



Billing Guidelines Manual for Contracted Professional HMO Claims Submission

The Centers for Medicare and Medicaid Services (CMS) 1500 claim form is the acceptable standard for paper billing of professional medical services. This billing guide is designed to assist our providers with avoiding payment denials when Riverside Medical Clinic (RMC) receives the submission of incomplete (unclean) claims.

CLEAN CLAIMS ARE CLAIMS THAT:

- are submitted on the CMS 1500 claim form, with all fields completed accurately, *according to the Carriers Manual Part 4, Chapter 2, entitled “Health Insurance Claim Form”, Title 42 Part 424 Subpart C Section 424.30 through 424.40 in the Code of Federal Regulations and AB 1455 section 1300.71*. Basic guidelines for completing the claim form are provided by CMS. You will also find instructions on how to complete the 1500 claim form on the National Heritage Insurance Company website at www.palmettogba.com/J1

AUTHORIZATION:

- a hard copy authorization form or a valid RMC authorization number listed in box 23 of the CMS 1500 claim form. All non-emergency services **MUST** be prior authorized by the Utilization Management (UM) department of RMC.

ADDITIONAL INFORMATION:

- there may be instances when a clean claim will require additional information. Some examples may include, but are not limited to, medical records for substantiation of services rendered/billed, primary insurance explanation of benefits. (EOB/ MEOB).

CMS 1500 CLAIM FORM: CLEAN CLAIM REQUIRMENTS

The CMS 1500 form should be used by:

- Independent physicians, non-MD’s, and other suppliers, e.g., laboratories, physical therapists, chiropractors, podiatrists, optometrists, and DME suppliers.
- Hospital outpatient/emergency room department physicians.

The professional component **only** must be billed on a CMS 1500 form for the MD’s, DO’s, and podiatrists with the exception of clinical services. If there are physician extenders, i.e., nurse practitioners, physician assistants, nurse anesthetists, participating professional group for whom the hospital does the billing, then these professional services must also be billed on a CMS 1500 form.

REQUIREMENTS FOR COMPLETING THE CMS 1500 CLAIM FORM

Medicare has established guidelines for filling out the CMS 1500 form. Claims **cannot** be processed without completing the following **required** fields:

1, 1a, 2,4,6,7, 10, 11, 11a-c, 12, 14,17, 17a, 19, 20, 21, 23, 24a, b, d, e, f, g, k, 25, 27, 31-33

If the claim is missing any information in the above fields, the claim may be denied back to you requesting a new, complete claim be submitted to the claims office at RMC.

If using unlisted or miscellaneous codes, please attach notes or a description of the services rendered. If using BR or RNE codes, attach a copy of the appropriate reports. The correct two-digit place of service code is required. If billing with invalid CPT, ICD.9, Modifier or Place of Service codes, whiteout on your claim, or incorrect anesthesia time/units has been reported, the claim(s) will be processed back to you requesting you resubmit a corrected claim. When a new claim is received it will be re-considered for payment. Faxed copies will only be accepted upon our request, as they are oftentimes difficult to read. Faxed copies are not processed any differently than mailed claims. They are batched and filed according to the date the claims were received in our office. Please mail the new claim and information to the address listed under the **“Where to Send Your Claims”** section in this manual.

UNBUNDLING

This past April 2008, Riverside Medical Clinic (RMC) purchased the “Virtual Examiner” claims program as a technologically advanced tool for highlighting aberrant billing policies and procedures. Using nationally recognized payment and coding guidelines, the “Virtual Examiner” allows a claims examiner to pend, edit or deny claim entries.

One of the goals of our new compliance program is to focus on areas under government inspection and review. Under billing fraud and abuse, federal and state agents are looking at the following areas: unbundling, upcoding, medically unnecessary services, duplicate billing, and billing for services never rendered.

Unbundling is defined as reporting multiple CPT codes when one CPT code is sufficient. If incidental surgical procedures are coded separately, or office visits for uncomplicated follow-up care are separately coded, the unbundled codes will be denied.

