Medicare Advantage: tools and strategies to collecting

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Medicare Advantage
WHCA Fall 2017

Presenter:

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- Employed by Specialized Medical Services
  - 29 years in SNF and LTC, 18 at SMS
  - Areas of Expertise
    - Billing – all payers
    - Collections and A/R management
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Define Medicare Advantage

- Medicare Advantage plans are approved by Medicare but operated through private insurance companies.
- Some times referred to as MA plan, Part C or Medicare replacement. THESE ARE **NOT** supplemental insurance plans

Define Medicare Advantage

- Network of care providers in these plans
- Often include more benefits than Medicare A and B
  - Drug Coverage main selling point
- The amount of your premium determines benefits and coverage. There are varying copayments and deductibles.

What Medicare Advantage is not

- Private insurance
- Medicare supplement insurance
- Mandate – State of WI
- Medicare Secondary plan

Medicare Advantage plans and enrollees

- http://kff.org/ Kaiser family foundation
- 2018 - 2317 plans nationwide
  - 83 offered in WI
- 2004 5.3 million people had Medicare Advantage, 2017 19 million

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Team approach and learning

- Clinical involvement is key to Medicare Advantage plans and facility billing
- Billing needs to have basic understanding of the medical records and MDS
- Clinical needs basic understanding of how their work ties to billing.
  - Diagnosis
  - MDS to UB 04

Primary payer determination

- Medicare vs. Medicare Advantage
  - Medicare Card and insurance card
  - ID number
  - Check Medicare screens for Plan number and effective dates.
  - Medicaid portal

Sample plan names

- WI Family Care plans can be an Advantage and Medicaid Replacement
  - I-care, Community Care, UHC Community Plan, and Care WI (Inclusa sample Medicaid only)
- Humana, Dean, Security Health
- United Health Care
- Aetna Health, Network, and Anthem

Plan numbers assigned by CMS

- Medicare assigns a plan number to each Medicare Advantage plan
- This number is found in Medicare Common Working file for each person
  - H5211 = Security Health
  - H5216 = Humana Choice PPO
  - H6609 = Humana Choice PPO
  - H8145 = Humana Gold PFFS

Payer ID is assigned by Insurance company

- Network Health Plan payer id is 77076
- Network Medicare Advantage PPO plan number is H5215

Verify payer more than on admission

- Plans changing mid month, especially Family Care Partnership plans
- Plans terminated retroactively for not paying premium
- Employer groups changing to Advantage plans and then changing plans

On line plan identification

- Sample Ability Eligibility
- Sample CWF off Medicare DDE

Facility CONTRACTED payer

- Locate physical contracts (current)
- Know your contracts and equate to plan ID number in CMS data base
- Create facility data base with all information on plan
  - Provider representative

Facility CONTRACTED payer

- Requirements of plan
  - Authorization
  - Updates of medical information
- Reimbursement method
- Member out of pocket charges

Facility CONTRACTED payer

- Charges covered vs. exclusions
- Ancillary vendors billing based on plan coverage
- Clinical/Billing software set up
- Billing process and format
  - Claim address vs. electronic requirements
  - Timely filing rules

Non Contracted payer

- Records may be required
- Benefits may be different
- Larger co pays
- Billing Timeframes (often more time)

Authorizations/updates

- May need to periodically send updates
  - Method of sending
- Authorization needed on each hospital re admit for some plans
- Updates often trigger new authorizations
- CASE MANAGEMENT

NATIONAL GOVERNMENT SERVICES #06001
SC ELIGIBILITY DETAIL INQUIRY

HIC CURR XREF HIC PREV XREF HIC 000000000000
TRANSFER HIC 000000000000 C-IND 9 LTR DAYS 060
LN . FN MI F SEX
DOB 4 DOD
ADDRESS: 1 (2 MENASHA WI
3 4
5 6
ZIP:

CURRENT ENTITLEMENT
PART A EFF DT 060112 TERM DT PART B EFF DT 060112 TERM DT

CURRENT BENEFIT PERIOD DATA
FRST BILL DT 060617 LST BILL DT 071517 HSP FULL DAYS 60 HSP PART DAYS 30
SNF FULL DAYS SNF PART DAYS 61 INP DED REMAIN 1316.00 BLD DED PNTS 3

PSYCHIATRIC
PSY DAYS REMAIN 190 PRE PHY DAYS USED PSY DIS DT INTRM DT IND

PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF3-EXIT PF8-NEXT PAGE

Admit 6/6/17
Med A 7/1/17

NATIONAL GOVERNMENT SERVICES #06001

SC ELIGIBILITY DETAIL INQUIRY

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RI 1     MAMMO DT  00000000
                         PART B DATA
SRV YR 17   MEDICAL EXPENSE   183.00     BLD DED REM 3   PSY EXP
SRV YR      BLD DED                      CSH DED

                         PLAN DATA
ID CD H5215      OPT CD C      EFF DT 010116      CANC DT 063017
ID CD            OPT CD        EFF DT             CANC DT
ID CD            OPT CD        EFF DT             CANC DT

                        HOSPICE DATA
PERIOD    1ST DT              PROVIDER          INTER
OWNER CHANGE ST DT            PROVIDER          INTER
2ND ST DT          PROVIDER          INTER          TERM DT
OWNER CHANGE ST DT            PROVIDER          INTER
1ST BILL DT          LST BILL DT          DAYS BILLED


