11.11 *MEDICAL CLAIM REVIEW*

SHP conducts ongoing reviews to examine medical claims for consistency and accuracy in billing processes. The goal has always been to be fair and equitable in this endeavor. SHP continues to utilize globally accepted guidelines including CPT regulations as documented by the AMA, Correct Coding Initiatives (CCI) and Post-Operative Period Guidelines as outlined by the Center for Medicare and Medicaid Services (CMS).

In our ongoing efforts to improve performance in claims processing and payment, we implemented a new claims processing program in September 2007 to enhance our current platform. This will ensure a more thorough and comprehensive review of all claims. We have also conducted an assessment on previously paid claims to ensure coding compliancy. Several areas of our review are based on the following globally accepted coding principles:

1) ***Global Surgical Principles***: CMS has defined specific time periods when the Evaluation and Management (E/M) services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the surgical procedure code. These procedure codes are evaluated based on major and minor service categories with different defined global day allocations for each.

2) ***Add-On Principles:*** Both CPT and CMS define codes that require the presence of a primary procedure code for appropriate coding. These rules follow the direction set forth in the CPT manual that describes Add-on codes as “procedures/services that are always performed, by the same physician” and “are always performed in addition to the primary service/procedure, and must never be reported as stand-alone codes.”

3) ***Assistant Surgeon Principles***: CMS rules based on the need for an assistant surgeon, co-surgeons and team surgeons for all surgical procedures. CMS is the only governing body that continues to evaluate the need for this type of service.

4) ***CCI- National Correct Coding Initiative:*** As defined by CMS:

   a) Comprehensive: These procedure codes have been identified as inappropriate unbundling of comprehensive procedure codes into its component parts (codes).

b) <u>Mutually Exclusive</u>: **These procedures codes are not to be reported together because they are mutually exclusive of each other and cannot occur during the same operative session.**

5) ***Duplicates:*** For the following areas: Radiology, Date Range Duplicates, Lifetime Duplicates and E/M Service Range.

6) *Unbundled Procedure Principles:* **In addition to CCI, there are code pairs that are considered to be a component of another procedure code, filed on the same date of service by the same provider.**

7) ***Evaluation and Management Crosswalk Principles:*** Multiple submissions of E/M codes within the same category and/or two different categories, by the same provider on the same date of service.

8) ***IN – Incidental Procedures:*** The Incidental Procedures category of edits identifies procedure codes classified as not payable due to a status of B (bundled) or P (bundled/excluded) in the CMS National Physician Fee Schedule Relative Value File.

9) ***MN — Medical Necessity Based on Appropriate ICD-9 Codes***

These are Regional and National Medical Necessity guidelines from CMS. Services reported must have the appropriate ICD-9 codes submitted on the claim that demonstrate medical necessity.

SHP is confident that with your help, the improved claims review process will ensure that appropriate services are delivered and paid correctly. By working together, we can all keep costs reasonable for our customers and make the most efficient use of limited health care dollars.

11.12 *FRAUD AND ABUSE MONITORING*

SHP adheres to the following legislation with regards to the monitoring and identification of Fraud and Abuse in billing of services rendered to SHP members:

NYCRR Title 10, Section 98-1.21: Pursuant to Public Health Law section 4414, every MCO that participates in public or government sponsored programs with an enrolled population of 10,000 or more persons in the aggregate in any given year shall develop a plan for the detection, investigation and prevention of fraudulent activities in this state and those fraudulent and abusive activities affecting policies or state or local department of social services contracts issued or issued for delivery in this state.

(1) For the purposes of this section, ***fraud*** means any type of intentional deception or misrepresentation made by a person with the knowledge that the

deception could result in some unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state law, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee or other person(s). A “provider” includes any individual or entity that receives funds in exchange for the provision, or arranging for the provision, of health care services to an MCO enrollee.

(2) For the purposes of this section, ***abuse*** means provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or MCO, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee. It also includes enrollee practices that result in unnecessary cost to the state or federal government, MCO, contractor, subcontractor or provider. For the purposes of this paragraph, *provider* includes any individual or entity that receives funds in exchange for providing, or arranging for the provision, of a service.

Suffolk Health Plan has contracted with **Ingenix** to perform periodic evaluations of providers’ claims to identify billing patterns that are aberrant compared to their peers. If Ingenix identifies an aberrant pattern of billing, they will request medical records from the provider. The medical records will be reviewed to determine if the documentation supports the procedure(s) billed. If it is determined that the medical records do not support the billing, Suffolk Health Plan may initiate a recovery for the deemed amount of overpayment.

