Health Partners Plans

Claims 101

October 25, 2018

Health Partners Plans

Agenda

- Initial Claim Submission
- Claims Appeal Process
- Claims Call Center
- Claims Recovery Unit
- Q&A

Initial Claim Submission

Speaker: Rosa Reyes, Manager Claims

Claims Receipts

Paper Claims:

- Paper claims are received from the post office on a daily basis. The mailing address for paper claims:
  - **Medicaid and Medicare**
    Health Partners Plans
    Attn: Claims
    P.O. Box 1220
    Philadelphia, PA 19105-1220
  - **KidzPartners (CHIP)**
    Health Partners Plans
    Attn: Claims
    P.O. Box 1230
    Philadelphia, PA 19105-1220

Claims Receipts

- Claims are opened, sorted and scanned within 24 hours of receipt.
- All paper claims should be printed on a red and white form to insure proper scanning.
- Claims are edited against coding reference files (CPT, diagnosis, revenue, etc.).
- 837 files are created and loaded into the claims processing system within 48 hours of receipt.

Claims Receipts

Electronic Claim Submission:

- Electronic Data Interchange (EDI) claims are submitted daily from providers through Change Healthcare.
  - 96% of facility claims
  - 94% of professional claims
- HPP can provide a detailed status for each claim submitted through Change Healthcare. The status message will show which claims were accepted, rejected and/or pending, and provide the amount paid on the submitted claim once it has been finalized.
- Reminder: All providers are responsible for monitoring and updating any claim errors that appear on the daily R022 / RPT – 05/05A and R059 / RPT – 10 EDI claim rejection reports. Corrected claim data should be immediately retransmitted electronically to HPP.
- For more information on setting up electronic submission for claims, find the EDI FAQ on our website.

Helpful hints for claim submissions

- All Health Partners (Medicaid) claims must be submitted with the member's nine (9) digit HPP ID number.
  - *Newborn claims should be submitted with baby's individual HPP ID number. Do not submit claims with mother's ID number. Claims will be rejected effective October 1, 2018.*
- All KidzPartners (CHIP) claims must be submitted with the ten (10) digit member ID number that starts with a three (3).
- All Health Partners (Medicare) claims must be submitted with seven (7) digit member ID number that starts with a five (5).
- All physician claims must be submitted with the individual rendering provider's 10-digit National Provider identifier (NPI) number.
- All facility and ancillary claims must be submitted with the group or organizational 10-digit NPI number.

Helpful hints for claim submissions

- For CMS-1500 claims, individual physician's NPI number should be entered in the "Rendering Provider ID #" field (box 24J). The billing provider's group NPI number should be entered in the "Billing Provider Info & PH #" field (box 33A).
- All Medicaid/Chip providers must have a valid PROMISe ID number. Claims without a valid PROMISe ID will be denied.
- NDC codes must be included with all biological drugs.
- ***DME and home health Medicaid claims must have a referring / ordering physician in box 17 on the HCFA 1500. Non physician practitioners, such as physician assistants, certified nurse practitioners, podiatrists and chiropractors are not allowed to order DME or home health services for Medicaid.***

Claims Appeal Process

Speaker: Erica Gadson, Manager Claims

Guidelines

- **Appeals**: Claims Reconsideration is responsible for receiving and handling all appeals where a provider believes their claim was processed and paid incorrectly or denied inappropriately. A claim reconsideration request must be received within **180 calendar** days from the date of the EOP advising of the adjudication decision.
- **Appeal time**: This may be extended with proof of claim submission to another insurance company, depending on the subsequent denial/adjustment. If applicable, the appeal timeframe would then be calculated from the date of the other insurance company's EOP.
- **Member eligibility denials:** Automatically overturned in cases of a retroactive eligibility decision.
- **Credentialing**: If the claim was denied because the provider is non-participating and lacked authorization, but the provider believes he or she is participating, there may be a problem with credentialing. The provider must contact HPP for assistance at **215-991-4350** or **1-888-991-9023** to verify the provider's identification number and participating status. The issue would need to be resolved before the claim can be reconsidered.

How to Submit Claim Denials

- Contact Utilization Management for denials for medical reasons, lack of authorization, or services not matching the authorization. If resolved, the provider must submit a claim for reconsideration for payment.
- Includes claims for elective or SPU admissions that are non-emergent related
- Includes claims that denied because the requested authorization or level of care was not approved.