      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE  PF8-CWF INQUIRY
```

Reimbursement: LEVEL

- Level based on care level needed
  - Indicated by level of service
  - 0191 is Level one
  - Example level descriptions attached
  - Can someone go from one level to another with payer? New Auth?

Example Level with dollars

- Level payer example: Anthem rate of payment for level two (0192) is $500/day on coverage 10 days PAID $5,000.00
  - Therapy is charging 1.10/minute for all therapy provided in the SNF (payer not a factor)
    - 120 minutes therapy/day for 10 days = $1,320.00
  - IV costs are $2567.00 for month
  - RX and Therapy total $3,887.00

Reimbursement: CHARGES & RUGS

- Charge on claim 24,590.33, pay the same
- RUGS similar to Medicare A
  - Reduction of 10% of RUGS Humana contract
  - Agree to one RUGS on admission pay entire time frame
  - Pay Rugs and extra reimbursement for list of items

Team payer communication

- How is team made aware of payer?
  - Does clinical know if RUGS needed?
  - Update on status process

Software set up

- Check for software calculating the charges and reimbursement correctly
  - Example: Level payer – reimbursement is 400/day. 400 times covered days should be the A/R. Often systems still book RUGS revenue or full charges
  - If charges are 45,000 this is revenue on A/R

Software set up

- Example: Care WI MCO replaces Medicare (also have a Medicaid replacement plan)
  - RUGS reimbursement (like Medicare)
  - Very common incorrect revenue
    - Net Revenue RUGS only not full charges

Level

A. **Skilled Nursing Facility**

The Provider agrees to bill for skilled nursing services provided using UB92, its electronic equivalent or successor(s), utilizing standard codes.

The Provider agrees to bill and accept as payment in full from Payor, the lesser of the rates as set out below or the Provider's submitted charges for services provided to all Members, less any applicable copayments.

Sub acute Care Level I	**(Rev Code 191)**	**$385.00 per diem**

Patient care services include, but are not limited to:

- Room and board
- 24-hour nursing care
- Prepared meals
- Laboratory and radiology services
- Medications, oral (PO), intramuscular (IM), and subcutaneous (SQ) antibiotics, chemotherapy agents, and total parental nutrition
- Pain control analgesia pump
- Medical/disposable supplies
- Discharge planning
- Bowel and bladder training
- General supportive care of patients with terminal illnesses and those patients falling under a do-not-resuscitate (DNR) status order
- New and existing ostomy care, training, and supplies
- Oxygen and respiratory care, including suctioning, tracheostomy care
- New and existing tube feedings (NG, gastrostomy, PEG) with nutritional supplements, and supplies
- All stages of wound care, dressing changes and supplies, including stage 3 and 4 decubitus care
- DME
- Therapy: Eight units or less per week of physical therapy, occupational therapy, speech therapy, respiratory therapy

Level Based

Sub acute Care Level II | **Rev Code 192** | **$495.00 per diem**

Patient care services include, but are not limited to:

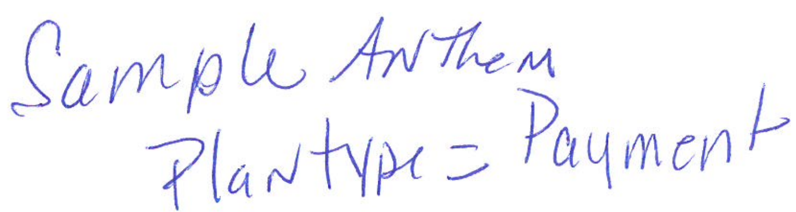
- Level I services
- Telemetry
- Unlimited units of therapy: Physical therapy, occupational therapy, speech therapy, and respiratory therapy
- Respiratory medications
- Subclavian, central and PICC lines
- Total parenteral nutrition with formula
- Isolation

Sub acute Care Level III | **Rev Code 193 and 194** | **$660.00 per diem**

Patient care services include, but are not limited to:

- Level I services
- Level II services
- Ventilator care (weanable and chronic) and supplies, including all medical supplies, specialty laboratory tests (i.e. blood gases), pulse oximetry, pulmonary testing, and pulmonary rehabilitation

Dialysis services and supplies, hemodialysis and/or peritoneal



			HMO/POS	HMO/POS	PPO	Traditional	Medicare HMO/PPO	Medicaid
			Blue Preferred/ Blue Preferred Plus	Blue Priority WI / Blue Priority X-WI	Blue Access	Blue Traditional	Medicare Advantage	Medicaid
ANCILLARY	**Definition/Coded Service Identifier**	**Payment Method**						
Skilled Nursing Level I	Rev Code 191	Per Diem	$508	$508	$508	$508	100% WI CMS	100% WI Medicaid
Skilled Nursing Level II	Rev Code 110, 120, 130, 192	Per Diem	$633	$633	$633	$633	100% WI CMS	100% WI Medicaid
Skilled Nursing Level III	Rev Code 193	Per Diem	$822	$822	$822	$822	100% WI CMS	100% WI Medicaid
Skilled Nursing Level IV	Rev Code 194	Per Diem	$822	$822	$822	$822	100% WI CMS	100% WI Medicaid
Ancillary Other		Reimburse %	70%	70%	70%	70%	100% WI CMS	100% WI Medicaid

Please note: Any above codes will be automatically updated as codes are established or deleted.

Rate changes based on:	Inpatient	Outpatient	Ancillary
Annual Rate Increase Fixed Services	3%	3%	3%
Annual Rate Price Protection	3%	3%	3%
Q-Hip Incentive	N/A	N/A	N/A

PROVIDER REIMBURSEMENT ATTACHMENT

FOR COMMERCIAL & MEDICARE ADVANTAGE PLANS

I. INPATIENT SERVICES SNF/SNU SERVICES – SNF PPS Methodology

Provider agrees to accept as payment in full from **Payors** for Covered Services provided to **Payor's** Medicare Advantage Members and Commercial Members, covered under such Plans offered by **Payors** with access to **ChoiceCare**, ninety **(90%)** percent of Provider's Medicare allowable amount in effect as of the date such services are rendered in accordance with Medicare Advantage laws, state laws, rules and regulations, or Provider's billed charges whichever is less, less any co-payments, coinsurance, deductibles or other cost-share amounts due from such Members.

II. OUTPATIENT SNF/ SNU SERVICES – OPPS Methodology

Provider agrees to accept as payment in full from **Payors** for Covered Services provided to **Payor's** Medicare Advantage Members and Commercial Members, covered under such Plans offered by **Payors** with access to **ChoiceCare**, **(90%)** percent of Provider's Medicare allowable amount in effect as of the date such services are rendered and in accordance with Medicare Advantage laws, state laws, rules and regulations, or Provider's billed charges whichever is less, less any co-payments, coinsurance, deductibles or other cost-share amounts due from such Members.

III. ANCILLARY SERVICES

Provider and other Participating Providers shall provide only those laboratory, injectable, infusion therapies, durable medical equipment, radiology, nuclear medicine, physical therapy and other ancillary health care services which Participating Provider is qualified to provide by license, certification, and state and/or federal law.

RUGS Based

HEALTH CARE CONTRACT
BETWEEN
COMMUNITY CARE, INC.
AND

APPENDIX B - COMPENSATION SCHEDULE

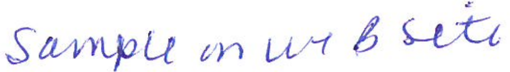
I. Skilled Nursing Facility Daily Rate

Community Care will reimburse Provider as listed in Grid #1 below for all of the following situations:

- Medicaid-Eligible Only/Medicaid Stay
- Medicare-Medicaid Eligible/Medicare Qualified Stay – Medicare Benefits Exhausted
- Medicare-Medicaid Eligible/Non-Medicare Qualified Stay

Grid #1

<table>
<tr><th>Facility Name & Address</th><th>Detailed Description of Services</th><th>Procedure Code</th><th>Unit</th><th>Unit Rate</th></tr>
<tr><td rowspan="8"></td><td rowspan="2">NH Placement</td><td>0194</td><td>Day</td><td>100% of the Current Wisconsin Medicaid person specific facility based RUG, as determined by the most recent MDS assessment</td></tr>
<tr><td colspan="3">Nursing Home admission and ongoing stay being paid at Medicaid RUG rates</td></tr>
<tr><td>NH Bed Hold</td><td>0185</td><td>Day</td><td>100% of the Current Medicaid Bed Hold Rate</td></tr>
<tr><td>Hospice Stay (Family Care Only)</td><td>0169</td><td>Day</td><td>95% of the Medicaid person specific RUG rate</td></tr>
<tr><td rowspan="2">Ventilator Unit</td><td>0946</td><td>Day</td><td>100% of the Current Medicaid Ventilator Rate</td></tr>
<tr><td colspan="3">Individual remains on ventilator after Medicare qualified stay ends or Medicare criteria is no longer met or Medicaid only stay</td></tr>
<tr><td rowspan="2">Respite Services</td><td>0663</td><td>Day</td><td>$125</td></tr>
<tr><td colspan="3">For extraordinary circumstances, Provider and Community Care may agree to another rate on a case by case basis, or Facility may submit an MDS for Medicaid RUG reimbursement.</td></tr>
</table>



Community Care will reimburse Provider as listed in Grid #2 below for the following situation:

- Medicare-Medicaid Eligible/Medicare Qualified Stay

Grid #2

<table>
<tr><th>Facility Name & Address</th><th>Detailed Description of Services</th><th>Revenue Code</th><th>Unit</th><th>Unit Rate</th></tr>
<tr><td rowspan="4"></td><td rowspan="2">NH Placement</td><td>0022</td><td>Day</td><td>100% of the Current Medicare RUG Rate</td></tr>
<tr><td colspan="3">Nursing Home admission and ongoing stay paid at Medicare RUG rates. Must meet Medicare coverage criteria.</td></tr>