Ingenix is considered a HIPAA Business Associate who has access to providers and/or members’ Protected Health Information (PHI). Therefore, if you receive a request from Ingenix for medical records, on behalf of Suffolk Health Plan, please comply with their request. Failure to comply may result in an automatic recovery of payments pertaining to the claims in question.

11.13 *NEVER EVENTS*

Effective January 1, 2010, Health Plans throughout New York State are required to have procedures in place to address the inpatient claims that report a Never Event.

- There are thirteen (13) Never Events. These Never Events include:
  1. Surgery performed on wrong body part.
  2. Surgery performed on wrong patient.
  3. Wrong surgical procedure done on patient.
  4. Retention of a foreign object in a patient after surgery or other procedure.
  5. Patient disability after medication error.
  6. Patient disability associated with a reaction to ABO incompatible blood or blood products provided by a healthcare facility.

7. Patient disability associated with the use of contaminated drugs, devices, biologics.
8. Patient disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended.
9. Patient disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
10. Patient disability associated with an electric shock while being cared for in a healthcare facility
11. Any incident in which a line designated for oxygen or other gas is contaminated with a toxic substance.
12. Patient disability associated with a burn incurred from any source while being cared for in a healthcare facility.
13. Patient disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.

- Never Events 4, 6 and 9 listed above will be monitored administratively in a way similar to the procedure used by CMS.
- The remaining 10 Never Events will be done by chart review. MedReview will request and review hospital medical charts for SHP.
- There is no significant experience across the nation to help in the development of policies and procedures for handling Never Events. Some data is available via NYPORTS.
- Hospitals must always submit the Present on Admission (POA) indicator on all claims.
- There are no national standardized codes so for the 10 Events that will be reviewed by MedReview; SDOH has developed three (3) rates codes that will indicate a Never Event occurred. They are:

Rate Code	Description
2590	Hospital will use this code to identify that a Never Event happened that was so severe that the hospital does not expect any payment on the claim.
2591	Never Event occurred and may have impacted DRG. Full or Partial payment is expected. Claim requires MedReview review.
2592	Never Event occurred and may have impacted Per Diem payment. Full or Partial payment is expected. Claim requires MedReview review.

- For rate codes 2591/2592, MedReview will conduct review of the chart. Hospitals will be given 30 days to send MedReview the chart. If chart is not received within this time period claim will be denied for any payment.
- MedReview's charge in reviewing these claims will be to:
  - Determine if the Never Event happened.
  - If the Event did happen did it cause any repercussion such as increase in increased length of stay, increased DRG or was no harm done.
  - Set Reimbursement.
- Once decision is made by MedReview, Hospital will get thirty (30) days to review and appeal.
- SHP/MedReview will track Never Events by type of event and Hospital.

- Since Never Events affect payment it falls under OMIG's Fraud and Abuse policies and procedures.
- The entire process with chart request to final decision should be handled within 90 days.

Frequently Asked Questions and Answers:

1. **What is the effect on Prompt Payment Requirements?**
   Rate code 2590 would be denied with no payment as hospital would not expect to receive payment.

   For rate codes 2591/2592, hospital will submit an original claim which would get paid then hospital would be expected to submit a second claim with one of these rate codes for claim to be reviewed and adjusted. Since original claim would be paid there is no violation of the Prompt Payment Laws.

2. **How will the Hospitals be notified?**
   Hospitals will be notified via meetings with various Hospital Associations, direct communications to Hospitals and Medicaid Update Newsletter.

3. **Why would a Hospital ever use rate code 2590 and not expect payment on a claim?**
   Failure to identify these situations could position the facility for being sanctioned for fraud and abuse.

4. **How can the Events affect payment?**
   a) Event could change the DRG from a lower cost DRG to a higher cost DRG
   b) Event could add to a DRG by turning the DRG into DRG with complications
   c) Event could cause the DRG to become a high cost outlier

5. **How will Never Events impact professional claims?**
   It is very possible that professional claims will be affected but this will be looked at a later date.

6. **Are any facilities excluded from the Never Events legislation?**
   Currently, Nursing Homes are the only facilities excluded both at a Federal and New York State level.

   However, while excluded by the Federal Government, Critical Access Hospitals and Cancer Hospitals **are included** for New York State.

7. **What should be done in cases where the Hospital will not release the medical record because there is litigation and the Risk Management department of the facility will not release the data?**
   Hospitals get 30 days to submit the requested chart. Failure to do so will result in the claim being denied.