AR GENERAL UPDATES

VERBIAGE:

This is just some guidance for Follow-up and notes across the system.

Please avoid using the word hence if possible. It isn't a word that we commonly use in this area.

SECONDARY MEDICAID / MEDICAID HMO:

1. There is an issue happening in secondary Medicaid posting in 835. If you notice any balance has been billed to patient after Medicaid insurance it should be adjusted off.

2. OA23 – Primary insurance processed and secondary Medicaid / HMO insurance is processed the denial with reason code "OA23 – CHG PAID BY ANOTHER CARRIER & OA45-CHGS EXCEED FEE ARRANGEMENT". It should be adjusted off.

   The above rule is applicable for all the datasets.

   Note: Client updating the overrides on the CCO insurances in Healthpac to prevent the OA23 from flipping to patient balance.

RE-FILING CLAIMS:

Whenever refilling the corrected claim to insurance. Do not send just one line item of a corrected claim. It is causing the insurance companies to request a refund for the original payment on the lines that were not resubmitted on corrected claim.

To avoid this issue in the future, please resubmit all line items on the claim when submitting a corrected claim.

PRIMARY PAID MORE THAN ALLOWED AMOUNT:

Effective from 04/19/18, Secondary claims processed and paid $0.00 stating Primary Paid more than Allowed amount. We need to adjust-off the balance.

Example: Allcare CCO, Trillium Community Healthcare, Jackson Care Connect CCO, Mutual of Omaha

ONE HEALTH PORT:

As of 06/03/19 the following Health Plans are available online through OneHealth Port. Phone calls can be prevented by accessing information online

AETNA
ASURIS NORTHWEST HEALTH
BRIDGE SPAN
CAREOREGON

CIGNA
Comagine Health (formerly Qualis Health)
FIRST CHOICE HEALTH
Health Net (PPO)
Kaiser Permanente - Oregon and SW WA
Kaiser Permanente - Washington Region
LIFEWISE ASSURANCE COMPANY
Life Wise Health Plan of Oregon
Life Wise Health Plan of Washington
Moda Health (formerly ODS/OEA)
MOLINA HEALTHCARE
NORTHWEST PHYSICIAN NETWORK
PACIFICSOURCE HEALTHPLANS
PREMERA BLUE CROSS
PREMERA BLUE CROSS BLUE SHIELD OF ALASKA
PREMERA MEDICARE ADVANTAGE
PROVIDENCE HEALTH PLANS
PROVIDERONE
QBS
QUALIS HEALTH
REGENCE BLUECROSS BLUESHIELD OF OREGON
REGENCE BLUESHIELD
SAMARITAN HEALTH PLANS/INTER COMMUNITY
WASHINGTON HEALTH ALLIANCE

ZELIS WEBSITE: [ALL DATASETS]

- The below listed payers that come through **[**https://www.zelispayments.com]. So, use this website to check the claims & eligibility status instead of directly move to calling.

  Note: These 835s are delivered through instamed as they pass through Zelis.

a) Administrative Concepts
b) Allegiance
c) Ameriben
d) American National Insurance Company
e) Benesys
f) Cypress Benefit Administrators
g) Delta Health Systems
h) EBMS
i) Shasta Administrators

AR FOLLOW-UP COMMENTS:

Effective from 10/10/17 – Update the comments only for action taken accounts and do not update the need assistance or question related notes / comments into comments section.

PAYER PAID TO OTHER ADDRESS (NOT ON MMSS ADDRESS)

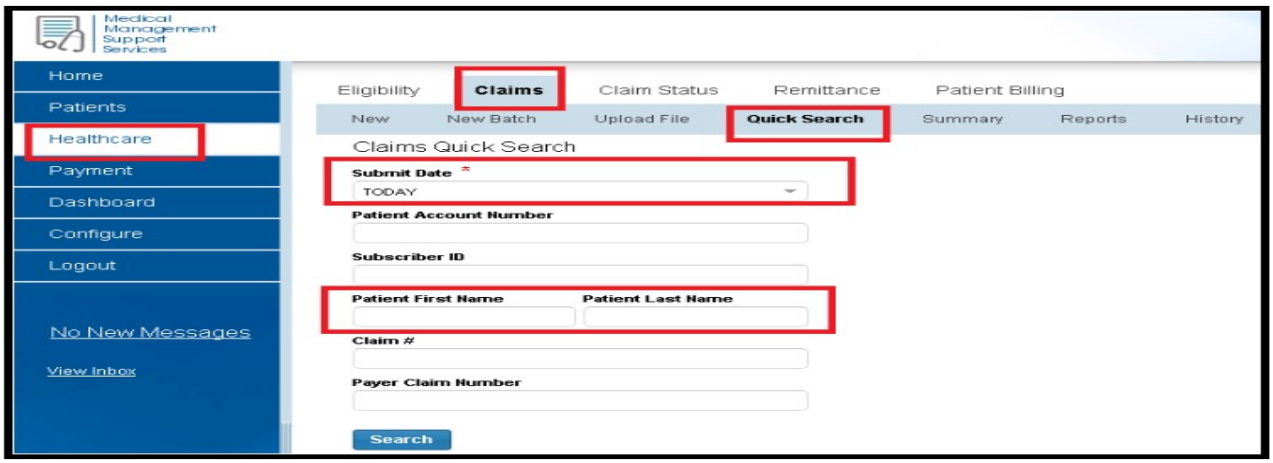
If the payer says it has paid to an address other than 1208 Beall Ln, have the follow up staff please make sure to ask what would be necessary to update the payment address to 1208 Beall. This information should be sent back to us so that we can make sure to update the address. The payment will be uploaded to 1208 Beall Ln Central Point, OR 97502

CLEARING HOUSE: Instamed

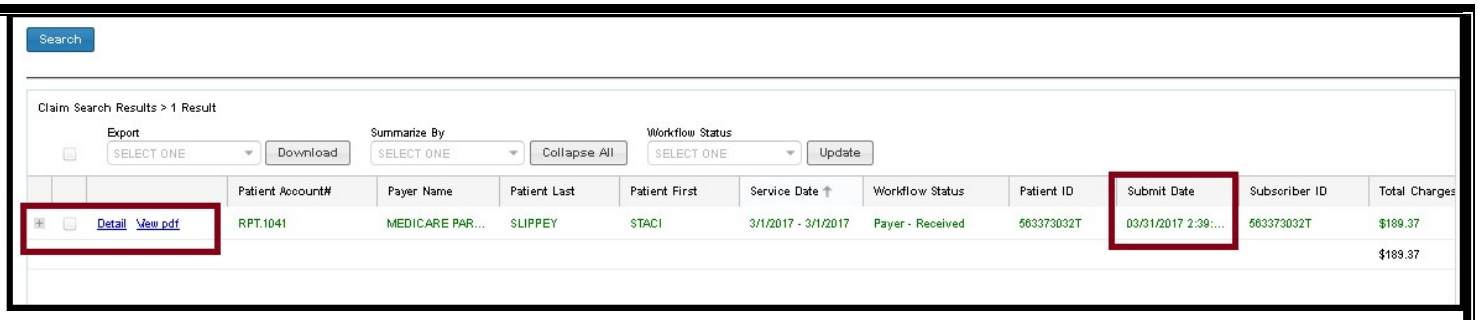
We can view the claim information at the clearinghouse level by going to Healthcare → Claims→ then quick Search.

Once you identify a claim you can go to the Details and then review the responses tab to see the path from original claim through to the submission to the payer and their initial response.

Instamed will only provide information for electronic claims (some are still sent paper).



CLAIMS SEARCH DETAILS:

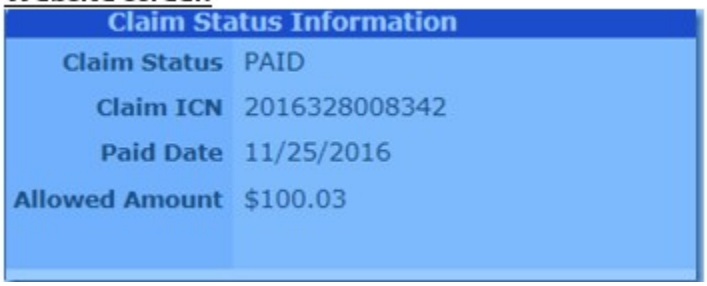


UTILIZING DMAP PORTAL

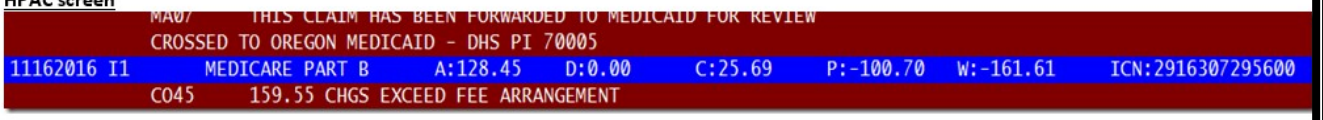
- If we are unable to find the required claim in DMAP website when searched under the correct provider ID, there is no need to call for that scenario, even the representatives will find the same information and provide us.

- If the claim status is PAID it means that claim is approved by DMAP. If so we can compare the AA (Allowed Amount) from DMAP site and the Medicare paid amount (Payment + Sequestration Reduction) and conclude it as Primary paid more that secondary AA (Allowed Amount).

Website screen

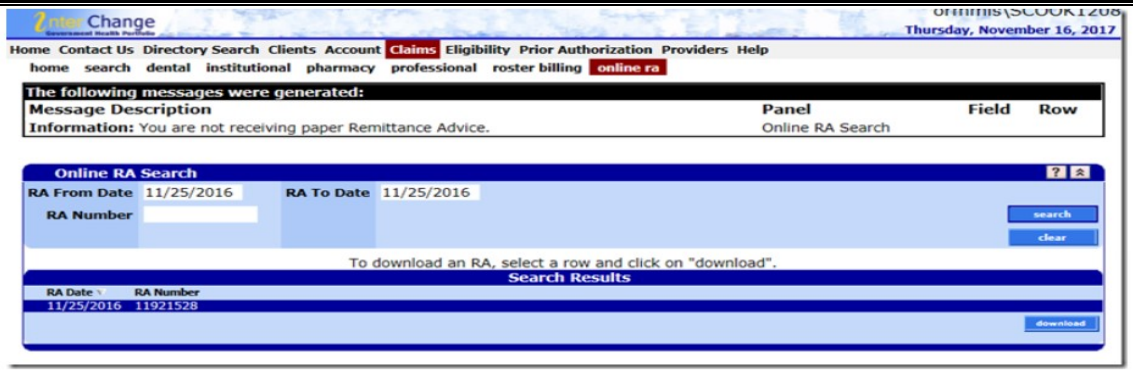


HPAC screen

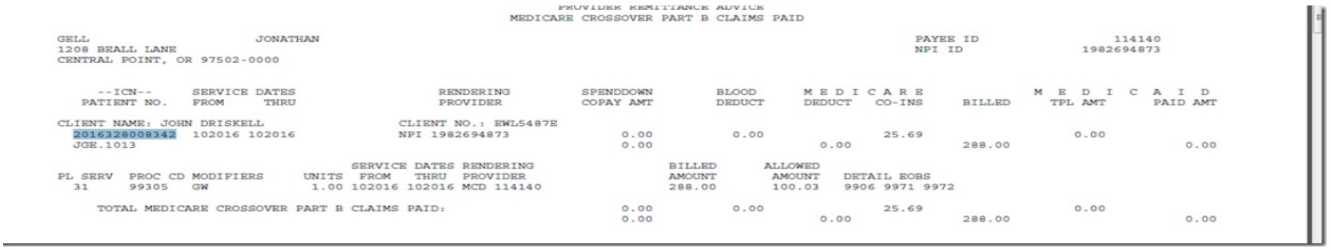


- The Remark codes (HIPAA Adjustment Reason Code) when viewing in website will have all reasons related to the claim and if so the best way is to download the EOB from “online ra” option where we can use the paid date to download the EOB. Select the paid date and download. And the same applies for denials too, It is best to refer the remittance for the more appropriate denial reason.

DOWNLOADING EOB



DMAP EOB WILL HAVE THE AA AMOUNT AND MORE DETAILED REASON CODES.



PROVIDER REMITTANCE ADVICE
MEDICARE CROSSOVER PART B CLAIMS PAID

GELL JONATHAN
1208 BEALL LANE
CENTRAL POINT, OR 97502-0000

PAYEE ID 114140
NPI ID 1982694873

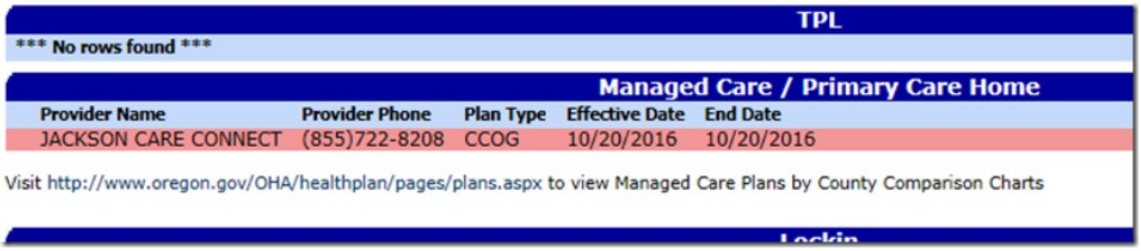
--ICN-- PATIENT NO.	SERVICE DATES FROM	THRU	RENDERING PROVIDER	SPENDDOWN COPAY AMT	BLOOD DEDUCT	MEDICARE DEDUCT	MEDICARE CO-INS	BILLED	MEDICAID TPL AMT	MEDICAID PAID AMT
CLIENT NAME: JOHN DRISKELL			CLIENT NO.: EWL5487E							
20163280083420	102016	102016	NPI 1982694873	0.00	0.00		25.69		0.00	
JGE.1013				0.00		0.00		288.00		0.00

PL	SRV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	THRU	RENDERING PROVIDER	BILLED AMOUNT	ALLOWED AMOUNT	DETAIL REASONS
31		99305	GW	1.00	102016	102016	MCD 114140	288.00	100.03	9906 9971 9972

TOTAL MEDICARE CROSSOVER PART B CLAIMS PAID:								
	0.00	0.00		25.69		0.00		
	0.00		0.00		288.00		0.00	

When checking DMAP eligibility and if there is MCO listed please do consider the Plan type. Only MCO under plan type CCOA & CCOB will cover for Medical benefits of that patient.