Billing correctly the first time will prevent delays in processing your claims.

CPT CODE RANGE GENERAL DEFINITIONS

99201 - 99215	Physicians Office or other service
99241 - 99245	Office/Hospital Consultation
99271 - 99275	Confirmatory Consultations
99281 – 99288	*Emergency Department Services
99381 - 99397	Preventative Medicine
99401 - 99429	Counseling and/or Risk Factor Reduction / Intervention
90801 - 90899	Psychiatry

UB92 CLEAN CLAIM REQUIREMENTS

There are a few services billed on UB92 claim forms which RMC **may** have the financial responsibility of payment. The following types of services should be billed on a UB 92 form:

- Outpatient Facility diagnostic services
- Ancillary services

REQUIREMENTS FOR COMPLETING THE UB92 CLAIM FORM

UB92 outpatient claims cannot be processed without completing the following fields:
1, 2, 4-6, 12-15, 17-23, 43-47, 50a-c, 54, 58-62, 67-75, 76, 80, 81a-e, 82, 85, 86

Should the UB92 claim form be missing any information, the claim will be processed back to you requesting the submission of a new claim with the required information on it. When the new claim is received, it will be re-considered for payment.

WHERE TO SEND YOUR CLAIMS

It is important for you to send your claims to the appropriate office at **the initial billing** to avoid delays in processing, or denials for untimely claims submission. Riverside Medical Clinic is responsible for processing all professional service claims, or as outlined in our health plan contracts of financial responsibility. Below is the address you will need to mail your claims to:

**Riverside Medical Clinic
Prepaid Business Office / Claims
3660 Arlington Avenue.
Riverside, CA. 92506
Telephone (951) 782-3060**

*To prevent delays in receiving your checks, should you have a change in address, you **MUST** notify RMC in writing as soon as possible. (This also applies to New Providers)*

CHECKING THE STATUS OF A CLAIM

There are two different ways you may check the status of your claim(s):

1. You may **call** the Claims Customer Service Unit at **(951) 782-3060**. In order to identify the correct patient, be prepared to provide the representative with the name of the provider you are calling for, the patient name, date of service, patient date of birth,

Social Security # and the amount billed. If you call the main telephone number for RMC at (951) 683-6370, you may be directed to the wrong department. To avoid delays with answering or returning your calls, only call the Claims Customer Service number listed above.

2. You may also access the **RMC Claims Inquiry Website at <http://as400.rmeps.com>**, however, you cannot access the website until you are provided a user name and password. When speaking with one of our customer service representatives at the phone listed above, inform them you would like to be assigned a password so you may access the website. The representative will ask you for the name of the individual we are to provide the user I.D. and security code. You will then be notified within 10 working days, in writing, of your security pass code. Once this letter is received, you may contact customer service and they will assist you with the initial inquiry.

WHEN A REPORT OR ADDITIONAL INFORMATION IS NEEDED

There are several reasons why Riverside Medical Clinic might request a report, additional information or a corrected claim. Some common examples are listed below:

MEDICAL RECORDS

Should RMC receive a claim for services which were not authorized, the services billed do not match the authorization, RMC needs to review and substantiate the services rendered, or the services do not meet the criteria for an emergency, RMC will request additional information substantiating the services performed. An EOB will be sent to you requesting the submission of all pertinent medical records. The claim will remain closed until such records are received. Processing code 1.29 is used for this request, as you will notice on the explanation of benefits.

MODIFIERS

The CPT coding system includes two-digit modifier codes, which are used to report that a service or procedure has been “altered or modified by some specific circumstance” without altering or modifying the basic definition or CPT code. The proper use of modifiers can speed up claim processing and increase reimbursement, while improper use of modifiers may result in claim delays or denials. In addition, using certain modifiers, for example, 59 too frequently, may trigger a billing audit.

