Billing Procedures

BILLING PROCEDURES

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** This section contains information regarding the EPDST Service: Medical Protocol and Periodicity Schedule and EPSDT/PPHSD Screening Service Codes.

1. Introduction

The Fallon Health Weinberg (FHW) Provider Manual billing section provides you with an overview of our billing requirements. It includes detailed information on our policies and procedures, allowing you to be more efficient in your billing practices.

This manual will be updated as new or revised procedures are established or policies are changed. It is our goal that this manual will make the process of filing claims as easy and trouble-free as possible.

This manual also refers to commonly used codes supplied by the American Medical Association's Manual of Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services Common Procedure Coding System (HCPCS). If you have any comments or suggestions, please contact Provider Relations at 1-855-827-2003 or 716-810-1893

Fallon Health Weinberg is a customer driven organization that is dedicated to the prompt and accurate claims payment of our providers' claim submissions in accordance with regulatory and contractual requirements.

2. Fallon Health Weinberg's commitment to quality

A. Claims department quality audits

Fallon Health Weinberg (FHW) is committed to giving our customers quality service. To ensure claims processing quality, our Claims Department audits claims every month, verifying the accuracy of claims entry and adjudication. The data from these audits is used for additional training and for updating our procedures.

B. Claim code auditing

In order to keep pace with ever changing medical technology and coding complexities, FHW has enhanced its claim checking capabilities. FHW's auditing program exists to evaluate billing and coding accuracy on submitted claims. FHW's auditing program is guided by the coding criteria and protocols established by various industry sources including the Centers for Medicare and Medicaid Services (CMS), the CPT Manual published by the American Medical Association (AMA) and specialty society guidelines.

FHW continually evaluates, edits and modifies the auditing program to accommodate FHW payment methodology.

FHW implements bi-annual version upgrades to auditing software. These upgrades typically occur in March and November.

The following list represents an example of the different edits and their definitions.

Age conflicts
Identifies billed procedure codes that are inconsistent with the age of the member.

Assistant surgeon edits
Determines if an assistant surgeon is clinically necessary for the billed procedure.

Cosmetic surgery edits
Identifies procedures that FHW considers to be cosmetic and suspends the claim for additional review.

Evaluation and management (E&M) services not paid separately edits
Identifies the separate reporting of E&M services when a substantial diagnostic or therapeutic procedure is performed. FHW does not reimburse for E&M services performed on the same day as a procedure unless a significant, separately, identifiable service is documented in the medical record.

Experimental procedures
Identifies codes that are considered experimental and determined not to be reimbursable by FHW.

Gender conflicts
Identifies billed procedures that are inconsistent with the patient's gender.

Incidental procedure auditing
Identifies procedures that FHW considers to be clinically integral to the primary procedure and not allowable for separate reimbursement.

Intensity of service auditing
Compares the ICD-9-CM diagnosis to the intensity of the billed office visit. Recommends the appropriate E&M code and is stated on your Remittance Advice Summary (RAS).

Modifier auditing
Compares the CPT/ HCPCS procedure with the billed modifier for clinical appropriateness.

Mutually exclusive auditing
Identifies two or more procedures that produce the same clinical result, but are performed by different methods or are procedures that usually are not performed together during the same patient encounter and therefore not allowable for separate reimbursement.

Pre-Operative and Post-Operative edits
Identifies E&M services that are reported with surgical procedures during the associated pre/post-operative periods. The pre and post-operative periods are designated in CMS's National Physician Fee Schedule. If submitting modifier 24, medical notes are required.

Unbundling auditing
Identifies billing scenarios where two or more procedures are listed separately when a more accurate comprehensive procedure code exists. The correct codes for the clinical scenario will be allowed and/or automatically added to the claim.

Unlisted procedure edits
Identifies procedure codes defined by CPT as unlisted services. Unlisted procedure codes should never be used when a more descriptive procedure code is available.

3. Claims guidelines

A. Submitting a claim

Claims need to be submitted to FHW in one of the following formats:

Electronic file

CMS 1500 claim form

UB-04

Each of these formats is described in detail in #4 below.

Paper claims should be submitted by mail to:

Fallon Health Weinberg

Claims Department

PO Box 15672

Worcester, MA 01615

Note that FHW reserves the right to refuse hand written claims that are incomplete or illegible. Claim forms should be typed or computer generated to insure appropriate processing. For chiropractic, non-emergency dental, and pharmacy claims, see 3-G.

B. Referrals and prior authorizations

Please note that for services that require authorization, all contracted providers are responsible for ensuring that the appropriate authorization is in place prior to services being rendered. If medically necessary services are rendered to an eligible plan member and there is no prior authorization, the provider will not be reimbursed for related charges and the member may not be billed.

Members' coverage for services is subject to their eligibility based on their benefits, contract policies and exclusions.

To ensure reimbursement to specialists and facilities when a referral or prior authorization is required by the plan, please follow the following guidelines:

- The PCP submits a claim to FHW for services rendered by entering the PCP name and NPI number in Box 31 and 33.
- The specialist submits a claim to FHW with evidence of a referral (the PCP's NPI number) from the member's PCP. The following information

should be entered on the CMS 1500 or equivalent as evidence

- Box 17 – enter referring provider/PCP‘s name
- Box 17b – enter referring provider/PCP‘s NPI number

For FHW direct claims submitters

- Loop 2310A Segment NM1 –enter the referring provider/PCP‘s name
- FHW Loop 2310A segment NM109 enter the referring provider/PCP NPI

FHW‘s contracted claims clearinghouses have the capability to send the referring provider‘s FHW vendor number.

Failure to include complete referral information (the referring provider‘s name and NPI number) on the claims will result in a denial.

C. Filing limits

Claims must be received within 120 days of the date of service. If your contract with FHW specifies a different time limit, that limit may apply. Non-contracted providers must submit claims within 1 year from date of service.

Exceptions are as follows:

If…	You should …
You believed FHW was the secondary insurer, but we were actually the primary insurer.	Submit a paper claim to FHW along with the other insurer‘s Explanation of Benefits (EOB). You must submit within 120 days of the date on the other insurer‘s EOB. If your contract with FHW specifies a different time limit, that limit may apply.
The claim is related to a motor vehicle accident.	Submit claims to FHW after the personal injury protection (PIP) is denied and include copy of PIP letter.
The claim is related to workers‘ compensation.	Submit claims to FHW with a copy of the workers‘ illness/injury compensation insurer‘s denial.

Written documentation of initial submission of claims filed beyond your filing limit must be provided.

See 9-C for appeals of filing limit issues.

Note: FHW members cannot be billed for claims denied due to late submission.

D. Late charges

Late charges will be accepted electronically for Institutional claims provided the claim contains the appropriate late charge Bill Type (xx5).

Inpatient:

Any charge not included on the original inpatient room and board claim should have a bill indicator type of 115 entered in box 4 on the UB-04 form. Only the late charge should be on the claim form. In some cases, the late charges may be added to the original inpatient claim depending on the provider‘s contractual terms. For EDI providers, Bill Type should be submitted in Loop 2300 CLM05-1 and CLM05-3.

Outpatient:

Any charge not included on the original outpatient claim should have a bill indicator type of 135 entered in box 4 on the UB-04 form. Only the late charge should be on the claim form. In some cases, the late charges will be added to the original outpatient claim. For EDI providers, Bill Type should be submitted in Loop 2300 CLM05-1 and CLM05-3.

FHW

E. Balance billing

Balance billing FHW members (other than deductibles, copayments or coinsurance) is not allowed for covered services.