PLAN TYPE OF THE MCO:



TPL

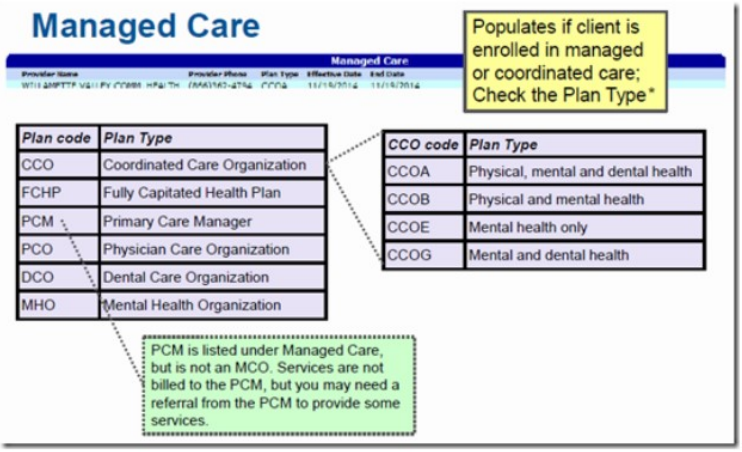
*** No rows found ***

Managed Care / Primary Care Home

Provider Name	Provider Phone	Plan Type	Effective Date	End Date
JACKSON CARE CONNECT	(855)722-8208	CCOG	10/20/2016	10/20/2016

Visit http://www.oregon.gov/OHA/healthplan/pages/plans.aspx to view Managed Care Plans by County Comparison Charts

Lockin



Managed Care

Populates if client is enrolled in managed or coordinated care; Check the Plan Type*

Plan code	Plan Type
CCO	Coordinated Care Organization
FCHP	Fully Capitated Health Plan
PCM	Primary Care Manager
PCO	Physician Care Organization
DCO	Dental Care Organization
MHO	Mental Health Organization

CCO code	Plan Type
CCOA	Physical, mental and dental health
CCOB	Physical and mental health
CCOE	Mental health only
CCOG	Mental and dental health

PCM is listed under Managed Care, but is not an MCO. Services are not billed to the PCM, but you may need a referral from the PCM to provide some services.

ONLY QMB PLAN COVERAGE:

- If patient have Medicare as Primary, processed as (Copay &Co-Insurance), & DMAP as secondary have only the QMB PLAN coverage we will adjust off the secondary balance.

- If patient have Other Insurance carrier (Medicare Advantage) as primary, processed as (Copay, Co-Insurance & Deductible), & DMAP as secondary have only the QMB PLAN coverage we will bill the secondary balance to patient.

- Also we will check whether there is any TPL/Managed care plan is available, if yes will bill the claim to appropriate Insurance.

OHP PLAN COVERAGE:

- If patient OHP plan coverage we will bill the secondary balance to TPL/MANAGED CARE PLAN (if Available) else will bill the claim to DMAP for processing.

- If Primary Insurance (Medicare Advantage) processed as (Copay &Co-Insurance) & DMAP/Medicaid Advantage plan denied stating (OA23 & CO45) will adjust off the secondary balance.

CLIENT INSTRUCTION:

OHP PLANS:

BMD-PLAN ASSISTS WITH MEDICAL, ADDED DRUG PLANS. (ACTS AS AN OPEN CARD). DO NOT BILL PATIENT.
CWM-LIFE THREATENING COVERAGE ONLY. PT RESPONSIBLE FOR MEDICAL THAT IS NOT CONSIDERED LIFE THREATENING
QMB- COPAYS, PREMIUMS, DEDUCTIBLES ARE WRITTEN OFF. DO NOT BILL PATIENT.
MED- COVERS COPAYS, CO-INS, ETC. (IF THE MCR IS PRIMARY AND DOESN'T COVER, OHP WILL NOT COVER). DO NOT BILL PATIENT.
BMM- OPEN CARD, IF MCR DOESN'T PAY, OHP WILL PAY THE ALLOWED. DO NOT BILL PATIENT.
SMF-NO MEDICAL COVERAGE (USUALLY 2ND TO MCR, WITH NO SECONDARY MEDICAL COVERAGE). OK TO BILL PATIENT.
SMB-NO MEDICAL COVERAGE (USUALLY 2ND TO MCR, WITH NO SECONDARY MEDICAL COVERAGE). OK TO BILL PATIENT.

RECEIVED REPLY FROM MMSS:

In this case I prefer to write off the balance when DMAP processes. This way they have the data for the claim and if for some reason their primary insurance recoups the payment we have the claim on file with the state and also if the patient is no longer eligible for Medicaid we would find out.

As far as follow up – if a claim has been submitted to DMAP and it has been more than 30 days. The patient should be checked for eligibility and if eligible and there would be no additional payment the amount can be written off.

BENEFIT AND HSC INQUIRY: - (Patient is eligible and there would be no additional payment)

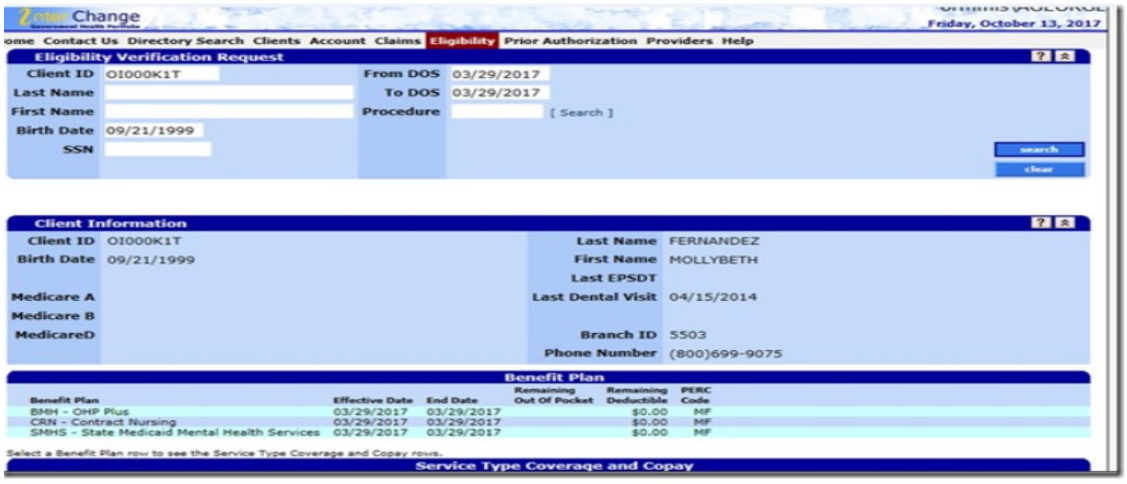
When we come across the scenario like "Patient is active for the DOS with DMAP with no MCO and still services are denied as non covered service we can get more detailed information in the Benefits and HSC Inquiry.

a) If MORE claims denied under the scenario, we will prepare the write-off batches and send to you to adjust-off at our end.

b) If few claims only denied under this scenario, we will mention the AR code as “PER DMAP HSC INQUIRY – NEED TO ADJUST-OFF” to take care of at your end.

BENEFITS AND HSC INQUIRY: SHOWING THE CPT IS NOT ELIGIBLE.

GENERAL ELIGIBILITY SCREEN: SHOWING PATIENT IS ACTIVE



DMAP – MTP Diabetic Shoes: (A5500 & A5513)

- Effective from DOS 03/01/19, for Medicare we will bill on separate lines and add modifier RT and LT and only 1 unit per line for the diabetic shoes HCPCS (A5500 & A5513). Also, do not add –KX modifier as it was automatically added for Medicare insurance.

- For the Diabetic shoes code (A5500 & A5513), follow the instructions as below;

- If we billed the codes with Modifier RT & LT in separate line like below, we need to edit the claim in DMAP online web portal and resubmit with a single line item by adding the units and modifiers(RT & LT)

Detail

Item	Procedure	Units	Charges	Status	Allowed Amount
1	A5500	1.00	$90.00	PAID	$56.41
2	A5500	1.00	$90.00	DENIED	$0.00
3	A5513	3.00	$165.00	PAID	$103.05
4	A5513	3.00	$165.00	DENIED	$0.00

Detail

	Item	Procedure	Units	Charges	Status	Allowed Amount
M	1	A5500	2.00	$180.00	PAID	$56.41
M	2	A5513	6.00	$330.00	DENIED	$0.00
D	3	A5513	3.00	$165.00	PAID	$103.05
D	4	A5513	3.00	$165.00	DENIED	$0.00

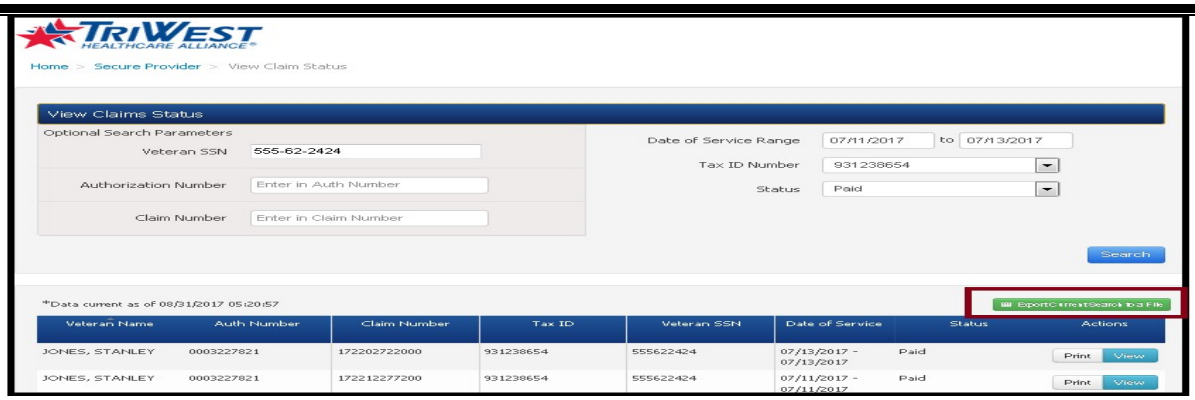
- Then delete the duplicate code and resubmit the claim to DMAP Insurance.
- Review the Example Account MTP.SALGUI0000 for reference.

ACTION TO BE TAKEN:

- Billing Patient.
- Rebilling or Billing the appropriate Insurance.
- Taking Appropriate Adjustments.
- If an item is found to be already paid we need to verify it.

VA CHOICE CARD - Updates:

- For EFT payment, we can prepare and as payment batches for scanning. If it is a check payment which is indicated on the payment info online, it requires a call to see the check cleared the bank. So, we need to call the insurance company and check was cleared.
- If VA claim paid by check and the provider is Susan Sheeley, the checks were being sent to an incorrect address. This was already corrected with enrollment. We need to confirm, the address was updated as 1208 Beall Ln with VA and have to verify the status whether the check has been re-issued to correct address".
- Also, we can filter the VA claims based on paid claims and download a spreadsheet from the site then sort by payment date. We can call the insurance for only one patient from the list of patients based on the paid dates. [i.e. We have to ask the status for one patient per paid date].
- For In process claims need to update the chart notes as "Claim is in process and Claim# xxxxxxxx".



nputs:	Tax ID	SSN	From Date	To Date	Auth Number	Claim Num	Status							
	931238654	555622424	7/11/2017	7/13/2017			paid							
Current Time:09/02/2017 02:14:07														
Veteran Name	Auth Number	Claim Number	Tax ID	Veteran SSN	Dates of Servi	Status	Amount Bil	Amount Pa	Check Number	Date Paid	Denial F	Claim Type	Date Last Updated	
ONES, STANLEY	0003227821	172202722000	931238654	555622424	07/13/2017 -	Paid	$236.28	$113.49	171174125	8/28/2017		Out Patient	08/31/2017 05:20:57	
ONES, STANLEY	0003227821	172212277200	931238654	555622424	07/11/2017 -	Paid	$218.78	$113.49	171174125	8/28/2017		Out Patient	08/31/2017 05:20:57	

TRILLIUM INSURANCE:

- Trillium Insurance providing only one claim status per call.

Effective from 04/01/2017 they no longer process for Retro authorization.

Appeal address is same as claims PO BOX 5030, FARMINGTON, MO 63640-5030. no fax.

First step is to submit dispute using the dispute form available in website, the time limit from the denial date to submit dispute fir Medicare Advantage plan is 120 days & for Medicaid Community plan is 180 days.

Dispute gets processed and upheld again then provider can appeal with medical records.

If a denial is posted as provider ineligible it means provider is non par with DMAP under group (if we DMAP number for that individual provider).

TIMELY FILING LIMIT EXCEEDS CLAIMS:

- If claims exceeding the TFL (Time Filing limit). Please escalate to client end. The client will take care of the TLF Expire claims.
- If Claims not submitted to insurance and TFL will be expiring, we need inform to client. It has been taken care by client end.

CPT 99401 (Medicare Advantage Plans):

- If any Medicare Advantage Plan like HEALTHNET 3023 denies 99401 as “Non-covered service or bundled Service” it is to be written off.

