Claims Submissions

In general, CareSource follows the claims reimbursement policies and procedures set forth by the Michigan Department of Community Health (MDCH) and Centers for Medicare and Medicaid Services (CMS). Reimbursement is based on the prevailing state Medicaid or Medicare fee schedule.

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Billing Methods

CareSource accepts claims in a variety of formats, including paper and electronic claims.

We encourage providers to submit claims electronically to take advantage of the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Minimal staff training or cost

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Electronic Claims Submission

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business data in standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA).

CareSource has invested in an EDI system to enhance our service to participating providers. Our EDI system complies with HIPAA standards for electronic claims submission. We are committed to offering you the most flexible and efficient means possible of doing business with us.

EDI Clearinghouses
To submit claims electronically, providers must work with an electronic claims clearinghouse. CareSource currently accepts electronic claims from Michigan providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claims submission. Please provide the clearinghouse with the CareSource payer ID number: **38325**.

*Please provide the clearinghouse with the CareSource payer ID number: **38325**.*

CareSource EDI Vendor	Phone Number	Website
Netwerkes	(269) 695-3391	www.netwerkes.com
Practice Insight	(713) 333-6000	www.practiceinsight.com
Emdeon	(800) 845-6592	www.emdeon.com

File Format
CareSource accepts electronic claims in the **837 ANSI ASC X12N (004010A1)** file format for professional and hospital claims.

NPI and Tax ID Numbers
Your National Provider Identifier (NPI) number and tax ID are required on all claims. Claims submitted without these numbers will be rejected. Please contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Your NPI number and tax ID are required on all claims.

Location of Provider NPI, TIN and Member ID Number
On **professional** claims, the Rendering Provider NPI should be in the following location:

- 2310B Loop — Rendering Provider Name
  - Identification Code Qualifier — NM108 = XX
  - Identification Code — NM109 = Rendering Provider NPI

  The Billing Provider TIN (Tax Identification Number) must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:
  - Reference Identification Qualifier — REF01 = EI (for EIN) or SY (for SSN)
  - Reference Identification — REF02 = Billing Provider TIN or SSN

On **institutional** claims, the Billing Provider NPI should be in the following location:

- 2010AA Loop — Billing Provider Name
  - Identification Code Qualifier — NM108 = XX
  - Identification Code — NM109 = Billing Provider NPI

  The Billing Provider Tax Identification Number (TIN) must be submitted as the secondary provider identifier using a REF segment, which is either the Employer Identification Number (EIN) for organizations or the Social Security Number (SSN) for individuals, see below:
  - Reference Identification Qualifier — REF01 = EI (for EIN) or SY (for SSN)
  - Reference Identification — REF02 = Billing Provider TIN or SSN

On **all** electronic claims, the CareSource member ID number should go on:

- 2010BA Loop — Subscriber Name
- NM109 = Member ID Number

Paper Claim Forms

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.

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If you submit on paper forms, please, submit claims on one of the following claim form types:

- CMS 1500, formerly HCFA 1500 form — AMA universal claim form also known as the National Standard Format (NSF)
- CMS 1450 (UB-04), formerly UB92 form for Facilities

Paper claim submissions must be done using the most current form version as designated by the Centers for Medicare and Medicaid Services (CMS) and the National Uniform Claim Committee (NUCC). We cannot accept handwritten claims or SuperBills.

- **www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf** CMS 1500 form instructions
- **www.nucc.org** UB-04 form instructions

Paper Claim Forms are Required for Services that Need Special Processing:

- Procedures performed that do not have a corresponding CPT procedure code
- Drug injections that don't have specific J code descriptions (J9999 and J3490)
- Sterilization procedures — Consent forms must be attached
- Services billed by report — Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus any other documentation that will assist in determining reimbursement
- Coordination of Benefits (COB) documentation such as other carrier EOB or documentation regarding no other insurance

All claims must include the following information:

- **Patient (member) name**
- **Patient address**
- **Insured's ID number** — Be sure to provide the complete CareSource member ID number of the patient.
- **Patient's birth date** — Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.
- **Place of service** — Use standard CMS (HCFA) location codes.
- ICD-9 diagnosis code(s)
- **HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS)** code(s) and modifiers, where modifiers are applicable
- **Units, where applicable (Anesthesia claims require minutes)**
- **Date of service** — Include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain From/To formats. Please enter each date individually.
- **Prior authorization number, where applicable** — A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required a prior authorization.

Always include the member's date of birth. This allows us to identify the correct member in case we have more than one member with the same name.

- **National Provider Identifier (NPI)**
- **Federal tax ID number or Physician Social Security number** — Every provider practice (i.e., legal business entity) has a different tax ID number.
- **Signature of physician or supplier** — The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.
- **For Medicaid members only** — Prenatal or delivery services, the last menstrual period date is required on claims. For delivery services, the birth weight is required.
- **NDC Code for designated CPT/HCPCS code per MDCH requirements** — National Drug Code (NDC) and Units are required for certain drugs specified by CMS for outpatient facility and professional claim submissions.

