17.2 General Billing and Claim Submission Requirements

Submitting Claims Electronically

For all electronic claims, Healthfirst utilizes the Emdeon clearinghouse and MD On-line, a free online service for providers who do not have claims submission software. Claims submitted electronically receive a status report indicating the claims accepted, rejected, and/or pending, and the amount paid on the claim once it has been finalized. Claims submitted electronically must include:

1. Healthfirst Payer ID Number **80141** on each claim.

2. Complete **Healthfirst Member ID Numbers** (see member ID card or monthly enrollment roster).

3. A National Provider Identifier (NPI) should reside in:

- 837 Professional (HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109. NM108 must qualify with an XX (NPI);
- 837 Institutional (UB04) - Loop 2010AA Billing Provider, Segment/Element NM109. NM108 must qualify with an XX (NPI).

To sign up for electronic billing with Emdeon, providers must contact their software vendor and request that their Healthfirst claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon. Please call Healthfirst at **1-888-801-1660** to set up electronic billing. To sign up for electronic billing with MD On-line or for more information, visit www.healthfirstmdol.com or call **1-888-499-5465.** Providers who sign up for electronic billing may also sign up for electronic fund transfer/electric remittance advice (EFT/ERA). See Section 17.5 for more information.

Reports are available through billing software vendors to review electronic submission of claims and rejection errors. Although this may be an optional feature, providers are encouraged to obtain this reporting tool to better manage their submissions. The following are two (2) report options providers should review for claim submission activity:

The Initial Acceptance Report (R022/RPT-05)

The R022 report shows that the clearinghouse accepted the claim submission and routed it to the designated insurance carrier. Acceptance of a claim on the R022 report is acceptance by the clearinghouse and not by the Plan.

Providers should wait until they receive confirmation on the Insurance Carrier Rejection Report (R059).

Insurance Carrier Rejection Report (R059/RPT-11)

The R059 report consists of two (2) summaries. The first section confirms that the claims were accepted by Healthfirst.

The second section lists the claims rejected and the reason(s) for each rejection. This report may be used to substantiate timely filing to Healthfirst.

Note: In 2009, both the R022 and R059 reports were discontinued and replaced with the RPT reports.

Submitting Claims on Paper

All paper claims should be submitted to:

Healthfirst Claims Department

P.O. Box 958438

Lake Mary, FL 32795-8438

All paper claims should include the National Provider Identifier (NPI) and well as the Healthfirst-assigned Provider ID Number (the latter is not required for electronic claims). The Healthfirst Provider ID is a unique provider number for each practice site and hospital affiliation he/she has and must be included with paper claims.

The letter after the hyphen—A, B, C, D, etc.—corresponds to one (1) of the provider's practice sites. The two (2) digits at the end of the provider number correspond to the provider's hospital affiliation. The following table illustrates the potential provider numbers an individual practitioner may have:

Number of	Number of Hospitals					
Practice Sites	1	2		3		
1	123456-A12	123456-A12 123456-A20		123456-A12 123456-A20 123456-A26		
2	123456-A12 123456-B12	123456-A12 123456-B12	123456-A20 123456-B20	123456-A12 123456-B12	123456-A20 123456-B20	123456-A26 123456-B26
3	123456-A12 123456-B12 123456-C12	123456-A12 123456-B12 123456-C12	123456-A20 123456-B20 123456-C20	123456-A12 123456-B12 123456-C12	123456-A20 123456-B20 123456-C20	123456-A26 123456-B26 123456-C26

If the member's PCP is affiliated with the same hospital as the specialist, the specialist should choose the provider number by first matching the hospital code and then selecting the letter (A, B, C, etc.) that corresponds to the practice site where the services were rendered. To confirm the correct provider number, please call Provider Services at **1-888-801-1660.**

Note for group practices and facilities: When submitting claims, please ensure separate billing NPI and provider NPI numbers are entered in the appropriate fields. Office visit claims submitted for the group practice owner, with an organization NPI number instead of the individual NPI number, cannot be processed.

Claims Submission and Encounter Data

Healthfirst is required to report encounter data to New York State, CMS, and other regulatory agencies which lists the types and number of healthcare services members receive. Encounter data is essential for claims processing and utilization reporting as well as for complying with the reporting requirements of CMS, New York State, and other governmental and regulatory agencies. Further, for some Healthfirst providers, it will impact the provider's eligibility for bonuses paid for certain preventive care services. It is essential that this information be submitted in a timely and accurate manner.

