CountyCare Provider Billing Manual

Table of Contents

Provider Billing Manual Overview

Hello and thank you for being a CountyCare Health Plan Provider!

The goal of this manual is to provide overall assistance and guidance when it comes to billing for services provided to CountyCare Health Plan members. In addition to this manual, we also strongly encourage you to visit our Provider Billing Resources website at **www.countycare.com/providers/provider-billing-resources.**

Provider Billing Resources Website

This website includes specific and detailed billing guidance that deep-dives into provider types, claim types, denial and rejection codes, and more.

For additional questions regarding billing requirements that are not answered within this manual OR within the guidance on our Billing Resources webpage, please contact your CountyCare Health Plan Provider Relations representative. If you do not know who your Representative is, please utilize the Reference LookUp located on the Provider Resources page:

Page: **http://www.countycare.com/resources**

PDF Link: **http://www.countycare.com/Media/Default/pdf/CCR_0188_Provider_Representative_Notice-051517.pdf**

You may also call our Provider Relations general number at **312-864-8200 or toll free 855-444-1661, Option 6.**

Procedures For Claim Submission

CountyCare Health Plan is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. Claims will be rejected or denied if not submitted correctly. In general, CountyCare Health Plan follows the CMS (Centers for Medicare & Medicaid Services) and IL HFS specific billing requirements. For questions regarding billing requirements, contact a CountyCare Health Plan Provider Relations representative at 312-864-8200 or toll free 855-444-1661 or visit our Provider Billing Resources website at www.countycare.com/providers/provider-billing-resources

When required data elements are missing or are invalid, claims will be rejected or denied by CountyCare Health Plan for correction and re-submission.

- Rejections may occur prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- Denials only occur once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP) or Electronic Remittance File (835).

Claims for billable services provided to CountyCare Health Plan members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

All claims filed with CountyCare Health Plan are subject to verification procedures. These include but are not limited to verification of the following:

- All required fields are completed on an original CMS 1500, UB-04 paper claim form, or EDI electronic claim format.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.
- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).
- Principle Diagnosis billed reflects an allowed Principle Diagnosis as defined in the volume of ICD-10 CM or ICD-10 CM update for the date of service billed.
- Member is eligible for services under CountyCare Health Plan during the time in which services were provided.
- Services were provided by a participating provider or if provided by an "out of network" provider, authorization has been obtained to provide services to the eligible member (excludes services by an "out of network" provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services).
- An authorization has been given for services that require prior authorization by CountyCare Health Plan, regardless of contracted status
- Medicare coverage or other third party coverage

CLAIMS FILING DEADLINES

Original claims must be submitted to CountyCare Health Plan within 180 calendar days from the date services were rendered or compensable items were provided.

All corrected claims, requests for reconsideration or claim disputes must be received within 60 calendar days from the date of notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 60 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by CountyCare Health Plan or the Illinois Department of Health and Family Services (HFS).

CLAIM REQUESTS FOR RECONSIDERATION, CLAIM DISPUTES AND CORRECTED CLAIMS

All claim requests for reconsideration, corrected claims or claim disputes must be received within 60 calendar days from the date of notification of payment or denial is issued.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are multiple ways in which the provider can contact CountyCare Health Plan. Member history with a PCP. The algorithm will first look for a previous relationship with a provider.

1. **Submit a Corrected Claim via EDI submission or paper submission to:**

   CountyCare Health Plan
   P.O. Box 211592
   Eagan, MN 55121-2892

- Resubmissions should be typed or printed on a red and white claim form and must include the original claim number in field 22 of a CMS 1500 (02/12) or field 64 of a CMS 1450 (UB-04) and the original EOP must be included with the resubmission.
- Failure to resubmit on a red and white claim form and include the original claim number and include the EOP may result in the claim being denied as a duplicate, a delay in the reprocessing, or denied for exceeding the timely filing limit.

2. **Contact a CountyCare Health Plan Provider Service Representative at 312-864-8200 or toll free 855-444-1661 to request a Claim Reconsideration**

- Providers may discuss questions or request a claim reconsideration with CountyCare Health Plan Provider Relations Representatives regarding amount reimbursed or denial of a particular service.

