17. Billing & Claims Processing

Billing and reimbursement policies serve as a supplement to the Provider Compensation section of the Provider Manual. Please refer to Appendix XIV for a complete list of coding requirements.

17.1 Member Eligibility

Payment for services rendered is subject to verification that the member was enrolled in Healthfirst at the time the service was provided and to the provider's compliance with the Healthfirst Medical Management and prior authorization policies at the time of service.

Providers must verify member eligibility at the time of service to ensure the member is enrolled in Healthfirst. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with Healthfirst after the date of service. Therefore, verification of eligibility is not a guarantee of payment by Healthfirst. Please contact Overpayment Recovery at **1-866-635-1520** in cases where members retroactively lose coverage so that you can obtain further information, including any other payor that may be billed.

Claims submitted for services rendered without proper authorization will be denied for "failure to obtain authorization." No payment will be made.

In certain cases, a managed care plan member, including Healthfirst members, may change health plans during the course of a hospital stay. When this occurs, providers should bill the health plan to which the member belonged at the time of admission to the hospital.

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 numbers submitted on HIPAA standard transactions)	X	X
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.

17.3 Time Frames for Claim Submission, Adjudication and Payment

Timely Claim Submission

Providers should submit all claims within thirty (30) days of the date of service for prompt adjudication and

payment. However, claims for services that are submitted later than the time period set forth in the provider's agreement with Healthfirst will not be paid except under certain circumstances. In no event will Healthfirst pay claims submitted more than one hundred eighty (180) days after the date of service. Please refer to Section 17.2 for electronic and paper submission of claims.

Late Claim Submission

In certain circumstances, Healthfirst will process claims submitted after the time period required under the provider's agreement with Healthfirst. Please note that "unclean" claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to the time period required. The following situations allow for special handling of claims. Claims must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider's control.

Reason for Delay	Time Frame for Submission
Litigation involving payment of the claim	Within sixty (60) calendar days from the time the submission came within the provider's control
Medicare or other third party processing delays affecting the claim	Within sixty (60) calendar days from the time the submission came within the provider's control
Original claim rejected or denied due to a reason unrelated to the 180-day rule	Within sixty (60) calendar days of the date of notification (submit with original EOP)
Administrative delay (enrollment process, rate changes) by NYSDOH or other State agencies	No time frame
Delay in member eligibility determination	Within sixty (60) days from the time of notification of eligibility (submit with documentation substantiating the delay)
PRO denial/reversal	No time frame
Member's enrollment with Healthfirst was not known on the date of service	Within sixty (60) days from the time the member's enrollment is verified. Providers much make diligent attempts to determine the member's coverage with Healthfirst

The Insurance Carrier Rejection Report—R059/RPT-11 (refer to Section 17.2)—may be used to substantiate timely filing to Healthfirst.

Healthfirst adjudicates and pays all claims for its Medicaid, FHP, CHP, and commercial plans according to Section 3224-a of the New York State Insurance Law, also known as New York's "prompt pay" law. Healthfirst adjudicates and pays all claims for its Medicare lines of business pursuant to Section 3224-a of the New York State Insurance Law, except that the applicable prompt pay interest rate shall be that applicable to Medicare fee for service interest rate. Out of Network Medicare claims are adjudicated pursuant to the applicable regulations governing Medicare Advantage Plans.

Grace Period Impact to Commercial and Leaf Plan Providers

Provider payment is subject to member's insurance coverage status; refer to Section 4.4: Eligibility Verification. Members who receive advance premium tax credit (APTC) subsidies are entitled to a 90-day premium payment grace period. Claims submitted during days 31–90 of the member's grace period will not be subject to prompt pay provisions until the member pays their premium in full. Providers are not permitted to balance-bill members during days 31–90 of their grace period. If the member's premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the member premium is not paid in full by the end of the grace period, claims incurred during days 31–90 of the grace period will be denied.

17.4 Coordination of Benefits (COB)

Coordination of benefits (COB) ensures that the proper payers are held responsible for the cost of healthcare services and is one (1) of the factors that can help hold down copayments and premiums. Healthfirst follows

all standard guidelines for COB. Members are asked to provide information about other insurance plans under which they are covered.

Healthfirst is Always the Secondary Payer in the Following Circumstances

- Workers' compensation.
- Automobile medical.
- No-fault or liability auto insurance.