For participating providers who are paid on a fee-for-service basis, the claim usually provides the encounter data Healthfirst requires. In addition, participating Healthfirst providers reimbursed on a capitated basis are still required to submit claims so that encounter data is reported to Healthfirst.

Healthfirst submits encounter and claims data monthly to the NYSDOH Office of Managed Care Medicaid Encounter Data System (MEDS). MEDS serves as the information warehouse by which the state has the capacity to monitor, evaluate, and continuously improve its managed care programs. It is essential that providers submit claims promptly for all services, including capitated services. MEDS is the standard by which the performance of Healthfirst and other managed care organizations is measured. To meet the state mandate, Healthfirst requires its providers to satisfy MEDS requirements when submitting claims and encounter information. Please refer to the Claims section (see Section 17) for the specific requirements when submitting claims or encounters. Please refer to each reporting measure as described in this section for specific measure requirements.

Present on Admission (POA)

The POA indicator applies to diagnosis codes for certain healthcare claims. POA indicator reporting is

mandatory for claims involving inpatient admissions to general acute care hospitals or other facilities. It clarifies whether a diagnosis was present at the time of admission. Healthfirst requires POA indicators for all primary and secondary diagnosis codes as well as the external cause of injury codes, regardless of the manner in which claims are submitted (i.e., paper or electronic). Please refer to the instructions provided by CMS regarding identification of the POA for all diagnosis codes for inpatient claims submitted on the UB-04 and ASCX12N 837 Institutional (837I) forms.

Requirements for Billing by Facilities

Facilities, including hospitals, must submit inpatient and outpatient facility claims on the UB-04 or on electronic media:

- Report the name, NPI, and Healthfirst provider ID number of the attending provider in Field 76 (Healthfirst provider ID number is not required on electronic transactions).
- Include the Healthfirst authorization number on claims submitted for inpatient services. Claims will be matched to prior authorization data in the Healthfirst system and processed in accordance with applicable Healthfirst policies and procedures.

Professional services that are not part of the facility claim should be billed on a CMS 1500 form.

Facilities billing on behalf of employed providers must submit claim reporting data on the UB-04 for outpatient services or directly to Healthfirst via electronic claim submission. Report the name, NPI, and Healthfirst provider ID number of the attending provider in Field 76 (Healthfirst provider ID number is not required on electronic transactions).

Required Data Elements and Claim Forms

Prior to being adjudicated, all claims are reviewed within the Healthfirst Claims department for completeness and correctness of the data elements required for processing payments, reporting, and data entry into the Healthfirst utilization systems. If the following information is missing from the claim, the claim is not “clean” and will be rejected:

Data Element	CMS 1500	UB-04
Patient Name	X	X
Patient Date of Birth	X	X
Patient Sex	X	X
Subscriber (Member) Name/Address	X	X
Healthfirst Member ID Number (including Client Identification Number [CIN] for all newborn babies, when applicable)	X	X
Coordination of Benefits (COB)/other insured’s information	X	X
Date(s) of Service	X	X
ICD-9 Diagnosis Code(s), including 4th and 5th Digit when Required (ending 9/30/2015) ICD-10 Diagnosis Code(s), including 4th, 5th, 6th, and 7th Digit when Required (beginning 10/1/2015)	X	X
CPT-4 Procedure Code(s)	X	X
HCPCS Code(s)	X	X
Service Code Modifier (if applicable)	X	X
Place of Service	X	
Service Units	X	X
Charges per Service and Total Charges	X	X
Provider Name	X	
Provider Address/Phone Number	X	
National Provider Identifier – NPI (Healthfirst does not accept legacy provider ID	X	X

numbers submitted on HIPAA standard transactions)		
Tax ID Number	X	X
Healthfirst Provider Number – **For Paper Claims Only**	X	X
Healthfirst Payer ID Number 80141 – **For EDI Claims Only** (refer to Section 17.2)	X	X
Hospital/Facility Name and Address		X
Type of Bill		X
Admission Date and Type		X
Patient Discharge Status Code		X
Condition Code(s)		X
Occurrence Codes and Dates		X
Value Code(s)		X
Revenue Code(s) and corresponding CPT/HCPCS Codes when billing outpatient services		X
Principal, Admitting, and Other ICD-9 (ending 9/30/2015); ICD-10 (beginning 10/1/2015) Diagnosis Codes		X
Present on Admission (POA) Indicator (if applicable)		X
Attending Physician Name and NPI		X
Healthfirst Authorization Number	X	X

CMS 1500 forms and UB-04s can be used to bill fee-for-service encounters. The UB-04 form should be used by facilities and by facilities billing on behalf of employed providers.