3. **Submit a Claim Appeal in writing to CountyCare Health Plan:**

   CountyCare Health Plan
   P.O. Box 211592
   Eagan, MN 55121-2892

- A Claim Appeal is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
- The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name.
- The documentation must also include a detailed description of the reason for the request.
- to be used only when a provider has received an unsatisfactory response to a request for reconsideration.

If the corrected claim, request for reconsideration, or the claim appeal results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP.

CLAIM PAYMENT

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 90% of clean claims will be processed within 30 business days of receipt
- 99% of clean claims will be processed within 90 business days of receipt

Procedures For Electronic Submission

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim format. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing. Claims that are not submitted correctly or containing the allowed field data will be rejected and/or denied.

FILING CLAIMS ELECTRONICALLY

How to Start

- First, the provider will need specific hardware/ software requirements. There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims, whether through direct submission to the clearinghouse or through another clearinghouse, you can submit claims electronically.
- CountyCare's clearinghouse will work with all downstream clearinghouses for EDI claims submission at no additional cost- providers do not need to use the same clearinghouse.
- Second, the provider needs to contact their clearinghouse and confirm they will transmit the claims to the clearinghouse used by CountyCare Health Plan- Change Healthcare.
- Third, the provider should confirm with their clearinghouse the accurate location of the CountyCare Health Plan Payer ID number- 06541
- For more information on how to submit electronically visit http://www.countycare.com/providers/claims-and-electronic-transactions

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high-level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this manual. **Please contact the clearinghouse you intend to use and ask if they require additional data record requirements.**

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to CountyCare Health Plan, all EDI claims must first be forwarded to CountyCare's Health Plan's clearinghouse, Change HealthCare (CHC) (either submitted direct to CHC or through a downstream clearinghouse). This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to CountyCare Health Plan. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to CountyCare Health Plan, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to CountyCare Health Plan by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims and these claims need to be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgments for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, **submitted claims not accepted by the clearinghouse are not transmitted to CountyCare Health Plan.**

- If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to CountyCare Health Plan must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being acknowledged by CountyCare Health Plan. In these cases, the claim was not received by CountyCare Health Plan and must be corrected and re-submitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Electronic Billing Inquiries

Please direct inquiries as follows:

ACTION	CONTACT
If you have questions about specific claims transmissions or acceptance Claim status reports…	Contact your clearinghouse technical support area
If you have questions about claims that are reported on the Remittance Advice / Explanation of Payment	Contact Provider Relations at 312-864-8200, option 6 or toll free 855-444-1661
If you have questions about your claim status	Network Providers can review claim status via the Provider Portal at CountyCare.com or contact Provider Relations at 312-864-8200 option 6

Exclusions

Certain claims are excluded from electronic billing.

- Excluded Claim Categories – At this time, these claim records must be submitted on paper.

These exclusions apply to inpatient and outpatient claim types.

Excluded Claim Categories

- Claim records requiring supportive documentation or attachments. Note: COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim.
- Claim records billing with miscellaneous codes
- Claim records for medical, administrative or claim reconsideration or dispute requests
- Claim requiring documentation of the receipt of an informed consent form
- Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics). Provider is required to submit the invoice with the claim.
- Claim for services requiring clinical review (e.g. complicated or unusual procedure). Provider is required to submit medical records with the claim.
- Claim for services needing documentation and requiring Certificate of Medical Necessity - oxygen, motorized wheelchairs

NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the provider number fields are empty.

Important Steps to a Successful Submission of EDI Claims

1. Select clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to CountyCare Health Plan.
3. Inquire with the clearinghouse what data records are required.
4. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to CountyCare Health Plan and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by CountyCare Health Plan. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted correct and resubmit.
5. MOST importantly, all claims must be submitted with providers identifying numbers. See the CMS 1500 (2/12) and UB-04 1450 claim form instructions and claim forms for details.

Claim Form Requirements

CLAIM FORMS

CountyCare Health Plan only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

- Professional services and medical supplies are billed on the CMS 1500 (02/12) claim form and institutional services are billed on the CMS 1450 (UB-04) claim form.
- CountyCare Health Plan does not supply claim forms to providers. Providers should purchase these from a supplier of their choice.
- All paper claim forms submitted must be typed or printed with either 10 or 12 Times New Roman font and on the required original red and white version.
- **Black and white forms and handwritten forms will be rejected and returned to the provider.**
- To ensure clean acceptance and processing, be sure typed data is strictly within the outlines of the data fields; any information that extends beyond the box may cause the claim form to be rejected.
- To reduce document handling time, do not use highlights, italics, bold text or staples.

