TheHealthPlan

Chapter 3

Claims

Provider Manual

Claims Submission

Physicians and practitioners should submit claims through Change Healthcare's clearinghouse using payer ID 95677 or through the THP MyPlan Provider Portal.

Hospitals, facilities, and ancillary providers should submit claims through Change Healthcare's clearinghouse using payer ID 95677.

Paper claims must be submitted on red Optical Character Recognition (OCR) forms to:

THP
1110 Main Street
Wheeling, WV 26003

THP will not accept handwritten paper claim forms or paper claim forms in non-OCR format.

THP requires complete and accurate procedure and diagnosis codes on claims submission including ICD-10 Z-codes to collect information about THP members' social determinants of health (SDoH).

THP encourages the submission of HCPCS Category II codes to report performance measures. Using category II codes will decrease the need for THP to request medical records.

When entering the THP member ID on a claim, please include the entire member ID number with the two-digit suffix. Do not use dashes or spaces.

THP member ID numbers begin with the letter H, then eight numeric characters, and then two-numeric suffix indicates the member type.

Suffix definitions:

01 – Subscriber
02 – Spouse
03 – Child (eldest)
04 – Child (next eldest)

Timely Filing and Timely Adjudication

For THP's Commercial Fully Insured, West Virginia Mountain Health Trust (MHT) and Medicare Advantage lines of business:

- Initial claims must be submitted within180 days from the date of service.
- Corrected claims must be submitted withing 180 days from the date of the original denial or within 180 days from the date of service, whichever is greater.
- Coordination of benefits (COB) claims must be submitted within 180 days from the date of service or 90 days from the date of the primary carrier's explanation of benefits (EOB).

For THP's Self Insured / Administrative Services Only customers:

- All claims must be submitted within the timely filing requirements set forth in the employer group's plan design unless otherwise required by applicable state or federal regulations.

THP will adjudicate clean claims within (thirty) (30) days from receipt, or as otherwise required by prompt pay requirements.

If a clean claim is not paid within the applicable timeframes, appropriate interest is applied to the claim when paid as required by state law, Medicare, or West Virginia Mountain Health Trust (MHT).

- For MHT services interest is paid to in-network providers at 18 percent per annum calculated daily for the full period the claim remains unpaid beyond the 30-day clean claims payment deadline.

Coordination of Benefits (COB)

COB is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical treatment. COB is designed to eliminate the opportunity for a person to profit from an illness as a result of duplicate group health care coverage.

Commercial Fully Insured and ASO

Each employer group contracting with THP has a COB provision in their contract. In accordance with your provider contract, claims for THP members with another insurance should be submitted to the primary carrier first for payment.

- Primary plan – plan that reviews for payment first
- Secondary plan – plan that reviews for payment second

When THP is the secondary payer, THP will adjudicate the balance of covered services not paid by the primary plan, so long as the total payment does not exceed 100 percent of your contracted rates.

National Association of Insurance Commissioners (NAIC) COB Calculation

Some Commercial Fully Insured and ASO customers follow NAIC guidelines for COB calculation. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

West Virginia Mountain Health Trust Members

For members that have primary insurance coverage from a source other than Mountain Health Trust (MHT), THP will honor coverage and utilization management decisions made by the primary carrier for those services in the primary carrier's benefits package. If THP is responsible for West Virginia MHT, including WV Medicaid, and WV Children's Health Insurance Program (WVCHIP) services that are carved out of the primary carrier's benefit package, THP has utilization management responsibility for those carved out services.

COB and Benefit Order Determination Rules

Non-Dependent or Dependent: The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan. Example below:

- **Employee:** The plan covering the person as an employee pays benefits first. (If the patient is our subscriber THP is primary.)
- **Spouse:** The plan covering that person as a dependent pays benefit second. (If the patient is the spouse of our subscriber, THP is secondary to the spouse's insurance.)

Dependent children: The plan covering the parent whose birthday falls earlier in the year is determined before those of the plan of the parent whose birthday falls later in that year. The term "birthday" refers only to the month and day of birth during the calendar year. (If both parents have the same birthday, the benefits of the plan that covered the parent the longest is the primary plan.)

Dependent children of separated or divorced parents: When parents are separated or divorced, the birthday rule applies when the court decree does not designate a specific parent to carry insurance for the child as primary. However, if specific terms of a court decree state that one parent is responsible for the health care expenses of the child, the plan of that parent is primary.