F. Claims that should not be submitted directly to FHW

We contract with outside vendors to provide certain services. Claims for those services should be directed as follows:

BEHAVIORAL — Behavioral Health claims for providers with behavioral health credentials should be sent to:

Beacon Health Strategies
500 Unicorn Park Drive
Woburn, MA 01801 1-888-421-8861

CHIROPRACTIC	Contracted chiropractors should submit claims to: Claims Administration American Specialty Health Networks P.O. Box 509001 San Diego, CA 92150-9001 1-800-972-4226
	Non-contracted chiropractors should submit claims to: Fallon Health Weinberg ATTN: CLAIMS DEPARTMENT 10 Chestnut St Worcester, MA 01615
PHARMACY	All contracted retail pharmacies should contact: CVS/CAREMARK 1-800-777-1023

4. Claims submission

A. Submitting claims directly to FHW

FHW accepts direct submission of Institutional and Professional claims, submitted in the HIPAA-compliant format. Submitting your claims directly to FHW eliminates the need for a clearinghouse and is offered with no transaction fee.

FHW offers the following ways to transmit your files: SFTP and Secure File Transfer via the Web.

To begin the enrollment process for submitting your claims directly to FHW, please visit our Web site at www.fallonwienberg.org, click on the ―Physicians & providers‖ tab and then click on ―Electronic data submission or call our EDI coordinators at 1-855-827-2003 or 716-810-1893

B. Submitting claims electronically through an FHW-contracted clearinghouse

Electronic claim submission offers quicker turnaround time, lower working costs, more efficient payments and a confirmation that claims have been received by the clearinghouse. FHW‘s EDI process is secure and HIPAA compliant. Please refer to the Provider Relations Section to review FHW‘s Electronic Data Transmission policies and procedures.

These items cannot be filed electronically:

- Status checks
- Invoiced items (such as supply charges for serum)
- Claims requiring attached documentation

FHW is contracted with the following clearinghouses:

McKesson	(also known as Relay Health) Call 1-800-981-8601 or visit their Web site at www.mckesson.com
Emdeon Corporation™	(formerly known as WebMD) Call 1-800-845-6592 or visit their Web site: www.emdeon.com Carrier code: 22254

You must enroll with one of the above contracted clearinghouses prior to claims submission.

When submitting claims electronically through either a clearinghouse or directly to FHW:

Providers must submit claims using their assigned NPI number.

You must notify FHW and the clearinghouse if your practice information changes (e.g., tax number, address changes).

New providers in your practice must be enrolled with the clearinghouse, credentialed and contracted by FHW.

Membership number on each membership card. You must transmit all of the numbers. The patient's date of birth, full name and address must be entered correctly. If a claim contains an invalid or improper membership number, the wrong date of birth, or a misspelled name it may not file in our system.

Submit exact names as indicated on the membership card (no nicknames or hyphenated names).

If you are submitting for services that took place in different settings (e.g., office, outpatient, ER) a separate claim must be submitted for the office visit, the outpatient visit and the ER visit. We cannot process claims when multiple places of service are billed.

For more information contact one of our EDI coordinators at 1-855-827-2003 or 716-810-1893 or e-mail at EDI.Coordinator@fallonweinberg.org

C. Using the CMS 1500 claim form

The CMS 1500 claim form should be used for billing all professional services rendered by the following:

Independent providers

Hospital-based physicians

Laboratories

Radiology groups

Emergency physician groups

Ambulance companies

DME providers

Early intervention services

Medical supply vendors

Pharmacy

Physical, speech, occupational therapists

When submitting a claim:

Do not bill future dates of service.

Do not bill for two or more places of service on one claim. FHW is unable to process with different places of service.

Use appropriate modifiers, up to four when necessary.

Claims should be submitted for complete length of service. Interim billing is not accepted.

Unlisted CPT/HCPCS codes must have documentation attached.

Per CMS guidelines, unique physician identification numbers are required. Please submit in box #33 of the CMS 1500 form.

Follow the guidelines below when submitting a CMS 1500 claim form to Fallon Health Weinberg.

The required column indicates if a specific field is required by FHW or is optional.
More information on the CMS 1500 claim form or how you can order the form can be found on the CMS web site:
HYPERLINK http://www.cms.gov/site-search/search-results.html?q=HCFA%201500

For specific fields required for EDI claim submission, refer to our companion guide: Health Care Claims Submission X12N 837 (Version 5010) Implementation Guide—Professional at www.fallonweinberg.org

Place of service codes (line 24-B) and modifiers (line 24-D) are listed in the reference section of this manual.

Box #	Field name	Required	Instructions
1–13 - Patient and insured information			
1	Type of health insurance	Optional	Show type of health insurance coverage applicable to this claim by checking the appropriate boxes.

Box #	Field name	Required	Instructions
1a	Insured‘s ID number	YES	Enter FHW membership number as indicated on the membership card.
2	Patient‘s name	YES	Enter patient‘s last name, first name and middle initial as name appears on card.
3	Patient‘s birth date and sex	YES	Enter patient‘s eight-digit birth date (MMDDYYYY) and sex (M or F).
4	Insured‘s name	YES	Enter policyholder‘s last Name, first name, middle initial as name appears on card. If patient and insured are the same, enter -Same.‖
5	Patient‘s address	YES	Enter patient‘s mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.
6	Patient relationship to insured	YES	Check the appropriate box for patient‘s relationship to the insured.
7	Insured‘s address	YES	Enter insured‘s address and telephone number. When address is the same as the patient‘s, enter the word —Same.‖ Complete this box only when boxes 4 and 11 are completed.

Box #	Field name	Required	Instructions
8	Patient status	YES	Check the appropriate box for patient‘s marital status and whether employed or a student.
9	Other insured‘s name	YES	Enter last name, first name, and middle initial of the insured if it is different from that entered in box 4. If the same, enter the word ―Same.‖
9a	Other insured‘s policy	YES	Enter policy or group number of the other insured‘s or group number health insurance policy.
9b	Other insured‘s date of birth	YES	Enter other insured‘s date of birth (MMDDYYYY) and sex.
9c	Employer name or school	Optional	Enter other insured‘s employer‘s name or school name.
9d	Insurance plan name or program name	Optional	Enter other insured‘s insurance plan name. Attach an *Explanation of Benefits* from the primary insurer to the claim.
10	Is patient‘s condition related to: a. Employment? (current or previous) b. Auto accident? c. Other accident?	YES	Check ―YES‖ or ―NO‖ to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in item 24. Enter State postal code. Any item checked ―YES‖ indicates there may be other insurance primary. Identify primary insurance information in item 11.

Box #	Field name	Required	Instructions
10d	Reserved for local use	NO	Not applicable to FHW
11	Insured‘s policy group or FECA number	YES	If the patient has other insurance, enter the policy number.
11a	Insured‘s date of birth	YES	Enter insured‘s date of birth (MMDDYYYY) if different from box 3.
11b	Employer name or school name	YES	Enter employer‘s name or school name if applicable.
11c	Insurance plan name or program name	YES	Enter insurance plan or program name, if applicable.
11d	Is there another health benefit plan?	YES	Check YES or NO to indicate if there is or if there is not any other health insurance.
12	Patient‘s or authorized person‘s signature	Optional	The patient or authorized representative must sign and date unless their signature is on file. In lieu of signing the claim, patient may sign a statement to be retained in provider, physician or supplier file. If an authorized person signs the form, the statement‘s signature line must indicate patient‘s name followed by ―by‖ and representative‘s name, address, relationship to patient and reason the patient cannot sign.