<tr><td rowspan="2">Medicare Co-Insurance (Family Care Only)</td><td>0022</td><td>Day</td><td>100% of the Current Medicare Co-Insurance Rate</td></tr>
<tr><td colspan="3">Medicare is primary payer and Family Care pays the Medicare co-insurance</td></tr>
</table>

Respite
Given the brief nature of respite stays, an MDS will not be required. For extraordinary circumstances, Provider and Community Care may agree to a rate outside of the contracted compensation schedule on a case by case basis.

Co-insurance
Provider shall bill Family Care co-insurance for Medicare qualified stays with code 0022.

Hospice
When a Family Care Member is receiving care in Provider's SNF while the Member is also enrolled in hospice, Community Care will reimburse Provider at 95% of the Member's person specific RUG rate. Provider should use code 0169 to bill under this scenario.

Ventilator Services
For skilled nursing facilities that have a ventilator unit, if a Medicare Qualified stay has ended or the Medicare criteria are not met, Community Care will pay the Medicaid Ventilator rate. The facility will bill with code 0946 for members remaining on a ventilator in the nursing home.

RUG Methodology
Reimbursement is based upon the rates and RUG payment methodology in effect at the time the services are rendered. Reimbursement shall apply to the date of admission and all full days of residence, but not to the day of discharge. All claims made by Provider shall be considered final unless adjustment is requested in writing by Provider and approved by Community Care within 45 days after receipt of the payment by Community Care. (Note: reimbursement will be made for each day that a member is in the facility past midnight, meaning the day of discharge is not reimbursable.)

Ancillary Services/contracts

- Vendor ancillary contracts
  - Therapy, Pharmacy, X-ray etc.
  - Are contracts based on reimbursement/payer contract?
  - Do vendors share in contract risk?
  - Do vendors know Medicare Advantage excluded list and are they billing directly?

Charge capture & ancillary contracts

- Therapy Contracts
  - Therapy vendors and other vendors want to treat the patients the same way Medicare patients are treated.
  - Example UHC pays $385/day not matter level of care. Is therapy provided at the same intensity as a Medicare A person?
  - Facilities/vendors vary in philosophy regarding case management

Possible Exclusions

- DME, Oxygen, Enteral Products and some Medical Supplies
- Therapy
  - Some need charges on HCFA 1500 billed separate from Room & Board
  - Screenings some 2/year/therapy $20.00
- IV Meds (NDC code based)
- Vaccines/preventative care

Possible Exclusions

- **Challenges in billing**
  - Facilities learn of these upon Ancillary vendor saying they were denied for a service
  - May need separate authorization
  - May need billing performed on HCFA 1500
  - If contracted with payer try deal with contract representative
  - Insurance companies not super helpful

Billing process to correct payer

- Bill correctly the first time
  - Billing payer or electronic
  - Paper claims sent to insurance are scanned at payer
    - Some software UB 04 scan better than others
    - Example Security Health/Advocare
  - Paper need to go to the correct address
    - Dean example

Billing common issues UB-04

- Bill correctly the first time
  - FL 4 -- Type of Billing needs to be 4 digits
  - FL 39 -- Value Code
    - 80 for covered days 10.00 = 10 days
    - 50 51 52 not to be used
  - FL 42 -- Revenue code 0022 for RUGS put in a charge of zero 0.00, if blank some insurances deny

1. Skilled Nursing Facilities

Covered Services for inpatient skilled nursing facility care shall be reimbursed by [illegible] at:

Level	Rate
Level 1 (Rev code 191)	$470 per diem
Level 2 (Rev code 192)	$585 per diem
Level 3 (Rev code 193)	$760 per diem
Level 4 (Rev code 194)	$760 per diem

- Services excluded from the Compensation rates. Certain supplies, when billed with the HCPCS codes listed below, shall be excluded from the Compensation Rates above and shall be reimbursed at seventy percent (70%) of Provider billed charges. Services to which this exclusion applies are as follows:

  1. Custom beds (clinitron, oversized beds) billed with Revenue Code 291 and HCPCS codes E0194, E0302-E0304;
  2. Custom wheelchairs billed with Revenue Code 291 and HCPCS codes K0002-K0009, E1031;
  3. Non-standard walkers billed with revenue code 291 and HCPCS codes E0140-E0149; and
  4. Orthotics and prosthetics billed with Revenue Code 274 and HCPCS codes E0000-E9999, K0000-K9999, and L0000-L9999.

  This exclusion applies only to those items for which Provider is invoiced by the supplier. Any items provided and invoiced directly to the Member by a medical equipment supplier must be submitted to [illegible] by that supplier.

  With the exception of the items listed above, all other supplies and equipment provided by Provider for use by the Member shall be included in the current per diem Reimbursement Rates.

- Outpatient Services. In the event that Provider provides Physical and Occupational therapy services on an outpatient basis, it shall be billed with revenue codes 42X through 43X will be reimbursed by [illegible] at seventy percent (70%) of Provider's billed charges.

[illegible]: Inpatient Service Category Table

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Skilled Nursing Services Revenue Code 0110, 0119, 0120, 0129, 0130, 0139	**Per Diem**	**$335.00**
Intensive Service Delivery Day Revenue Code 0193	**Per Diem**	**$515.00**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Blood Glucose Monitoring (Revenue Code 0300 and CPT Code 82962)	**Per Unit via CMS Fee Schedule**	**100% CMS**
Enteral Services (Revenue Code 0229 and HCPC Code B4149-B4157)	**Per Diem**	**$18.00**
Infusion Services (Revenue Code 0260)	**Per Diem**	**$100.00**
Physical Therapy (Revenue Codes 0420-0423, 0429)	**Per Diem**	**$75.00**
Occupational Therapy (Revenue Codes 0430-0433, 0439)	**Per Diem**	**$75.00**
Speech Therapy (Revenue Codes 0440-0443, 0449)	**Per Diem**	**$75.00**
Pre-Therapy Evaluation – Physical Therapy (Revenue Code 0424)	**Per Diem**	**$90.00**
Pre-Therapy Evaluation – Occupational Therapy (Revenue Code 0434)	**Per Diem**	**$90.00**
Pre-Therapy Evaluation – Speech Therapy (Revenue Code 0444)	**Per Diem**	**$90.00**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Semi-Annual Physical ,Occupational and Speech Therapy Screening (Revenue Code 0920 and CPT Code 99368) Facility shall provide two (2) therapy screenings per calendar year to each I-SNP Customer. Any therapy screenings provided in excess of two (2) per calendar year will not be reimbursed and Payer retains the right to recover any amounts paid for therapy screenings in excess of two (2) per calendar year per I-SNP Customer. Facility shall not bill the I-SNP Customer for any therapy screening services that are denied for payment due to Facility's failure to comply with the above.	**Per Diem**	**$20.00**
Supplies: Ostomy, Tracheostomy or Wound Care (Revenue Code 0270, 0272, 0274, 0623 and HCPC Code A4361-A4434, A4623, A4625, A4626, A4629, A5051-A5093, A5120-A5200, A6000-A6550, A7501-A7509, A7520-A7522, A7524-A7527) Facility shall bill Payer for ostomy, tracheostomy or wound care supplies only. Payer retains the right to recover any amounts paid for supplies that were not used for ostomy, tracheostomy or wound care services for an I-SNP Customer.	**Per Unit via CMS Fee Schedule**	**100% CMS**
All Other Outpatient Services Service categories not defined above in Table 2 or below in Table 3 for which a Revenue Code and CPT/HCPC code are required in accordance with CMS billing guidelines.	**Per Unit via CMS Fee Schedule**	**100% CMS**
All Other Outpatient Services Service categories not defined above in Table 2 or below in Table 3 for which (a) a Revenue Code only (i.e. no CPT/HCPC code) is required in accordance with CMS billing guidelines or (b) there is no CMS Fee Schedule amount for the applicable CPT/HCPC code.	**Percentage of Customary Charge**	**50%**
Level I Bed Surfaces Rental only; CMS purchase option capped rental applies (Revenue Code 0290, 0292 and HCPC Code E0181RR, E0182RR, E0186RR, E0187RR, E0196RR)	**Per Unit via CMS Fee Schedule**	**100% CMS**
Level II Bed Surfaces Rental only; CMS purchase option capped rental applies (Revenue Code 0290, 0291 and HCPC Code E0193RR, E0277RR, E0371RR, E0372RR, E0373RR)	**Per Unit via CMS Fee Schedule**	**100% CMS**
Medical Transportation Per Unit = One Way (Revenue Code 0542 and HCPC Code A0130) Plus: **Medical Transportation Ground Mileage** Per Unit = Per Mile (Revenue Code 0542 and HCPC Code S0209)	**Per Unit** **Per Unit**	**$20.00** **$2.00**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Semi-Annual Physical ,Occupational and Speech Therapy Screening (Revenue Code 0920 and CPT Code 99368) Facility shall provide two (2) therapy screenings per calendar year to each I-SNP Customer. Any therapy screenings provided in excess of two (2) per calendar year will not be reimbursed and Payer retains the right to recover any amounts paid for therapy screenings in excess of two (2) per calendar year per I-SNP Customer. Facility shall not bill the I-SNP Customer for any therapy screening services that are denied for payment due to Facility's failure to comply with the above.	**Per Diem**	**$20.00**