In the absence of a court decree, the following rules apply:

a. The plan of the parent (with custody) who is the residential parent and legal custodian of the child pays first.

b. The plan of the spouse of the parent (with custody) who is the residential parent and legal custodian of the child pays next.

c. The plan of the parent (without custody) who is not the residential parent and legal custodian of the child pays next.

d. The plan of the spouse of the parent (without custody) who is not the residential parent and legal custodian of the child pays last.

Active/inactive employee: The primary plan is the plan that covers a person as an employee who is neither laid off nor retired, or that employee's dependent. The secondary plan is the plan that covers that person as a laid-off or retired employee, or the employee's dependent. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the non-dependent or dependent rule can determine the order of benefits.

Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

COB Billing

- Bill the primary insurance first even if there is a deductible to be met so that the service can be applied to the deductible.
- Bill the secondary insurance and attach the primary explanation of benefits (EOB) to expedite payment from THP.
- If billing electronically, COB information must be included in the electronic submission.
- If billing on paper, a separate EOB must be submitted for each claim
- All payments indicated on the claim must be supported by an EOB or the claim will be denied.
- All prior authorization requirements apply when billing THP as secondary.
- DO NOT highlight on claims or inquiries. Please underline or star items that you wish to bring to THP's attention.

COB Denials

Each COB claim is reviewed to determine whether THP is primary. If you receive a COB denial (listed below), please resubmit accordingly, based on the denial, for THP to review again.

- When sending documentation to the attention of the COB Department, please indicate if you have previously spoken to a representative at THP.
- For questions regarding your voucher or disputes related to COB, contact the COB Department at 1-800.624.6961, ext. 7903.
- All other voucher questions should be directed to the Customer Service Department at 1.800.624.6961

Type	Description
D095	INCOMPLETE/INVALID EXPLANATION OF BENEFITS
D237	PATIENT IS ENROLLED WITH HOSPICE
D393	THIS IS A WORK-RELATED INJURY/ILLNESS AND THUS THE LIABILITY OF THE WORKER'S COMPENSATION CARRIER.
D491	MISSING EXPLANATION OF BENEFITS
D548	MISSING/INCOMPLETE/INVALID PRIOR INSURANCE CARRIER EOB

Members with Double THP Coverage

- Bill the copay, deductible, and/or co-insurance shown on the payment voucher by using the member's secondary ID number.
- Attach a copy of the voucher showing THP's payment.

Original Medicare Primary

Any physician who has submitted an assigned claim to Original Medicare has agreed to accept Medicare's reasonable charge as payment in full for their services. Per the Medicare's Carriers Manual, section 3045.1, the physician is in violation of their signed agreement if they bill or collect from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the reasonable charge.

THP, as a Medicare supplemental insurer, is functioning as a private insurer. Therefore, THP will be reimbursing the physician for THP covered services, when that reimbursement amount *does not exceed* THP's standard reimbursement.

THP will pay deductibles, copayments, co-insurances, and other member responsibility amounts not paid by the primary carrier so long as the total payment does not exceed the amount THP would pay as the primary carrier. This process is applied to each individual service

Original Medicare Members

Below are steps to follow when billing for a Medicare member:

1. **REGULAR MEDICARE (red, white and blue card):** THP evaluates primary and secondary coverage with Medicare in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Please call the COB Department at THP at 1.800.624.6961, ext. 7903 for clarification of primary responsibility for Medicare members with this ID card.
2. **SECURECARE HMO/SECURECHOICE PPO**: Bill THP directly for all charges. We are the Medicare carrier for Part A and Part B services.
3. **MEDICARE SUPPLEMENT:** Bill Medicare first and then bill THP for any co-insurance or deductibles (see Medicare crossover notice).

Medicare Crossover Notice

Effective as of Dates-of-Service 8/29/2016
For Medicare Supplement Plans ONLY

- When your patient presents this ID card from THP, you will no longer have to submit a claim to THP after Medicare pays.
- Medicare will send us your claim information and we will then process for the remaining copayment, co-insurance, or deductible.
- As a reminder, this plan will only cover those services that have been allowed or paid by Medicare. If Medicare denies the service, THP will also deny your claim.