LMP may be calculated — MDCH requires that all delivery claims paid by CareSource must include the last menstrual period (LMP) date for the mother. We realize that this information may not always be available to the provider who delivers the baby, especially if the member received prenatal care from another provider or facility. Please remember that participating providers may estimate the LMP on delivery claims based on the gestational age of the child at birth. MDCH has approved this as an acceptable method for establishing the date of the mother's last menstrual period. This will help ensure that your delivery claims do not go unpaid because of missing claim form information.

Tips for Submitting Paper Claims

For the most efficient processing of your claims, CareSource recommends you submit all claims electronically.

CareSource uses optical/intelligent character recognition (OCR/ICR) systems to capture claims information which increase efficiency, improve accuracy and result in faster turnaround time. Claims that do not meet the following requirements may be delayed in claims processing:

- EDI claims are generally processed more quickly than paper claims
- If you submit paper claims, we require the most current form version as designated by CMS and NUCC
- No handwritten (including printed claims with any handwritten information) claims or SuperBills will be accepted
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website
- Fonts should be 10-14 point (capital letters preferred) with printing in black ink
- Do not use liquid correction fluid, stickers, labels or rubber stamps
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form
- It is recommended that you submit your 12-digit CareSource provider ID in conjunction with your NPI number
- Federal tax ID number or physician SSN is required for all claim submissions

CareSource uses optical/intelligent character recognition (OCR/ICR) systems to capture claims information which increase efficiency, improve accuracy and result in faster turnaround time.

Send all paper claim forms to CareSource at the following address:

CareSource Claims Dept.
Attn: Claims Department
P.O. Box 1307
Dayton, OH 45401-1307

Claim Submission Timeframes

Claims must be submitted within **365 days** of the date of service or discharge. We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim. If this happens, providers have **365 days** from the date of service to submit a corrected claim.

*Claims must be submitted within **365 days** of the date of service or discharge.*

If you feel a claim payment has been denied or reduced in error you may appeal it. You have **365 days** from the date of service or discharge to file an appeal.

Claims Processing Guidelines

- Providers have 365 days from the date of service to submit a claim. If the claim is submitted after 365 days, the claim will be denied for timely filing.
- If you do not agree with the decision of the processed claim, you have 365 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a member has other insurance and CareSource is secondary, the provider may submit for secondary payment within 365 days of the original date of service or within 90 days from the other carrier's Explanation of Payment (EOP). If a copy of the claim and EOP is not submitted within the required timeframe the claim will be denied for lack of timely filing.

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following five code sets when submitting health care claims electronically. CareSource also requires HIPAA-compliant codes on paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on health care providers and health plans. Local or proprietary codes are no longer allowed.

- *International Classification of Diseases*, 9th Edition, Clinical Modification (ICD-9-CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (Fax) and from many other vendors.
- *Current Procedural Terminology*, 4th Edition, (CPT-4). Available at **http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml**.
- *HCFA Common Procedure Coding System* (HCPCS). Available at **http://www.cms.hhs.gov/default.asp**.
- *National Drug Codes* (NDC). Available at **http://www.fda.gov/**.

If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information, as applicable, with the claim form:

- A full, detailed description of the service provided
- A report, such as an operative report or a plan of treatment
- Any information that would assist in determining the service rendered

This information is also needed if a procedure is assigned an unlisted CPT/HCPCS code. For example, 84999 is an unlisted lab code that would require additional explanation.

Clinical Editing

At CareSource, we employ the latest in proven computer technology to process your claims accurately and efficiently. To this end, CareSource uses clinical editing software to help evaluate the accuracy of diagnosis and procedure codes on submitted claims. CareSource's clinical editing software finds any coding conflict or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or sex and diagnosis, such as a pregnancy diagnosis for a male patient. Our software resolves these conflicts or indicates a need to seek additional information from the health care provider.

At CareSource, we employ the latest in proven computer technology to process your claims accurately and efficiently.

Please remember that CareSource's clinical editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure. We believe that clinical editing software helps ensure that your claims are processed consistently, accurately and efficiently.

Explanations of Payment (EOPs)

EOPs are statements of the current status of your claims that have been submitted to CareSource and entered into our system. Usually EOPs are generated every week. However, you may not receive an EOP each time they are generated depending on your claims activity. EOPs include paid and unpaid claims. Any unpaid claims appear on the EOP with a message code indicating the reason the claim is unpaid. For denied claims, it is the provider's responsibility to resubmit them with the corrected or completed information needed for processing. In the Forms/Supplements section of this manual is an example of an EOP containing explanations of the information that is included on them and where it appears.

EOP Delivery — EOPs are available on the Provider Portal. Register at **https://providerportal.caresource.com/MI**/.

EOPs are available on the Provider Portal.

Reimbursement checks and most hard-copy EOPs are mailed to providers through regular U.S. mail. However, if your EOP is over 40 pages long and you have a post office address, it will be sent to you via Priority Mail. All other EOPs over 40 pages long are sent via UPS ground.