Healthfirst Does Not Pay for Services Provided Under the Following Circumstances When There is COB

- The Department of Veterans Affairs (VA) or other VA facilities (except for certain emergency hospital services).
- When VA-authorized services are provided at a non-VA hospital or by a non-VA provider.

The Following Applies to Healthfirst Medicare Plan Only

Healthfirst will use the same guidelines as Medicare for the determination of primary and secondary payer. As a result, Healthfirst is the secondary payer for all of the cases listed above as well as for the following:

- Most Employer Group Health Plans (EGHP).
- Most EGHPs for disabled members.

All benefits payable under an EGHP in the case of individuals who are entitled to benefits solely or partly on the basis of end-stage renal disease (ESRD) during a period of thirty (30) months. (This applies to all services, not just to ESRD. If the individual entitlement changes from ESRD to over sixty-five [65] or disability, the coordination period will continue.)

17.5 Explanation of Payment (EOP)/Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)

The EOP describes how claims for services rendered to Healthfirst members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim. There are separate EOPs for inpatient facility services and for outpatient services. The outpatient services EOP includes outpatient facility services, provider services, and ancillary services such as DME (see Appendix XIV-C). The EOP shall include the following elements:

- Name and Address of Payor
- Toll-free Number of Payor
- Subscriber's Name and Address
- Subscriber's Identification (ID) Number
- Member's Name
- Provider's Name
- Provider Tax Identification Number (TIN)
- Claim Date of Service
- Type of Service

- Total Billed Charges
- Allowed Amount
- Discount Amount
- Excluded Charges
- Explanation of Excluded Charges (Denial Codes)
- Amount Applied to Deductible
- Copayment/Coinsurance Amount
- Total Member Responsibility Amount
- Total Payment Made and to Whom

The EOP is arranged numerically by member account number. Inpatient facility claims are sorted separately from all other claims. Each claim represented on an EOP may comprise multiple rows of text. The line number indicated below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:

- **Paid Claim Lines**: If the Paid Amount field reads greater than zero (0), the claim was paid in the amount indicated.
- **Denied Claim Lines**: If the Not Covered field is greater than zero (0) and equal to the allowed amount, the service was denied.
- **Claim Processed as a Capitated Service**: **I**f the amount in the Prepaid Amount field is greater than zero (0), the service was processed as a capitated service.
- **End of Claim**: Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

Providers may request a copy of an EOP on our website at www.healthfirst.org or by calling **1-888-801-1660.**

Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA)

Healthfirst's Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) program is a convenient service for the automatic reimbursement of Healthfirst claims.

EFT is the direct electronic deposit of claim reimbursements into your bank account, and **ERA** is the statement that allows you to reconcile these reimbursements to your member accounts. Advantages of these programs include:

- Prompt payment – no waiting for checks to clear.
- Reduced paperwork.
- No lost checks or mail delay.
- Savings of administrative and overhead costs.
- Simplified and organized recordkeeping.
- Improved cash flow.

You **must** be able to submit claims electronically to use EFT/ERA. When claims are submitted for payment, the payment is deposited electronically into your bank account. Capitation checks can also be deposited directly into your account. When you enroll in EFT/ERA, you will continue to receive an Explanation of Payment (EOP) for a sixty (60) day grace period. The EOP shows the member's name, dates of service,

services rendered, and amounts of Healthfirst payments. After the grace period, you will receive only the ERA. Bank statements will continue to reflect deposited amounts and dates of deposit. Your clearinghouse/software vendor **must** be able to accept the ERA file which is in the 835 HIPAA standard format.

Please refer to our website at www.healthfirst.org for information on how to enroll in EFT/ERA. You can also call Provider Services at **1-888-801-1660.**

17.6 Claim Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process

Claim Inquiries

Providers can view claims status on our website at www.healthfirst.org. Providers may also call Provider Services at **1-888-801-1660**, 24 hours a day, seven (7) days a week, to access claim status on a service line or service code basis instead of a claim's total.

As described below, Healthfirst provides a two (2)-level process for providers to appeal a claim denial or payment which the provider believes was incorrect or inaccurate. Please note that the provider appeal process described in this Section 17 does not apply to utilization management determinations concerning medical necessity. See Section 15 for information on medical necessity appeals.