Medicare Primary Payment Example

THP Employer Group Coverage Secondary

BILLED AMOUNT	140.00
MEDICARE ALLOWABLE	81.90
MEDICARE PAYMENT	65.52
MEDICARE CO-INSURANCE	16.38
HEALTH PLAN PAYMENT	16.38

THE ABOVE ARE EXAMPLES AS THEY WILL APPEAR ON YOUR PAYMENT VOUCHER

Medicare Primary Payment as Displayed on Voucher

CPT	BILLED	ALLOWED	DISALLOWED	COPAY	COINS	COB AMT	PAID	REF W/H	NON Ref W/H	ADJ CD
99205	140.00	81.90	.00	.00	.00	65.52	16.38	.00	.00	.00
	(Reduced to Medicare's Allowable)									

Documentation Submission

THP has a dedicated fax line to submit documentation. The fax number is 740.699.6163.

In order to assure the required documentation is routed correctly, please complete THP's fax cover sheet in its entirety. A copy of the Fax Cover Sheet to Support Electronic Claim Submission is available on THP's provider portal myplan.healthplan.org. Failure to complete the fax cover sheet may result in claim denials. A separate fax cover sheet is required for each claim documentation.

*Your electronic claim should be marked in the **claim note** or **claim line** area with notification stating additional documentation has been faxed. Placing the word **FAX** in the **claim note** area will alert our claim reviewers.*

All required documentation must be faxed within 24 hours of your electronic claims transmission.

Never Events and Avoidable Hospital Conditions

Never Events

Wrong procedures, or procedures performed on the wrong side, wrong body part, or wrong person, are commonly referred to as "never events." These never events are not medically necessary as they are not required to diagnose or treat an illness, injury, disease, or its symptoms and are not consistent with generally accepted standards of medical practice. All never events involving a wrong procedure, or a procedure performed on the wrong side, wrong body part, or wrong person are considered not medically necessary, and reimbursement is not permitted. Hospitals generally refrain from billing members for these never events. In the instance where THP does receive bills for such services, these are appropriately denied for lack of medical necessity.

Avoidable Hospital Conditions

Avoidable hospital conditions (hospital-acquired conditions) are conditions "which could reasonably have been prevented through application of evidence-based guidelines." These conditions are not present when patients are admitted to a hospital but present during the stay.

Effective October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) identified the following as preventable hospital acquired conditions:

- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.
- Falls and trauma
- Foreign objects retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Manifestations of poor glycemic control
- Mediastinitis, following coronary artery bypass graft (CABG)
- Pressure ulcers stages III and IV
- Surgical site infection following bariatric surgery for obesity
- Surgical site infection following cardiac implantable device (CEID)
- Surgical site infection following certain orthopedic procedures
- Vascular catheter-associated infection and surgical site infection

CMS provided that effective October 1, 2007, hospitals shall submit inpatient hospital charges with a present on admission (POA) indicator. POA is defined as a condition that is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including the emergency department, observation, or outpatient surgery are considered as POA.

THP reviews and tracks admissions with identifiable never events and avoidable hospital conditions. When it is determined there were additional hospital inpatient days at a participating provider facility, which directly and exclusively resulted from an avoidable hospital condition (not present on admission), reimbursement for additional inpatient days and/or services may be denied. Further, avoidable hospital conditions and never events shall not be considered in DRG determinations for facilities reimbursed through a DRG methodology. Denials for inpatient hospital days or services which are the result of such circumstances are not billable to the member. These reimbursement denials will not apply to hospital admissions in which the avoidable hospital condition was present on admission, or where another secondary diagnosis is a major complicated/comorbidity (MCC) or complication/comorbidity (CC) in addition to the POA diagnosis, and potentially impacted the avoidable hospital condition.

Never Events Codes/Hospital-Acquired Conditions/Healthcare Associated Conditions

Codes	Events	Examples
NA	Preventable	Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
NB	Serious Preventable	Any death or serious injuries associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
NC	Serious Preventable	Patient death or serious injury associated with unsafe administration of blood products or the administration of incompatible blood.
ND	Catheter	Urinary tract infections associated with a catheter.
ND	Pressure Ulcers	Stage III & IV (decubitus ulcers) acquired after admission/presentation to a health care setting.
NF	Vascular	Catheter associated infection
NG	Surgical Site Infection	Mediastinitis within 30 days of coronary artery bypass surgery (CABG).
NH01	Hospital-Acquired Injury	Falls and fractures
NH02	Hospital-Acquired Injury	Dislocations
NH03	Hospital-Acquired Injury	Intracranial injury
NH04	Hospital-Acquired Injury	Crushing injury
NH05	Hospital-Acquired Injury	Burns
NH06	Hospital-Acquired Injury	Other unspecified effects of external causes
NH07	Hospital-Acquired Death	Postoperative death of a healthy patient (ASA Category 1).