Box #	Field name	Required	Instructions
13	Insured's or authorized person's signature	Optional	The insured's or authorized person's signature authorizes payment of benefits to participating provider or supplier.
14	Date of current illness, injury or pregnancy	YES	Enter eight-digit date (MMDDYYYY) current illness, injury or pregnancy.
15	If patient has had same or similar illness, give first date	Optional	Enter first date. (MMDDYYYY)
16	Dates patient unable to work in current occupation	Optional	Enter dates (MMDDYYYY) patient is unable to work in current occupation. An entry in this field may indicate employment-related insurance coverage.
17	Name of referring, covering provider or other source	YES	Enter last name, first name and middle initial of referring or ordering provider if service or item was ordered or referred by a physician. *Referring physician:* A physician who requests an item or service for the beneficiary for which payment may be made by FHW. *Covering physician:* A physician providing coverage on behalf of the patient's primary care physician. *Ordering physician:* A physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services or durable medical equipment.

Box #	Field name	Required	Instructions
17a	ID number of referring physician	Optional	Enter FHW provider ID number of the referring physician or ordering physician for ancillary services. To obtain this number, contact Provider Relations at 1-855-827-2003 or 716-810-1893
17b	NPI number of referring physician	YES	Enter NPI number of the referring physician or ordering physician for ancillary services.
18	Hospitalization dates related to current services	YES	Enter date (MMDDYYYY) when medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	NO	Not applicable
20	Outside lab	Optional	Indicate if laboratory work was performed outside the physician's office. If YES, indicate which tests and the associated costs.
21	Diagnosis or nature of illness or injury	YES	Enter appropriate ICD-9-CM diagnosis code to indicate patient's diagnosis or condition. Enter up to four codes in priority order beginning with the primary. Codes listed must be complete ICD-9-CM diagnosis codes carried out to the fourth or fifth digit.

Box #	Field name	Required	Instructions
22	Medicaid resubmission code	NO	Not applicable
23	Prior authorization number	YES	Enter FHW preauthorization number, if applicable.
24a	Dates of service	YES	Enter date (MMDDYYYY) for each procedure, service or supply. When billing a consecutive date range, please do not bill future dates of service.
24b	Place of service	YES	Enter appropriate CMS place of service code from the list provided in the reference section of this manual.
24c	Type of service	NO	Not applicable.
24d	Procedures, services or supplies	YES	Enter appropriate CPT4, HCPCS Level II or ADA codes. CPT codes are required for all professional claims. When applicable, use the appropriate modifier, up to four. The modifier that affects payment must be submitted first.
24e	Diagnosis code	YES	Enter diagnosis code reference number as shown in item 21, to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, enter the primary diagnosis code for each service.

Box #	Field name	Required	Instructions
24f	$ Charges (Dollar amount of charges)	YES	Enter charge for each listed service.
24g	Days or units	YES	Enter number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes or oxygen volume. 1 unit of anesthesia = 15 minutes. If only one service is performed, the numeral 1 must be entered. If this is left blank, you will be reimbursed for 0 units.
24h	EPSDT Family Plan	NO (believe this is required -- CP checking)	Not applicable.
24i	ID Qualifier	NO	Not applicable.
24j	Rendering provider ID NPI number	YES	Enter rendering provider NPI number.
25	Federal tax ID number	YES	Enter service provider or supplier federal tax ID (employer identification number) or Social Security number.
26	Patient's account number	Optional	Enter patient's account number assigned by service provider's or supplier's accounting system. This field is optional to assist you in patient identification. The account number will appear on your *Remittance Advice Summary (RAS).*

Box #	Field name	Required	Instructions
27	Accept assignment?	YES	Check appropriate block to indicate whether the provider of service or supplier accepts assignment for the claim. By checking Yes, physician agrees to accept the amount paid by the third party as payment in full.
28	Total charge	YES	Enter total charges for the services (i.e., total of all charges in item 24f).
29	Amount paid	YES	If applicable, enter amount of payment received from another insurance carrier prior to submitting claim to FHW.
30	Balance due	YES	Enter balance due. (box 28 minus box 29)
31	Signature of physician or supplier including degrees or credentials	YES	Enter signature and typed name of physician/supplier and the date the form was signed. Only one provider of service allowed per claim.
32	Name and address of facility where services were rendered	YES	Enter facility name, address if services were furnished in a hospital, clinic, laboratory or facility other than patient's home or physician's office, and NPI number.
33	Physician's supplier's billing name, address, zip code and phone	YES	Enter service provider's or supplier's billing name and NPI number, address, zip code and telephone number identifying where payments should be sent.

Source: Centers for Medicare and Medicaid Services, Health Insurance Claim Form – CMS 1500

D. Billing and payment guidelines for professional claims

All professional covered services, unless otherwise specifically stated in your contract, will be paid at the lesser of your billed charges or the contracted rate minus any applicable copayments, coinsurance and/or deductibles.

Topics	Billing and payment guidelines
Ambulance	Origin and destination modifiers are required on all CMS 1500 claim forms. Refer to the modifier listings in the reference section of the manual for further details. Hospitals should bill ambulance services separately from outpatient services. Claims should be submitted with HCPCS transportation codes A0021 – A0999.
Anesthesia	Anesthesia claims must be submitted with CPT codes in the 00100-01999 range. Providers are required to report the total anesthesia time in minutes in field 24g of the claim form. Also include the start and end time (i.e., 11:15 a.m. – 12:45 p.m.). Time units are determined on the basis of one time unit for every 15 minutes of anesthesia. Anesthesia time is defined by the continuous actual presence of the anesthesiologist (or CRNA). All anesthesia codes require a modifier: o AA - performed personally o AD - medical supervision by a physician: more than four concurrent anesthesia procedures o QK - medical direction of two, three or four concurrent procedures o QY - medical direction of one CRNA by an anesthesiologist Certified Registered Nurse Anesthetist (CRNA) should bill with modifiers: o QX - CRNA service with medical direction by a physician o QZ - CRNA service without medical direction by a physician No modifiers or time is required on pain management services.

Topics	Billing and payment guidelines
	These encounters should be submitted using the appropriate CPT-4 code and appropriate units in field 24g. Please do not bill the base units in field 24g. Example: code 62319-nerve block. This code may be used for the first day of pain management. For the following days, procedure code 01996 should be used. We recognize that anesthesiologists perform non-anesthesia type procedures such as intubation, central venous access and consultations. These encounters should be submitted using the appropriate CPT-4 code and one unit in field 24g. The reporting of physical status modifiers (P1–P6) and qualifying circumstances (99100 – 99140) does not affect reimbursement; please note some contract provisions may vary.
Chiropractic Services	All chiropractic services should be submitted to: Claims Administration American Specialty Health Networks P.O. Box 509001 San Diego, CA 92150-9001 A copy of the prescription must be included with the initial claim submission to ASHN. Chiropractic health claims for Fallon Health Weinberg members should be mailed to: Fallon Health Weinberg Claims Department Box 15672 Worcester, MA 01615
Drugs Excluding Oral (HCPCS codes)	May require itemized invoice depending on contract to be submitted with the claim to ensure appropriate reimbursement of injectable/pharmacy material.