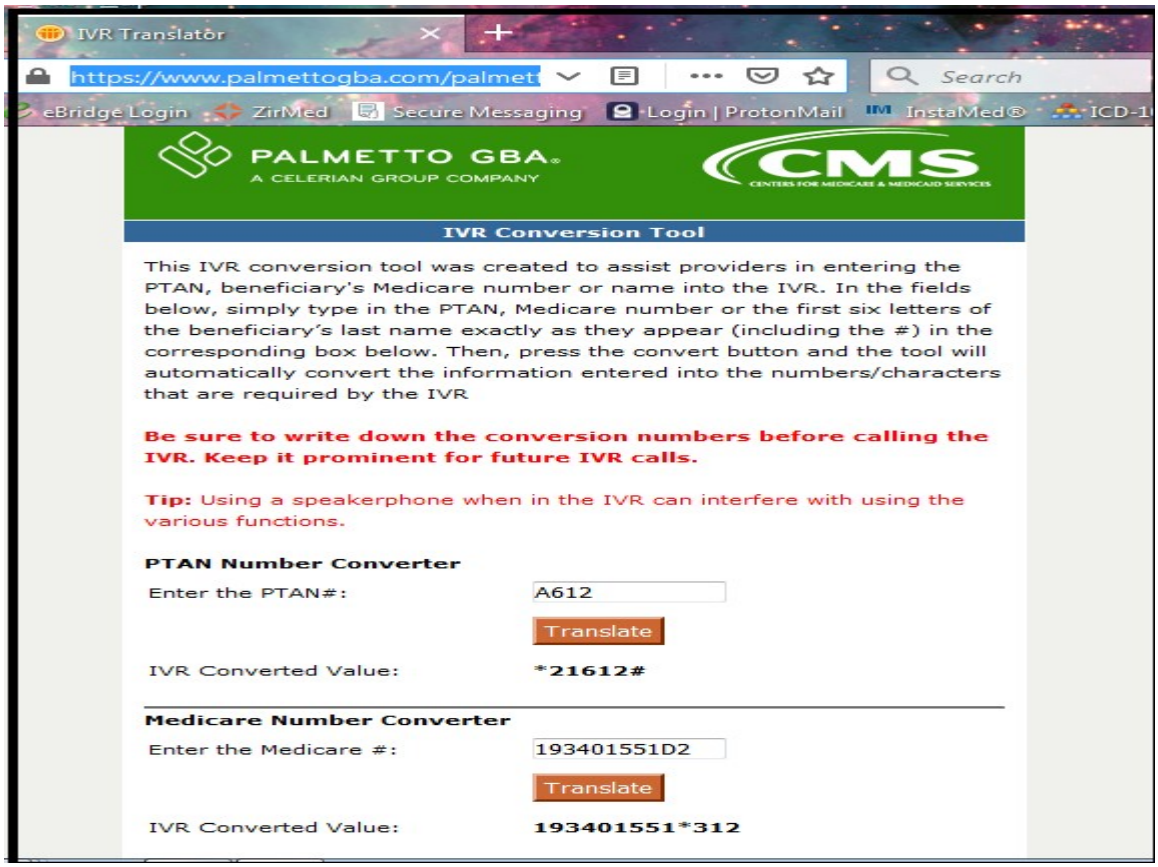
MEDICARE CCI EDITS:

- According to CCI data, there are not any CCI conflicts for the codes 97140 vs. 97110. So there is no bundled relationship between these two codes and CCI modifiers are not applicable. If the claim got denied as “Payment is included in the allowance for the basic service/procedure”, then we need to check (Call to Medicare or Check the eligibility status in online access) whether patient is under Home health episodes of care. If patient is under Home health care — these codes should not be written-off for the bundled denial reason. Instead, we need to submit the claim to Home health Agency. Please add in query since Chris has already contacted the provider office to work on this.

MEDICARE – IVR TRANSLATOR:

- Here we are able to get the Converted value to update the information quickly in Telephone as below

Link: https://www.palmettogba.com/palmetto/ivrt.nsf/Main?OpenForm



MEDICARE ID LOOK-UP (MBI) ON MEDICARE PORTAL:

- When we are in need of a patient's new Medicare number or MBI that is mandatory as of 01/01/2020. If we have the patient's first and last name, social security number, and date of birth, we can find the new MC number on the Medicare Portal using the MBI lookup inquiry.

- Instead of Eligibility tab, choose MBI Lookup Inquiry tab and fill in patient information.

AUDIT LOG [AF4] IN HEALTH PAC VS. INSTAMED

- Please check the Audit log if any changes has been done after claim filed to insurance. Make sure to verify the same has been updated while submitted thru Instamed (Clearing house). If –GP modifier not shown in Instamed, then add and submit thru Instamed.

- Example account RPT.2161 – In this account originally claim was submitted on 12/13/16 without –GP modifier. Later –GP was added on 12/14/16 AFTER claim was filed to insurance. In this case go to instamed and cross verify whether claim was added with –GP in the Instamed. If not, please add –GP modifier and resubmit the claim.

DUPLICATE FLR CODES:-

- If claim denied for reason "N572 - NOT PAYABLE UNLESS NON-PAYABLE REPORTING CODES/MODIFIERS ARE SUBMITTED", then check whether same FLR codes are entered twice (e.g. G8985- CJ & G8985-CI), then we need to correct the FLR codes (G8984 –CJ & G8985 – CI). The FLR codes should be entered as below with appropriate C* modifiers (Limited, restricted Impaired). [CH, CI, CJ, CK, CL, CM, CN]

CH - 0 percent impaired, limited or restricted
CI - At least 1 percent but less than 20 percent impaired, limited or restricted
CJ - At least 20 percent but less than 40 percent impaired, limited or restricted
CK - At least 40 percent but less than 60 percent impaired, limited or restricted
CL - At least 60 percent but less than 80 percent impaired, limited or restricted
CM - At least 80 percent but less than 100 percent impaired, limited or restricted
CN - 100 percent impaired, limited or restricted

- G8984 - Carrying, moving and handling objects functional limitation, current status, at therapy episode outset and at reporting intervals.

- G8985 - Carrying, moving and handling objects, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.

- G8986 - Carrying, moving and handling objects functional limitation, discharge status, at discharge from therapy or to end reporting.

It should be entered in the following order: Current status to Goal status (or) Goal status to Discharge status

ONLINE SUBMISSION [DMAP]:-

- DMAP claim can be submitted electronically through Health Pac. Recently MMSS had setup the ability to send electronic secondary claims to DMAP through our clearinghouse Instamed.

- Resubmit the claim electronically. Let me know if you need detail for how to resubmit electronically using A, F – Resubmit Claim. This only works if the EDI Enrollment has been completed. You can tell if it has been completed by going to B, F, then seeing if the payer numbers is entered in Health Pac.

- Payer numbers should only be entered by MMSS office manager (Laurie Tovar) or Carmen Diaz.

CREDIT CPT:-

Do not follow-up the CREDIT CPT and it will be taken care by MMSS. Assign these accounts' AR code status as "MMSS-FOLLOW-UP".

SELF PAY PATIENT:

If there is not an indication on the patient alert that the patient is paying for their services in full then it should be billed to the patient at the full fee.

BUNDLED PROCEDURE [CPT-98960]:

- If all other CPT's got paid then CPT 98960 is denied as bundled. Okay to adjust the balance.

WRITE OFF-CPT CODE (99072):

If all other Cpt's got paid then the below codes are denied for reason as follows; Okay to adjust the balance. We do not bill this serive to patients if it is denied by insurance.

CO234
CO96
COB15
OA23
PR1
PR204
PR49
PR96
M80

REGENCE BLUE CROSS BLUE SHIELD AND OBESITY COUNSELING G0447:

- Regence Medicare Advantage is denying G0447 when billed with an office visit stating that they are following CMS policy and it is not allowed. We can show that Medicare pays this scenario every time and Regence is not following CMS. They do not have a medical policy showing this is not payable.

- Verified in the Regence Claims Editor in Availity Payer Spaces that if billed with modifier 25 on the G0447 and also on the office visit it will pay. This has been added to a Wiki Page for Regence in Only Office and we are working on updating Healthpac so only for Regence Medicare Advantage the modifier would be

required when billed with an office visit.
https://onlyoffice.mmsspro.com/products/community/modules/wiki/default.aspx?page=Regence_Blue_Cross_Blue_Shield_of_Oregon_BCBSO.

- Now we have an edit for WFP, MHA, and AJA where if G0447 is billed to I8A Regence Medicare Advantage it will automatically append modifier 25. Do not see any scenarios where the patient only is served for the obesity counseling. They always receive a separate E&M Service.

PROVIDER NPI:

1. RPT they have two Group PTANS which are used depending on the location. For Canyonville and Glendale the Group PTAN is R108252 for all other locations it is R102653.

STATE ACCIDENT INSURANCE FUND:

2. If insurance representative says they do not work with Third Parties then "DO NOT WORK" these accounts and mention the AR Code as "MMSS-FOLLOW-UP". MMSS will take care of it.

ALLCARE – CALLING:

3. For Insurance calling - Allcare insurance representative providing only 3 claims per provider and day. So, we need to assign the calling accounts accordingly to caller.

4. Also, need to notify MMSS what % of volume received from this insurance.

WRITE-OFF [CPT-98960]:

If all other CPT's got paid then CPT 98960 is denied as bundled. Okay to adjust the balance.

BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED:

If the claim denied for this scenario, follow the instruction as below;

CO -119(Benefit maximum for this time period or occurrence has been reached).

- Check Benefit Information through website/Calls
- If NO - Call the carrier and send the claim to reprocess.

PR – 119(Benefit maximum for this time period or occurrence has been reached)

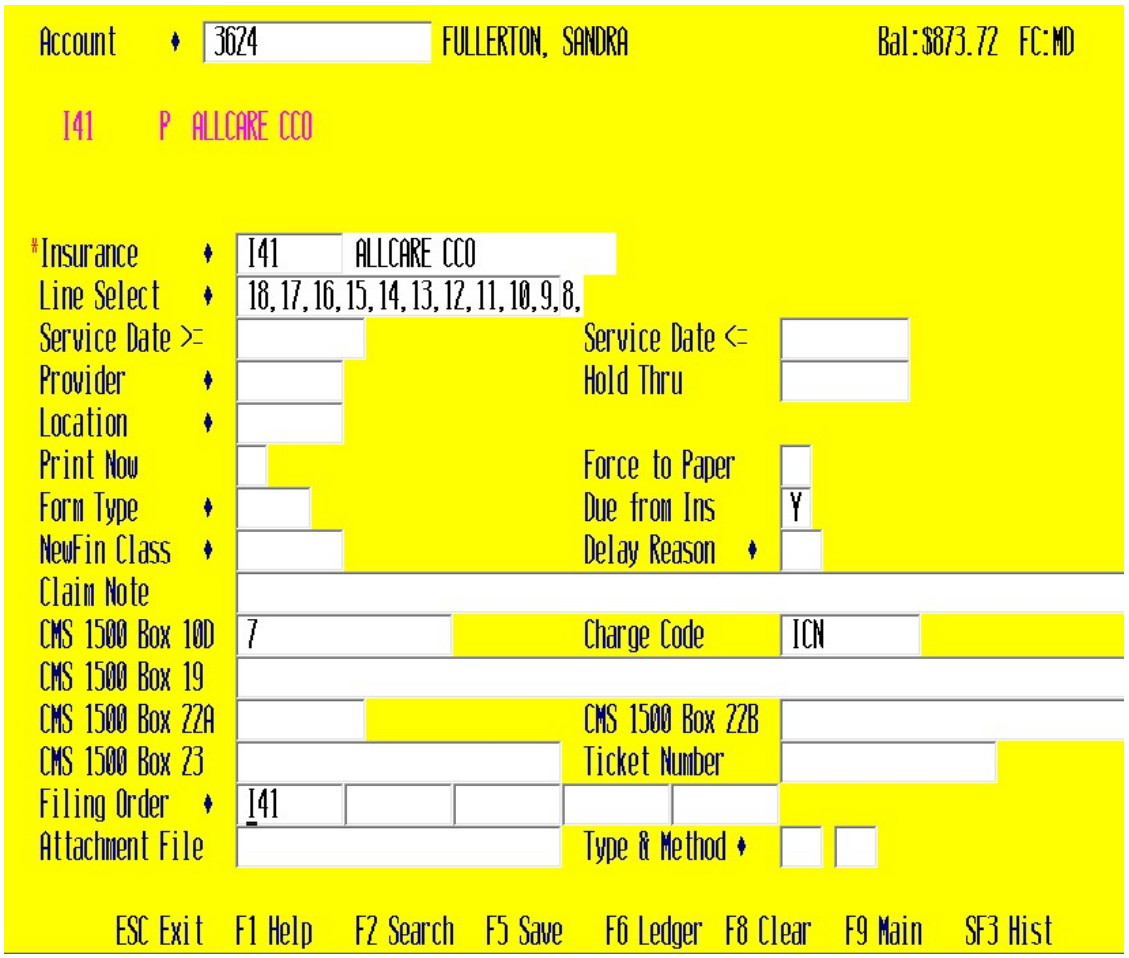
- Check Benefit Information through website/Calls
- If YES - Then Bill the Patient

BILLING PATIENTS – ENTIRE CLAIMS:

If the account(Entire pending claims) are actually need to flip the patient, we can press Shift F4 to then select to flip all items to patient that are currently displaying on the ledger.

CORRECTED CLAIM RESUBMISSION:

Corrected claim Resubmission – If we notice any global issue, we will resubmit all the claims instead of submitting for that particular line item. Please see below for reference;



NDC REJECTIONS/DENIED

- If the claim as getting rejected/Denied for the reason NDC CODE (MISSING OR INVALID NDC NUMBER). Please review whether the claim submitted with the correct NDC format (11 DIGIT), if not claim will rejected/Denied by the Insurance.
- When we taking action for the NDC denial, we need to submit the claim with correct format like below to get the payment. E.g. Accounts - PCC.1520 & PCC.1621.

Converting NDCs from 10-digits to 11-digits

10-Digit Format on Package	10-Digit Format on Example	11-Digit Format	11-Digit Format Example	Actual 10-digit NDC Example	11-Digit Conversion of Example
4-4-2	9999-9999-99	5-4-2	**0**9999-9999-99	0002-7597-01	**0**0002-7597-01
5-3-2	99999-999-99	5-4-2	99999-**0**999-99	50242-040-62	50242-**0**040-62
5-4-1	99999-9999-9	5-4-2	99999-9999-**0**9	60575-4112-1	60575-4112-**0**1

VA CHOICE INSURANCE:

Correct claim address is "913 NW GARDEN VALLEY, ROSEBURG, OR 97471". If any claim is previously denied as "Need to submit claims to Local VA", please verify the claim mailing address and re-submit.