Supplies: Ostomy, Tracheostomy or Wound Care (Revenue Code 0270, 0272, 0274, 0623 and HCPC Code A4361-A4434, A4623, A4625, A4626, A4629, A5051-A5093, A5120-A5200, A6000-A6550, A7501-A7509, A7520-A7522, A7524-A7527) Facility shall bill Payer for ostomy, tracheostomy or wound care supplies only. Payer retains the right to recover any amounts paid for supplies that were not used for ostomy, tracheostomy or wound care services for an I-SNP Customer.	**Per Unit via CMS Fee Schedule**	**100% CMS**
All Other Outpatient Services Service categories not defined above in Table 2 or below in Table 3 for which a Revenue Code and CPT/HCPC code are required in accordance with CMS billing guidelines.	**Per Unit via CMS Fee Schedule**	**100% CMS**
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Level I Bed Surfaces Rental only; CMS purchase option capped rental applies (Revenue Code 0290, 0292 and HCPC Code E0181RR, E0182RR, E0186RR, E0187RR, E0196RR)	**Per Unit via CMS Fee Schedule**	**100% CMS**
Level II Bed Surfaces Rental only; CMS purchase option capped rental applies (Revenue Code 0290, 0291 and HCPC Code E0193RR, E0277RR, E0371RR, E0372RR, E0373RR)	**Per Unit via CMS Fee Schedule**	**100% CMS**
Medical Transportation Per Unit = One Way (Revenue Code 0542 and HCPC Code A0130)	**Per Unit**	**$20.00**
Plus: **Medical Transportation Ground Mileage** Per Unit = Per Mile (Revenue Code 0542 and HCPC Code S0209)	**Per Unit**	**$2.00**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
Annual Vaccination – Influenza (Revenue Code 0636 and CPT Codes 90654-90698, HCPCS codes Q2034-Q2039)	**Per Unit via CMS Fee Schedule**	**100%CMS**
Annual Vaccination Administration – Influenza (Revenue Code 0771 and HCPC Code G0008)	**Per Unit via CMS Fee Schedule**	**100%CMS**
Annual Vaccination - Pneumococcal (Revenue Code 0636 and CPT Code 90670 or 90732)	**Per Unit via CMS Fee Schedule**	**100%CMS**
Annual Vaccine Administration – Pneumococcal (Revenue Code 0771 and HCPC Code G0009)	**Per Unit via CMS Fee Schedule**	**100%CMS**
Chemotherapy Drugs (Revenue Code 0250, 0255, 0258, 0636 and HCPC Code J9000-J9999) Facility shall bill Payer for chemotherapy drugs only. Payer retains the right to recover any amounts paid for any non-chemotherapy drugs for an I-SNP Customer.	**Per Unit via CMS Fee Schedule**	**100% CMS**
Diagnostic Radiology (Revenue Code 0320, 0324 and CPT Code 70010-70015, 70030-70390, 71010-71130, 72010-72120, 72170-72190, 72200-72220, 73000-73085, 73090-73140, 73500-73550, 73560-73660, 74000-74022, 74210-74235, 74240-74283, 74290-74330)	**Per Unit via CMS Fee Schedule**	**100% CMS**
Laboratory Services (Revenue Code 0300, 0301, 0305, 0310 and CPT Code 80047-80076, 80150-80299, 80400-80439, 81000-86804, 86850-87999, 88104-88140, 88160-88162, 88172-88173, 88182-88299, 89049-89240)	**Per Unit via CMS Fee Schedule**	**100% CMS**
Level I Bed Surfaces Purchase only (Revenue Code 0290, 0292 and HCPC Code E0184NU, E0185NU, E0188NU, E0189NU, E0197NU, E0198NU, E0199NU)	**Per Unit via CMS Fee Schedule**	**100% CMS**

UB-04 form

Field	Value
4 TYPE OF BILL	021X
6 STATEMENT COVERS PERIOD FROM	090117
6 STATEMENT COVERS PERIOD THROUGH	093017
39 VALUE CODES CODE (a)	80
39 VALUE CODES AMOUNT (a)	30 00
66 DX	0

Line	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0022	RUGS		010117		0 00		
8	0420				108	3000 00		
10	0420				26	3000 00		
23	0001	PAGE 1 OF 1	CREATION DATE	10172017	TOTALS	6000 00		

1 | 2 | 3a PAT. CNTL # | b. MED. REC. # | 5 FED. TAX NO. | 7
8 PATIENT NAME | 9 PATIENT ADDRESS | 10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18–28 CONDITION CODES | 29 ACDT STATE | 30
31–34 OCCURRENCE CODE DATE | 35–36 OCCURRENCE SPAN CODE FROM THROUGH | 37 | 38 | 40 VALUE CODES | 41 VALUE CODES
50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | 57 OTHER PRV ID
58 INSURED'S NAME | 59 P.REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME
66 DX | 67 | 68 | 69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73
74 PRINCIPAL PROCEDURE CODE DATE | a.–e. OTHER PROCEDURE CODE DATE | 75
76 ATTENDING NPI QUAL LAST FIRST | 77 OPERATING NPI QUAL LAST FIRST | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST
80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Medicare Advantage
WHCA Fall 2017

Billing common issues UB-04

- Bill correctly the first time
  - FL 45 -- date not required
  - FL 46 -- Unit/days field for ancillary
    - Number of calendar days of treatment
    - So much confusion as Medicare A claims don't need anything in this field for non room charges/rugs
  - FL 66 -- ICD 10 Indicator box 0 needed

Billing denials: insurance based

- Date of Admit on claim match Authorization
  - Really check as many require new authorization
  - Authorization number in FL 63 – pulls from software
  - Does software treat discharges as transfer vs. discharge? – this can impact what admit date is on the claim

Billing denials: insurance based

- Authorization not go until discharge day only day prior causes denials
  - Authorization is 10/1 to 10/12, resident went home 10/13.
    - Claim is billed 10/1 to 10/13 showing discharge = **DENIED**
- Diagnosis match authorization
- Resident hospice at time of stay

Who is payer for out of pocket costs?

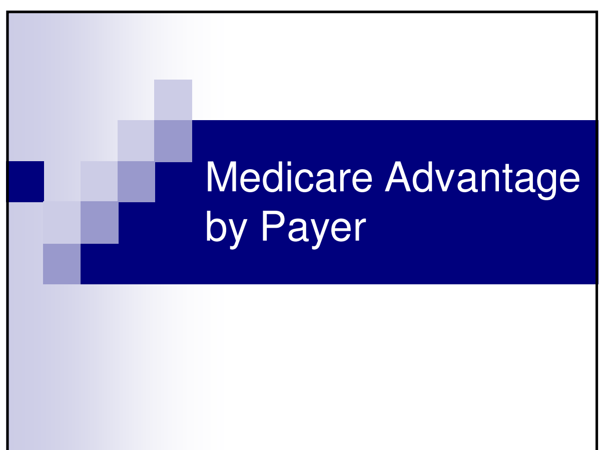
- Medicaid
  - Collect liability if due
- Family Care
  - Need auth for correct revenue code for that plan
- Private pay – does contract determine when you can collect? Follow Medicare?

Triple check

- Medicare Advantage Triple check is more detailed than Medicare A
- Need more information to really check claim if you want to be paid correctly

MA Triple check items needed to check UB 04 claim form

- Admission payer
- Authorization
- Ancillary exclusions vs. inclusions
- Clinical RUGS and Diagnosis
- Any QIO status and codes needed on claim
- Revenue booked on for month



On line tools for ALL staff

- Availity
- Forward Health
- Family Care portals
- Optum and UHC portal
- Zirmed
- Esolutions
- Emdeon
  - Dean, WPS, Aetna, Care WI etc.
- EDI software open 277
- PC Ace open 835

Edits

- Many software packages and billing tools have WAY too many edits that not required
- Example: admission on last day of month and no therapy on the claim is flagged on some software packages

Humana

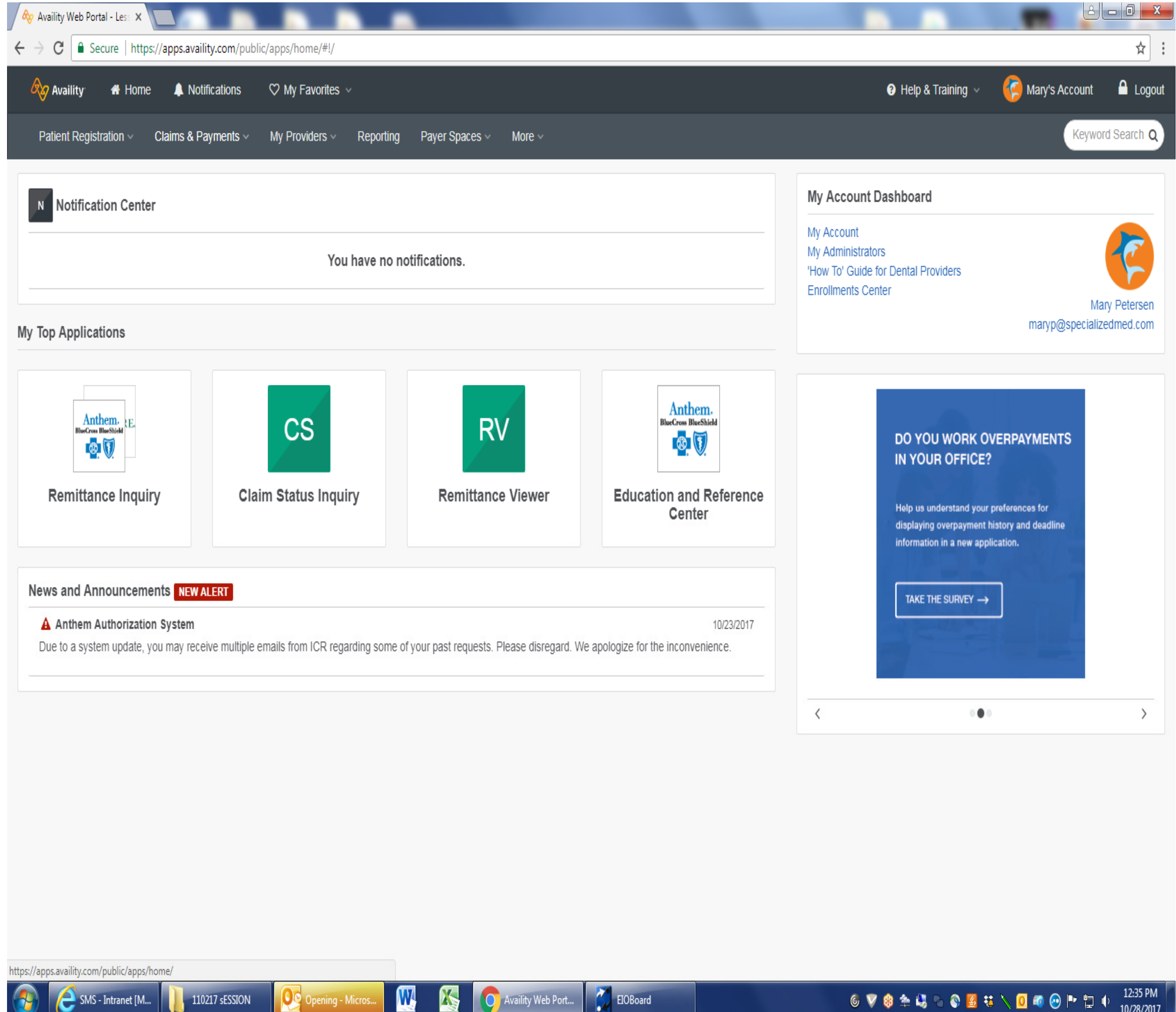
- **MUST USE AVAILITY or Humana site in clinical and financial to have a chance on payment that is not recouped**
- (Humana has their own portal that is a stand alone)

Humana claim vs. clinical

- Clinical information vs. the UB
  - Diagnosis match authorization?
  - Units of Therapy
  - Look back 7 days
  - Don't reimburse more than charged amount
    - Calculate expected reimbursement
    - Wait for late charges

Humana medical review and claim denial

- Clinical information
  - Medical review (post or pre-payment)
  - Auto deny medical review based on diagnosis
    - Diagnosis missing digit, invalid or not match authorization
  - Primary reason on Humana therapy but no therapy charges on claim (payer, software issue)
  - Upload medical records on line in Availity


Availity Web Portal - Les
Secure https://apps.availity.com/public/apps/home/#!/
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Mary's Account
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Anthem Authorization System
10/23/2017
Due to a system update, you may receive multiple emails from ICR regarding some of your past requests. Please disregard. We apologize for the inconvenience.
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My Account
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'How To' Guide for Dental Providers
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Mary Petersen
maryp@specializedmed.com
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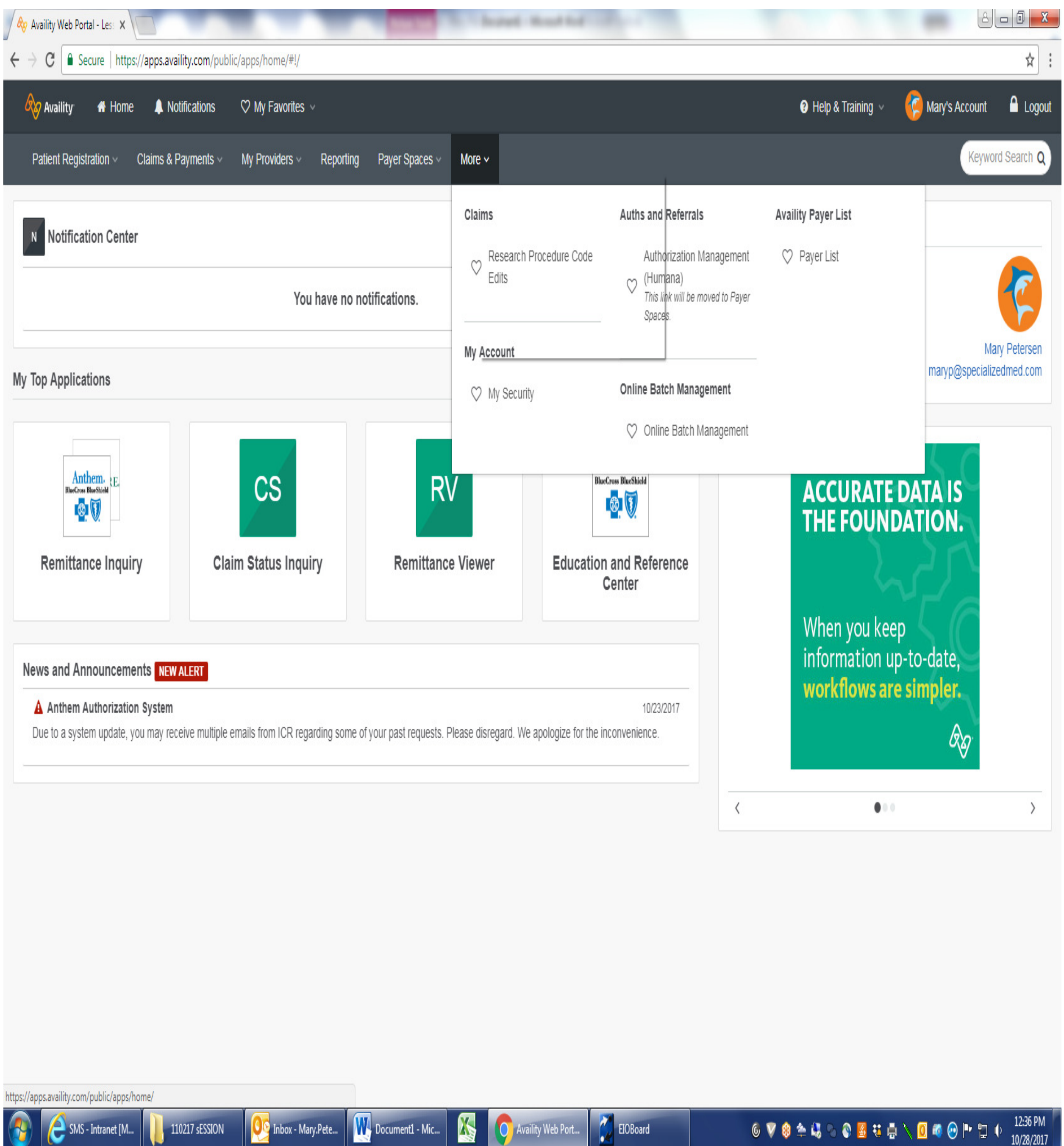
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Secure | https://apps.availity.com/public/apps/home/#!/
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Help & Training
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Reporting
Payer Spaces
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Research Procedure Code Edits
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maryp@specializedmed.com
My Top Applications
Remittance Inquiry
Claim Status Inquiry
Remittance Viewer
Education and Reference Center
ACCURATE DATA IS THE FOUNDATION.
When you keep information up-to-date, workflows are simpler.
News and Announcements
NEW ALERT
Anthem Authorization System
10/23/2017