Topics	Billing and payment guidelines
Durable Medical Equipment	Do not bill future dates of service. Use appropriate HCPCS codes as follows: Orthotics: L0100–L4398 Prosthetics: L5000–L9900 DME: K0001–K0730 E0100–E8002 Use the appropriate modifiers as necessary. Unlisted HCPCS codes require pre-authorization and must be submitted with supporting documentation.
Eye Care	When billing for routine eye exams to FHW please use the following codes*: S0620 - Routine ophthalmologic exam - new patient S0621 - Routine ophthalmologic exam - established patient * CPT codes 92002, 92004, 92012 and 92014 are not interchangeable with HCPCS codes S0620 and S0621. Therefore, codes 92002, 92004, 92012 and 92014 will not be reimbursed under the benefit and guidelines for routine eye exams.
Eye glass frames	When billing for eyeglass frames to FHW please use the following codes: V2020 – Standard frame V2025 – Deluxe frame *Please bill the code for the frame with the full amount on one claim line indicating one unit for each pair of frames dispensed. Do not bill on 2 claim lines using both codes when one frame is dispensed.
Injectables	See Drugs excluding oral (HCPCS codes) See Vaccines
Laboratory	Claims should be submitted with CPT/HCPCS industry standard codes. Claims must be submitted with the appropriate diagnosis code. The referring physician should be listed in Box 17 of the CMS

Topics	Billing and payment guidelines
	1500 claim form.
Nurse Practitioner	Direct payment may be made to the NP or to the employer or contractor of the NP. NPs are required to submit claims with their own billing identification numbers for their professional services rendered. The NP's NPI number must be submitted in item 33 of the CMS 1500 claim form. In a group setting, this number is reported in item 24j and the group NPI number in item 33. NP assistant at surgery claims will be paid to their employing physician or group. Add modifier AS to the surgery procedure code and indicate the NP's NPI number on the claim in item 24j of the CMS 1500 claim form. Ordering and referral services are included in the payment for services performed. No separate payment is made for ordering or referring services. NPs must abide by the same preauthorization requirements as FHW contracted physicians.
Pathology	Claims should be billed with CPT/HCPCS industry standard codes. Claims must be submitted with the appropriate diagnosis code. The referring physician should be listed in Box 17 of the CMS 1500 claim form.
Physical Therapy	Each date of service must be reported individually. Claims should be submitted with CPT codes in the 97001–97799 range. The following CPT codes should be used for the initial visits: o 97001 - physical therapy evaluation

Topics	Billing and payment guidelines
	o 97003 - occupational therapy evaluation o 92506 - speech therapy evaluation
Physician Assistant	Payment for services of a PA will be made only to the actual employer of the PA. The employer may be a physician, medical group, professional corporation, hospital, skilled nursing facility or nursing facility. An ambulatory surgical center is not an acceptable employer. The claim must have the employing physician or group's name, address and NPI number in item 33 of the CMS 1500 claim form. PA assistant at surgery claims will be paid to their employing physician or group. Add modifier AS to the surgery procedure code and indicate the PA NPI number on the claim in item 24j of the CMS 1500 claim form. When PAs are ordering or referring services, they must submit their name and NPI number in item 17 and 17b of the CMS 1500 claim form. PAs must abide by the same preauthorization requirements as the FHW contracted physicians.
Radiology	Claims should be billed with CPT/HCPCS industry standard codes. Claims must be submitted with the appropriate diagnosis code. The referring physician should be listed in Box 17 of the CMS 1500 claim form. Modifiers should be used to indicate technical or professional services. Refer to the modifier listings in the Reference section of this manual for further details. When reporting (bilateral) radiological services you should use the –RT and –LT modifiers. Radiological services should be billed on two claim lines with the –RT and –LT modifier and one unit on each line. Do not use the –RT and –LT modifier to report services already identified as bilateral by definition.

Topics	Billing and payment guidelines
Reciprocal Billing/ Locum Tenens Arrangements	The reciprocal provider and locum tenens are responsible for adhering to the same FHW's policies and procedures as the absentee physician. The absentee physician may submit the claim and receive payment for part B covered arrangements services under Locum Tenens and/or reciprocal billing arrangements. Services of a substituting physician are identified by entering modifier Q5 or Q6 in item 24d of the CMS 1500 claim form. The NPI number of the substituting physician must be reported on the claim submitted by the billing –absentee‖ physician in item 23 on the CMS 1500 claim form. The billing –absentee‖ physician's NPI number must be reported in item 33 on the CMS 1500 claim form for a solo practice and item 24j on the CMS 1500 claim form for group practice arrangements.
Surgical Global	Attach operative notes for all surgery submissions over $1,000. Providers should submit each encounter to record rendered services. Use code 99024 when reporting postoperative care that is reimbursed within the global allowance. Providers are permitted to collect applicable copayment for services billed within the global period. Use -51 modifier to indicate that more than one surgical service was performed. Reimbursement for second through fifth surgical service will be at 50% of the billing physician's contracted rate. When separate payment is requested within the post-op period because the services are unrelated to the diagnosis for which the surgery was performed, the appropriate E/M code with a -24 modifier and supporting documentation must be submitted.
Vaccines	FHW does not reimburse for the cost of vaccines that are available free of charge by the State of New York. When billing a supplied vaccine, append the SL modifier to the appropriate vaccine CPT code. Preauthorization is not required for vaccines, with the exception

Topics	Billing and payment guidelines
	of unlisted vaccine/toxoids submitted with CPT code 90749. When there is a documented shortage of a state-supplied vaccine, FHW will reimburse providers who have purchased vaccines. When billing for vaccines in the event of a shortage, bill the appropriate vaccine CPT code. You should not append the SL modifier in this scenario. An invoice must be submitted with claims for those vaccinations not supplied by the Massachusetts Department of Public Health Immunization Program. Use codes 90465–90474 for reporting and for reimbursement of the administration of vaccines. Minimal office visit procedure 99211 will be denied with the administration of drug procedure 90465–90474 guidelines. *Flu Vaccine:* (No invoice required) If administered on the same day as a physician service is performed, use code 90471 to report the administration of the vaccine. If purchased, bill codes 90655, 90656, 90657, 90658 or 90660 and G0008 for the administration. If obtained through the state, bill with codes 90655, 90656, 90657, 90658, or 90660 with a SL modifier, and charge of $0.00, and the code G0008 for the administration.

E. Using the UB-04 claim form

The UB-04 claim form should be used for billing all technical services rendered by the following:

Hospital inpatient services.

Hospital outpatient and emergency department services. Outpatient services include day surgery, observation bed status, PT, OT, ST and ancillary testing.

Skilled nursing facility.

Surgery services.

VNA services/Home Health Care services.

When submitting a claim:

- Use the appropriate 4 digit revenue and CPT/HCPCS codes.
- Unlisted CPT/HCPCS codes must have documentation attached.
- Do not bill for future dates of service.
- DRG-related inpatient claims should have the appropriate DRG listed on the UB-04 claim form in box 84.

When submitting a claim for late charges:

- In box 4 of the UB-04 claim form, a bill indicator of 115 (inpatient claims) or 135 (outpatient claims) must be used to indicate that the claim is for late charges.
- Late charges will be accepted electronically for Institutional claims provided the claim contains the appropriate Bill Type. For EDI providers, Bill Type should be submitted in Loop 2300 CLM05-1 and CLM05-3.
- Only the late charge should be submitted on the claim.
- No charges previously submitted should be billed.
- In some cases, late charges will be added to the original claim.

Follow the guidelines below when submitting a UB-04 claim form to Fallon Health Weinberg. The –Required‖ column indicates if a specific field is required by FHW or is optional.

For specific fields required for EDI claim submission, refer to our companion guide: Health Care Claims Submission X12N 837 (Version 5010) Implementation Guide—Institutional at http://www.fallonweinberg.org.

Many codes are required on a UB-04 claim form. For a complete listing of UB-04 codes go to the CMS Web site.

