A. Claims Submissions

Purpose
To ensure that all claims, whether submitted electronically or on a CMS-1500, contain all the necessary data elements for adjudication. Submission of “clean” claims expedites processing and reduces rework for physicians/providers and claims staff.

Scope
Applies to all fee-for-service and capitated claims from contracted physicians, providers and vendors.

Standards
1. THIPA pays contracted fee-for-service claims within 60 calendar days of the date THIPA receives the claim. All claims are adjudicated using Medicare coding guidelines and industry standards. THIPA uses industry accepted software like Virtual Examiner to incorporate Medicare and Correct Coding rules. The only exceptions are specific contractual agreements.

2. Providers can verify receipt of electronic claims within 2 working days on-line through SynerMedConnect™ or by calling 310-257-7250 extension 5345 for electronic claims not shown as received in SynerMedConnect™. Receipt of paper claims is verified within 15 working days of submission with the return of our Claims Submission Summary Sheet. You can also verify THIPA’s receipt of paper claims using SynerMedConnect™, https://www.synermedconnect.com. Links to SynerMedConnect™ can also be found on the THIPA website at thipa.org.

3. THIPA receives monthly data updates on eligibility from each health plan. When a claim is submitted and our system does not show that the member is eligible, eligibility is verified directly with the health plan either by Data Tug (an electronic eligibility verification system), telephone or the plan website. Claims are either paid or denied based on the most current information available.

4. Evaluation and Management: THIPA uses Medicare guidelines to pay for evaluation and management services. THIPA reserves the right to pay at a lower level of care and request medical documentation for review. All documentation is reviewed by a coder. For complete information regarding Medicare approved coding for evaluation and management services, refer to the annual CPT manual. Many providers have blended rates for E and M codes and no documentation is required.

5. Claims for services related to newborn multiple births, e.g. twins, triplets etc. cannot be submitted electronically. Each patient’s claims must be submitted on separate CMS-1500s; mark the top of the claim “twins”. SynerMed’s electronic claims processing cannot differentiate between twins until a unique member ID is assigned. Electronic submissions will be denied as duplicates.

6. All claims and reasonably relevant medical documentation must be received in the THIPA office within 120 days of the date of service. First-time submission of claims older than 120 days will not be paid. Only “claim inquiries” with proof of prior submission within the 120 days will be accepted.
day timeframe will be considered for payment. Proof of submission for Office Ally claims must be a copy of the Office Ally claims inventory which shows accepted claims and for paper claims is a copy of the THIPA claims submission sheet. Claim inquiries should be made within 30 days from receipt of the EOB.

7. THIPA will allow an additional 30 days from the date of service (total of 150 days) if there is attached proof of processing by another payor. THIPA will not pay any claims submitted more than 150 days beyond the date of service. If records or other documentation are requested on the EOB, the requested information must be submitted within 30 days from the EOB date. If the requested information is not received or received more than 30 days from the EOB date, the claim will be closed and no payment will be made.

8. Checks are printed every Tuesday for claims processed the preceding week. (Occasional exceptions may be made.) Our system (MAS-90) automatically dates the check for Thursday to ensure that interest payments are calculated correctly. Checks are signed on Wednesday and mailed on Thursday. Please make sure that you deposit your check within 14 days to ensure compliance with health plan standards.

Providers are requested to establish electronic fund transfer with their bank. This allows immediate payment to the provider. EOBs are sent electronically or on paper. Electronic posting of EOBs is done each Tuesday via SynerMedConnect™. Please contact the Accounting department at 310-257-7250 to set up electronic funds transfer.

9. The billing elements required to pay claims include the following:
   a. Patient’s ID number (health plan ID number)
   b. Patient’s Name (Last name, First name, Middle initial)
   c. Patient’s Date of Birth (MM/DD/YYYY)
   d. Patient’s Sex
   e. Patient’s Health Plan
   f. Name of Subscriber
   g. Patient’s relationship to insured
   h. Other insured policy or group number
   i. Other insured 8 digit date of birth and sex
   j. Patient’s mailing address
   k. Employer or school name
   l. Patient’s condition related to employment or accident if applicable
   m. Authorization Number
   n. Eight digit date for each procedure, service or supply including to and from dates
   o. Procedure codes, CPT, HCPCS, and modifier code if applicable. Diagnostic codes (ICD-9) coded to the highest specificity as required. Diagnosis pointers. NDC codes if applicable. For diagnostic codes in excess of four, please use box 19 for paper claims.
   p. Place of service
   q. Number of days or units of service
   r. Name of rendering provider
   s. Provider’s address, telephone number and tax ID number
   t. Name and Address of facility where services were rendered, if other than the office. Include nine digit zip code.
   u. All required National Provider Identification Numbers (NPI)
   v. Name of referring provider
   w. Total charges
   x. Signature of Provider
y. Acceptance of assignment
z. Other elements may be needed for specific claims
   aa. Name and address of billing entity. Must be a physical address.