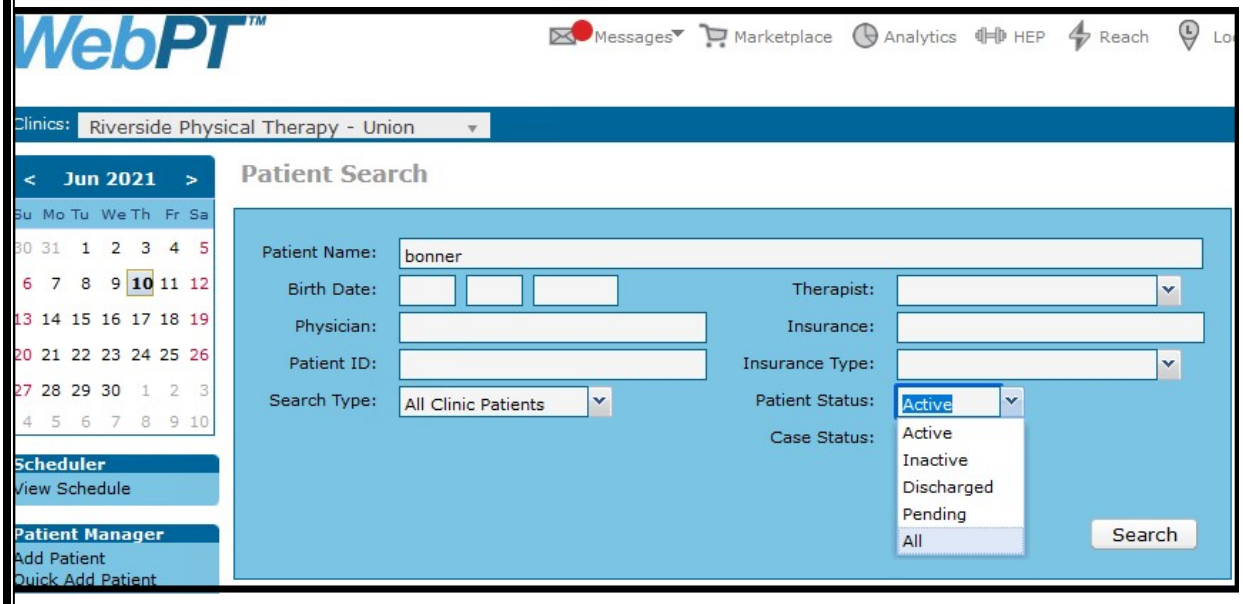
Note: Recently claim mailing address changed by [Zip code 90470 to 97471] client end.

VA COMMUNITY CARE NETWORK (VA CHOICE):

Starting from June 9th of 2021 there will be a new payer number for the VA Community Care Network (I111) VA Choice. According to Triwest this will be TWVACCN.

RPT VA CHOICE FOLLOW-UP (AUTHORIZATION):

WEBPT – Select patient status as "ALL" to view the patients and Authorization information.



1) At the time of charge entry if new auth was not found in WebPT under eDocs for the auth exceeded claims and should have been added in query. In some cases, the auth# not changed and extended the date range for future visits with same auth#. So, they have linked the same auth# without adding in query. It should have been added in query as "Auth exceeded and new auth# not available in eDocs" to MMSS attention.

2) While doing the follow-up for the auth exceeded accounts, need to verify the eDocs in WebPT and Healthpac software under "AF8 Auth" option. Also, link the new auth# for the associate date-of-services instead of moved to MMSS assistance.

Advised team to add the query if new auth# not found in eDocs whenever auth exceeded alert shows even though date range is valid for entering date-of-service in charge entry. Also, informed follow-up team to check all the criteria before moving to your end.

WSH – CPT UPDATES:

- CPT 99408 (Alcohol and Substance abuse Screening) – If claim denied as 99408 is inclusive service (CO97) when billed with Nursing and home visit codes by Atrio Medicare Advantage. Per Medicare & coding guidelines this is a Depression screening which will not be paid separately. So please go ahead and adjust off this scenario.

- CPT 99483 (Assessment of and care planning for a patient with cognitive impairment) – If claim denied as Incomplete POS or Non-covered charges and the claim billed with POS 31. Provider cannot bill 99310, 99497 and 99483 on same date. The 99483 or 99497 will be included in E&M. So please adjust off this scenario.

- CPT 99309 has a conflict with 96127. 99483 have a conflict with 96127 so when billed together, one is going to be denied as included and no modifier is allowed. So ok to adjust these off in this scenario.

- Providers can't bill CPT code 99483 on the same day as these services:
  - 90785 (Psych diagnostic evaluation complex interactive)
  - 90791 (Psych diagnostic evaluation)
  - 90792 (Psychiatric diagnostic evaluation with medical services)
  - 96103 (Computer administered, computer-graded, psychologic assessment)
  - 96120 (Computer administered neuropsychological testing)
  - 96127 (Report behavioral assessments in children and adolescents)
  - 99201– 99215 (Office/outpatient visits)
  - 99324–99337 (Domiciliary rest home visits, new patient)
  - 99341–99350 (Home visits)
  - 99366–99368 (Team conference with the patient by health care professionals)
  - 99497 (Advanced care plan 30 min)
  - 99498 (Advanced care plan additional 30 min

- CPT 93793 – If it is denied as Inclusive and got payment for code 99310-25 for the same DOS. Ok to adjust off for this scenario.

MMSS FOLLOW-UP

If any claims, contains the patient comment as "Forwarded to SARA or any other AR coordinator name and it was not followed up by client end; we need to follow-up those claims.

TIMELY FILING & APPEALING LIMIT EXCEEDED:

If any claims exceed the TFL limit & Appeal Limit, need to prepare the write-off batch and send it to client [Laurie] for write-off approval.

CLAIM PROCESSED DEDUCTIBLE:

When we follow-up the old claims, if any claims have patient responsibility – DO NOT BILL OLDER [2016 & Less than 2016] claims to Patient. Write-off batch and send it to client [Laurie] for write-off approval.

VA CHOICE – NPD DATASET

The VA Choice Program doesn't contract with Labs and only contracted providers can have online access. I am speaking with the representative from Regence who is the contractor so see if we can get around this situation. For now they say they don't contract with labs for VA Choice so the only option is to call. Since they can't motivate providers to sign a contract by paying them more it seems they restrict portal access so they have something to offer. I'll let you know if we find a way to be included for online access for this situation. For now it means calls need to be made.

CHANGES HAVE BEEN MADE WITH HEALTHNET OPTIONS (MEDICARE ADVANTAGE PLAN).

Health net Options - for dates of service after 01/01/18 need to be billed to insurance code 3023 in Healthpac. Dates of service prior to 01/01/18 need to be billed to 2023 in Healthpac.

This has been updated for all clients in Healthpac and Greenway. For Wellspring the insurance code for dates of service prior to 01/01/18 is 1027 and the insurance code for dates of service after 01/01/18 is 1404.

HEALTH NET MEDICARE ADVANTAGE AUTHORIZATIONS:

- Health Net Medicare Advantage denying in error for RPT stating that an "AUTHORIZATION IS REQUIRED".
- For Physical Therapy if the practice is in network they allow 12 visits without an auth. The 13th requires an auth.
- If the practice is an out of network, service required an Authorization to process the claim.
- For Health net please verify if a denial is required at the following site: **https://or.healthnetadvantage.com/for-providers/medicare-pre-auth.html**
- Also after enter the CPT and then see clues regarding if an authorization is truly required. If you find they are denying in error we need to keep track of this in a task for each client. This way we can refer to it later. I have created an example task in RPT with the information. **https://onlyoffice.mmsspro.com/products/projects/tasks.aspx?prjID=5&id=499**

- If Health Net insurance denied in error, move the claim to calling and ask the insurance rep to reprocess the claim with details explanations.

HEALTH NET MEDICARE ADVANTAGE – APPEALS & CHART NOTES:

Health Net Medicare advantage we can login online and select the Tax ID for MTP and create reconsideration and upload the chart notes. Please see below for Username & Password;

Username: 3023chris@mmsspro.com
Password: Available in Website Information spreadsheet.

PARTNERSHIP HEALTH PLAN – NPD DATASET

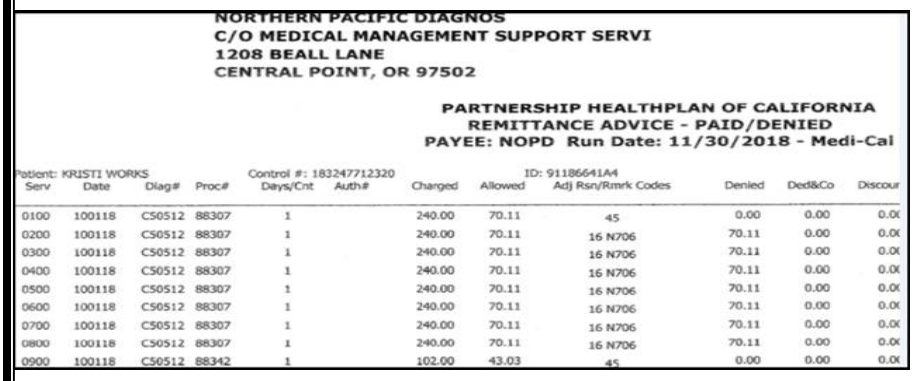
For Partnership Health Plan for NPD they are requiring chart notes all lab services if more than one service is provided per day.

Please make sure that the CARC code CO16 is posted when it applies and also N706. We have set Healthpac to automatically append the action code DN so we can see that chart notes are needed. It is not necessary to create a separate query in this case for client NPD. Since you are unable to have access to EPIC we have to pull chart notes on this end. Please update instructions that for client NPD if a denial states CO16 for Partnership Health insurance 5 it can be posted and there is no need to add a query.

CLAIM STATUS CHECKING – NPD DATASET:

We have online access at https://provider.partnershiphp.org/ui/eAdmin.aspx for Claim status.

Here is an example EOB.



NORTHERN PACIFIC DIAGNOS
C/O MEDICAL MANAGEMENT SUPPORT SERVI
1208 BEALL LANE
CENTRAL POINT, OR 97502

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
REMITTANCE ADVICE - PAID/DENIED
PAYEE: NOPD Run Date: 11/30/2018 - Medi-Cal

Patient: KRISTI WORKS Control #: 183247712320 ID: 91186641A4

Serv	Date	Diag#	Proc#	Days/Cnt	Auth#	Charged	Allowed	Adj Rsn/Rmrk Codes	Denied	Ded&Co	Discour
0100	100118	C50512	88307	1		240.00	70.11	45	0.00	0.00	0.0(
0200	100118	C50512	88307	1		240.00	70.11	16 N706	70.11	0.00	0.0(
0300	100118	C50512	88307	1		240.00	70.11	16 N706	70.11	0.00	0.0(
0400	100118	C50512	88307	1		240.00	70.11	16 N706	70.11	0.00	0.0(
0500	100118	C50512	88307	1		240.00	70.11	16 N706	70.11	0.00	0.0(
0600	100118	C50512	88307	1		240.00	70.11	16 N706	70.11	0.00	0.0(
0700	100118	C50512	88307	1		240.00	70.11	16 N706	70.11	0.00	0.0(
0800	100118	C50512	88307	1		240.00	70.11	16 N706	70.11	0.00	0.0(
0900	100118	C50512	88342	1		102.00	43.03	45	0.00	0.00	0.0(

HEALTHNET MEDICARE ADVANTAGE - ONLINE APPEALS AND CHART UPLOADS:

If you see that HEALTHNET Medicare Advantage is denying a claim and we need to submit chart notes. The chart can now be submitted on line once you pull up the denied claim. Then select RECONSIDER claim and you will be able to attach chart notes directly to the claim and upload to HEALTHNET Medicare Advantage.

This will be massively useful for specialists with any bundling denials.

The login is at:
https://provider.healthnetoregon.com/sso/login?service=https%3A%2F%2Fprovider.healthnetoregon.com%2Fcareconnect%2Fj_spring_cas_security_check

Username; 3023chris@mmsspro.com
Password would be provided separately.

CPT 99100 – MEDICARE NOT COVERED – WRITE OFF:

If the CPT code 99100 denied and other codes are got paid by Insurance Medicare, we can adjust off the CPT 99100 as "NON COVERED BY MEDICARE".

ALLCARE HEALTH PLANS - ALLCARE MEDICARE ADVANTAGE AND ALLCARE CCO:

ALLCARE HEALTH PLANS HAS THREE PLANS:

- Allcare Medicare Advantage
- Allcare CCO (this is Oregon Health Plan Medicaid/Managed Care/Coordinated Care)
- Allcare PEBB

ENROLMENT INFORMATION:

- Online Access is available at https://providers.allcarehealth.com/security/Account/Login Enrollment must be completed by Carmen Diaz for each individual Account for each Client. If you do not have access to Allcare online please contact Carmen for enrollment.carmen@mmsspro.com.

AUTHORIZATIONS:

- For Physical Therapy the Initial Evaluation 97161-97163 does not require authorization. If an authorization is entered it will cause the service to deny in error needing a corrected claim. Authorizations must be 20 digits - if less than 20 will deny.

- Allcare Accepts Electronic Corrected Claims.

FOLLOW-UP PHONE CALLS (VOICE MAIL):

There are times when the insurance carrier will not speak, because they do not have a reference number. Please leave the patients account number when you leave a voicemail when calling insurance companies. This way they can provide the account number and we can look up the account and take the next steps.

For Voicemails, usually we are trying to reach 3 different timings in same day. If still not reached, then we left the voice mails with the below details.