CURRENT PROCEDURAL TERMINOLOGY CODES (CPT)

The CPT coding system is maintained by the American Medical Association and a revised edition of the CPT book is published each fall. Physicians, hospitals, and other health care professionals use CPT codes to report specific medical, surgical and diagnostic services. Claims must be itemized with accurately with **valid** CPT codes indicating accurately the services performed by the provider of service. A valid code is one taken from the current coding books for the calendar year the services were rendered. If the claim is not billed properly, it will be processed and an EOB will be sent requesting a corrected claim. The claim will remain unpaid

until requested information is received. For all unlisted procedure codes, a description must follow. If there is no description, the claim will remain unpaid until the appropriate information is received.

INTERNATIONAL CLASSIFICATION OF DISEASES (ICD.9)

CMS has prepared guidelines for using ICD.9 codes and provides instructions on how to report the codes accurately on claim forms. Health care professionals must list a minimum of one ICD.9 code and may list up to a total of four codes on the claim. ICD.9 codes should be used to their highest level of specificity. You will only assign three digit codes if there are no fourth digit codes within the coding category. You will assign four digit codes only if there are no fifth digit codes within the coding category, and you will assign a fifth digit sub-classification for those categories where it exists. Claims submitted with three or four digit codes where four and five digit codes are available, will be denied. You will be required to submit a claim with the valid codes assigned. The claim will remain closed until a clean claim has been submitted.

THERE IS NO AUTHORIZATION ON FILE

The provider **MUST** have an authorization for services. Without an authorization, RMC may not reimburse the provider for services rendered. Any charges incurred will become the financial responsibility of the provider. **Documentation**, which may include copies of operative reports and/or medical records, **will be requested on all unauthorized services**. Fees associated with the copying of such reports are not payable by RMC, and per the Knox-Keene Act of 1974, as well as the provider contract with RMC, these charges cannot be billed to the patient.

For hospital-based physicians, the authorization issued to the hospital for inpatient or outpatient services will be considered a valid authorization. RMC will link that authorization to any claim when submitted.

THE AUTHORIZATION ON FILE DOES NOT MATCH THE SERVICES PERFORMED

The provider must perform **ONLY** those services, which were authorized procedures by the UM department at RMC. **All additional testing, procedures, or treatment protocols MUST receive PRIOR authorization. Those done without authorization may forfeit reimbursement.** You may dispute the denial by sending, along with the claim, the appropriate documentation, which may include copies of operative reports and/or medical records.

THE PROCEDURE PERFORMED IS “BR” (by report) or “RNE” (relativity not established)

All BR and RNE services will be reviewed by Riverside Medical Clinic claims professionals for conformity to the definitions contained in the RBRVS, CPT, ASA codebooks and the CMS Physicians Medicare Fee Schedule. RMC reserves the right to change or modify billed procedure codes after the supporting documentation has been received and indicates that the billed procedure does not conform to definitions in the appropriate reference materials, nor is supported by the patient’s diagnosis. Inaccurate information billed on claims may constitute an “unfair billing pattern” and may be subject to an audit.

ANESTHESIA SERVICES

For anesthesia claims, if a separate procedure was performed aside from the administration of anesthesia, documentation supporting the separate procedure must accompany the claim in order for payment to be considered. If such documentation is not received the service will be denied as included with the primary surgical procedure.

EMERGENCY SERVICES

A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable person with an average knowledge of health care and medicine, could reasonably expect in the absence of immediate medical attention, to result in, a) serious jeopardy to the health of an individual, or in the case of a pregnant woman or her unborn child; b) serious impairment of a bodily function; or c) serious dysfunction of any body organ or part. ***Medical records and/or reports must be attached to the claim on all emergency services.***

EXPLANATION OF BENEFITS IS REQUIRED FROM THE PRIMARY CARRIER

If the patient has another insurance, which is primary, the other insurance must be billed first. After receiving the explanation of benefits (EOB/MEOB) from the primary insurance, attach a copy to the claim and forward the claim to RMC for processing the remaining balance. Please follow the billing time frames as outlined in your provider contract, or refer to the “Filing Deadlines” section of this manual. If claims are received outside of that time frame, the claim will be denied as “untimely”.