**Procedure**

1. Patient health plan eligibility should be verified at each visit.
2. Claims can be submitted on a CMS-1500 or electronically. Do not split a patient’s claim for the same date of service unless the number of claim lines exceed the claim’s capacity.
3. For CMS-1500 submissions: Provider offices are to use THIPA’s Claims Submission Summary Sheet (attached) or a similar form (with prior THIPA approval) that includes all of the data elements on the THIPA form. THIPA staff will verify every batch of claims received with its summary sheet and return a signed copy indicating what was received in the claims batch. This summary sheet provides evidence of whether or not a claim was sent to and received by THIPA within 120 days of the date of service. THIPA will neither respond to nor investigate any assertion of lost claims unless there is evidence of timely submission verified on a Claims Submission Summary Sheet or its THIPA approved equivalent.
   For electronic submissions: Claims submitted electronically should appear in SynerMedConnect™ within 48 hours of your submission.
   All procedures requiring authorization are designated in THIPA’s current Referral Process. A copy of this can be found on thipa.com. Please verify that you have an authorization number before submitting a claim for services requiring an authorization. THIPA will not approve requests for retro-authorization for claims that have been previously submitted and denied with EOB code of DNA (Claim payment denied. Not authorized. Do not bill member). If you have to provide a service and cannot obtain an authorization prior to the service, please obtain an authorization before submitting the claim.
   For CMS-1500 submissions: Include the authorization number in Box #23. It is not necessary to attach the referral form if the prior authorization number is in Box #23.
   For electronic submissions: If we cannot locate the required corresponding authorization number in the system, the claim will be denied with the EOB code of DNA. You will need to appeal the claim with the substantiating documentation.
4. For CMS-1500 submissions: You do not need to attach the Referral Form for claims related to Direct Referrals but you must include the referring provider’s name in Box #17. For electronic submissions please include the referring provider information.

**B. Claims Inquiries and Appeals**

**Purpose**

1. To provide a mechanism to check the status of a claim when payment has not been received after 60 calendar days from THIPA’s received date.
2. To provide an appeal mechanism for processed claims where there is a question or disagreement with the payment.

**Scope**

Applies to all fee-for-service claims from contracted physicians and providers.

**Policy**

All claims inquiries and appeals must be submitted using a Claims Inquiry form (attached). Claim inquiries may be submitted by fax at 424-212-5071. Responses will be made within 5 business days.
**Procedure**

a. Inquiries: Submit Inquiries when payment is not received within 60 calendar days of the claim submission to THIPA. Please do not submit claim inquiries before 60 days from the date of submission if you are only checking status. Check claim status on SynerMedConnect™.

b. We expect you to follow good business practice and regularly reconcile your EOBs with your “Claims Submission Summary Sheet” or your proof of submission from Office Ally. See also section D. Understanding Your EOB. All EOB information for electronically submitted claims can be also accessed in SynerMedConnect™.

c. If you are inquiring about more than 5 claims, please call the claims department to request our Paid Claims Report before submitting the Claims Inquiry form. Specify the time period in question.

d. Complete the upper part of the Claims Inquiry form for each claim in question. Include your fax number so we can respond to you.

e. If the claim was previously submitted and denied for timely filing, you must include as proof of submission a copy of the “Claims Submission Summary Sheet” or a copy of your proof of submission from Office Ally for electronic claims (please submit the inventory report only), otherwise the claim will be rejected with the EOB code of DTF (Claim denied for timely filing). Claims will not be considered for payment if the “inquiry” is more than 120 days from the original submission summary sheet date.

2. Attach a copy of the claim. Mail or fax the documents to THIPA Claims will not be considered for payment if the inquiry or appeal is more than 120 days from the original submission sheet date.