- Provider Name
- Provider Tax id#

- Patient details
- Date of service.
- Billed amount.
- Patient account#
- Patient Name
- Call Back#
- Fax#

CPT J1094 - INVALID PROCEDURE CODE:

If payment is received on the same Date of Service, the CPT J1094 can be written off if processed by insurance as packaged service (CW 02/03/2020)

CPT 96127 – BUNDLED PROCEDURE:

If payment is received for all other CPT on the same DOS, then the CPT 96127 can be adjusted off as included in the other services for the encounter. (CW 02/03/2020)

CPT 45385 – BUNDLED PROCEDURE (APPEAL):

If 45385 are denied as bundled along with other services do not adjust the service. Additional payment should be received but at a reduced rate based on the endoscopic base code.
If a company does not pay the additional service at all it is to be appealed with chart notes. (CW 02/03/2020)

NOT COVERED BY PATIENT PLAN:

If it is a Medicaid Plan like Jackson Care Connect, Allcare CCO, Care Oregon CCO if they deny as not a covered benefit it is usually because of being below the funding line. We are not able to bill the patient and the service must be reviewed to see if there is a payable DX otherwise it must be written off. If it is a commercial plan you can bill the patient. (CW 02/03/2020)

NEED COB INFORMATION:

If the insurance needs COB information from the patient, the patient should be billed and it should be noted that this is the reason for sending the bill. (CW 02/03/2020)

CPT 90471 (NON-COVERED CHARGE):

The CPT G0008 is only for Medicare and Medicare Advantage plans. If it is for a non Medicare plan the proper action would be to contact the plan and get their response in writing why they are denying it. Is there a policy from the payer stating they bundle the administration or are they stating that it should be a different administration. (CW 02/03/2020)

CAREOREGON - COB ISSUE: (Oct'10 2019)

JUST FOR INFORMATION:

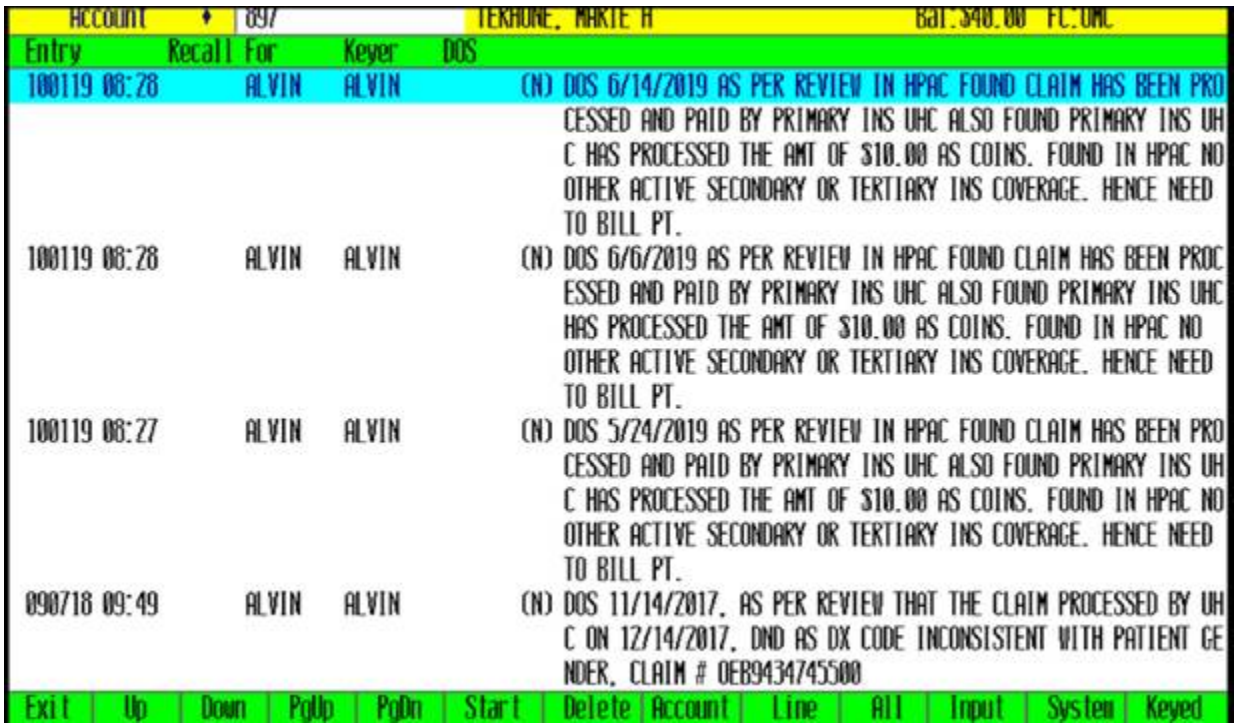
- Jessica S just identified an issue with Careoregon where they are denying claims stating that they did not receive the primary insurance EOB information. They have now admitted that this is incorrect and a system issue on their part that they are working to correct.
- If Careoregon tells you that the primary EOB was not received please make sure they verify if the claim is in this issue and if they can reprocess immediately instead of needing to resend a claim with primary information.

CARC PI234 - ISSUE: (Oct'11 2019)

- It appears that one of our CARC overrides was preventing items from being billed to patients when there was PI234 on CPT 94760. When this was received from United the edit allowed the adjustment on the 94760 but prevented the office visit copay from moving to the secondary or the patient. I can see many accounts that have been identified in follow-up where it was found that it was necessary to flip the balance to patient and that Healthpac didn't automatically do this.

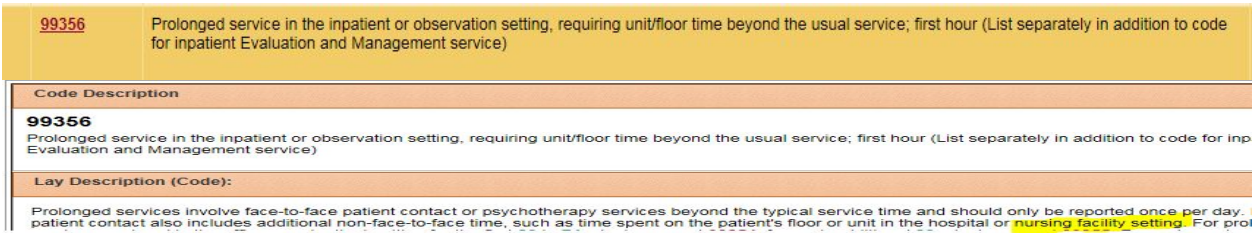
- In this case please notify the follow-up staff that if there is a pattern where they see the claim isn't being automatically billed to the patient and it should be please let us knows. This issue might have been included in the queries or clarification documents (it it was - I apologize for missing it) we didn't realized that it was a systematic issue and we have identified the accounts impacted and flipped them to patient or secondary. Please have the staff be on the lookout for patterns so that we can eliminate the unnecessary task of flipping an item to patient or secondary that should have been automated.

- An example account is MAN.897 - Each service was identified as in need of billing the patient which is correct but these shows something must be causing the system to not flip automatically that needs to be reviewed.



CPT 99358 Denial

CPT 99356 best suits the prolonged care (first hour) for Medicare patients. Ok to leave the accounts that got adjusted off, on a go forward, if you see denials for the 99358, please delete the code 99358 and change to 99356 and submit to Insurance as corrected claim(except Medicare).



99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)

Code Description

99356

Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inp Evaluation and Management service)

Lay Description (Code):

Prolonged services involve face-to-face patient contact or psychotherapy services beyond the typical service time and should only be reported once per day. patient contact also includes additional non-face-to-face time, such as time spent on the patient's floor or unit in the hospital or nursing facility setting. For prol

FROM CMS WEBSITE (MEDICARE):

Prolonged Services Definitions

In the **office or other outpatient setting,** Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services with CPT code 99355.

In the **inpatient setting**, Medicare will pay for prolonged physician services (code 99356) (with direct face-to-face patient contact which require one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.

CHARGE SHOULD BE DELETED VS WHEN TO USE VOIDC:

CHARGES SHOULD ONLY BE DELETED IN THE FOLLOWING SITUATIONS:

- A keying error identified within the same month.
- A correction from a client identified within the same month.

Deletions are restricted to authorized staff members only and must be handled very accurately. Deletions are never to be applied

If a charge has been posted for a prior month (Batch Date) and we have instruction that the charge should be changed to another charge the original charge should be brought to zero using the VOIDC adjustment.

Delete would be used when the code was billed in error. VOIDC would be used when the code was properly billed based on what was supplied by the practice and then recoded later.

VOIDC should not be used to void payments or adjustments.

AETNA INSURANCE FLU ADMINISTRATION:

Effective from DOS 08/16/2018 - Aetna insurance will not cover the CPT 90471 Immunization administration code. We need to use following CPT G0008 Administration of influenza virus vaccine instead of 90471. Please see below URL for your reference and act accordingly.

CORRECTED CLAIM ISSUES:

I tested the information from Instamed and can see that Healthpac is sending the proper information to Instamed. It looks like when you display the claim in Instamed as a HCFA it doesn't show the corrected claim indicator or box 19 but when I look at the EDI data from Instamed the information is on the electronic claim. It seems to be just an error in the display from Instamed. I exported the EDI data from Instamed and can see the proper corrected claim fields on the electronic claim.

If there are duplicate claim issues for corrected claims we would need to see more detail to get to the bottom of this since it does not appear to be a formatting issue. Either it is a human issue when sending or an issue with a specific insurance company and their electronic requirements.

I reviewed EDI information from a sample carrier to find more information about the electronic formats. https://www.bcbsil.com/pdf/claims/claim_frequency_codes_prof.pdf There are other fields in the electronic claim but all fields appear to be correct in our format.

Here are the fields when I viewed them using Mirth.

F8 in REF01 with the Qualifier F8 is being sent and in Ref O2 the ICN is going.

```
<REF>
    <REF.01>
        <REF.01.1>F8</REF.01.1>
    </REF.01>
    <REF.02>
        <REF.02.1>7394714205 0063868769</REF.02.1>
    </REF.02>
```

NTE Segment includes Corrected Claim information from Box 19.

```
<NTE>
    <NTE.01>
        <NTE.01.1>ADD</NTE.01.1>
    </NTE.01>
    <NTE.02>
        <NTE.02.1>CORRECTED CLAIM</NTE.02.1>
    </NTE.02>
</NTE>
```

In the CLM 05.3 field it shows the 7 indicator which is correct.

```
<CLM>
    <CLM.01>
        <CLM.01.1>PSO.Z515605</CLM.01.1>
    </CLM.01>
    <CLM.02>
        <CLM.02.1>4108.15</CLM.02.1>
    </CLM.02>
    <CLM.03/>
    <CLM.04/>
    <CLM.05>
        <CLM.05.1>11</CLM.05.1>
        <CLM.05.2>B</CLM.05.2>
        <CLM.05.3>7</CLM.05.3>
    </CLM.05>
    <CLM.06>
        <CLM.06.1>Y</CLM.06.1>
    </CLM.06>
    <CLM.07>
        <CLM.07.1>A</CLM.07.1>
    </CLM.07>
    <CLM.08>
        <CLM.08.1>Y</CLM.08.1>
    </CLM.08>
    <CLM.09>
```

JACKSON CARE & CAREOREGON:

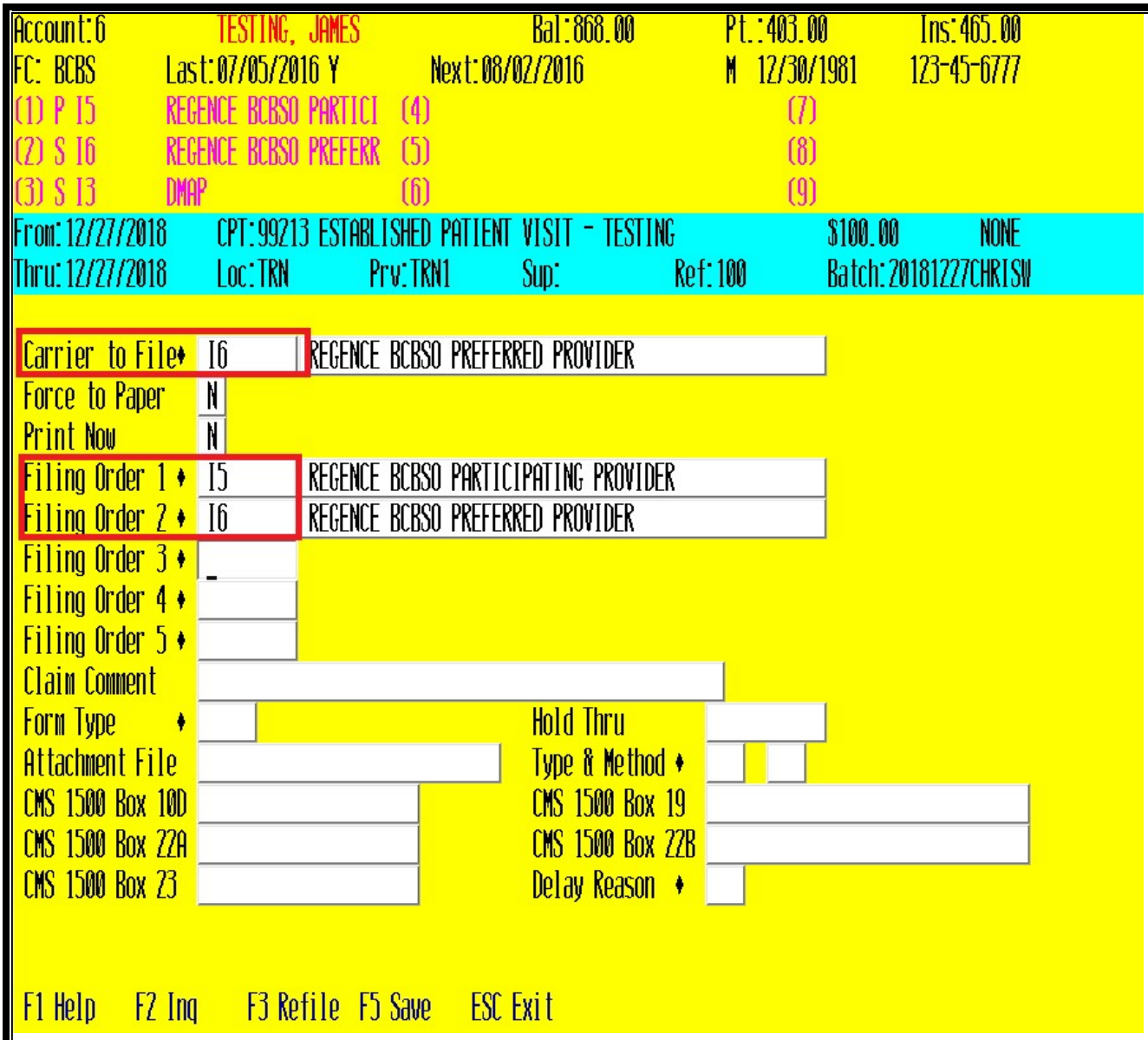
If a new patient denied as “COB16 - New Patient' qualifications were not met as of now”. This typically would be correct in a case where a patient was seen within the last three years. In this case we want to call the insurance company and ask to reprocess the claim with detailed explanations.