Due to a system update, you may receive multiple emails from ICR regarding some of your past requests. Please disregard. We apologize for the inconvenience.
https://apps.availity.com/public/apps/home/
SMS - Intranet [M...
110217 sESSION
Inbox - Mary.Pete...
Document1 - Mic...
Availity Web Port...
EIOBoard
12:36 PM
10/28/2017

Humana records

- Person pulling records together should have claim in hand prior to sending records
  - Ancillary services
  - Actual RUGS on claim (issues when clinical and financial two different software products)

Humana records

- 18 months to request records after payment date of claim
- Humana list of what is to be included in record request
  - MDS entire time of claim and for look back periods
    - COT, EOT
  - Therapy evaluation, minutes, and progress notes FORMAT IS KEY

Humana example

- Claim dates are 7/1-7/31/17
  - Assessments: 5 day, 14 day and COT
  - Sheet from Humana says GO 7 days past 7/31 for records

Humana

- Who is tracking cases in review ?
  - Add to list who is back up Medicaid
- On line secure email for questions
- Phone numbers on records request letters
- Plan type of Humana determines what appeal/grievance process to follow
- **FREE TRAINING ON LINE WEBINARS**

Aetna

- Increasing market share
- Often employer picked retirement plan
- RUGS based but % reduction greater 2%
- Miss lines in processing and short pay
- Corrected claim process challenging
- Missed authorization allow fax records with appeal request form (GR-69140)

Aetna

- Availity for corrected claim info needed
  - Print remit for claim number
  - Can view benefits on line

A A A Adjust Text Size

Provider History

1st request

Request Information

Request ID:

Date Requested:

Start Date of Service:

End Date of Service:

Business Area:

Department:

Claim Number:

Response Needed Time Frame:

Request Reason: RUG Bill Rvw

Record Types: Nurse Notes,Medication Records,Physical/Speech/Occup. Therapy Notes,Minimum Data Set (MDS),All Therapy Notes/Grids

Comments: Records Required for skilled dates of service 09/16/2016 - 10/22/2016. all MDS assessments with Supporting documents for each ARD 7 day look back including ADL documentation all Therapy Evals Therapy Notes (must include all daily minutes PT OT ST) nursing RUGS require supporting documentation.

Patient Information

Member ID:

Patient Name:

Patient DOB:

Patient Account Number:

Provider Information

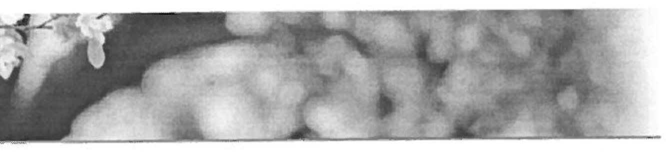
Site/Provider Name: H

Tax ID:

History

Request Method: US Mail

Event	Date
Request Open	5/19/2017 7:08:38 AM
Notification	
Notification	



Record requirements

Medical Records Management

Post-payment reviews

Prepayment reviews

Technical Denial

Humana Provider Payment Integrity Medical Record Review Requirements

Humana, or its designee, has the right to conduct reviews of physicians' and other health care providers' records related to services rendered to Humana-covered patients in certain circumstances. As stated in their participation agreements, health care providers will, upon request, grant Humana access to medical records and billing documents to conduct reviews. The health care provider should be able to provide detailed itemizations of charges to support the supplies and services billed.

For an overview of Humana's review processes, please refer to the Humana Provider Payment Integrity Policy for Post-payment Reviews and the Humana Provider Payment Integrity Policy for Prepayment Reviews.

The health care provider should include all records and/or documentation that substantiate the services that were provided to the patient and all information necessary to allow accurate adjudication of the claim. A health care provider who does not submit or refuses to provide a medical record may receive a technical denial. Please refer to the Humana Provider Payment Integrity Technical Denial Policy for more information.

Types of records Humana or its designee may request include, but

are not limited to, the following:

- Activities of daily living (ADL) sheet, including flow sheets and/or logs
- Admission assessments
- Anesthesia records (including time of anesthesia administration)
- Case management notes
- Change of therapy (COT) assessment
- Chat logs
- Chemotherapy orders
- Clinical trial information, including consents and treatment plans
- Consultation notes
- Diagnosis notes, including past medical history
- Discharge/transfer summaries
- Drawings and photos, when applicable
- Emergency department reports
- Evaluations: any evaluation related to the service provided
- Face sheets
- Face-to-face encounter documentation
- For durable medical equipment/home infusion/home health: delivery receipts for supplies or drugs/proofs of delivery
- For inpatient rehabilitation: patient assessment instrument (PAI)
- For skilled nursing facilities: minimum data set (MDS)
- Hospice/end-of-life-care documentation
- Implant detail: sticker sheet and copies of invoices for implants or high-cost drugs; implant logs with additional information on implants, screws and plates
- Itemized bill
- Laboratory and pathology reviews: Clinical reviews of pathology claims often require additional information to make determinations. Medical records from the ordering physician, as well as the requisition form and lab results, are necessary to complete a full and fair review of the

pathology claim. Please note that this documentation will be requested from the entity that submitted the pathology claim.

- Laboratory reports and X-rays from ordering physician, along with written interpretations of X-rays, tests and/or laboratory results
- Letter/certificate of medical necessity (CMN) for services
- Medication records/medication administration records (MAR), including strength, National Drug Code (NDC) and waste, mixing logs, infusion medication sheet and transfusion/infusion logs
- Nurse or any other health care provider's progress, treatment, SOAP (subjective/objective assessment and plan), dietary notes and daily notes
- Obstetric/newborn services
- Operating reports and records
- Operative reports
- Patient history
- Physical exam
- Physician office records: complete records, including office visit documentation, demographic/face sheet, patient history, laboratory and procedure results and all correspondence with other health care providers, including consultation requests and reports
- Physician orders
- Plans of care (POCs), treatment plans (tried and failed conservative treatments) and any related evaluations and updates or recertifications for the time period during which the patient was treated. The POC and recertifications should be signed by a physician.
- Preanesthetic evaluation
- Preoperative and postoperative notes
- Prescriptions
- Progress notes
- Psychiatric evaluation notes
- Physician query (if applicable): If the facility's coder requests additional information from the physician for clarification on documentation, he/she would submit a query to the physician.

- Skilled nursing, physical therapy, occupational therapy, speech therapy, respiratory therapy and medical social worker (MSW) documentation, including notes and therapy logs that detail the number of minutes each service was provided
- Test orders/results/reports including, but not limited to, pathology, radiology and laboratory (include results, when applicable)
- The outcome assessment information set (OASIS) for home health claims: This must be completed in its entirety. All six digits of the diagnosis code must exactly match between POC, OASIS and the claim. Any correction must be applied by the end of the episode; fields cannot contain N/A, OASIS; fields M2200 and M0110 cannot be blank or contain N/A.
- Toxicology reports
- Treatment notes
- Uniform billing form (UB-04)/ Health Care Finance Administration Form (HCFA 1500)
- Wound care assessment

Humana!

Have questions? Contact us

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SNF PPS: RUG-IV Categories and Characteristics

Major RUG-IV Category	RUG-IV Score	Characteristics Associated With Major RUG-IV Category
Rehabilitation Plus Extensive Services	RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX	Residents satisfying all of the following three conditions: •Having a minimum activity of daily living (ADL) dependency score of 2 or more. •Receiving physical therapy, occupational therapy, and/or speech-language pathology services while a resident. • Ultra (U)-720+ minutes • Very High (V)-500-719 minutes • High (H)-325-499 minutes • Medium (M)-150-324 minutes • Low (L)-45-149 minutes •While a resident, receiving complex clinical care and have needs involving tracheostomy care, ventilator/respirator, and/or infection isolation.
Rehabilitation	RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB	Residents receiving physical therapy, occupational therapy, and/or speech-language pathology services while a resident. • Ultra (U)-720+ minutes • Very High (V)-500-719 minutes • High (H)-325-499 minutes • Medium (M)-150-324 minutes • Low (L)-45-149 minutes • ADL Score ○ 11-16 = C ○ 6-10 = B ○ 0-5 = A