3. THIPA will inform the requestor of the outcome of the review.

**C. Claims Disputes**

Provider disputes following a disputed appeal or inquiry must be submitted in writing to the THIPA Provider Dispute Department. Providers may use the dispute resolution process for appeals or reconsideration of a claim. Please refer to THIPA’s Claims Settlement Practices & Dispute Resolution Mechanism policy. The policy can be found on the THIPA website at www.thipa.com.

**D. THIPA Claims Standards**

1. **THIPA Claims Standards for Preoperative Visits**

   Please code your visits for preoperative examinations, using CPT codes 99381-99397 and a diagnostic code of V72.83.

2. **THIPA Claims Standards for Preventive Visits**

   Several physicians have stated that there is either not enough time to perform a pelvic examination and cervical cancer screening during a woman’s preventive visit or the Pap smear is postponed for other reasons. Patients are therefore asked to return at another time for cervical cancer screening.

   We understand the time constraints under which physicians work but the CPT definition for preventive medicine services is specific. From the AMA CPT:
Preventive Medicine Services

The “comprehensive” nature of the Preventive Medicine Services codes 99381-99397 reflects an age and gender appropriate history/exam and is NOT synonymous with the “comprehensive” examination required in Evaluation and Management codes 99201-99350.

Preventive visit codes can be billed only if all age and gender appropriate services are provided. This means that women must have cervical cancer screening during the same visit that the rest of the general physical examination is performed. We realize that this creates some financial inequities and we will allow the additional 99213 reimbursement when cervical cancer screening is performed at the same time as the general physical examination for Primary Care Physicians.

Code your claims as follows:

Men
For a complete physical examination, bill the appropriate preventive visit CPT code (99381-99397) with the proper ICD-9-CM V code (i.e., V70.0—Routine general medical examination at a health care facility).

Women
Complete preventive visit (general physical examination and cervical cancer screening on the same date of service)
Bill the appropriate preventive visit CPT code (99381-99397) with ICD-9-CM V code V70.0 and an additional 99213 with modifier 25 and with ICD-9-CM V code V76.2 (Routine cervical Papanicolaou smear or V72.31 (routine gynelogical exam). We have modified the system to not apply an office copay on the 99213.

E. Understanding Your Explanation of Benefits (EOB)
All processed claims are reported to providers with an explanation of benefits or EOB. EOB reasons are codes next to each claim detail line. The THIPA EOB Code Description accompanies all EOBs.
Examples of code descriptions follow:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#C</td>
<td>Capitated Service</td>
</tr>
<tr>
<td>DNA</td>
<td>Denied Not Authorized</td>
</tr>
<tr>
<td>V073</td>
<td>E&amp;M visits are disallowed on the same date of reported minor/major surgery</td>
</tr>
</tbody>
</table>

F. Appropriate Use of Modifiers

1. Certain THIPA policies utilize modifiers such as the use of modifier 25 when a PAP is done in conjunction with a physical.
3. Certain modifiers affect the payment of a claim detail line such as 50, 51, 62, AS, 80. Other modifiers determine whether a service is payable such as 25 and 59. THIPA has seen an expediential increase in the use of these modifiers. They are being applied to claims where there will be no effect on payment such as a single claim line of 99213-25. Modifiers 25 and 59 pend the claim and slows down claim adjudication.
4. If there is a separately identifiable E and M service or other service provided, please indicate this with the modifier and the use of appropriate diagnostic codes. Medical records may be requested for review to support the use of this modifier

G CPT Category 2 codes

1. Category 2 codes are used primarily for reporting purposes, for Pay for Performance and Medicare Star quality measures for seniors. Most codes are not payable. THIPA will pay for these codes on an annual basis. You will not be paid on each claim. We will collect the data from your claims and pay accordingly. The codes should be submitted at least once a year and will be paid for if submitted up to twice in a year.

2. THIPA pays for the use of the blood pressure codes for diabetics only. When submitting codes 3074F-3080F please remember to include a diagnosis of 250.xx This applies to both senior and adult commercial members as this is both a P4P and Medicare Star measure.

3. THIPA additionally will pay for the following codes for senior members only:
   a. Dx Codes V85.0-V85.5 to report BMI on adults.
   b. 1159F and 1160F to report medication review on seniors.
   c. 1170F to report review of functional status on seniors.
   d. 0521F,1125F and 1126F to report pain screening on seniors.
   e. 1157F and 1158F to report Advanced Directive Planning on seniors