PLACE (LOCATION) OF SERVICE (POS)

The actual setting in which the services were rendered must be indicated on the claim. A listing of current codes can be found on the Medicare website listed on the first page of this manual.

CLAIM FILING DEADLINES

PARAMETERS OF PAYMENT

You must initially submit your claims directly to RMC within the timeframes as outlined in your Provider Services Agreement. **Failure to submit your claim(s) in a timely manner may result in loss of payment.**

RMC will then reimburse at the contracted rate, less any applicable co-payment and/or deductible collected from the member at time of service. (RMC is not responsible for reimbursing the provider for member co-pay's or deductibles).

If the claim was denied because of an “untimely filing”, you may *dispute for good cause*, the payment denial by submitting a statement of activity with proof of the original submission dates to RMC. This proof may include, but is not limited to, a ledger card showing the original bill date, a print out of the billing history, or an EOB from another insurance carrier. The billing history must show the name and address of where the claim was submitted.

If the claim was submitted after the billing limit but the circumstances were beyond your control, you may *dispute for good cause*, this type of denial by sending a letter documenting the reason(s) why the claim could not be submitted within the appropriate period of time. You must include a copy of the claim form with your documentation. Examples of this are:

- The member supplied incorrect insurance information.
- A computer error caused a delay in billing
- The member has a primary insurance and you have just received the EOB from them

For hospital-based physicians, if you were supplied inaccurate insurance billing information from the hospital, and you billed the wrong provider or health plan, please attach a copy of the hospital face sheet with your claim. For all other providers, your Provider Services Agreement with RMC states you are to submit your claims directly to RMC.

TIMING OF PAYMENT BY RMC

For **commercial HMO** member claims, Riverside Medical Clinic shall compensate the provider based on the timeline outlined in the Provider contract or if not otherwise stated within **forty-five (45) working days (64 calendar)** following receipt of a clean claim. All contracted **Medicare** claims will be processed within **60 calendar days** from the receipt of a clean claim, or within the timelines outlined in your provider contract.

*****RMC will deduct all applicable co-pays and/or deductibles at time of processing. Remember, it is your responsibility to collect any co-payments due from the patient.*****

WHEN TO SEND A TRACER

WHAT IS A “TRACER”?

A tracer is a claim that you have previously submitted more than forty-five (45) working days prior to the last submission date, and no information has been received regarding the claim.

Tracer claims may be submitted by sending a copy of the original claim marked “**TRACER**”. If a claim was never submitted and the filing limit is approaching, do not submit a tracer claim. Please follow the directions outlined in this manual under “Filing Limit Appeals”.

CORRECTED BILLINGS/RESUBMISSIONS

If you are submitting a “corrected billing”, it must be submitted within the timeframes as outlined in your contract. The appropriate claim form would be a CMS 1500 or UB92 claim form with the words “**CORRECTED BILLING or RESUBMISSION**” stamped on the front of the claim. Attach a copy of the RMC explanation of benefits indicating the original request for the corrected claims. Mail the corrected claims to the address listed under the “**Where to Your Send Claims**” section in this manual.

CONDITIONS OF PAYMENT

- Services provided are covered services in accordance with the evidence of coverage benefit document provided to health plan members who meet eligibility requirements.
- Services were **prior authorized** by Riverside Medical Clinic UM department.
- Emergency services were medically necessary and meet the definition of an emergency. “An emergency service is a service needed immediately due to acute symptoms (including pain) which a reasonable person feels could result in serious jeopardy to their health”...as well as outlined by the members health plan. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility **MUST** be available 24 hours a day.
- Riverside Medical Clinic must have received the original claim within the time frame described in the “**Filing Deadline**” section of this manual. Any claims submitted after the filing deadline may forfeit reimbursement.
- Services were billed on the appropriate medical claim form, using appropriate, **valid** CPT, ICD.9, ASA, Place of Service, and HCPC’s codes provided annually by the American Society of Anesthesiologists, American Medical Association and Medicare.