Corrected Claims

Definitions

Rejected claim: A claim that was received by Healthfirst and determined to be unclean. The claim is never loaded to the adjudication system. The claim is returned to the provider along with the reason for the rejection.

Re-submission claim: Represents a claim that was rejected by Healthfirst. Once the provider makes the appropriate changes to the claim, the provider must re-submit the claim within timely filing guidelines for new claims. **Note: This re-submitted claim is always treated as a new claim.**

Accepted claim: A claim that was received by Healthfirst and passed all criteria. The claim was successfully loaded to the adjudication system. The system then makes a final determination of paid or denied.

Corrected claim: Represents a claim that was accepted by Healthfirst. The corrected claim has changed data elements that will potentially effect the payment of the claim.

EDI Corrected Claims:

When submitting an EDI "Corrected" Professional and/or Institutional claim to Healthfirst the following requirements must be met:

1) The claim type/frequency (CLM05-03) must be a 7.

   Ex. CLM*8084*96.98***11>B>7*Y*A*W*I*P~

2) The Healthfirst **original claim ID must be sent** in the REF*F8 segment in the 2300 loop. The Healthfirst claim ID is made up of a 2 digit branch code, 6 digit batch date, 3 digit batch sequence, and a 2 digit sequence ID. The Healthfirst claim ID can be found on the EOP and/or 835.

   Ex. REF*F8*010414153906 1~

Paper Corrected Claims:

When submitting a Paper "Corrected" Professional and/or Institutional claim to Healthfirst, the Providers should stamp or handwrite on the claim "CORRECTED" or "CORRECTED CLAIM" and **must include the original claim number** being corrected.

Note: Corrected Claims submission must follow timely filing guidelines for new claims (Refer to Section 17.3 for timely filing rules).

Requests for Review and Reconsideration of a Claim

At times, a provider may be dissatisfied with a decision made by Healthfirst regarding a claim determination. Some of the common reasons include, but are not limited to:

incorrectly processed or denied claims;
the untimely submission of claims;
a failure to obtain prior authorization.

Providers who are dissatisfied with a claim determination made by Healthfirst must submit a **written** request for review and reconsideration with all supporting documentation to Healthfirst within **ninety** (90) calendar days from the paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, are accepted via the Healthfirst provider website at www.healthfirst.org or addressed to the following location:

Healthfirst Correspondence Unit

P.O. Box 958438,
Lake Mary, FL 32795-8438

All written requests for Review and Reconsideration via the provider website or P.O. Box 958438 should include the following information: a copy of the EOP, the claim, supporting documentation, and a written statement explaining why you disagree with Healthfirst's determination as to the amount or denial of payment.

Examples of information and supporting documentation that should be submitted with written requests for review and reconsideration include:

- A written statement explaining why you disagree with Healthfirst's claim determination.
- Provider's name, address, and telephone number.
- Provider's identification number.
- Member's name and Healthfirst identification number.
- Date(s) of service.
- Healthfirst claim number.
- A copy of the original claim or corrected claim, if applicable.
- A copy of the Healthfirst EOP.
- A copy of the EOP from another insurer or carrier (e.g., Medicare), along with supporting medical records to demonstrate medical necessity.
- Contract rate sheet to support payment rate or fee schedule.

- Evidence of eligibility verification (e.g., copy of Healthfirst member ID card).
- Evidence of timely filing:
    - RO59 Report (Insurance Carrier Rejection Report) or Emdeon Vision "Claim for Review"/"Claim Summary" Report;
    - **Please note:** Healthfirst **does not** accept copies of certified mail or overnight mail receipts, or documentation from internal billing practice software as proof of timely filing.
    - Copy of the approval number issued by Medical Management.

Healthfirst will investigate all written requests for Review and Reconsideration, and issue a written explanation stating that the claim has been either reprocessed or the initial denial has been upheld, within thirty (30) calendar days from the date of receipt of the provider's request for Review and Reconsideration.

Healthfirst will not review or reconsider claims determinations which are not appealed according to the procedures set forth above. If a provider submits a request for review and reconsideration after the ninety (90) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for review and reconsideration is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services Unit at **1-888-801-1660.**

Claim Appeals Process

Providers who are dissatisfied with the outcome of the Review and Reconsideration may submit a **written** request for a formal appeal within **sixty (60) calendar days** from the date listed on the reconsideration determination letter.