If you have questions regarding what type of form to complete, contact a CountyCare Health Plan Provider Relations representative at 312-864-8200 or toll free 855-444-1661.

Coding of Claims

CountyCare Health Plan requires claims to be submitted using codes from the current version of ICD-10 CM, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Claims will be rejected or denied if billed with:

- Missing, invalid, or deleted codes
- Codes inappropriate for the age or sex of the member
- An ICD-10 CM code missing the 4th or 5th digit

For more information regarding billing codes, coding, and code auditing and editing refer to your CountyCare Health Plan Provider Manual or contact a CountyCare Health Plan Provider Relations Representative at 312-864-8200or toll free 855-444-1661.

Code Auditing and Editing

CountyCare Health Plan uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes against rules that have been established by the American Medical Association (AMA), Center for Medicare and Medicaid Services (CMS), public-domain specialty society guidance, clinical consultants, who research, document, and provide edit recommendations based on the most common clinical scenario and the State of Illinois. Claims billed in a manner that does not adhere to these standard coding conventions will be denied.

The code editing software contains a comprehensive set of rules, addressing coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Services – identifies procedures that have been unbundled.

Example: Unbundling lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

CODE	DESCRIPTION	STATUS
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable.

Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

CODE	DESCRIPTION	STATUS
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Add

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

Bilateral Surgery – bilateral surgeries are identical procedures performed on bilateral anatomical sites during the same operative session.

Example:

CODE	DESCRIPTION	STATUS
69436 DOS=01/01/10	Tympanostomy	Disallow
69436 50 DOS=01/01/10	Tympanostomy billed with Modifier 50 (Bilateral procedure)	Allow

Explanation: identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). Note: Modifiers RT (right), or LT (left) should not be billed for bilateral procedures.

Duplicate services *– submission of the same procedure more than once on the same date for services that cannot be or are normally not performed more than once on the same date.*

Example: excluding a duplicate CPT

CODE	DESCRIPTION	STATUS
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation: Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.

- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services – submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

GLOBAL SURGERY

Procedures that are assigned a 30-day global surgery period are designated as major surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (30-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the Illinois Fee Schedule with an asterisk.

Example: global surgery period

CODE	DESCRIPTION	STATUS
27447 DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 DOS=06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/ nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face with patient and/or family.	Disallow

Explanation:

- Procedure code 27447 has a global surgery period of 30 days.
- Procedure code 99213 is submitted with a date of service that is within the 30-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

***Example*:** evaluation and management service submitted with minor surgical procedures

CODE	DESCRIPTION	STATUS
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
99213 DOS=01/23/10	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face with patient and/or family.	Disallow

Explanation:

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

SAME DATE OF SERVICE

One (1) evaluation and management service is recommended for reporting on a single date of service.

Example: same date of service

CODE	DESCRIPTION	STATUS
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with patient and/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with patient/family.	Disallow

Explanation:

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services.
- Interventions, provided during an evaluation and management service, typically include the components of an office consultation

NOTE:

MODIFIERS – Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance

MODIFIER – 25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

MODIFIER – 26 (professional component)

Definition: Modifier - 26 identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier -26 appended.

Example:

CODE	DESCRIPTION	STATUS
78278 POS = Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS = Inpatient	Acute gastrointestinal blood loss imaging	Allow

Explanation:

- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier - 26.

MODIFIER – 59, distinct procedure or service, used to identify procedures/services that are commonly bundled together but are appropriate to report separately under some circumstances. A health care provider may need to use modifier 59 to indicate that a procedure or service was distinct or independent from other services performed on the same day.

MODIFIER - 80, -81, -82, and -AS (assistant surgeon)
Definition: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.
Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Example:

CODE	DESCRIPTION	STATUS
42820-81	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation:

- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

CPT® CATEGORY II CODES

CPT Category II Codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional and are not required for correct coding and may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

BILLING CODES

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-10 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-10 codes and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member's diagnosis. We require the use of valid ICD-10 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-10 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-10 manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-10 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the fifth digit, if appropriate. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC, and V72.85 for Other Specified Exam as the principal diagnosis on the claim. Please consult your ICD-10 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC, and V72.85 for Other Specified Exam as the principal diagnosis on the claim.