Box #	Field name	Required	Instructions
1	Provider name, address and telephone number	YES	Enter name, address and telephone number of the hospital, surgery center or VNA.
2	Pay to name	Optional	Not applicable to FHW.
3a	Patient control number	Optional	Enter patient account number assigned by the provider. This information can be used to facilitate payment posting.
3b	Medical record number	Optional	
4	Type of bill	YES	Enter three-digit code indicating type of bill being submitted. The first digit identifies type of facility. The second classifies type of care. The third indicates sequence of this bill in this particular episode of care, known as the frequency code. Use 135 - To submit an outpatient charge not included on original bill. Use 115 - To submit an inpatient charge not included on original bill. For the list of complete codes go to the CMS Web site.
5	Federal tax number	YES	Enter federal tax ID number.
6	Statement covers period	YES	Enter beginning and ending dates of the period included on this bill (MMDDYYYY).
7	Untitled		
8a	Patient ID #	YES	Enter patient‘s ID number.
8b	Patient name	YES	Enter patient‘s last name, first name, middle initial as name appears on ID card.

Box #	Field name	Required	Instructions
9	Patient address	YES	Enter patient's mailing address.
10	Birth date	YES	Enter patient's date of birth (MMDDYYYY).
11	Sex	YES	Enter patient's sex M = Male F = Female
12	Admission date	YES	Enter date of admission (MMDDYYYY).
13	Admission hour	YES	Enter time of admission or visit.
14	Type of admission	YES	For inpatient admission, enter code indicating the priority of this admission. 1 – Emergency 2 – Urgent 3 – Elective 9 – Information not available
15	Source of admission	YES	Enter code indicating the source of this admission/visit. 1 – Physician referral 2 – Clinic referral 3 – HMO referral 4 – Transfer from a hospital 5 – Transfer from a SNF 6 – Transfer from another facility 7 – Emergency room 8 – Court/law enforcement 9 – Information not available A – Transfer from a rural primary care hospital
16	Discharge hour	YES	Enter time patient was discharged.

Box #	Field name	Required	Instructions
17	Patient status through	YES	Enter code to indicate patient status as of date on this billing.
19-28	Condition codes	YES	Enter codes to identify conditions related to this bill that may affect processing.
29	Accident state	NO	
31-36	Occurrence codes and dates	YES	Enter code(s) and associated date(s) defining specific event(s) relating to this bill that may affect processing.
37	Untitled	NO	Not applicable to FHW.
38	Responsible party name/address	NO	
39-41	Value codes and amounts	NO	Not applicable to FHW.
42	Revenue code	YES	Enter billing revenue code. (Medicare revenue codes)
43	Revenue description	YES	Enter the Revenue Code description. Use CPT-4 HCPCS definitions whenever possible.
44	HCPCS/rates	YES	Enter the CMS procedure code or CPT-4 code.
45	Service date	YES	Enter the date service was provided.(MMDDYYYY)
46	Service units	YES	Enter the units of service rendered per claim line. Physical therapy and home health services—bill units as indicated in contract.

Box #	Field name	Required	Instructions
47	Total charges	YES	Enter the charges for each claim line.
48	Non-covered charges	YES	Reflect non-covered charges related to a specific revenue code or line item.
49	Untitled	NO	Not applicable to FHW.
50	Payer	YES	Enter all health insurance carriers. Attach an EOB from other carrier, if applicable. Use this box to indicate if result of an accident (MVA, Workers Compensation, subrogation).
51	Provider number	YES	Enter your FHW provider ID number.
52	Release of information	Optional	A "Y" code indicates the provider has on file a signed statement permitting the provider to release data in order to adjudicate the claim. An "N" code indicates no release on file.
53	Assignments of benefits	Optional	Enter Y or N.
54	Prior payments	YES	Enter all prior payments. Attach an EOB from other carrier, if applicable.
55	Estimated amount due	NO	Not applicable to FHW.
56	NPI	YES (eff 5/23/07)	
57	Other provider ID	NO	
58	Insured's name	YES	Enter the name of the individual in whose name the insurance is carried.

Box #	Field name	Required	Instructions
59	Patient's relationship to insured	YES	Enter the code, which indicates the patient's relationship to the insured. 01 – Subscriber 02 – Spouse 03 through 99 – Dependent child
60	Certificate/ Social Security #/ health insurance claim/identification #	YES	Enter the FHW ID # as indicated on the member's ID card.
61	Group name	YES	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance group number	YES	Enter the number assigned by FHW to identify the group under which the individual is covered.
63	Treatment auth. codes	YES	Enter the authorization/referral number assigned by FHW.
64	Document control number		
65	Employer name	YES	Enter the name of the employer who provides health care coverage for the individual identified in box 58.
66	Diagnosis version qualifier	YES	
67	Principal diagnosis code	YES	Enter the ICD-9-CM diagnosis code indicating the principal diagnosis; describing the condition established to be chiefly responsible for the admission or outpatient care. The code reported must be the full ICD-9-CM diagnosis code including all digits applicable (i.e., fourth or fifth digit).
68	Untitled	YES	
69	Admitting diagnosis	YES	Enter the ICD-9-CM diagnosis code provided at the time of the admission as stated by the physician.

Box #	Field name	Required	Instructions
70	Patient reason for visit Code		
71	PPS Code		
72	External cause of injury (E-code)	YES	Enter the ICD-9-CM diagnosis code for external cause of an injury, poisoning or adverse effect.
73	Untitled		
74	Principal procedure code	YES	Enter the ICD-9-CM procedure code to indicate the principal procedure performed for this billed service. Enter the date the procedure was performed. (MMDDYYYY)
74 (a–b)	Other procedure	YES	Enter the ICD-9-CM procedure code identifying all significant procedures, other than the principal procedure. Enter the dates the procedures were performed. (MMDDYYYY)
75	Untitled		
76	Attending physician ID NPI number and name	YES	Enter the last name, first name and middle initial.
77	Operating physician ID NPI number and name		
78	Other physician ID NPI number and name	YES	Enter last name, first name and middle initial.
79	Other physician ID NPI number and name		
80	Remarks	NO	
81 (a-d)	Code-Code		

Source: Centers for Medicare and Medicaid Services, Health Insurance Claim Form – CMS 1500

F. Billing and payment guidelines for facility claims

Topics	Billing and payment guidelines
Emergency Department Services	Charges for emergency department resulting in an observation stay are considered part of the observation charge and will be paid as observation room services. Charges for emergency department services resulting in an outpatient surgery performed outside of the emergency room will be reimbursed as a same day surgery. If the emergency department results in an admission, the emergency department charges will be considered under the inpatient stay. The emergency department technical charge is considered part of the inpatient stay and will be paid as inpatient services.
Laboratory	Only technical services should be billed on UB-04 claim forms. Revenue, CPT and HCPCS codes should be used. Ordering physician should be listed in Box 78 on the UB-04 claim form.
Medical Supplies (Revenue codes 0270 and 0279)	Must include itemization if billed amount exceeds $200 (other than services billed as part of a same-day surgery, emergency department, observation or inpatient claim.)

Outpatient

Topics	Billing and payment guidelines
Observation	Bill observation (room charges) services under revenue code 0762 for both outpatient and inpatient claims. Bill observation (room charges revenue code 0762) services on one claim line indicating the total number of hours in the service unit field. Bill all services administered during the observation service on the same claim. Observation services not related to a subsequent admission, the hospital must bill as an outpatient service and FHW will pay either the lower of charges or the contracted observation services rate if the FHW Case Manager has authorized the observation service. For observation services provided on the day prior to or the day of an inpatient admission, observation services will fall under the all-inclusive inpatient per diem or case rate for that inpatient stay. Observation services will not be reimbursed separately. Observation services billed in conjunction with a surgical procedure that is categorized as same day surgery will be processed as same day surgery. Observation services will not be reimbursed separately.
Outpatient Clinic/ Facility Charges	FHW does not reimburse for facility charges (0510) associated with Evaluation and Management services, unless contractually obligated. The hospital should bill for services of salaried physicians on a CMS-1500 claim form. (The professional reimbursement is a global payment that includes an allocation for the administrative cost of using the facility.)