Providers should submit all written requests for an appeal of a claim determination to the following location:

Healthfirst Provider Claim Appeals

P.O. Box 958431

Lake Mary, FL 32795-8431

Providers should provide a written statement explaining why they disagree with Healthfirst's decision regarding the review and reconsideration, a copy of that determination, and, if the provider submitted the request for Review and Reconsideration via the Healthfirst provider website, the specific Healthfirst tracking number. Providers should also specify the name, address, and telephone number of an individual who may be contacted regarding the appeal and include any additional relevant documentation to support the provider's position (see above for examples of documentation). Healthfirst will not accept appeals from providers that are not made in writing and that fail to address the reason for the appeal.

For appeals on payment rates, providers should specify in writing the basis for the dispute and enclose all relevant documentation, including, but not limited to, contract rate sheets or fee schedules.

Healthfirst will investigate all written requests for appeal and issue a written explanation stating that the claim has been either reprocessed or upheld, within thirty (30) calendar days from the date of receipt of the provider's request for appeal.

Healthfirst will not consider appeals that are not submitted according to the procedures set forth above. If a provider submits a request for appeal after the sixty (60) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services, irrespective of the merits of the underlying dispute, if the request for appeal is not timely filed. In such cases, providers may not bill members for services rendered.

All questions concerning requests for review and reconsideration should be directed to the Provider Services

Unit at 1-888-801-1660.

17.7 Overpayments, Duplicate Payments, and Underpayments

Healthfirst periodically reviews payments made to providers to ensure the accuracy of claim payments pursuant to the terms of the provider contract or as part of its continuing utilization review and fraud control programs. If Healthfirst identifies that we have overpaid a provider for certain services, Healthfirst will notify the provider and, in certain circumstances, recoup the overpayment amount consistent with Section 3224-b of the New York State Insurance Law and the procedures detailed below.

Healthfirst will not pursue overpayment recovery efforts for claims older than twenty-four (24) months after the original payment date unless the overpayment is: (1) based upon a reasonable belief of fraud, intentional misconduct, or abusive billing, (2) required or initiated by the request of a self-insured plan, or (3) required by a state or federal government program. The above restrictions shall not apply to any overpayment recovery efforts made by Healthfirst prior to January 1, 2007, when notice has been provided to the provider of such recovery efforts.

We Will Provide Notice of Overpayments Before Seeking Recovery

If Healthfirst determines that an overpayment has occurred, Healthfirst will provide sixty (60) days advance written notice to the provider of the overpayment before engaging in any overpayment recovery efforts. This notice will include the member's name, service dates, payment amount(s), proposed adjustment, a reasonably specific explanation of the reason for the overpayment, and the proposed adjustment. In response to a notice of overpayment, the provider may either (1) dispute the finding or (2) remit payment to Healthfirst as outlined below.

If You Agree That We Have Overpaid You

If a provider agrees with Healthfirst's overpayment determination as detailed in the overpayment notice, providers may voluntarily submit a refund check made payable to the corporate entity named on the demand letter (e.g., Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc.) within sixty (60) days from the date the overpayment notice was mailed by Healthfirst. Providers should further include a statement in writing regarding the purpose of the refund check (e.g. payment of identified overpayment) and a copy of the overpayment notice to ensure the proper recording and timely processing of the refund. **Refund checks should be mailed to**: Healthfirst Finance Department, P.O. Box 5198, New York, NY 10275-0304, Attention: Overpayment Recovery.

If You Disagree That We Overpaid You

If a provider disagrees with Healthfirst's overpayment determination as detailed in the overpayment notice, the provide must submit the following in accordance with the "Claims Appeals Process" as detailed in Section 17.6 **within sixty (60) days from the date the overpayment notice was mailed:** (1) a written request for an appeal, and (2) any supporting documentation. Upon making a determination on the provider's appeal request and supporting documentation, Healthfirst will provide written notice of the appeal determination. If Healthfirst upholds the overpayment determination, providers may initiate arbitration, as provided pursuant to their provider agreement. Healthfirst will proceed to offset the amount of the overpayment prior to any final determination made pursuant to binding arbitration.