In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of CountyCare Health Plan.

Claims Mailing Instructions

Submit claims to CountyCare Health Plan at the following address:

First Time Claims, Corrected Claims and Claim Reconsideration Requests:

CountyCare Health Plan
P.O. Box 211592
Eagan, MN 55121-2892

Claim Second Level Plan Appeals (previously processed and reconsidered) must be submitted to:

CountyCare Health Plan
P.O. Box 211592
Eagan, MN 55121-2892

Please do not use any other post office box that you may have for CountyCare Health Plan as it may cause a delay in processing. CountyCare Health Plan encourages all providers to submit claims electronically. Any claim sent to Administrative Office, 1900 W Polk St, Chicago IL will be returned and not processed for payment. These claims must be submitted to CountyCare claims address above within the timely filing deadline of 180 days from dates of service for consideration.

Rejections And Denials

All paper claims sent to the Claims Office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

An EOP (Explanation of Payment) will be sent that includes the denial or rejection reason. A list of common rejections and denials can be found listed below. For a comprehensive listing of all Claim Remark Codes (found on EOPs) – please reference our Claim Remark Code file available and updated regularly at http://www.countycare.com/providers/provider-billing-resources

COMMON CAUSES OF UPFRONT REJECTIONS

- **Unreadable Information** – Information within the claim form cannot be read. The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or information is hand written or submitted on a black and white claim form.
- **Member DOB** (date of birth) is missing.
- **Member Name or identification (ID) number** is missing or invalid
- **Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) number** is missing.
- **DOS** – The DOS (date of service) on the claim is not prior to receipt of claim (future date of service).
- **DATES** – A date or dates are missing from required fields. Example: "Statement From" UB-04 & Service From" 1500 (02/12). "To Date" before "From Date".
- **TOB** – Invalid TOB (Type of Bill) entered.
- **Diagnosis Code** is missing, invalid, or incomplete.
- **Service Line Detail** – No service line detail submitted.
- **DOS** (date of service) entered is prior to the member's effective date.
- **Admission Type** is missing (Inpatient Facility Claims – UB-04, field 14)
- **Patient Status** is missing (Inpatient Facility Claims – UB-04, field 17).
- **Occurrence Code/Date** is missing or invalid.
- **RE Code** (revenue code) is missing or invalid.
- **CPT/Procedure Code** is missing or invalid.
- **Incorrect Form Type** – The form is not a form accepted by CountyCare Health Plan or not allowed for the provider type.
- **CLIA** – Missing/incomplete/invalid CLIA certification number
- **Wrong Form Type** – The paper claim form submitted is not on a "red" dropout OCR form.
- **Procedure or Modifier Codes** entered are invalid or missing.
- **Revenue Code** is invalid.

COMMON CAUSES OF CLAIM PROCESSING DELAYS AND DENIALS

- **Diagnosis Code** is missing the 4th or 5th digit.
- **DRG** code is missing or invalid.
- **EOB** (Explanation of Benefits) from the Primary insurer is missing or incomplete.
- **Place of Service Code** is invalid.
- **Provider TIN and NPI** does not match.
- **Dates of Service** span do not match the listed Days/Units.
- **Physician Signature** is missing.
- **Tax Identification Number** (TIN) is invalid.
- **Third Party Liability** (TPL) information is missing or incomplete.

IMPORTANT STEPS TO A SUCCESSFUL SUBMISSION OF PAPER CLAIMS

1. Complete all required fields on an original, red CMS 1500 (02/12) or UB-04 form.
2. Ensure all Diagnosis, Procedure, Modifier, Location (Place of Service), Type of Bill,Type of Admission, and Source of Admission Codes are valid for the date of service.
3. Ensure all diagnosis and procedure codes are appropriate for the age and sex of the member.
4. Complete the ICD code type on both HCFA (box 21 upper right corner and UB-04 box 66) with a 9 for ICD9 and 0 for ICD10.
5. Ensure all diagnosis codes are coded to their highest number of digits available (fourth and fifth digit).
6. Ensure member is eligible for services under CountyCare Health Plan during the time period in which services were provided.
7. Ensure an authorization has been given for services that require prior authorization by CountyCare Health Plan.
8. Ensure claims are submitted on an original red and white form. Handwritten and black and white claim forms will be rejected and returned to the provider.