SECONDARY CLAIMS SUBMISSION (PRIMARY EOB REQUEST):

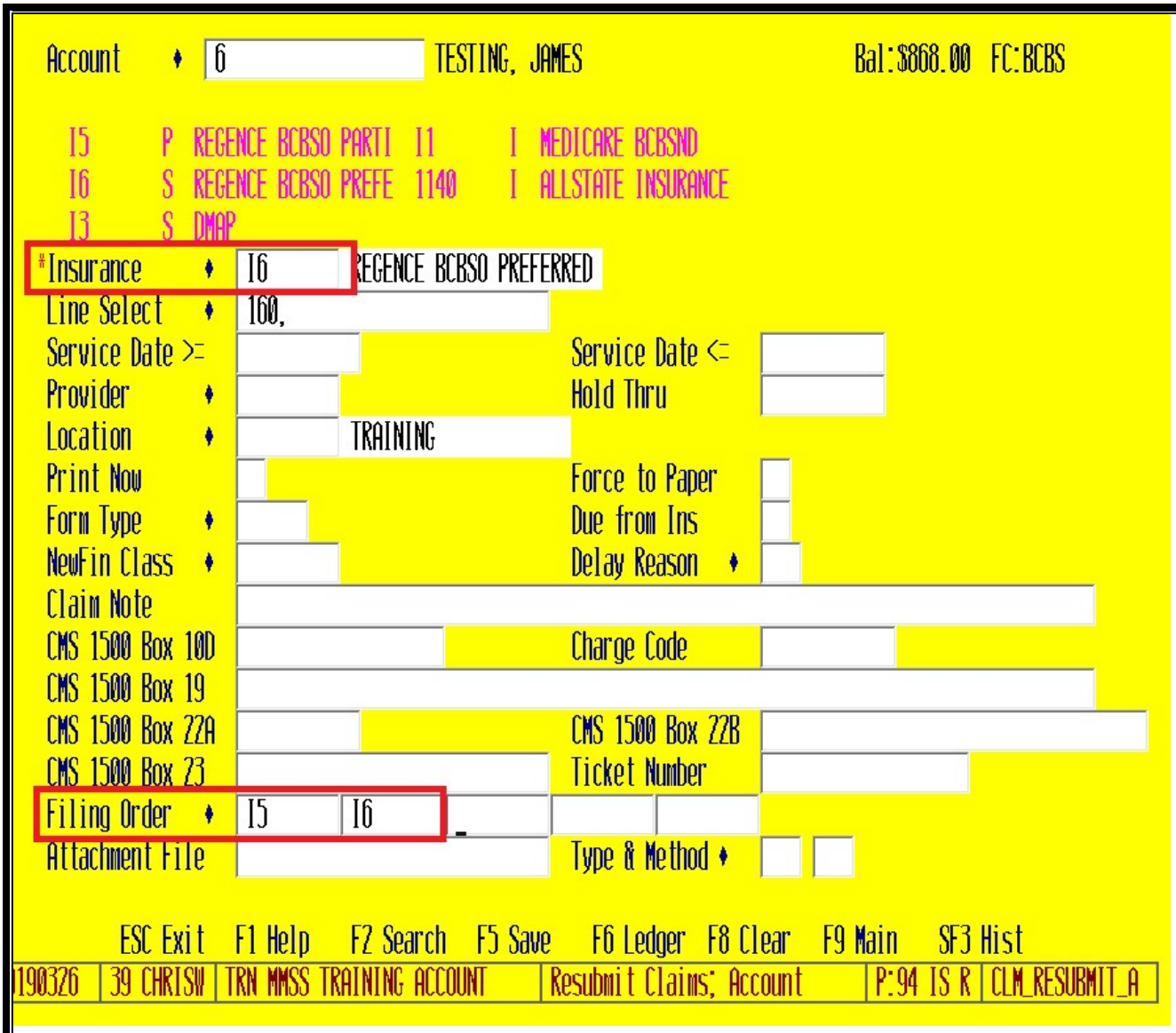
We can directly submit the electronic secondary claim in software as given below; also you must make sure that the filing orders it correct when submitting a secondary claim.

From the ledger make sure the filing order is correct.

For example in the Training Dataset for patient TRN.6. If we were submitting to the secondary plan we would have the carrier to file as I6 and then in the filing order we would have I5 as primary and I6 as secondary. Then press F3 to refile



In the resubmit insurance claim screen the filing order would look like the information below;



CLAIM NOT ON FILE - CLAIM RESUBMITTING:

If we received ***claim not on file*** status from Insurance rep or websites, need to resubmit the claim thru electronically in software if payer ID is available, even if insurance rep request to submit the claim thru fax or paper. E.g. Account: MTP.HUFF0004

HEALTH SHARE – PROVIDENCE:

When checking benefits online via MMIS for Oregon Medicaid it only lists the plan as Health Share of Oregon but that Health Share of Oregon isn't the plan to bill. Once we know they are Health Share we then have to check the next step to find if they are Providence CCO or Careoregon CCO or some other plan.

Managed Care / Primary Care Home

Provider Name	Provider Phone	Plan Type	Effective Date	End Date
MULTNOMAH CO FQHC CLINICS	(503)988-7468	APM	09/17/2019	09/17/2019
HEALTH SHARE OF OREGON	(888)519-3845	CCOA	09/17/2019	09/17/2019

Here is the instruction for Health Share:
https://onlyoffice.mmsspro.com/products/community/modules/wiki/default.aspx?page=HealthShare_of_Oregon

CLARIFICATION – CLIENT RESPONSE:

PROVIDENCE HEALTH PLAN E & M CODES (CO-97):

If we billed the more than 1 E & M Code, the providence Health plan Insurance will pay only for the one service and other visits will deny for the reason "INCLUSIVE/BUNDLED". Per client response "Providence only allows one evaluation and management per day. Either the preventive or the medical visit is going to get paid - LT". So the denied code should be adjusted off.
Example accounts - MHA.3568 & MHA.3745.

CPT Q0091 (CO-97):

If other codes are paid by the Insurance and CPT Q0091 denied for the reason "INCLUSIVE/BUNDLED". Per client response it should not be paid separately needs to be adjusted off.
Example accounts - MHA.3711 & MHA.3756

ONLY OFFICE (CRM) – PROVIDER INFORMATION:

The CRM section has the info for all clients. You can search using the magnifying glass in the upper right hand corner. CRM has the contact information and client specific numbers. When you search use the practice name instead of the three character practice code. It also has information for some insurance plans. Also the community section has instruction for most clients and processes. We are working on adding all instruction into the community area in the wiki.

MODA HEALTH APPEALS:

Appeals for Commercial Claims can be faxed to 855.260.4527 along with letter of appeal and chart notes. These must include the Policy Number of the patient and the ICN for each denied claim.

UNBUNDLED SERVICE APPEALS:

A new Letter has been created for when a service is improperly denied as Bundled. If a service was billed properly according to CCI edits and still bundled the BUNDAP letter can be used when you supply chart notes to the insurance company.

Please download the BUNDAPPEAL.docx file and save it to your C:\HEALTHPAC\FORMS folder.

The Healthpac Letters information can be found at
https://onlyoffice.mmsspro.com/products/community/modules/wiki/default.aspx?page=Generating_Documents_from_Healthpac__Letters_%2f_Appeals_%2f_Fax_Cover

CHART NOTES - COLOR OR BLACK AND WHITE PRINT QUEUE:

ITEMS FOR PRINTING:

For items uploaded to the Color or Black and White Print Queue. We need to make sure that cover pages are always included and each file is able to be easily printed and mailed without inserting other documents. This batch just had the notes but no other information and not enough to print and mail.

NOTES IN ACCOUNTS:

Please make sure that when action is taken the note is in Healthpac software.

CHART REQUESTS THAT NEED TO BE MAILED:

It would have needed a cover page that includes the patient and carrier information. You can simply generate a cover page from Healthpac in the ledger using Control+F4 and using the CHARTREQ letter and making sure to enter the insurance information so it automatically populates and Print Now Y. This will automatically populate the patient, date of service and policy information. MMSS will print and mail this.

BLUE SHIELD OF CALIFORNIA - ITEMS TO FAX:

The required Blue Shield accounts are need to fax each claim with patient information and ICN information to Blue Shield and note the accounts in Healthpac. The Blue Shield Fax number has been added to Ring Central Contacts to make it easier. They can be faxed to (209) 371-3049 but keep in mind to keep 1 fax per patient and include the ICN from Blue Shield for each Case. Must use the MMSS Fax Cover, Chart Notes letter(CHARTREQ) & Chart Notes.

Note: Here are is the instruction reference that is also in Only Office at https://onlyoffice.mmsspro.com/Products/Files/doceditor.aspx?fileid=4733 on page 7

RING CENTRAL FAX:

I have updated the access and allowed you full access to the client folders.

Also we have updated online fax and instructions for how to use it. I would like the follow-up staff to be able to fax Claims with Chart notes when possible. Here is the layout and we will need to work through the details so follow-up staff have access to what they need.

Faxing Claims with Chart Notes:

Print the Claim from Healthpac to PDF then adds the HCFA Watermark

Print Chart Notes to PDF.

Complete the Fax Cover page and prints to PDF. (cover page is attached) It must be printed to PDF to be able to successfully merge or Fax.

Merges all three items and faxed to insurance carrier.

The new Fax credentials are as follows: https://login.ringcentral.com

Username: chris@mmsspro.com

Password: MMss7913

The fax instructions are saved in the Wiki at https://onlyoffice.mmsspro.com/products/community/modules/wiki/default.aspx?page=Faxing_Using_Ring_Central

Items that need to be mailed to insurance carriers with attachments.

If an item needs to be mailed with a claim and chart notes currently the request is sent to our office to complete. I would like to be able to have Allzone staff create the entire document and upload it for printing.

Here is the workflow.

Print the Claim from Healthpac to PDF then adds the HCFA Watermark.

Print Chart Notes to PDF.

Merge the Claim and appropriate Chart Notes.

Upload file containing claim and chart notes into the !INBOX\Print Queue\COLOR so that we can print and mail the item.

This way claims with chart notes can be entirely accomplished through Fax or mailed without the need to sending a query to another staff member to pull the chart note, print a claim and mail the item. This would be useful for practices where we have access to their EHR systems and can directly pull the specific Chart notes needed for the claim.

Are you able to add watermarks to PDFs using your PDF programs? If not we would need to setup access to our PDF Software (Nuance Power PDF) either by accessing remote machines at our office or by arranging to purchase the licensing for the program. I would prefer to reduce the need for accessing remote machines if possible. I have attached the HCFA file that we use as the Watermark. We print from Healthpac to PDF and then apply the HCFA Watermark and then we can fax or merge chart notes and have complete batch ready to print on the color printer. Then we just need to print and mail the items. Please let me know what would be necessary to give your staff the power to create files that we can just print and mail.

FAXING CLAIMS/ELECTRONIC PAYER IDS /AND FAXINGW9S:

FAXING CLAIMS:

Generating Documents from Healthpac Letters / Appeals / Fax Cover:

In order to generate letters directly from Healthpac you will need to be familiar with downloading the template files and saving them to your C:\HEALTHPAC\FORMS folder on your computer.

Video Instructions can be found at: https://onlyoffice.mmsspro.com/products/files/#preview/1682

here is a list of the forms Currently Available to be printed from Healthpac and their revision dates.

Healthpac LETTER	DOCUMENT NAME	PURPOSE	REVISION DATE
10	10DAY.docx	10 Day Demand for Payment	08/09/2019
AUTHAPP	AUTHAPP.docx	Authorization Appeal Letter	02/21/2020
BCREFUND	BCREFUND.PDF	BLUE CROSS Refund Form	02/21/2020
BUNDAP	BUNDAPPEAL.DOCX	Bundling Appeal	02/02/2020
COAPPEAL	COAPPEAL.pdf	CareOregon Appeal Form	08/09/2019
CORETRO	CORETROAUTH.PDF	CareOregon RetroAuthorization Appeal Form	02/21/2020
DMAPEDMS	DMAP-EDMS-3970.pdf	DMAP Electronic Document Management Cover MSC 3970	02/21/2020
HARD	HARDAPP.pdf	Hardship Application for All Clients	02/21/2020
HARD-SP	HARD-SP.docx	Hardship Application for All Clients in Spanish	01/14/2020
CARD	CCFORM.pdf	Basic Credit Card Payment Form	02/21/2020
COLLECT	MMSSCOLLECT.pdf	Review for Collection Form	08/09/2019
FAX	MMSSFAXCOVER.pdf	Fax Cover	08/09/2019
REFUND	MMSSREFUND.pdf	Refund Request Form	08/09/2019
MNAPP	MNAPPEAL.docx	Medical Necessity Appeal	08/09/2019
PREXAPP	PREXAPPEAL.docx	Pre-Existing Condition Appeal	08/09/2019
REFAPP	REFAPPEAL.docx	Refund Appeal	08/09/2019
INFO	REQ4INFO.docx	Request for Information Form	02/21/2020
TFAPP	TFAPPEAL.docx	Timely Filing Appeal	08/09/2019
TWEST-TF	TRIWESTTIMELY.pdf	TriWestTimely Filing Appeal	09/05/2019

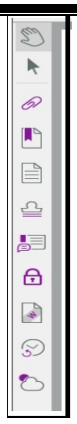
Please download all of the current forms from the following location:
https://onlyoffice.mmsspro.com/products/files/#215

does not print these to pdf to save them to your computer. Select the Download Button and save them in your C:\HEALTHPAC\FORMS folder on your local computer.

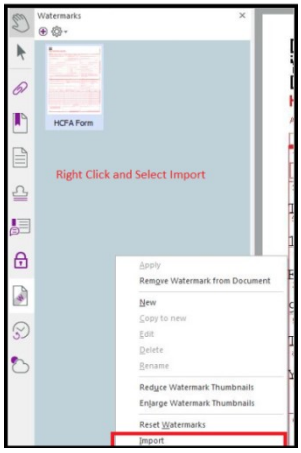
Forms in PDF are automatically filled. Forms in .docx format can be easily edited for the situation. All Appeals are to be honest and specific to the situation. The Appeal Forms are to help with wording but should be edited to fit the situation as needed.

<u>Setting up HCFA Watermark for Nuance Power PDF - HCFA 1500</u>
In order to be able to print a claim to PDF and add the HCFA 1500 red lines you will need to have a few items installed. Nuance Power PDF and also the HCFA Watermarks on your computer.
This is used only when printing to PDF and you need send by Fax, Secure Email, or if an attachment is required. If the payer is only in need of a paper claim you can refile from Healthpac without the need to print to pdf.