Codes	Events	Examples
NI	Poor Glycemic Control	Diabetic ketoacidosis, non-ketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
NJ	Surgical Site Infection	An infectious or inflammatory reaction due to the implant of an orthopedic device following specific orthopedic procedures (spine, neck, shoulder, elbow) within 365 days.
NK	Surgical Site Infection	Surgical site infection within 30 days of bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
NL	DVT/PE	DVT or PE following specific orthopedic procedures (total knee/hip replacements), or a DVT that has occurred in an acute hospital and is diagnosed during the hospital stay.
NM	Surgery/Invasive Procedure NEVER EVENT	A surgery or invasive procedure on the wrong body part.
NN	Surgery/Invasive Procedure NEVER EVENT	A surgery or invasive procedure on the wrong patient.
NO	Surgery/Invasive Procedure NEVER EVENT	Wrong surgery/invasive procedure performed on a patient.
NP	Surgical Site Infection	Surgical site infection following a cardiac implantable electronic device (CIED).
NQ	Iatrogenic Pneumothorax	Iatrogenic pneumothorax caused by the diagnosis, manner, or treatment of a physician (i.e., inserting venous catheterization).

When any of the above variance codes are identified, a case is generated. Each case is assigned a number, and medical records are ordered for review. A written evaluation of findings is created, and cases may be reviewed at an interdisciplinary team meeting. If immediate review is necessary, the situation is immediately brought to the attention of the medical director.

Never events, hospital acquired conditions (HACs), and healthcare associated conditions continue to be investigated by THP. Any of the diagnoses or conditions clearly documented as present upon an inpatient admission are not preventable by CMS guidelines.

Notice of Readmissions Review Occurring Within 30 Days

All clinically related /potentially preventable readmissions occurring within a thirty (30) day period are subject to review. Final review decisions are made by a THP medical director. Readmissions are denied when any of the following are determined:

- If the readmission was medically unnecessary
- If the readmission resulted from a prior premature discharge from the same hospital,
- If the readmission resulted from a failure to have proper and adequate discharge planning OR
- If the readmission resulted from a failure to have proper coordination between the inpatient and outpatient healthcare teams and/or if the readmission was the result of circumvention of the contracted rate by the hospital

Physicians and practitioners should follow these guidelines:

- Hospital readmissions within 30 days for the same or similar diagnosis/DRG should be billed and paid as one claim.
- The hospital should combine both inpatient admissions on one claim and bill a corrected claim
- The index admission date should be reported
- Combine the appropriate number of observation and inpatient days for the index admission and the readmission
- Enter 180 (or the appropriate leave code) and appropriate service units to account for the days between the admission and the readmission when the member was not receiving services. $0.00 should appear in"Total Charges;"
- To resubmit a hospital claim electronically:
  - Indicate the original claim number in Loop 2300, Segment REF02
  - Indicate 6 (corrected claim) for the Claim Frequency Code in Loop 2300, Segment CLM05-3
- Once the corrected claim is received by THP, the index admission payment will be reversed, and the corrected claim will be reviewed and processed.

Remittance

The payment remittance contains three sections:

- Claims paid by line of business
- Claims denied by line of business
- Claims in process

Resubmission of Claims Denied for Documentation

The following procedures have been implemented to expedite the processing of claims that are denied for additional documentation when the diagnosis does not support the level of service for Medicare, Commercial and Self-funded lines of business.

Initially, the claim will be reviewed and if the diagnosis does not support the level of service, the claim will be denied with the more descriptive denial codes. If the provider agrees with the denial, they may resubmit the claim with the appropriate level of service. If the provider disagrees with the denial, they may submit appropriate documentation such as office notes, progress notes, etc. to support the level of service originally billed. The provider has 180 days from the claim payment/denial date or 180 days from the date of service to correct and resubmit the claim or supply additional documentation to support the level of service billed.