Returned Claims
Claims may be returned to the provider if there is incomplete, incorrect or unclear information. If the provider or facility information does not correspond to the information in CareSource's claim processing system, or if there is no W-9 on file.

If the information in CareSource's claim processing system does not match the information on the billed claim or if there is no W-9 on file, CareSource will return the claim to the provider with a letter explaining the reason for the returned claim along with a provider profile, a W-9 form and any additional documentation needed to update the CareSource claim processing system.

Please mail the completed information to:

CareSource
Attn: Provider Database Maintenance
P.O. Box 23037
Lansing, MI 48909-3037

Once the CareSource claims processing system has been updated, a confirmation will be sent to the provider. The confirmation will include the updated provider billing number, remittance address, claim form type and other information. The provider can then resubmit the claim(s) to CareSource for processing.

Claims Status
If you have billed a claim to CareSource and you'd like to check the status, visit our website at **www.caresource.com**.

Claim Processing Inquiries
Occasionally, you may encounter processed claims on your EOP that you would like to have investigated. When you would like to have the processing of a claim investigated, you may use the Provider Claim Research Request Form. Please fill out the form in its entirety, including your fax number, a description of the issue, and attach any supporting documentation such as a copy of the claim, other carrier EOBs or letters and **fax the information to (937) 224-3388, Attn: CareSource Claim Research**.

A claim processor will review your claim. If an error is detected, the claim will be reprocessed. Appropriately denied claims will require the filing of an appeal. The form will be faxed back to the provider with an explanation of the resolution. If you continue to have questions after the investigation has been completed, you may contact your provider relations representative for assistance.

Other Coverage

Coordination of Benefits (COB) — CareSource members may have other health insurance coverage through an employer, or children may have coverage through their other parent's insurance carrier. Providers are encouraged to help us obtain this information from patients. Claims involving COB will not be paid until an explanation of benefits/payment has been received from the primary carrier indicating the amount the carrier will pay. CareSource, as a Medicaid and Medicare health plan, is always the last payer for all patients who have other insurance coverage. We are primary only to other Medicaid and Medicare health plans.

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Third-Party Liability — Providers are asked to take reasonable measures to ascertain any third-party resources available to members such as automobile insurance, homeowner's insurance or litigation. Payment for covered services will only be made after any available third-party benefits are exhausted. Providers should bill the proper agency or insurance company *prior* to billing CareSource. After receiving a third-party payment or denial, a claim can be submitted for reimbursement of the balance. A copy of the third party's explanation of benefits should accompany the claim.

Claims indicating that a third-party paid in full (0 balance) must still be submitted to CareSource for processing. This is due to state regulations. The 0-balance claims must be submitted to CareSource within 365 days from the date of service or 90 days from the third party's explanation of benefits/payment, whichever is greater.

Claims indicating that a third-party paid in full (0 balance) must still be submitted to CareSource for processing. This is due to state regulations.

If a provider receives a third-party payment after receiving payment from CareSource for the same items or services, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider or providers can issue refund checks to CareSource for any overpayments. Providers should not refund any money received from a third party to a member.

Workers' Compensation — All claims indicating that a member's diagnosis was caused by the member's employment will not be paid. The provider will be advised to submit the charges to Workers' Compensation for reimbursement.

Subrogation — All claims indicating that a disability was caused by an accident will be considered as a case of possible subrogation. Any third-party liability will be determined. CareSource will generally pay the provider for all covered services. Then, we will pursue reimbursement from any third-party involved.

Medicaid Member Billing Policy

State and federal regulations prohibit health care providers from billing CareSource Medicaid members for services provided to them except under specific circumstances as described below. CareSource monitors this activity based on reports of billing from members. We will implement a stepped approach in working with our providers to resolve any member billing issues that includes notification of excessive member complaints and education regarding appropriate practices. Failure to comply with regulations after intervention may result in potential termination of your agreement with CareSource.

Please remember that regulations state that health care providers must hold members harmless in the event that CareSource does not pay for a covered service performed by the provider unless CareSource denies prior authorization of the service, and you notify the member in writing that the member is financially responsible for the specific service. This must be done prior to providing the service and the member must sign and date the notification. We appreciate your adherence to these requirements.

State and federal policy also prohibits health care providers from billing Medicaid consumers for missed appointments. This includes CareSource members. CareSource encourages members to keep scheduled appointments and call to cancel, if needed. We also provide transportation for many doctor's visits to help ensure our members make it to needed medical appointments. Please feel free to call our Case Management Department if you are concerned about CareSource members who miss appointments. We can assist you with education and follow-up.

We also provide transportation for many doctor's visits to help ensure our members make it to needed medical appointments.

No Co-Payments for Members — CareSource Medicaid members are not responsible for co-payments on covered services or prescription drugs. CareSource reimbursement is adjusted to cover co-payment charges.

SNP Medicare Member Billing Policy
Special Needs Plan (SNP) members are dual-eligible members, meaning they also have Fee-For-Service (FFS) Medicaid coverage. Members who received bills for covered services should contact CareSource with questions.