Outpatient

Topics	Billing and payment guidelines
Pathology	Only technical services should be billed on UB-04 claim forms. Revenue, CPT and HCPCS codes should be used. Ordering physician should be listed in Box 78 on the UB-04 claim form.
Pharmacy Services (Revenue codes 0250 and 0636)	Requires itemization (name and quantity of drugs dispensed) if the billed amount exceeds $200 (other than services billed as part of a same-day surgery, emergency department, observation or inpatient claim). Claims submitted with 0636 must include the HCPCS code and an itemized invoice.
Physical Therapy	Revenue, CPT and HCPCS codes should be used. Report each date of service individually.
Radiology	Only technical services should be billed on UB-04 claim forms. Revenue, CPT and HCPCS codes should be used. Ordering physician should be listed in Box 78 on UB-04 claim form. When reporting (bilateral) radiological services you should use the – RT and –LT modifiers. Radiological services should be billed on two claim lines with the –RT and –LT modifier and one unit on each line. Do not use the –RT and –LT modifier to report services already identified as bilateral by definition.

	Topics	Billing and payment guidelines
Outpatient	Same-Day Surgery	The CPT code for the surgical services must appear on each line next to the operating room revenue code. Claim lines with $0.00 amount billed will not be reimbursed. When multiple surgical procedures are performed at the same session, the primary procedure will be reimbursed at 100% of the billing facility's contracted rate. Reimbursement for second through fifth surgical procedures will be at 50% of the billing facility's contracted rate. The primary procedure is determined by the highest allowable rate. There is no additional reimbursement beyond the fifth procedure. Operative notes may be requested for claims with billed amounts of $5000 or greater.
	VNA	Revenue and CPT/HCPCS codes should be used for all services. Each date of service should be reported individually. For home health aide services, refer to your contract for the requirements on the number of units to bill. In some contracts, the units equal one per hour. Other contracts specify one unit equals fifteen minutes.

Inpatient

Topics	Billing and payment guidelines
Maternity	Mother and newborn charges must be submitted together when both parties are discharged on the same day. When newborn is not discharged at the same time as the mother, separate authorization is required beginning with the mother's discharge date. A separate claim for the newborn must be submitted with dates of service occurring after the mother's discharge date.
Transfers	Intra-hospital transfers from a medical/surgical unit to either a psychological or rehabilitation unit, or vice versa, must be billed separately according to the unit within which the care is provided.

5. Coordination of benefits

When more than one insurance plan covers a service, the plans work together to pay for the service. This is called coordination of benefits. This occurs when a person has coverage from more than one company, workers' compensation or an auto accident claim is involved. In order for services to be considered for payment as a secondary insurer, Fallon Health Weinberg's policy and procedures for referrals and authorizations must be followed.

Why do the insurance plans coordinate benefits?

Payments are coordinated to prevent total payments from exceeding the total charges for the patient's health services.

How do I know where to send the claims?

All insurance companies use the same rules to determine the primary and secondary carriers. These rules are explained below. If another company is the primary carrier, you should first send the bills to that company. After you receive the other insurer's Explanation of Benefits, submit a copy of that document to us with the CMS 1500 claim form or UB-04 claim form. Complete information on the other insurer must be shown in Boxes 11 and 24j of the CMS 1500 claim form or Box 50 on the UB-04 claim form. If you would like to submit coordination of benefits information electronically, please contact Fallon Health Weinberg's EDI Department at 1-855-827-2003 or 716-810-1893.

Are there limits on when a claim can be filed with FHW?

Claims must be filed within 120 days from the date on the other insurance carrier's Explanation of Benefits. If your contract with FHW specifies a different time limit, that limit may apply. Remember to include the Explanation of Benefits from the other carrier with your claim forms.

How is primary coverage determined?

Situation	Coverage
More than one possible carrier	
Spouse	If the subscriber's spouse has other health insurance, that is the spouse's primary plan.
Dependent children	Claims are processed using the birthday rule. The primary carrier is the insurance of the parent whose birth date occurs first in the calendar year. Example: mother's birthday is August 20; father's birthday is April 2. The primary carrier for the dependent child is the father's plan. When both parents have the same birth date, the primary carrier for the dependent child is the plan that has been in effect the longest.
Special situations for dependent children	
Joint custody	If neither parent is specified as responsible for health insurance, the birthday rule applies.
Court decree	If the court decree specifies that one parent is responsible for health coverage, that parent's plan is primary.
Single custody	The following order applies: 1. Parent with custody 2. Spouse of parent with custody.

Medicare	
Rules are determined by Medicare Secondary Payer (MSP) laws. These laws apply to age 65 or older active employees and their spouses who are enrolled in a group health plan of an employer with at least 20 employees. In these cases, the employee would have coverage through the group and also through Medicare.	
Subscriber is age 65 or older and is still working	FHW is primary Medicare is secondary
Subscriber is age 65 or older and is retired	Medicare is primary FHW is secondary
Actively employed subscriber's spouse is 65 or older	FHW is primary Medicare is secondary
Retired subscriber's spouse is 65 or older	Medicare is primary FHW is secondary
Medicare entitlement due to end stage renal disease or disability	Special rules apply. Please call 716-810-1893 ext: 6905 with any questions.

How are motor vehicle accident (MVA) claims handled?	
Determining primary coverage	The automobile insurance company is primary for the first $2,000 in medical expenses under the Personal Injury Protections (PIP). If the member is covered under the FHW, the automobile insurance is primary for $8,000 under the PIP. FHW will adjust claims accordingly if it is determined that services are a result of an MVA after the claims have been processed.
Submitting claims	Use the CMS 1500 claim form or UB-04 claim form. Record name of auto insurance carrier or other responsible party in Box 9 of the CMS 1500 claim form or Box 50 of the UB-04 claim form. Indicate that the services are as a result of an MVA and include the following: Auto claim number Date of accident PIP insurance carrier Address of PIP carrier Notice from the PIP carrier stating that benefits have been exhausted Name of patient's attorney FHW will process claims providing that the member completes an assignment of insurance payment form. If the member does not complete the form, claims will be held until the coordination of benefits with the automobile insurance or other responsible party is settled.
Filing limits	An MVA claim must be submitted to Fallon Health Weinberg within 120 days or your contracted time frame from the date of the other insurance Explanation of Benefit. Please attach the Explanation of Benefit or PIP exhaustion letter from the other insurance carrier.

How are motor vehicle accident (MVA) claims handled?	
Referrals and authorization guidelines	In order for services to be considered for payment, Fallon Health Weinberg's policies and procedures for referrals and authorizations must be followed. See section titled Referral and Preauthorization Guidelines.
Claims adjustments	Fallon Health Weinberg will adjust claims accordingly if it is determined that services are result of an MVA after the claims have been processed.
Balance billing	Balance billing FHW members is not allowed.

How are workers' compensation claims handled?	
Fallon Health Weinberg does not reimburse for services related to a work illness or injury.	
Submitting claims	The claim should first be submitted to the workers' compensation carrier. If the claim is denied, submit proof of the workers' compensation denial to FHW. Upon receipt, we will review the claims for payment. After claims have been processed, FHW will adjust claims accordingly if it is determined that services are the result of a work related injury.
Claims filing limits	Claims must be submitted to Fallon Health Weinberg within 120 days or your contracted time frame from the date of the denial from the workers' compensation carrier.
Referrals and authorization guidelines	In order for services to be considered for payment, Fallon Health Weinberg's policies and procedures for referrals and authorizations must be followed. See section titled Managing Care.