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Attn: Utilization Management/Appeals
901 Market Street, Suite 500
Philadelphia, PA 19107

How to Submit Claim Appeals

- **Written claim appeals**: Written claim appeals, including documentation, medical justification indicating why a denial/adjustment should be overturned, and a copy of the EOP indicating the denial/adjustment reason, should be sent to Claims Reconsideration via the mailing address below, along with a copy of the Claims Reconsideration request form:

  Health Partners Plans
  Attn: Claims Reconsiderations
  901 Market Street, Suite 500
  Philadelphia, PA 19107

- **HP Connect**: Submit claims appeals electronically via HP Connect. For assistance, call **1-888-991-9023** or **215-991-3450.**
- **Claims Reconsideration Template**: Providers that are assigned a Contract Specialist or a Network Account Manager (NAM), may submit their appeals via an Excel spreadsheet.

Outcomes

- **Outcomes**: Providers will be advised of the claim reconsideration outcome, generally within 30 calendar days of the date the request was received by Claims Reconsideration. (HP Connect has the quickest turnaround time).

- **Overturned**: Claims that are overturned and have payment issued will appear on the provider's EOP and no other notice will be provided. If the original denial is upheld, the provider will be sent a formal response via either a letter, an HP Connect notification, or the returned spreadsheet from the Contract Specialist or NAM. At that time, the provider has the right to dispute and appeal the outcome.

- A provider can also initiate an appeal by telephoning the Claims Reconsideration Call Center at **888-991-9023** or **215-991-3450** (M-F, 9 a.m. to 12 30 p.m. and 1:30 to 5 p.m.).

Claims Call Center

Speaker: Byron White, Manager Claims

Overview

The Claims Reconsideration Call Center provides resolution of provider claim inquiries regarding claim status or requests involving claim adjustments at **888-991-9023** or **215-991-3450** (M-F, 9 a.m. to 12 30 p.m. and 1:30 to 5 p.m.).

- Maximum of five claims per call related to any inquiry, complaint or appeal regarding possible claims processing discrepancies, whether the results of a provider billing error or an HPP processing error.
- Adjudicate claims online while servicing the provider on the phone.
- Review the history of appeals submitted by mail, provider portal, projects or previous telephone calls.
- Investigate and facilitate timely resolution of pended conditions using internal systems within 48 hours of receipt.
- Document all provider calls via a Service Form, which serves as the reference number for each claim inquiry addressed during a call.
- Accurate and complete information in response to providers' claim inquiries.
- Meet and maintain performance standards, such as five percent or less call abandonment rate and a 30 second or less average answer delay on 80 percent of serviced calls.

Claims Recovery Unit

Speaker: Erica Gadson, Manager Claims

Overview

- The Claims Recovery Unit develops processes to identify and prevent overpayments and initiate recovery. This department accounts for money received as restitution and through retractions.
- Conducting ongoing reviews of HPP medical claims, the Recovery Unit has oversight of external vendors acting on the behalf of HPP with DRG audits.
- The Recovery Unit focuses on procedure and diagnosis code consistency, accuracy and appropriateness.
- HPP uses coding software that integrates nationally accepted guidelines, including Current Procedural Terminology logic as documented by the American Medical Association, and Correct Coding Initiatives and Post-operative Guidelines as outlined by CMS.

Retroactive Dis-enrollments

- HPP members are occasionally retroactively dis-enrolled. When this occurs, any premiums paid to HPP are retracted by DHS, the Pennsylvania Insurance Department, or CMS.

- When this happens, claim payments to providers will be retracted for services occurred within the retro-disenrollment period.

Overpayments

- In-network providers are responsible for auditing themselves and reporting any findings that would have resulted in overpayment. A provider who is overpaid on a claim is obligated to reimburse the excess payment. All provider known overpayments should be returned to the below address with an explanation as to why the provider believes the amount to be an overpayment:

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Attn: Recovery Unit

901 Market Street, Suite 500

Philadelphia, PA 19107

- HPP follows the same recovery time period guidelines for non-fraud related claims as adopted by DHS: two years from the date of payment notice.
- If HPP discovers an overpayment, recovery will be initiated and will be reflected on the provider's current EOP.
- **Note:** If the amount owed to HPP by a provider exceeds the amount of money to be paid within a payment cycle(s), an EOP(s) will not generate until the credit balance is cleared. The provider can contact Claims Reconsideration for an update. Once the amount owed is offset by current payments, the retractions and the offsetting payments will generate on the most current EOP.

Returned Checks

There are multiple reasons why a provider would return a check. Below is a list of the common reasons and items that would need to be included when returning a check due to excessive payment:

- Duplicate payment: both the original and duplicate claim number
- Other Insurance Primary: the EOP of the primary carrier (when no EOP is available, the name of the other insurance and member's ID number is required)
- Incorrect billing: claim number and reason
- Invalid patient(s): the claim number(s) associated with the patient(s)

Questions?