Level I:

Once THP receives the additional documentation to support the level of service, it is sent to the Claims Department for review by a claim's reviewer other than the original claims reviewer. If the documentation supports the level of service, the claim is reprocessed and, depending on the review date, will show on your next voucher as paid. If the documentation does not support the level of service, the claim will continue to deny. At this time, the provider may correct the claim with the appropriate level of service.

Level II:

If the provider feels that the level of service is appropriate, they may submit a written request for a third review with additional documentation. This is sent to a medical director for review. The claim will be paid or denied upon completion of the medical director review. If the medical director agrees with the initial adjudication of the claim, the claim will deny.

Please send medical director review requests to:

THP
1110 Main Street
Wheeling, WV 26003

Level III:

If the provider does not agree with the medical director's decision, they may submit a written request for an outside independent review of the claim with the appropriate documentation to support the level of service. Send independent review requests to:

THP
1110 Main Street
Wheeling, WV 26003

The results of this review reflecting the medical director's determination will be sent back within 30 days from the date of the payment voucher.

Once the decision is received from the independent reviewer, the practitioner/provider will receive written notice of their decision. If the documentation supports the claim as submitted, the claim is reprocessed at the level of service billed. If the reviewer determines the documentation does NOT

support the claim as submitted, the provider may resubmit the claim with the appropriate level of service.

If the independent outside reviewer agrees with THP's adjudication of the claim, the provider is responsible for the charges of the independent reviewer, which may vary depending on the hourly rate and the number of claims reviewed. An invoice is sent to the provider along with the outside reviewer's decision.

If the independent reviewer rules in favor of the provider, the charges for the review are the responsibility of THP. The decision of the independent reviewer is final, and the provider will have 30 days from the date of the determination letter to resubmit a corrected claim.

Claims Resubmission

To resubmit a claim <u>electronically</u> through a clearinghouse:

- Use reason code "7" in claim information 2300 Loop Segment CLM05 to indicate replacement of a prior claim
- If you wish to void/cancel a claim, use "8" as the reason code in claim information 2300 Loop Segment CLM05
- Please Indicate the original claim number in the free text field

To resubmit a claim <u>via paper</u>:

- Box 22 on the HCFA 1500 professional claim form must contain one of the following codes:
  - 7 – Replacement of prior claim
  - 8 – Void/cancel prior claim
- Use Bill Type 117 on the UB04 facility claim form to represent a hospital inpatient replacement or corrected claim
- Attach a copy of the payment voucher with the member circled or underlined (THP's optical character reader will black out any highlighted text)
- A clear explanation and/or additional documentation as to why the claim is re-submitted
- Indicate on the claim form "corrected claim" or "resubmitted claim"

Mail corrected paper claims to:

THP
1110 Main Street
Wheeling, WV 26003

Handwritten claims, copies made from an original claim form, faxed or scanned claims (black ink) will not be accepted.

Overpayments and Credit Balance

Commercial Fully Insured, Medicare Advantage, and Self-Insured/ASO:

The provider or THP can identify an overpayment.

- If the provider identifies an overpayment, they can submit a refund check with an explanation of the refund to THP at:

  THP
  Attn: Funds Recovery Department
  1110 Main Street
  Wheeling, WV 26003

- If THP identifies an overpayment, notification is sent to request payments owed within 365 days of the date of the claim payment or within the timeframe as noted in the provider agreement. Providers have forty (40) days to notify THP of intent to pay or appeal the overpayment determination. If a refund is not received within forty (40) days, an offset the amount will be applied to the next payment remittance.

Mountain Health Trust (including WV Medicaid, and WV Children's Health Insurance Program):

- Refer to Chapter 5 of this Manual for further information.

Credit Balance Explanation

When a claim is credited against your account, the credit amount can carry over more than one payment. Accordingly, it may be necessary to hold multiple remittance vouchers and post them all at once. To assist your accounts receivable, here are steps to follow to balance your deposit when credits are applied over more than one remittance voucher process.

Evaluate every voucher you receive, even those that are not accompanied by a check or electronic deposit. Vouchers with zero payments often include denials that need worked as well as credits applied to current and future paid claims. In the event a credit balance appears on the voucher, you will want to hold the voucher to reference the credit activity until the credit has cleared (i.e., until your next voucher has a positive payment amount. This excludes any voucher that only lists "Claims in Process," i.e., no payments or credits).