Download the Watermarks File from the following Link:
https://onlyoffice.mmsspro.com/products/files/doceditor.aspx?fileid=1556&action=view
Once the Watermarks file is downloaded to your computer then you can import into Nuance Power PDF. Open Nuance Power PDF and on the left side tool menu, right click to display additional tools. Select Watermark. You should then see the Watermark Icon on the Tool Menu on the left side.

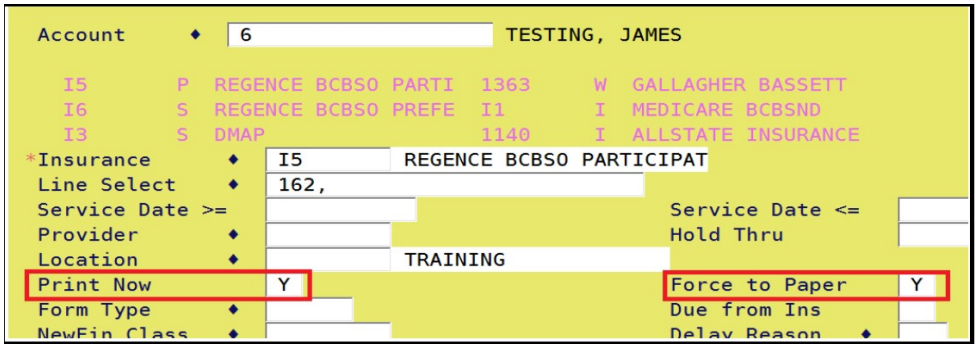


Select the Watermark Tool.
Then right click on any watermark and select Import. Then navigate to your downloads folder where you saved the Watermarks file.



To Apply the HCFA Watermark to a claim.

Be sure your printer is assigned to printer 94 for PDF. Then from Healthpac Print resubmit the claim and force it to paper and to print now.



The PDF claim should display without the form lines.

Select the Watermark tool on the left side of Nuance Power PDF.

Select the HCFA Watermark and then select Apply. Be sure to apply as background.

Your Claim should now be displaying with the red form lines.

Faxing Using Ring Central:

As of 03/08/19 we will be using Ring Central for their online fax service.

•Ensure that the attachment does not exceed 200 pages

•Ensure that the combined size of all attachments do not exceed 20MB.

On your desktop you should create a folder called "Document Prep"

Inside the Document Prep folder create a folder called "FINAL"

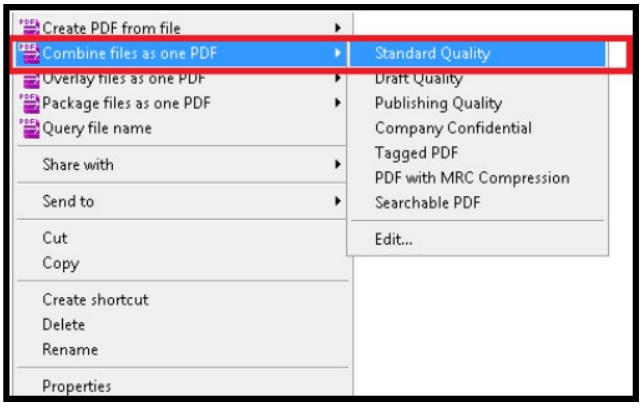
Inside the Final folder create a folder called "ARCHIVE"

Prepare your Document:

•Print to PDF the contents of your Fax. If you have more than one file to work with label the file name beginning with "01_", "02_" so that it can easily be sorted and merged. Save these documents into "Document Prep"

•Create a cover page using the MMSS Fax Cover form. Fill out the necessary information print the Form to PDF and save it on your computer in the same folder as the contents of your fax. Label the file beginning with "!_Cover_". Save this into "Document Prep"

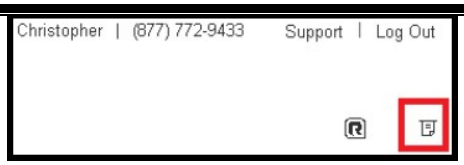
•Hold Control and Left click each document to be merged (Select All if these are the only documents in the folder. Once selected then right click and select combine as one PDF. Then Standard Quality, Save the document in the 'FINAL' FOLDER.



Login at: https://login.ringcentral.com

Username: chris@mmsspro.com

Password: Supplied separately and updated by management.

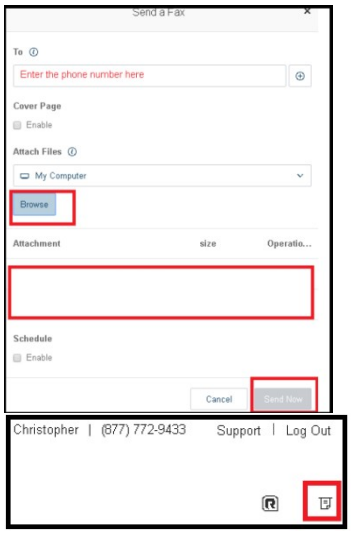


Select Fax Out in upper right hand corner.

Browse to your Final Fax file and attach your fax.

Always use the MMSS Cover Page.

Common Fax numbers can be loaded in the Contacts Area of Ring Central so they can be easily selected.



PRIMARY EOB:

When faxing a primary EOB please mark out the information for patients that are not relevant. Also the order should be the Fax Cover followed by the claim and then the primary EOB. If the primary is received by 835 then it can easily be generated from Healthpac using the EOB feature.

ELECTRONIC PAYER IDS:

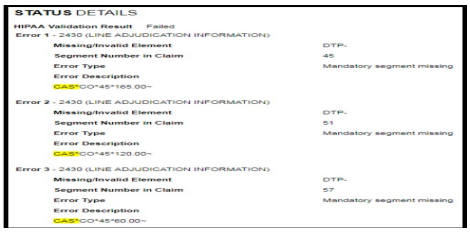
Payer List (EPID - Electronic Payer ID):

The current payer list can be found at the following link: https://onlyoffice.mmsspro.com/products/files/doceditor.aspx?fileid=2495Payer Codes are only to be loaded by those that have been trained and authorized to update the information. If you identify that a payer code is available please notify management so that the update can be made and so that others with the same insurance can be submitted electronically across all clients.

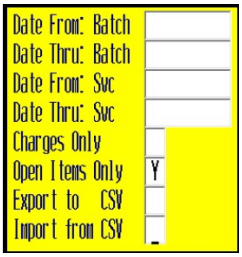
Working Rejections:
Video Instruction can be found at the following link:
https://onlyoffice.mmsspro.com/products/files/#preview/2496

Rejection Examples:

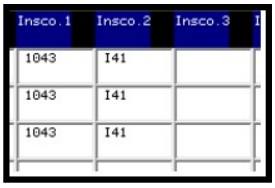
Missing Segment, if you see the error below – it is likely that we are sending information that says this is a secondary claim but we have not received payment.



To verify – in the Ledger go to the Change Screen- Control+F11.
Narrow Open Items Only.



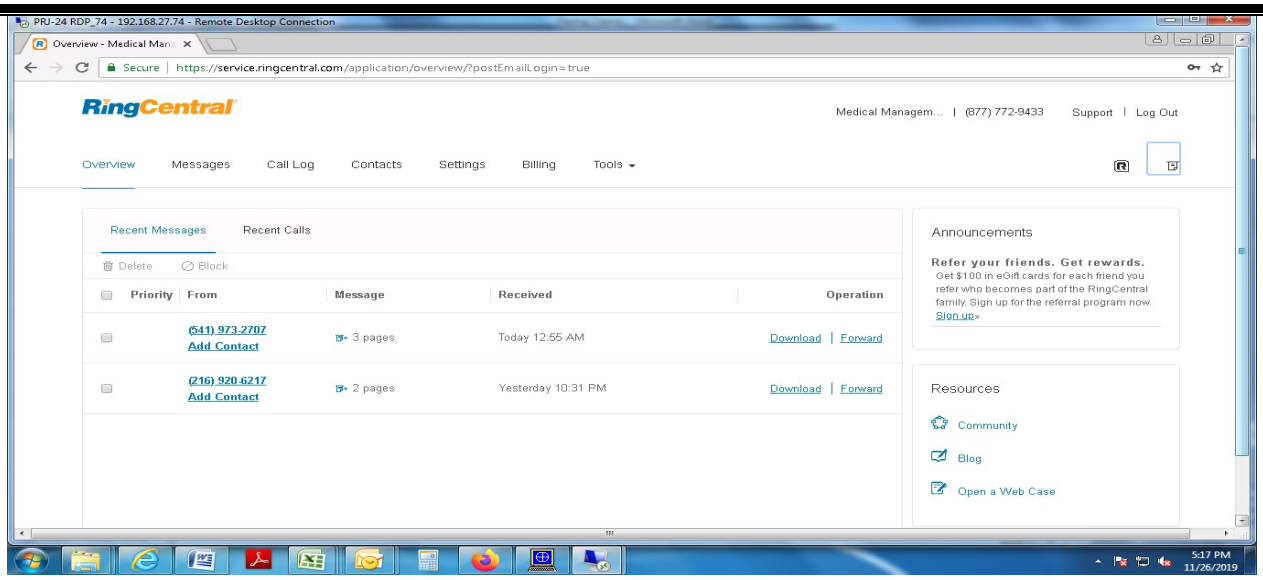
Examine the Insco1 Inso2 and Insco3 fields.

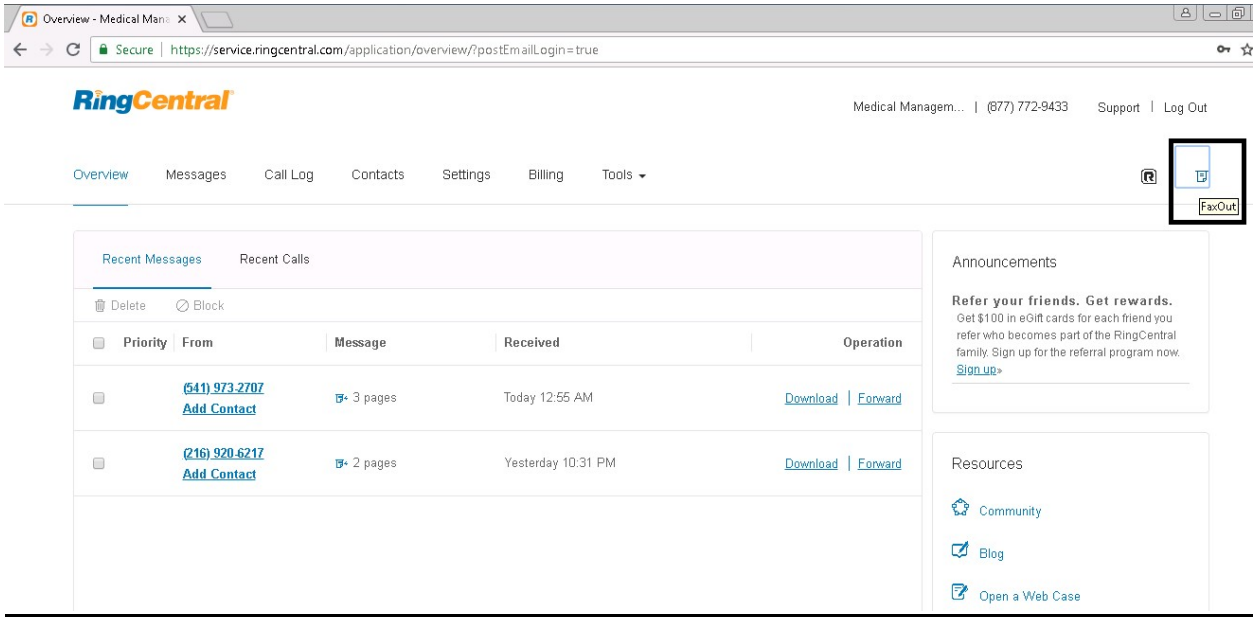


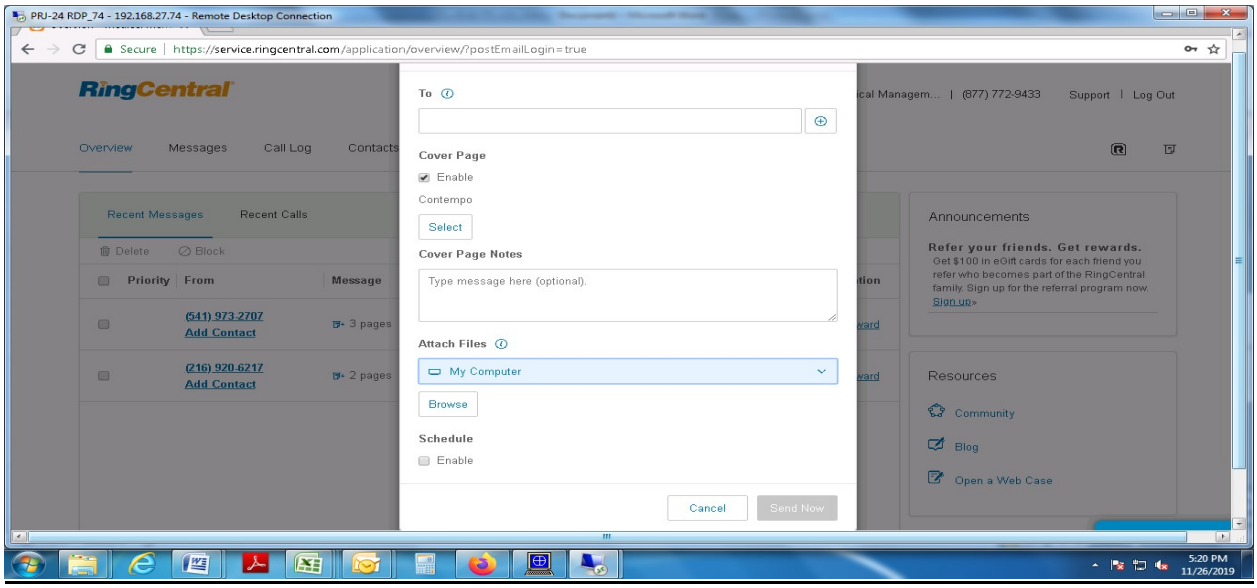
For example if we found that a patient had insurance I41 after we billed insurance 1043 we would need to update the filing order. The above order would cause a rejection in Instamed.
Simply refile the claim and update the filing status so primary insurance would be I41.
Tags: Instamed, Insta, Clearinghouse, Payer ID, Payer ID, EPID.