Extensive Services	ES3, ES2, ES1	Residents satisfying the following two conditions: •Having a minimum ADL dependency score of 2 or more. •While a resident, receiving complex clinical care and have needs involving: tracheostomy care, ventilator/respirator, and/or infection isolation.

Medicare criteria

SNF PPS: RUG-IV Categories and Characteristics

Special Care High	HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1	Residents satisfying the following two conditions: •Having a minimum ADL dependency score of 2 or more. •Receiving complex clinical care or have serious medical conditions involving any one of the following: comatose, septicemia, diabetes with insulin injections and insulin order changes, quadriplegia with a higher minimum ADL dependence criterion (ADL score of 5 or more), chronic obstructive pulmonary disease (COPD) with shortness of breath when lying flat, fever with pneumonia, vomiting, weight loss, or tube feeding meeting intake requirement, parenteral/IV feeding, or respiratory therapy.
Special Care Low	LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1	Residents satisfying the following two conditions: •Having a minimum ADL dependency score of 2 or more. •Receiving complex clinical care or have serious medical conditions involving any of the following: cerebral palsy with ADL dependency score of 5 or more, multiple sclerosis with ADL dependency score of 5 or more,— Parkinson's disease with ADL dependency score of 5 or more, respiratory failure and oxygen therapy while a resident, tube feeding meeting intake requirement, ulcer treatment with two or more ulcers including venous ulcers, arterial ulcers or Stage II pressure ulcers, ulcer treatment with any Stage III or IV pressure ulcer, foot infections or wounds with application of dressing, radiation therapy while a resident, or dialysis while a resident.
Clinically Complex	CE2, CE1, CD2, CD1, CC2, CC1, CB2, CB1, CA2, CA1	Residents receiving complex clinical care or have conditions requiring skilled nursing management, interventions or treatments involving any of the following: pneumonia, hemiplegia with ADL dependency score of 5 or more, surgical wounds or open lesions with treatment, burns, chemotherapy while a resident, oxygen therapy while a resident, IV medications while a resident, or transfusions while a resident.
Behavioral Symptoms and Cognitive Performance	BB2, BB1, BA2, BA1	Residents satisfying the following two conditions: •Having a maximum ADL dependency score of 5 or less. •Having behavioral or cognitive performance symptoms, involving any of the following: difficulty in repeating words, temporal orientation, or recall (score on the Brief Interview for Mental Status <=9), difficulty in making self understood, short term memory, or decision making (score on the Cognitive Performance Scale >=3), hallucinations, delusions, physical behavioral symptoms toward others, verbal behavioral symptoms toward others, other behavioral symptoms, rejection of care, or wandering.
Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	Residents whose needs are primarily for support with activities of daily living and general supervision.

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Session timeout in: 19:45 Renew

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Provider History

ONgoing appeal

Request Information

Request ID:

Date Requested:

Start Date of Service:

End Date of Service:

Business Area: FR

Department: FR-NAS

Claim Number:

Response Needed Time Frame: 30 days

Request Reason: RUG Bill Rvw

Record Types: Nurse Notes,Medication Records,Physical/Speech/Occup. Therapy Notes,Minimum Data Set (MDS),All Therapy Notes/Grids

→ **Comments:** *NOTICE* RECORDS RECEIVED ARE INCOMPLETE. Still missing, Need all MDS assessments and all Therapy daily minutes for all related dates of service in this claim period. *

Patient Information

Member ID:

Patient Name:

Patient DOB:

Patient Account Number:

Provider Information

Site/Provider Name:

Tax ID:

History

Request Method: US Mail

Event	Date
Request Updated - Additional Information Needed	3/22/2017 6:53:37 AM
Request Open	2/19/2017 2:48:22 AM
Notification	
Notification	
Medical Record Received by Humana	3/16/2017 12:00:00 AM
Medical Record Received by Humana	3/16/2017 12:00:00 AM
Medical Record Received by Humana	3/16/2017 12:00:00 AM
Medical Record Received by Humana	3/16/2017 12:00:00 AM
Medical Record Received by Humana	3/27/2017 11:44:00 AM
Medical Record Received by Humana	3/30/2017 12:15:00 PM
Medical Record Received by Humana	4/10/2017 12:00:00 AM
Medical Record Received by Humana	4/10/2017 12:00:00 AM

Medicare Advantage
WHCA Fall 2017

Network Health Plan

- Miss paying one line when 2 rugs on claim
- Therapy claims change if G codes or no G codes needed
- Portal from Network
  - Claims status
  - Remits
  - coverage

Network Health Plan

- Network requires more info to call into to provider claims
  - Medicare number
  - Home address

Anthem

- Access on Availity
  - Remits by date
  - Remits by person
  - Training resources
  - Authorizations
  - Claim status
- Some of better FASTED paying contracts seen by SMS

Anthem

- Review contract if UB or HCFA 1500 needed for therapy on commercial plans
- Anthem ID what does it mean?
  - See sample list
- Secure on line email system in Availity

Dean Advantage

- Time line 90 days
- Claims mailing address NOT MADISON
- Id number starts with A (usually)
- Emdeon portal
  - see remits
  - claims status
  - Authorizations

United Health Care – Advantage plan

- Authorization process on line
  - 2 step process
  - Many recent issues
- Often Level based
- New contracts 7/1/16 need to follow
- Admit date vs. authorization
- Medical review increasing post payment

5343 North 118th Court Milwaukee WI 53225
Phone # 414 476 1112
www.specializedmed.com

The local alpha prefixes listed are not all inclusive and represent the most common .

Products	Provider/Customer Service	Alpha-Prefixes	Information Available on Availity®	Claims Address	Provider Adjustment Requests (Claim Reconsiderations)	Provider Refunds (Contact Customer Service for the address for returning Anthem checks)	Utilization Management (UM) (Precertification of services **not** managed by AIM Specialty Health® or OrthoNet LLC and Case Management)
Anthem Commercial Products							
Blue Access® Blue Preferred® Blue Preferred® Plus POS Blue Traditional®	**Group and Individual Policies:** 888-571-9055	VZD, VZF, VZG, VZJ, VZO, VZR, VZT, AUJ, AYU, AYX	Eligibility, Remits, Benefits, Claim Status, Secure Messaging, Interactive Care Reviewer (ICR)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348-5557	**Voluntary Refunds:** Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177 **Requested Refunds:** Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197-5281	**800-242-1527** * Select the Medical Management Prompt for Precertification and/or Predetermination * Select Case Management for Care Coordination or call **888-662-0939** Fax: **866-959-2154** ***UM Appeals: See page 3***
Blue Priority Plus POS[(1)] [(1)] Product Available with Blue Priority WI Network in WI	**Group Policies:** 888-571-9055	VZW					
Well Priority[(1)] *[(1)] Product Available with Blue Priority WI Network in WI* *See Self-Funded section information on Administrative Services Only groups*	**Group Fully Insured Policies:** 888-571-9055	ZEZ	Eligibility, Remits, Benefits, Claim Status, Secure Messaging, Interactive Care Reviewer (ICR)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	**Voluntary Refunds:** Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177 **Requested Refunds:** Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197-5281	**800-472-8909** * Select the Medical Management Prompt for Precertification and/or Predetermination * Select Case Management for Care Coordination Fax: **866-959-2154** ***UM Appeals: See page 3***
Anthem (Bronze/Silver/Gold) Blue Priority **X** WI Individual product available with Blue Priority X-WI Network	**Individual Policies *(On Exchange)***: 855-854-1438	VZH, VZI	Eligibility, Remits, Benefits, Claim Status, Secure Messaging, Interactive Care Reviewer (ICR)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	**Voluntary Refunds:** Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177 **Requested Refunds:** Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197-5281	**800-472-8909** * Select the Medical Management Prompt for Precertification and/or Predetermination * Select Case Management for Care Coordination Fax: **866-959-2154** ***UM Appeals: See page 3***
Anthem (Bronze/Silver/Gold) Blue Priority WI Individual product available with Blue Priority WI Network.	**Individual Policies *(Off Exchange)***: 855-854-1438	JLK					
Anthem (Bronze/Silver/Gold) Blue Access PPO Small Group products available with Blue Access Network	**Small Group Policies *(Off Exchange)***: 855-854-1438	VZB					