RESUBMITTED CLAIM FORMS – CORRECTED OR VOIDED CLAIMS

All corrected claims must be received within 45 calendar days from the date of notification of payment or denial.

A corrected claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.). The new claim will be considered as a replacement of a previously processed claim. **A corrected claim is not an inquiry or appeal.**

A voided or cancel claim is appropriate when a previously submitted claim needs to be eliminated in its entirety. This would be necessary if the claim submitted was completely erroneous and was not appropriate for submission for any reason.

Corrected claims should be typed or printed on a red and white claim form and should always include the original claim number in field 22 of a CMS 1500 (02/12) or field 64 of a CMS 1450 (UB-04). The original EOP must also be included with the resubmission. Failure to do this could result in a claim denying as a duplicate, a delay in processing, or denied for exceeding the timely filing limit.

Please visit http://www.countycare.com/providers/provider-billing-resources and refer to the "CountyCare Corrected or Voided Claims Resubmission Guidance" for all details on submitting corrected or voided claims.

Appendix

APPENDIX I: COMMON REJECTIONS FOR PAPER CLAIMS

- **Member DOB** missing from the claim.
- **Member Name or Id Number** missing or invalid from the claim.
- **Provider Name, TIN, or NPI** Number missing from claim.
- **Claim data is unreadable** due to either too light (insufficient toner), dot-matrix printers, or too small font to allow for clear electronic imaging of claim. All black and white and handwritten claims will be rejected back to the provider.
- **Diagnosis Code** missing or invalid.
- **REV Code** missing or invalid.
- **CPT/Procedure Code** missing or invalid.
- **Dates missing** from required fields. Example: "Statement From" UB-04 & "Service From" 1500 (02/12). "To Date" before "From Date."
- **DOS on claim** is not prior to receipt of claim (future date of services).
- **DOS prior to effective date** of Health Plan or prior to member eligibility date.
- **Incorrect Form Type** Used (approved form types are CMS 1500 (02/12) for professional medical services or the UB-04 for all facility claims).
- **Invalid TOB** or invalid type of bill.
- **No detail service** line submitted.
- **Admission Type** missing (when Inpatient Facility Claim only).
- **Patient Status** missing (when Inpatient Facility Claim only).
- **CLIA certification** missing/invalid or incomplete.
- **Procedure or Modifier Codes Invalid or Missing** – Coding from the most current coding manuals (CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.
- **Revenue Codes Missing or Invalid** – Facility claims must include a valid three or four-digit numeric revenue code. Refer to UB-92 coding manual for a complete list of revenue codes.

APPENDIX II: COMMON CAUSES OF PAPER CLAIM PROCESSING DELAYS OR DENIALS

- **Billed Charges Missing or Incomplete** – A billed charge amount must be included for each service/ procedure/ supply on the claim form.
- **Diagnosis Code Missing 4th or 5th Digit** – Diagnosis should be billed to the highest intensity for proper coding and processing. Review the ICD-9-CM manual for coding to the 4th and 5th digit.
- **DRG Codes Missing or Invalid** – Hospitals contracted for payment based on DRG (Diagnosis Related Grouping) codes should include this information on the claim form for accurate payment. Invalid DRG codes will result in denial.
- **Primary Insurers EOB (Explanation of Benefits) is Missing or Incomplete** – Claims for Members who have OIC (other insurance carrier) must be billed along with a copy of the primary EOB from the OIC (either paid or denied). Include pages with run dates, coding explanations, and messages.
- **Place of Service Code Invalid** – A valid and appropriate two digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.
- **Provider TIN and NPI Do Not Match** – The submitted NPI does not match Provider's Tax ID number on file.
- **Date Span Billed does not match Days/Units Billed** – spanned dates of service can only be billed for consecutive days along with matching number of days/units (i.e. Date Span of 01/01 to 01/03 and days/ units = 3).
- **Signature Missing** – The signature of the provider of service, or an authorized representative must be present on the claim form
- **Tax Identification Number (TIN) Missing or Invalid** – Provider's Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with CountyCare Health Plan.

APPENDIX III: EOP DENIAL CODES AND DESCRIPTIONS

Please see the CountyCare Provider Billing Resources Website for a complete listing of Claim Remark Codes, including denials and rejections, at: http://www.countycare.com/providers/provider-billing-resources