What is subrogation?	
Subrogation applies when a payment for a member‘s illness or injury may be the responsibility of a third party. Examples of subrogation cases may be a result of an injury in a public place, slips and falls, or a dog bite.	
Submitting claims	Please provide: Date of accident File number Name of patient‘s attorney

6. Claim status checks

Contact the claims customer service team to check on the status of claims you have submitted. They are available to assist you Monday through Friday from 8 a.m. to 12 noon and from 1 p.m. to 5 p.m.

The Customer Service Department can be reached at:

Telephone number: 1-855-508-3390

Please note the following:

- Status requests can be mailed, faxed or telephoned. Or you can sign up for our provider tools that will provide status information on our website.
- Inquiries are limited to three per telephone call. High volume requests should be mailed or faxed.
- Status checks should be made 45 days after submission of a claim to FHW. This allows FHW time to process your claim and you time to resubmit prior to the filing limit.
- Please clearly mark the claim ―STATUS INQUIRY‖ in order to avoid duplicate entry.
- Please submit claims status requests separately from new dates of service. Please do not submit status requests electronically.

7. Understanding your remittance advice summary

For specific details on electronic Remittance Advice Summaries, please refer to our companion guide: Health Care Payment/Advice ANSI X12 835 (Version 004010X091A1) Implementation Guide

A. Remittance Advice Summary — Field Definition

A Remittance Advice Summary (RAS) is a printed explanation of the adjudication of a claim. Here is a description of each field on the RAS. See the reference section for a detailed description of FHW's adjudication codes.

	FIELD	DEFINITION
1	Provider	The name of the provider rendering services.
2	Member name	The name of the member to whom the service was provided.
3	Contract #	The member's ID number
4	Referral #	The number of the referral to which the claim is linked, if applicable.
5	Claim #	The number assigned by FHW to the claim.
6	Post date	The date on which the claim was posted to the system.
7	Account number	The account number submitted by the provider.
8	Statis flag (S/F)	Statis flag: Y or N appears in this field, indicating if the claim is approved as statistical (reporting purposes) or non-statistical (fee for service). Statistical (Y) or non-statistical (N).
9	Procedure	The procedure code(s) and description(s) submitted on the claim.
10	Modifier (MOD)	The primary modifier code submitted on the claim.
11	Service dates	The service from and to dates, on the claim line.
12	Billed	The total amount billed on the claim line.
13	Rejected	The total amount rejected on the claim line. Refer to legend for detailed explanation.
14	Deductible (Deduct)	The amount the member must pay towards his or her deductible and or coinsurance.
15	Copay amount	The amount the member must pay as a copayment and/or coinsurance.

	FIELD	DEFINITION
16	Approved	The total approved amount on the claim line.
17	Withheld	The total amount withheld based on the contractual agreement with the vendor.
18	Refund	The total amount of money received back from the provider and applied to the claim.
19	Interest	The total amount of money paid to the provider due to late payment by FHW.
20	Net	The net amount, including all non-statistical approved dollars on the claim line.
21	Claim totals	Subtotal, by claim.
22	Notes	An information field is provided at the end of a claim. The purpose of this field is to provide helpful information for future billing, such as ―Please update member's ID #‖.
23	Provider summary	Totals split out by statistical claim totals, non-statistical claim totals and negative balance amounts.
24	Provider net amount	The total amount of the check issues for this Remittance Advice Summary.
25	Legend	The legend indicates the claim line rejection disposition codes and their descriptions. Further explanations are located in Section 6B. Explanation of disposition codes.

A message section is provided on the last page of your RAS to notify you of important information or helpful facts.

B. Sample Pended Claims Report

The pended claims report is to notify you that we have received the claims. The claims are being reviewed and no further action is required at this time. When the review is completed the final disposition will appear on your Remittance Advice Summary.

8. Overpayments on FHW's part

What is an overpayment?
Overpayment occurs when we send you more money than we should have in payment of a claim.

What should I do if this happens?
You should either return our check or issue a refund check to FHW. Your refund to us will be credited to your account. Please follow the procedures below:

If you are returning our check, please include the following:

- The Remittance Advice Summary that was received with the check
- The reason you are returning the check
- Name and phone number of the contact person at your office

If you are sending us a refund check please include the following:

- Member name
- Membership number
- Member date of birth
- Date of service or the Remittance Advice Summary that was received with the check. Highlight the pertinent information.
- Reason for the refund
- Name and phone number of the contact person at your office

Checks should be mailed to:

Fallon Health Weinberg
Finance Department
10 Chestnut Street
Worcester, MA 01615-0121

9. Negative balances

Fallon Health Weinberg periodically audits claim payment activity to identify payments made to providers in error. Those payments made in error will be adjusted on the provider's account showing the amount overpaid as a negative amount originally paid in error.

In some instances a negative balance is generated when the total amount of adjusted claim dollars is greater than a provider's positive claim payment activity. If a provider is in a negative balance status with FHW, the last page of your Remittance Advice Summary (RAS) will show the total amount due to FHW. You will only receive the detailed patient claim information on the original negative balance RAS. Please be sure to keep this negative balance RAS as this will be needed to post your accounts.

If you anticipate the amount due FHW will be cleared by future claim submissions, you may choose not to remit a refund to FHW. However, if you wish to remit payment for the amount due, you may do so by making a check payable to FHW and sending it to the address below. Please include a copy of the last page of your RAS.

Fallon Health Weinberg
Attn: Adjustment Unit
10 Chestnut St.
Worcester, MA 01608

The Claims Department will send a report and a letter of explanation to the provider at intervals of 30/60/90 days from when the negative balance was created. FHW will not issue any future payments until the negative balance is cleared.

When sending your refund check, please enclose a copy of the letter and report sent to you

NEGATIVE BALANCE NOTIFICATION

RAS P>ae

Pay-To Provider Number:
P"'y-To Provider Name:
Erlity Number:
Dote:
Check Numbet: N!A
Ch4}ck Amount N'A

Name	Contract#	Referral lf	Provider	Claim#	Post Date	Accoont Number

Procedure	MOD	Service Dates	SJF	Bille:!	Rejected	Deduct	Copay	Approved	Withheld
85730			N	61.o:l	9.15 Rf001	0.00	0.00	51.85	0.00
Claim Total				197.0()	29.55	0.00	0.00	167.45	0.00

Adjuctod Cloim Totalt

Provider Summar •	Billed	Re'ected	Deduct	Copay	Approved	Withheld	Adj Net Amt
Provider Non-Statinical ::!aims Totals	23$,313.73	208,339.85	1,046.35	950.00	24,97753	0.00	25.303.89
Negative Balance Previoosly Applied							

Provider Cla-ms Totals

Povi er Net Am.0.'!''.t

FCHP has a 120 day adjustmert and appeal period from the data of your Remitt<nce Advice Summary. Any requests fqr an adjustment or appeal received •fter the 120 days will not be accepted. Pleae refer to the FCHP Provider Manual a1 www.fchp.org for additional information.

sell<;! Number	Description
205	Benefit requires authorization
611	Pdo..- autho.-i:.a,tion ha5 no available un-ts
DF013	Denied-bill as observation
DF033	Denied-i ncorrect bill
DF058	Denied-member not enrolld on dos
IF032	Rebill witt. correct admit date
MF01	Service net sepa rately reimbursed
RF001	Con:ract Adjustment
RF004	COB Applied

10. Adjustments and Appeals

If you do not agree with a claim determination made by FHW, you have the right to request a claim review.