RING CENTRAL:

The below screen shots are used to know how we need to send the fax to appropriate Insurance using Ring Central;


PRJ-24 RDP_74 - 192.168.27.74 - Remote Desktop Connection
Overview - Medical Mana
Secure | https://service.ringcentral.com/application/overview/?postEmailLogin=true
RingCentral
Medical Managem... | (877) 772-9433 Support | Log Out
Overview Messages Call Log Contacts Settings Billing Tools
Recent Messages Recent Calls
Delete Block
Priority From Message Received Operation
(541) 973-2707 Add Contact 3 pages Today 12:55 AM Download | Forward
(216) 920-6217 Add Contact 2 pages Yesterday 10:31 PM Download | Forward
Announcements
Refer your friends. Get rewards.
Get $100 in eGift cards for each friend you refer who becomes part of the RingCentral family. Sign up for the referral program now.
Sign up»
Resources
Community
Blog
Open a Web Case
5:17 PM
11/26/2019


Overview - Medical Mana
Secure | https://service.ringcentral.com/application/overview/?postEmailLogin=true
RingCentral
Medical Managem... | (877) 772-9433 Support | Log Out
Overview Messages Call Log Contacts Settings Billing Tools
FaxOut
Recent Messages Recent Calls
Delete Block
Priority From Message Received Operation
(541) 973-2707 Add Contact 3 pages Today 12:55 AM Download | Forward
(216) 920-6217 Add Contact 2 pages Yesterday 10:31 PM Download | Forward
Announcements
Refer your friends. Get rewards.
Get $100 in eGift cards for each friend you refer who becomes part of the RingCentral family. Sign up for the referral program now.
Sign up»
Resources
Community
Blog
Open a Web Case

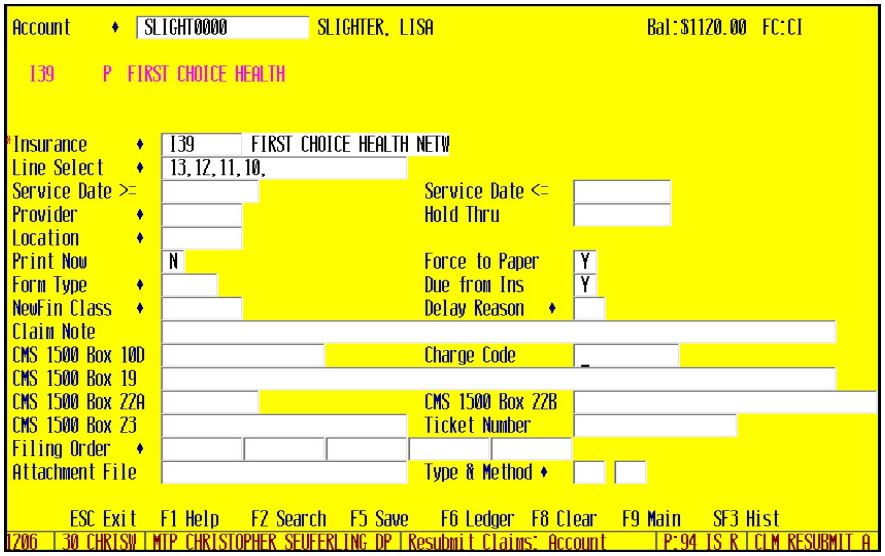

PRJ-24 RDP_74 - 192.168.27.74 - Remote Desktop Connection
Secure | https://service.ringcentral.com/application/overview/?postEmailLogin=true
RingCentral
To
Cover Page
Enable
Contempo
Select
Cover Page Notes
Type message here (optional).
Attach Files
My Computer
Browse
Schedule
Enable
Cancel
Send Now
Overview Messages Call Log Contacts
Recent Messages Recent Calls
Delete Block
Priority From Message
(541) 973-2707 Add Contact 3 pages
(216) 920-6217 Add Contact 2 pages
Announcements
Refer your friends. Get rewards.
Get $100 in eGift cards for each friend you refer who becomes part of the RingCentral family. Sign up for the referral program now.
Sign up»
Resources
Community
Blog
Open a Web Case
5:20 PM
11/26/2019

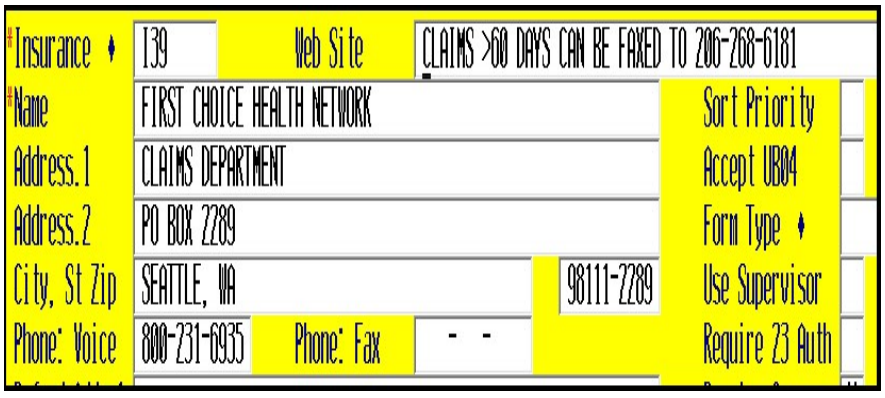
SENDING A CLAIM BY PAPER INSTEAD OF ELECTRONICALLY:

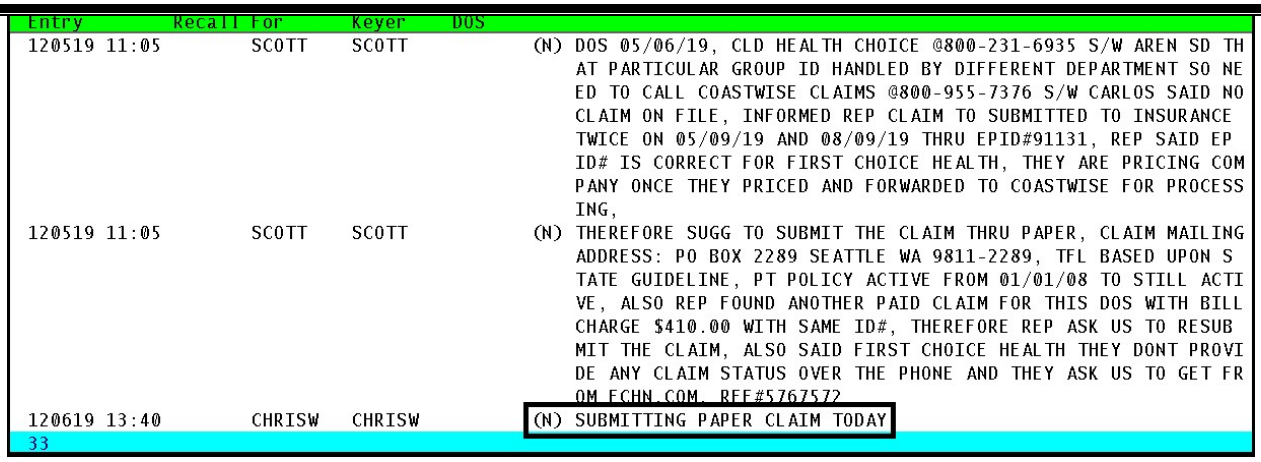
If the notes are asking for a paper claim to be mailed to the address that is on file for that insurance plan. This can be handled by the staff quickly while working the call.

First they would verify that the address for the carrier is the correct address by pressing F4 in the insurance plan number screen then typing the plan ID (I39 in this case). (This jumps them to the B, F - insurance plan table).

If the address is correct then all they have to do is resubmit the claim and select N for print now and Y for force to paper. This should be rare but if a paper claim is needed instead of electronic it should be handled by the follow-up staff. Also claims can be faxed to first choice at 206.268.6181.
EXAMPLE ACCOUNT: MTP.SLIGHT0000







Entry	Recall For	Keyer	DOS	
120519 11:05	SCOTT	SCOTT		(N) DOS 05/06/19, CLD HEALTH CHOICE @800-231-6935 S/W AREN SD TH AT PARTICULAR GROUP ID HANDLED BY DIFFERENT DEPARTMENT SO NE ED TO CALL COASTWISE CLAIMS @800-955-7376 S/W CARLOS SAID NO CLAIM ON FILE, INFORMED REP CLAIM TO SUBMITTED TO INSURANCE TWICE ON 05/09/19 AND 08/09/19 THRU EPID#91131, REP SAID EP ID# IS CORRECT FOR FIRST CHOICE HEALTH, THEY ARE PRICING COM PANY ONCE THEY PRICED AND FORWARDED TO COASTWISE FOR PROCESS ING,
120519 11:05	SCOTT	SCOTT		(N) THEREFORE SUGG TO SUBMIT THE CLAIM THRU PAPER, CLAIM MAILING ADDRESS: PO BOX 2289 SEATTLE WA 9811-2289, TFL BASED UPON S TATE GUIDELINE, PT POLICY ACTIVE FROM 01/01/08 TO STILL ACTI VE, ALSO REP FOUND ANOTHER PAID CLAIM FOR THIS DOS WITH BILL CHARGE $410.00 WITH SAME ID#, THEREFORE REP ASK US TO RESUB MIT THE CLAIM, ALSO SAID FIRST CHOICE HEALTH THEY DONT PROVI DE ANY CLAIM STATUS OVER THE PHONE AND THEY ASK US TO GET FR OM ECHN.COM. REF#5767572
120619 13:40	CHRISW	CHRISW		(N) SUBMITTING PAPER CLAIM TODAY

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MEDICAL RECORDS/APPEAL RESUBMISSION INSTRUCTIONS:

We are in need of a different arrangement when the follow-up staff identifies that the solution is that the Medical Record or an Appeal needs to be sent on a claim and the staff member is unable to perform the appeal.

Issue: For MTP items are being identified in follow-up where the chart note needs to be sent to the carrier in order to appeal for unbundling. We have to request this from the practice. When this information is returned to us on the follow-up reports it is 51 pages deep and extremely difficult for us to get through the other items before we see that the Medical Record needs to be requested from the practice.

For MTP would like the following update:

1. When a chart notes is needed please have the chart note request entered as a Query into the master query list that is shared in Only Office. This way it isn't buried in a follow-up report and we can more quickly identify that there is a need for chart notes and ask for it from the practice.
https://onlyoffice.mmsspro.com/products/files/doceditor.aspx?fileid=1688

2. Also for all items identified in follow-up that need Medical Records – please review the current follow-up reports and add these items to the master query. This way we can quickly request them from the practice.

FOR OTHER DATASETS:

For other clients where you cannot access the Medical Record and we need to coordinate and it is identified in Follow-up.

1. Please add these items as a separate query Called "Records/Appeals" and send them to MMSS end in weekly basis. This way we quickly know which items need to be requested from the client.

2. For clients that you have access to the chart notes you are approved to appeal using the letters in Healthpac that fits the situation, merge the fax cover, chart note and claim as needed an either Fax using Ring Central or Upload to the Color Print Queue for printing and mailing in our office.

In Only Office if an item needs to be printed we are saving it into the Print Queue and using either the black and white or Color Print queue if there is a claim that needs to be printed and is in Color in the pdf.

https://onlyoffice.mmsspro.com/products/files/#122

SECURE EMAIL ACCESS FOR FOLLOW-UP STAFF (CHART NOTES):

There can be instances where it is very useful for follow-up staff to be able to send chart notes or claims by secure email to insurance adjusters, especially for injury claims.

The follow-up staff can now have access to Approver to send secure email. They would login and then compose a message and can attach claims now that they have ability to print claims to PDF and apply the HCFA watermark and chart notes.

Secure Email Login: https://us2.securepem.com/mmsspro/web/
Username: specialists@mmsspro.com
Password: Winter#2018

This is a shared team account. Whenever a person uses this to send a secure email they need to finish the information in the signature line to show their name and phone number. The follow-up staff can use the phone number 541.665.4435. Please let me know if you have any questions.

DMAP – CHART (MEDICAL) NOTES NEEDED:

If DMAP denies claims needing medical documentation, you can only use the EDMS coversheet along with chart notes when the claim is in SUSPENDED status. If the claim has DENIED, you will need to submit the claim along with notes in (again) as once it is denied, there is no "claim" to attach the notes to :) It is also OK to fax claims w/chart notes to the same fax# 503.378.3086.

CHART NOTES UPLOAD – REQUIRED DOCUMENTS:

If Insurance needs the Consent for Sterilization when there is Sterilization. There is no need to supply the face sheet or other items in this situation. Also for other Anesthesia Record Requests it is not necessary to send the hospital face sheet to the insurance. Only send the other necessary pieces depending on the situation.

Comments: Update the notes for which type of records are uploading into the online web portal/Only Office. Please see below 2 Examples for reference;

Example 1 for MMA: CIF R202590190456 CREATED AND ***ANESTHESIA RECORD*** UPLOADED TO PARTNERSHIP HEALTH ON 12/11/2020 FOR DOS 08/17/20 SERVICES.

Example 2 for NPD: ***LAB REPORTS*** ARE UPLOADED TO ANTHEM ON 12/21/20 DOS 10/07/20

CPT 90750 – MEDICARE & MEDICARE ADVANTAGES PLAN:

The CPT 90750 will denied by insurance stating "**NON-COVERED SERVICES BECAUSE THIS IS A ROUTINE EXAM OR SCREENING PROCEDURE DONE**" because the code 90750 is covered under a Medicare Part D plan.

The Medicare and Medicare following doesn't pay for CPT 90750 Zoster (shingles) vaccine under Part A or Part B and may be covered by Medicare Part D Prescription Drug Coverage. That means the medical practice can't give it to Medicare patients and be reimbursed for it.

ACTION:

Please do not include these type of scenarios into coding assistance account and follow the below points;

1. If the patient is having secondary insurance, wait until it get paid by 2' insurance.
2. If secondary insurance also not paying for that, then it should be moved to patient responsibility.