Anthem (Bronze/Silver/Gold) Blue Preferred POS Small Group products available with Blue Preferred Plus Network	**Small Group Policies *(Off Exchange)***: 855-854-1438	VZC					
Anthem (Bronze/Silver/Gold) Blue Priority POS Small Group products available with Blue Priority WI Network	**Small Group Policies *(Off Exchange)***: 855-854-1438	VZU					
Anthem Lumenos Consumer Driven Health Plans (CDHP)							
Lumenos Consumer Driven Health Plan (CDHP) HRA, HSA, HIA, HIA Plus	800-972-6359	VZZ, VZK	Eligibility, Remits, Benefits, Claim Status, Secure Messaging, Interactive Care Reviewer (ICR)	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348-5557	**Voluntary Refunds:** Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177 **Requested Refunds:** Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197-5281	**866-398-1922** * Select the Medical Management Prompt for Precertification and/or Predetermination * Select Case Management for Care Coordination **Fax: 866-959-2154**
Self-Funded Groups - Administered by Anthem or Wisconsin Collaborative Insurance Company (WCIC)							
Anthem ID card (Back of card indicates "Benefits **administered by** Blue Cross Blue Shield of WI..." or "Benefits **administered by** Wisconsin Collaborative Insurance Company WCIC…")	See back of member ID card	Refer to Member's ID Card	Eligibility, Remits, Benefits, Claim Status, Secure Messaging	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187 (Back of ID card indicates submit claims to BCBS plan in state where services rendered)	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348-5557	**Voluntary Refunds:** Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177 **Requested Refunds:** Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197-5281	**866-643-7087** * Select the Medical Management Prompt for Precertification and/or Predetermination * Select Case Management for Care Coordination **Fax: 866-959-2154**

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Products	Provider/Customer Service	Alpha-Prefixes	Information Available on Availity®	Claims Address	Provider Adjustment Requests (Claim Reconsiderations)	Provider Refunds (Contact Customer Service for the address for returning Anthem checks)	Utilization Management (UM) (Precertification of services **not** managed by AIM Specialty Health® or OrthoNet LLC and Case Management)
BlueCard® (Non-Wisconsin Commercial and Medicare Advantage Blue Cross and Blue Shield Members' Plans)							
Eligibility	800-676-BLUE (2583)	Refer to Member's ID Card	Information dependent upon availability from Blue Plan's front-end system	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348-5557 (Send **requested** medical records with a copy of the request letter on top to this address.)	**Voluntary Refunds:** Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177 **Requested Refunds:** Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197-5281	Call the number on the back of the member's ID card
BlueCard Provider Service	866-791-2292						
Provider Finder (BlueCard® Network)	800-810-BLUE (2583)						
Note: Please use the contacts referenced above for Non-WI Blue Medicare Advantage PPO members.							
Federal Employee Program (FEP)							
Federal Employee Program (FEP)	800-242-9635 IVR: claim status, checks, remits, eligibility, benefits	R	Eligibility , Benefits, Claim Status, Remits, Secure Messaging	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348-5557	Same as claims address	Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177	**Precert:** 800-860-2156 **FAX:** 800-732-8318 **Care Management:** 800-711-2225
Anthem Medicare Supplement							
Medicare Supplement Products **Non-contracted products*	866-341-1053	VZQ, VZL, AUQ, VZA	Eligibility, Remits, Benefits, Claim Status, Secure Messaging	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Same as claims address	Anthem Medicare Supplement Voluntary Refunds PO Box 92420 Cleveland, OH 44193	Not applicable
Anthem Medicare Advantage							
Anthem Medicare Advantage Group Sponsored Plans	Provider Service 866-845-8609 for PPO 855-320-6557 for HMO Customer Service 866-845-8609 for PPO 855-320-6557 for HMO	VZM (PPO) VZP (HMO)	Eligibility, Remits, Benefits, Claim Status, Secure Messaging	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348-5557	**Voluntary Refunds:** Anthem Cost Containment Overpayment Avoidance PO Box 73651 Cleveland, OH 44193-1177 **Requested Refunds:** Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197-5281	**Precertification** 866-797-9884, Option 1 **FAX**: 866-959-1537
Anthem MediBlue Access (PPO) 2017 Available in the same 24 Wisconsin counties as 2016.	1-855-690-7802	VOE	Eligibility, Remits, Benefits, Claim Status, Secure Messaging	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187	Anthem Blue Cross and Blue Shield P.O. Box 105557 Atlanta, GA 30348-5557	**All Refunds (Requested and Voluntary)** Anthem Blue Cross and Blue Shield PO Box 933657 Atlanta, GA 31193-3657	**Precertification** 866-797-9884, Option 1 **FAX**: 866-959-1537
Anthem MediBlue Plus (HMO) 2017 Available in the same 18 counties as 2016. *See BlueCard section for non-WI Blue Medicare Advantage PPO member information.*	1-855-304-1774	ZRB					
Anthem MediBlue Dual Advantage (HMO SNP) 2017 Available in the same 18 counties as 2016. *Dual Special Needs Plans (D-SNP) coordinate Medicaid and Medicare programs and provide enhanced member benefits.*	1-855-304-1774	VOT					

Anthem Medicare Advantage Appeals*
Mail Information to: Anthem Blue Cross and Blue Shield - Senior Appeals and Grievances, 4361 Irwin Simpson Road, Mason, OH 45040 or Fax: 877-811-5116
**This information applies to all Anthem Medicare Advantage Plans. For more information on appeals and disputes for Anthem Medicare Advantage members, please to go www.anthem.com/medicareprovider*

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWi), Compcare Health Services Insurance Corporation (Compcare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWi underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC; Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association.. Availity® is an independent company providing a wide variety of online tools that allow providers to access real-time information from multiple payers via one secure sign-on.

The local alpha prefixes listed are not all inclusive and represent the most common .

Products	Provider/Customer Service	Alpha-Prefixes	Information Available on Availity®	Claims Address	Provider Adjustment Requests (Claim Reconsiderations)	Provider Refunds (Contact Customer Service for the address for returning Anthem checks)	Utilization Management (UM) (Precertification of services **not** managed by AIM Specialty Health® or OrthoNet LLC and Case Management)
Anthem Medicaid							
Anthem Blue Cross and Blue Shield Medicaid *For Wisconsin Medicaid Provider self-service, please go to our provider website at:* www.anthem.com/wimedicaiddoc	855-558-1443	ZRA	Eligibility , Benefits, Claims Status, Remits	Anthem Blue Cross and Blue Shield Claims PO Box 61010 Virginia Beach, VA 23466-1010	Anthem BCBS-Claim Appeals PO Box 61599 Virginia Beach, VA 23466-1599	**All Refunds (Requested and Voluntary)** Anthem Blue Cross and Blue Shield PO Box 933657 Atlanta, GA 31193-3657	**Authorization:** 855-558-1443

Other Information

Anthem Commercial Utilization Management Appeals

Phone: 800-325-3377 Fax 888-859-3046*
Mail additional information to: *Anthem UM Appeals Grievance & Appeals Department, P.O. Box 105568, Atlanta, GA 30348-5568
**Send appeals related to utilization management denials and true grievances and appeals to this address. Please do not use this address for complaints (claim reconsideration requests). See the Guide to Provider Complaints and Appeals posted on Anthem.com Answers@Anthem for more information.*

AIM Specialty Health®	Electronic Data Interchange (EDI)	OrthoNet LLC	Secure Provider Portal