Review Types

A Request for Claim Review may be related to one of the following:

Contract term(s): The provider believes the previously processed claim was not paid in accordance with negotiated terms**.**

Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.

Corrected Claim: The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made.

Duplicate Claim: The original reason for denial was due to a duplicate claim submission.

Filing Limit: The claim whose original reason for denial was untimely filing.

Payer Policy, Clinical: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.

Payer Policy, Payment: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.

Pre-Certification/Notification or Prior-Authorization or Reduced Payment: The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.

Referral Denial: The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.

Request for additional information: The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC Codes, Home Infusion Therapy).

Retraction of Payment: The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).

Submission Requirements

All claim review requests must be received in writing within 120 days from the date of the initial claim denial/Remittance Advice Summary (RAS) in order to be considered for review. All claims must be processed by FHW prior to the submission of a request for claim review.

A separate provider request for claim review form must be supplied for each appeal and all pertinent supporting documentation must be attached. Please refer to the Request for Claim Review Reference Guide for examples of review types and required documentation for each review request.

Please mail or fax your appeal request to:

Fallon Health
Weinberg
Attn: Request for Claims Review/Provider Appeals
10 Chestnut Street
Worcester, MA 01615-0121
Fax: 716-810-1903

Filing Limit Appeals

All claim review requests must be received in writing within 120 days from the date of the initial claim denial/Remittance Advice Summary (RAS) in order to be considered for review. All claims must be processed by FHW prior to the submission of a claim review request. Any request received after this timeframe will not be considered for review.

Filing Limit Appeal Requirements

Submit a separate Request for Claims Review Form for each appeal. Copy of FHW Claims Metrics Report or Copy of original FHW RAS CMS-1500/ADA/UB claim form
Supporting Documentation

Supporting Documentation

Paper claims
If you are requesting a filing limit claim review of a claim that was submitted on paper, the following are acceptable proofs of timely submission.

Copy of patient account ledger which indicates the patient‘s name, date of service and the date the claim was submitted to Fallon Health Weinberg.
If the member or another insurer had been previously billed, include proof that the member or another carrier had been billed (ledger).
Clinical notes, medical records, discharge summary (should the filing limit denial pertain to services such as an inpatient admission or outpatient observation
RAS from other insurer

EDI Claims

If you are requesting a filing limit claim review of an EDI claim, submitted either through a clearinghouse, or directly to Fallon Health Weinberg, only the following are acceptable proofs of timely submission.

999 Report
EDI Clearinghouse report indicating that the claim was accepted by FHW within the filing limit

Additional information regarding EDI Claims

Fallon Health Weinberg does not routinely waive the filing limit for EDI claims. It is the responsibility of a provider's office staff or billing service to process their EDI reports as well as remittance advice summaries on a regular basis and resubmit rejected/problematic claims within the filing limit. Due to the availability of these reporting and tracking tools, it is unusual for the FHW Claims department to expect late claim submission. Please resubmit any claims in question immediately. If the claim cannot be resubmitted, office staff should reprocess the claims on paper and send them directly to Fallon Health Weinberg within your contractual time frame.

Mail or fax your filing limit appeal request to:

Fallon Health
Weinberg
Attn: Request for Claim Review/Provider Appeals
10 Chestnut St
Worcester, MA 01615-0121
Fax: 716-810-1903

Provider Appeal Determinations

Following receipt of a completed request for claim review, FHW will research the request and notify the provider of the determination. When the original claim denial is upheld, a letter will be sent explaining the review determination. When a review is approved, the Remittance Advice Summary or 835 file will indicate the message of Approved per Provider Appeals. All claim review determinations will be final and binding and in keeping with the provisions of your contract with FHW.

Request for Claims Adjustment form can be found on the FHW website under resources.

Reference section

Coding
When you fill out a claim form, you will need to use the Health Care Financing Administration's Common Procedure Coding System (HCPCS) to tell us the nature of the procedure for which you are requesting payment. Accurate code selection is vital for accurate claims processing and payment. HCPCS consists of three code levels:

Level I: CPT Codes
CPT codes are used by the Centers for Medicare and Medicaid Services (CMS) to describe physician procedures and certain hospital outpatient services. CPT codes are updated annually by the American Medical Association (AMA). Providers are responsible for obtaining the update each year and for billing with the current CPT codes.

CPT modifiers are two-digit codes that may be added to the main procedure code. They allow physicians to indicate that the procedure being reported has been altered by specific circumstances.

Unlisted CPT codes should be used only when necessary. When there is no code that properly describes the service performed and an unlisted code is used, medical documentation must be attached to the claim.

Level II: HCPCS National codes
These codes supplement the CPT codes and provide a means to list non-physician procedures such as ambulance services, durable medical equipment, dental, specific supplies or the administration of drugs. These codes use a letter followed by four numbers.

Level III: Local codes
These are rarely used — only as need dictates. Local codes denote specific procedures or supplies for which there is no national code. Local level III codes were eliminated as of December 31, 2003.

CPT coding requirements
FHW requires most outpatient services to be coded with HCPCS/CPT codes. These codes are not only used to define the service, but also to define the payment method (i.e., ASC payment group, fee schedule). The existence of a CPT or HCPCS code does not guarantee that the code is acceptable to FHW or that the service is covered. The AMA is aware that CMS and other CPT-4 users may not provide payment under their programs for certain procedures identified in CPT-4. Accordingly, FHW may independently establish policies and procedures governing the way these codes are used within our operations.

Revenue codes
Revenue codes identify broad service classifications rendered by institutional providers. They are four-digit codes used to describe an accommodation or ancillary service. The COBRA act of 1986 requires hospital outpatient billing to make use of HCPCS coding. This requirement applies to all acute-care, long-term care, rehabilitation and psychiatric hospitals as well as hospital-based rural health clinics. HCPCS codes must be reported in tandem with specific revenue codes to describe the services rendered. Accurate code

selection of both the revenue code and the CPT or HCPCS Level II code is vital for accurate claims processing and payment.

ICD-9-CM codes
ICD-9-CM diagnosis codes are used to indicate patient‘s diagnosis or condition. An ICD-9-CM diagnosis code is required on all claims. You may submit up to eight ICD-9-CM diagnosis codes. Codes should be listed in priority order. You must use the complete ICD-9-CM diagnosis codes to the fourth or fifth digit. Claims submitted with incomplete ICD-9-CM diagnosis codes will be rejected with an explanation of ―Reject Incomplete Diagnosis Code.‖

New, revised and deleted codes
Each year, the American Medical Association and CMS review the CPT and HCPCS codes to determine whether codes should be added, revised or deleted. FHW adheres to the standard coding guidelines of the American Medical Association in conjunction with Medicare guidelines. To make sure that contract documents and payment mechanisms remain current with industry standards, FHW will add new codes for covered benefits to our claims payment system as contract language allows. Codes for new technology must first be reviewed by FHW to determine whether the procedure is a covered benefit. Codes deleted by the AMA will be deactivated from our system effective January 1st of each year.

In past years, updated codes have had a 90-day grace period during which deleted codes for that year could still be used. Effective October 1, 2004 (ICD-9-CM Diagnosis and Procedure Codes) and January 1, 2005 (CPT/HCPCS Codes), the 90-day grace period has been eliminated. This change is due to the HIPAA transaction and code set rule requiring use of the medical codes set that is valid at the time that the service is provided.