CLAIMS PAYMENT DISPUTE RESOLUTION PROCESS

DEFINITION OF A PROVIDER DISPUTE

A contracted provider dispute is a written notice to RMC and/or the member’s health plan challenging, appealing or requesting a reconsideration of a claim (or a group of substantially similar multiple claims that are individually numbered) that have been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute, or are disputing a request for reimbursement of an overpayment of a claim.

SENDING A PROVIDER DISPUTE

Contracted providers **MUST** use the “PROVIDER DISPUTE RESOLUTION REQUEST” form when submitting a claim dispute. If submitting “multiple like claim” disputes, you must also complete the spreadsheet, and submit with your claims. Both have been attached for your reference. All contracted Provider Dispute Resolution Forms must be sent to the RMC Prepaid/HMO Department at the following address:

Via Mail: **Riverside Medical Clinic
Prepaid Business Services/Appeals
3660 Arlington Ave.
Riverside, CA. 92506**

FILING LIMIT OF DISPUTES

Contracted provider disputes must be received within 365 days from the original determination. All claims submitted for the first time after the filing limit of 365 days will be denied as “untimely”.

SINGLE CLAIM DISPUTES

If your dispute concerns a single claim you must provide clear written identification of the item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial adjustment or other action is incorrect.

MULTIPLE SUBSTANTIALLY SIMILAR DISPUTES

Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted with a cover sheet describing each dispute reason.

TIME PERIOD FOR DISPUTE RESOLUTION

After all necessary documentation has been received RMC will issue a written determination stating the reasons for the determination within forty-five (45) working days after the date of receipt of the dispute. If additional payment is due, payment will be forthcoming. If your reconsideration is denied, an explanation will be documented on the Explanation of Benefits sent to you. If you do not receive any correspondence within forty-five (45) days from your original request, you may call the Customer Service Unit and they will investigate your issue.

CLAIM OVERPAYMENTS

If RMC has determined it has overpaid on a claim, RMC will notify the provider in writing through the Provider Dispute process, clearly identifying the claim, the name of the patient, the Date(s) of Service and a clear explanation of the basis upon which RMC believes the amount paid on the claim was in excess of the contractual amount which was due, including any interest and penalties on the claim.

If the provider contests RMC’s notice, written notice must be sent to RMC within 30 working days stating the basis upon which the provider believes the claim was not overpaid. If the provider does not contest RMC’s notice of overpayment, the provider **MUST** reimburse RMC within 30 working days of the notice.

Should the provider fail to reimburse RMC, along with any interest and penalties, RMC may offset any current claim submission when; the provider fails to reimburse RMC within the timeframes as outlined above, and RMC’s current contract with the provider specifically authorizes RMC to offset any future claims payments.

<h2>CLAIM DENIALS</h2>

There are several reasons why a claim may be denied. A denial letter will be sent to the patient notifying them of the exact reason the services were denied, and why they are financially responsible for the services. Some examples are, but limited to:

- **PATIENT NOT ELIGIBLE WITH HEALTH PLAN AT TIME OF SERVICE**
- **OUTPATIENT SERVICES WERE NOT PRIOR AUTHORIZED**
- **EMERGENCY SERVICES DID NOT MEET THE CRITERIA OF AN EMERGENCY**
- **NOT A COVERED BENEFIT**

Riverside Medical Clinic will not be held financially responsible for payment when a claim has been denied. Even if an authorization was previously obtained for services rendered, yet the patient became ineligible after the authorization was provided, the claim will be denied upon adjudication. Once the denial letter is received, you may bill the patient.

If any services rendered were denied, and a letter has been sent to the provider and member, it has been determined by the UM department at RMC, that the patient is financially responsible for the bill. You may then seek reimbursement from the member.

Call the Riverside Medical Clinic Prepaid Business Customer Service Unit at (951) 782-3060 regarding claims questions if you have the following issues:

- You have submitted the additional information that RMC requested and your claim was denied anyway
- It has been more than forty-five (45) working days from the original submission date for Commercial member claims, or (60) calendar days for senior member claims.
- Your request for reconsideration was denied.
- Your claims issue was not addressed in this manual