If You Fail to Respond to an Overpayment Notice

If a provider fails to dispute or otherwise respond to an overpayment notice within sixty (60) days from the date the overpayment notice was mailed by Healthfirst, the provider will be deemed to have acknowledged and accepted the overpayment amount demanded by Healthfirst and, subject to the provider's right to arbitration pursuant to the provider agreement, **Healthfirst will offset the overpayment amount against current and future claim remittance(s) until the full overpayment amount is recovered by Healthfirst.**

If an Offset Results in a Negative Balance

If an overpayment offset results in a negative balance, the provider will receive a special Negative Balance Letter from Healthfirst while the offset amount is being recovered, in lieu of the standard Explanation of Payment (EOP). This letter will contain the current negative offset balance and any claim activity that has taken place since during the check cycle period to reduce the negative balance. Once the entire negative amount has been recovered, the provider will resume receiving standard EOPs.

Duplicate Payments

Healthfirst may also apply the procedures described in this section to recoup duplicate claims payments. However, in accordance with 3224-b of the New York State Insurance Law, Healthfirst reserves the right to use other available procedures to recoup duplicate claims payments.

Underpayments

After a provider has complied with the Review and Reconsideration Process and/or the Claims Appeals Process as detailed in Section 17.6, if Healthfirst agrees with the provider's assertion that Healthfirst has underpaid any claim(s) to the provider, Healthfirst may offset such identified underpayments against any overpayments dating as far back as the claimed underpayment that have not yet been recouped. Prior to such offset, however, Healthfirst shall ensure compliance with the provisions in this Section 17.7 regarding notice of overpayments to the provider.

17.9 Avoidable Readmission Reimbursement Policy

Healthfirst's Avoidable Readmission Reimbursement Policy is designed to reduce avoidable readmissions to improve quality of care. Healthfirst will deny any claim for an acute-care hospital admission that meets the criteria for an avoidable readmission, as defined in this policy. This policy applies to all inpatient claims across all lines of business. An avoidable readmission is one that occurs within 30 days of discharge of the index (i.e., initial) admission from the same hospital or hospital system, for a condition with the same, a similar, and/or a related diagnosis group (same major diagnostic category (MDC)), provided that none of the exceptions listed below applies.
Subsequent admissions will not be subject to denial under this policy if any of the following is true:

» Patient transferred from out of network (OON) to in network (INN),
» Patient transferred to an inpatient rehabilitation facility,
» Patient transferred to a skilled nursing facility (SNF)
» Patient transferred to receive care not available at the first facility,
» The subsequent admission was a planned readmission for repetitive treatments (e.g., chemotherapy for cancer),
» The subsequent admission was a scheduled readmission for elective procedures,
» Patient left Against Medical Advice (AMA) from the index admission,
» Patient expired during the subsequent admission,
» Patient was enrolled in hospice during the subsequent admission,
» The index admission and/or subsequent admission was for:
o trauma, burns, malignancies, cystic fibrosis, eye, mental health, substance use disorders,
» The subsequent admission was to a psychiatric/substance abuse unit or facility
» The subsequent admission was related to treatment for pregnancy and/or newborns, or
» The subsequent admission occurred more than 30 days from discharge from the index admission.

If you feel a claim was denied in error or would like to dispute a denial, please follow the claim reconsideration and appeal process outlined in your Healthfirst Provider Manual.
Review Process:

1. If Healthfirst determines that the admission is a readmission of the index, the hospital will be notified of the claims denial.
2. The hospital has the right to a claims review and reconsideration (1st level) and to a claims appeal (2nd level) of the

determination. Denial of payment for the claim will be upheld unless it can be shown that the admission does not meet the criteria for an avoidable readmission.
3. The claims review and reconsideration, and the claims appeal process, will follow the Healthfirst standard claims reconsideration process as documented in Section 17.6 of this Provider Manual. If it is determined on appeal that the readmission did not meet the criteria for an avoidable readmission, the admission will be reimbursed in accordance with the terms of the applicable Participating Hospital Agreement.
4. Failure of the hospital to provide complete medical records from the index hospitalization and readmission hospitalization for review and reconsideration may result in an adverse determination under the reconsideration process.
5. Healthfirst reserves the right to look back within the maximum allowed recovery time frame per state guidelines or per specific provider contract to identify any claims that may be for an avoidable readmission.
6. Healthfirst reserves the right to deny the claim or to recoup and/or recover monies previously paid on a claim that is within the guidelines of this policy.
Members may not be charged for hospital admissions denied as avoidable readmissions under this policy.