Request Prospective Precertification Online via: Availity to AIM or access AIM ProviderPortalSM directly at providerportal.com. **Applicable Products and Services:** **• Diagnostic Imaging and Cardiology** **• Genetic Testing (effective 07.01.17)** **• Oncology (Radiation therapy)** **• Sleep studies** **• Sleep therapy/treatment** Call Center Phone: Number on back of member ID card or 800-554-0580 Hours: 7:30am-6:00pm CDT M-F **• Specialty pharmacy** Call Center Phone: Number on back of member ID card or 866-582-2343 Hours: 7:30am-5:00pm CDT M-F **AIM Web Help Desk: 800-252-2021** **Directions to CPT and HCPCS Code Lists on AIM secure website:** Quick Reference Guide to AIM Specialty Health	**EDI Solutions Help Desk:** 800-470-9630 **Email:** edi.ent.support@anthem.com **Information Available Online:** http://www.anthem.com/edi/ (Select WI & press Enter) **WI EDI Payor IDs for direct submitters:** Professional - 00950; Facility - 00450 **Electronic Funds Transfer (EFT) AND Electronic Remittance Advice (ERA) Enrollment:** CAQH EnrollHub™ at www.caqh.org. Choose "EFT & ERA Enrollment" **ERA Enrollment Only:** www.anthem.com/edi/ (Select WI & click enter and select ERA Only Registration under the "Register" menu)	**Commercial members** (alpha prefixes on page 1) Physical and Occupational Therapy **Phone:** 844-282-6994 **Fax:** 844-216-1599 (8:00-5:30 all time zones) **Website:** www.orthonet-online.com Select Provider>Blue Cross Blue Shield Plans (under Health Plan Contracts)>Commercial>Wisconsin **Medicare Advantage individual members** (alpha prefixes VOE, ZRB, VOT) **Out Patient Therapy Phone:** 844-340-6418 **Fax:** 844-340-6419 **Pain Management & Spinal Surgery Phone:** 844-788-4805 **Fax:** 844-788-4806 **Website:** www.orthonet-online.com Select Provider>Blue Cross Blue Shield Plans (under Health Plan Contracts)>Medicare>Wisconsin **Medicaid members** (alpha prefix ZRA) **Out Patient Therapy Phone:** 844-735-2621 **Fax:** 844-795-3183 **Pain Management & Spinal Surgery Phone:** 844-246-3443 **Fax:** 844-232-1909 **Website:** www.orthonet-online.com Select Provider> Blue Cross Blue Shield Plans (under Health Plan Contracts)>Medicaid>Wisconsin. *Register and submit prior authorization requests online through OrthoNet for Anthem Commercial, Medicare Advantage and Anthem Medicaid members.*	www.availity.com Phone: 800-Availity (282-4548) for assistance with registration, web-related questions and password resets. Important Note: Access to Anthem fee schedule inquiry and online provider remittance advice copies is offered exclusively through Availity. To access Payer Spaces>Applications>Fee Schedule Inquiry or Remittance Inquiry. Anthem reimbursement policies will be available via Availity in 2017. Until the move is complete you can find them via Availity by, selecting "More" and then My Payer Portals>Anthem Provider Portal.

I-care

- 3 options of plan
- Dual eligible different benefits
- MUST determine coverage type to know reimbursement and clinical information needed

Community Care

- Rugs location on claim
- Plan Medicaid only or can be Medicare and Medicaid plan
- Electronic vs. Paper
- Claim revenue codes need to match Authorization
- Billing manual on line

Payment & reading remit

- Payment correct?
- Payment based on what we learned on admit
- File corrected claim?

Payment & reading remit

- Adjusted billing
  - Corrected claim process
  - Claim number
  - 217, 227 or 237 bill type (7 means adjust)

Collection ideas/strategies

- Calls and more calls
- Provider representative contact
- Grievance process /appeal

Billing & Collections Time

- One Medicare Advantage equals about 4 Medicare A claims in time to work from start to collections
- New contracts more challenging
- Getting better in many insurance companies with processing and understanding SNF

HUMANA CLAIMS OFFICE
P. O. BOX 14603
LEXINGTON, KY 40512-4603

Humana.

PCK10B -005126-002-002-000000-000000-000000-0000011864

DATE 09/04/2017

PROVIDER ID:
FEDERAL TAX ID:
REMITTANCE ID:
CHECK NUMBER:
BANK CODE:
CLIENT:

1 2

HUMANA AUTOMATED REMITTANCE ADVICE

DATE OF SERVICE FROM	DATE OF SERVICE TO	SERVICE CODE	CHARGE	ALLOWED AMOUNT	DEDUCTIBLE	COPAY	COINSUR	PROVIDER DISCOUNT	FEE REDUCTION/ EXCLUDED	HUMANA/ ANSI (HIPAA) CODE	BENEFIT AMOUNT
BILLING NPI NUMBER: PROVIDER NAME: PATIENT NAME: SUBSCRIBER NAME: PLAN TYPE					RENDERING NPI NUMBE: MBR II PAT DO REL CL: SUBSCRIBER DRG: 000				CLAIM NUMBER: PAT ACCT: GROUP DAYS:		
07/14/2017	07/31/2017	0240	6,321.57	5,455.80	0.00	0.00	0.00	0.00	0.00		5,455.80
07/14/2017	07/31/2017	120	4,590.00	5,455.77	0.00	0.00	0.00	0.00	0.00		5,455.77
CLAIM TOTALS			10,911.57	10,911.57	0.00	0.00	0.00	0.00	0.00		10,911.57
EST MBR RESPONSIBILITY 0.00								TOTAL PAID 10,911.57			
Ancillary lines have been consolidated into an all-inclusive line.											
REMITTANCE TOTALS											
SERVICING PROVIDER NAME/ID: MAPLEWOOD OF SAUK PRAIRIE/391142308											
		TOTALS	10,911.57	10,911.57	0.00	0.00	0.00	0.00	0.00		10,911.57
EST MBR RESPONSIBILITY 0.00								TOTAL PAID 10,911.57			
ROLLUP TOTALS FOR REMITTANCE											
		TOTALS	10,911.57	10,911.57	0.00	0.00	0.00	0.00	0.00		10,911.57
EST MBR RESPONSIBILITY 0.00								TOTAL PAID 10,911.57			

SERVICE CODES/TREATMENT TYPES/DESCRIPTIONS

0240 AN ALL-INCLUSIVE ANCILLARY - GENERAL

120 SEMI PR RM GENERAL

3

SPECIAL MESSAGES

THE ESTIMATED MEMBER'S RESPONSIBILITY AMOUNT IS BASED UPON INFORMATION AVAILABLE AT THE TIME A CLAIM IS PROCESSED. THIS AMOUNT REPRESENTS ANY APPLICABLE DEDUCTIBLES, CO-INSURANCE, COPAYMENTS AND NON-COVERED SERVICES. IT INCLUDES ANY AMOUNTS THAT THE MEMBER MAY HAVE PREVIOUSLY PAID TO THE PROVIDER OF SERVICE. THE AMOUNT IS NOT REFLECTED IF THE CLAIM REPRESENTS A PREADMISSION PENALTY OR AN ADJUSTMENT TO A PREVIOUSLY PROCESSED CLAIM, ANY AMOUNTS DENIED FOR ADDITIONAL INFORMATION MAY BE RE-EVALUATED.

IF YOU SUSPECT FRAUD, PLEASE CONTACT HUMANA, INC., 1100 EMPLOYERS BLVD., GREEN BAY, WI 54344 OR CALL THE HUMANA FRAUD HOTLINE NUMBER AT 1-800-614-4126

UNITY HEALTH INSURANCE
840 CAROLINA STREET
SAUK CITY WI 53583
800-362-3309
REMITTANCE ADVICE

Date: 10/6/2017
Time: 8:26 PM

Remittance Detail
Vendor:

* Provider ID#:
* Provider Name:

Co. Name: UNITY   Check   Check Date: 10/11/2017
Claim #:

Patient Name: Date of Birth
Member ID

Service Date	Procedure /DRG	Billed	Allowed	Discount	Withhold	Provider Respons	After Ben Penalty	Disallow	Not Covered	Exc Ben Amt	Deduct	Copay/ Coins	Pat OOP	Adjust	Adj RSN	Primary Factors	Net Paymnt	Codes
08/17/17	0191	5625.00	5625.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	--	0.00		--	5625.00	45
08/17/17	0270	216.92	0.00	216.92	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	--	0.00		--	0.00	97/N525
08/17/17	0420	3195.83	0.00	3195.83	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	--	0.00		--	0.00	97/N525
08/17/17	0430	2963.79	0.00	2963.79	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	--	0.00		--	0.00	97/N525
08/17/17	0440	988.54	0.00	988.54	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	--	0.00		--	0.00	97/N525
Claim Totals:		12990.08	5625.00	7365.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	5625.00	

Interest Amount: 0.00
Penalty Amount: 0.00

Level I   15 days

Total for Processed Claims:	Billed	Allowed	Discount	Withhold	Provider Respons	After Ben Penalty	Disallow	Not Covered	Exc Ben Amt	Deduct	Copay/ Coins	Pat OOP	Adjust	Adj RSN	Primary Factors	Net Paymnt
	12990.08	5625.00	7365.08	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	5625.00

Is Medicaid back up payer?

Remember timely filing rules!!!!!

- Facilities often do not use:
  - Medicare or insurance requests records and does not pay for a claim. Medicaid will accept this claim if the denial was MEDICALLY BASED, 90 days from the date of the remit from primary payer
  - Timely filing appeals process all paper
  - Form number__________
  - Reason to get care level on these cases

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Specialized Medical Services, Inc.
5343 North 118th Court
Milwaukee, WI 53225
414-476-1112 fax 414-476-6118
email: info@specializedmed.com

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-13046 (08/15)

STATE OF WISCONSIN

FORWARDHEALTH
ADJUSTMENT / RECONSIDERATION REQUEST

Instructions: Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, F-13046A, for information about completing this form.

The provider is required to maintain a copy of this form for his or her records.

SECTION I — BILLING PROVIDER AND MEMBER INFORMATION

Indicate appropriate program.

☐ BadgerCare Plus / SeniorCare / Wisconsin Medicaid ☐ ADAP ☐ WCDP ☐ WWWP

1. Name — Billing Provider	2. Billing Provider's Provider ID
3. Name — Member	4. Member Identification Number

SECTION II — CLAIM INFORMATION

5. Remittance Advice (RA) or X12 835 Health Care Claim Payment / Advice (835) Report Date, Check Issue Date, or Payment Date	6. Internal Control Number / Payer Claim Control Number

☐ Add a new service line(s) to previously paid / allowed claim. (In Elements 7-15, enter information to be added.)
☐ Correct detail on previously paid / allowed claim. (In Elements 7-12, enter information as it appears on the RA or 835.)

7. Date(s) of Service From	To	8. POS	9. Procedure / NDC / Revenue Code	10. Modifiers 1-4 Mod 1	Mod 2	Mod 3	Mod 4	11. Billed Amount	12. Unit Quantity	13. Family Planning Indicator	14. EMG	15. Rendering Provider Number

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment

☐ Consultant review requested (include supporting documentation).
☐ Recoup entire payment.
☐ Other insurance — dental / pharmacy with OI-P $.
☐ Other insurance — professional / institutional (attach Explanation of Medical Benefits form, F-01234).
☐ Copayment deducted in error. ☐ Member in nursing home. ☐ Covered days . ☐ Emergency.
☐ Primary payer reconsideration.
☐ Correct service line.
☐ Other / comments.

17. **SIGNATURE —** Billing Provider	18. Date Signed

19. Claim Form Attached (Optional)

☐ Yes ☐ No