Claims Submissions

Humana – CareSource follows the claims reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. It is critical that all addresses and phone numbers on file with Humana – CareSource are up to date to ensure timely claims processing and payment delivery.

Billing Methods

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

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

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

Electronic Funds Transfer

Humana – CareSource now offers electronic funds transfer (EFT) as a payment option. Visit our provider portal at https://www.caresource.com/providers/kentucky/providerportal/ for additional information about the program and to enroll in EFT.

Providers who elect to receive EFT payment will receive an Electronic Remittance Advice (EDI) 835 file. Providers can download their Explanation of Payment (EOP) from the provider portal or receive a hard copy via the mail.

Benefits of EFT:

Simple — Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which increases payment processing efficiency.

Convenient — Available 24/7; works in conjunction with practice management systems. Humana – CareSource also offers free training for providers.

Reliable — Claim payments are electronically deposited into your bank account.

Secure — Access your account through the Humana – CareSource secure provider portal to view (and print, if needed) remittances and transaction details.

Simply complete the enrollment form at https://www.caresource.com/providers/kentucky/claims-information/ and fax it back to InstaMed, Humana – CareSource's EFT partner, at 1-877-755-3392. InstaMed will work directly with you to complete your enrollment in EFT.

Electronic Claims Submission
Electronic data interchange (EDI) is the computer-to-computer exchange of business data in standardized formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). Our EDI system complies with HIPAA standards for electronic claims submission.

To submit claims electronically, providers must work with an electronic claims clearinghouse. Humana – CareSource currently accepts electronic claims from Kentucky providers through the clearinghouses listed below. Please contact the clearinghouse of your choice to begin electronic claims submission.

Please provide the clearinghouse with the Humana – CareSource payer ID number KYCS1.

Clearinghouse	Phone	Website
Emdeon	1-800-845-6592	www.emdeon.com
Quadax	1-866-422-8079	www.quadax.com
Relay Health	1-800-527-8133, Option 2	www.relayhealth.com
Practice Insight	1-713-333-6000	www.practiceinsight.net
Zirmed	1-877-494-7633	www.zirmed.com

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

Humana – CareSource 5010 companion guides are now available online. These companion guides provide Humana – CareSource trading partners with guidelines for submitting electronic transactions.

Version 5010 Companion Guides/HIPAA Transaction	Chapter Version
Humana – CareSource 837 Dental 5010 Companion Guide	Version 1.1
Humana – CareSource 837 Institutional 5010 Companion Guide	Version 1.1
Humana – CareSource 837 Professional 5010 Companion Guide	Version 1.1

Visit https://www.caresource.com/providers/ohio/ohio-providers/claims-information/5010-compliance/ for more information.

5010 Transactions
In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This action was taken in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format.

Transactions covered under the 5010 requirement
- 837 Claims encounters
- 276/277 Claim status inquiry
- 835 Electronic remittance advice
- 270/271 Eligibility
- 278 Prior authorization requests
- 834 Enrollment

- 820 Payment order/remittance advice
- NCPDP Version D

National Provider Identifier (NPI), Tax Identification Number (TIN or tax ID) and Taxonomy
Your NPI and tax ID are required on all claims, in addition to your provider taxonomy and specialty type codes (Federally Qualified Health Center, Rural Health Center and/or Primary Care Center) using the required claim type format (CMS-1500, UB92 or Dental ADA) for the services rendered. As of October 1, 2013, Kentucky Department for Medicaid Services (KDMS) requires that all NPIs, billing and rendering addresses and taxonomy codes are present on its Master Provider List (MPL). Claims submitted without these numbers, or information that is not consistent with the MPL, will be rejected. Please contact your EDI clearinghouse if you have questions on where to use the NPI, tax ID or taxonomy numbers on the electronic claim form you are submitting.

Location of Provider NPI, TIN and Member ID Number
On 5010 (837P) professional claims, the provider NPI should be in the following location:

- Medicaid: 2010AA Loop – Billing provider name
- 2010AA Loop – Billing provider name
- Identification code qualifier – NM108 = XX
- Identification code – NM109 = billing provider NPI
- 2310B Loop – rendering provider name
- Identification code qualifier – NM108 = XX
- Identification Code – NM109 = Rendering provider NPI
- For form CMS-1500, the rendering provider taxonomy code in box 24J. ZZ qualifier in box 24I for rendering provider taxonomy.
- For the ADA form, the billing provider taxonomy goes in box 52A and the rendering provider taxonomy goes in box 56A.

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 for organizations (EIN) 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
- The billing provider taxonomy code in box 33b.

On 5010 (837I) 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 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
- The Billing Taxonomy code goes in Box 81.

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

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

Paper Claims
For the most efficient processing of your claims, Humana – CareSource recommends you submit all claims electronically. Paper claim forms are encouraged for services that require clinical documentation or other forms to process.

If you submit paper claims, please use 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)
- Standardized ADA J400 dental claim form
- CMS-1450 (UB-04), formerly UB92 form for facilities

Paper claim submission must be done using the most current form version as designated by the Centers for Medicare & Medicaid Services (CMS), National Uniform Claim Committee (NUCC) and the American Dental Association (ADA). We cannot accept handwritten claims or super bills. Detailed instructions for completing each form type are available at the websites below.
- CMS-1500 Form Instructions
  http://www.cms.hhs.gov/transmittals/downloads/R1104CP.pdf
- UB-04 Form Instructions: nucc.org

All claims (electronic and paper) must include the following information:
- Patient (member) name
- Patient address
- Insured's ID number — Be sure to provide the complete Humana – CareSource member ID for 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 location codes.
- ICD-9 diagnosis code(s) (or ICD-10 effective October. 1, 2015)
- HIPAA-compliant CPT or Healthcare Common Procedure Coding System (HCPCS) code(s) and modifiers when modifiers are applicable.
- Units, where applicable (anesthesia claims require number of minutes).
- Date of service — Please 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, when 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.
- National provider identifier (NPI) — Please refer to sections for professional and Institutional claim information.
- Federal tax ID number or physician Social Security number — Every provider practice (e.g. legal business entity) has a different tax ID number.
- Billing and rendering taxonomy codes that match with the KDMS MPL
- Billing and rendering addresses that match with the KDMS MPL.

- Signature of physician or supplier — The provider's complete name should be included. 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.

Instructions for National Drug Code (NDC) on Paper Claims
All of the following information is required for each applicable code required on a claim:
- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code — F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

What to Include on Claims that Require NDC
1. NDC and unit of measure (e.g., pill, milliliter [cc], international unit or gram)
2. Quantity administered – number of NDC units
3. NDC unit price – detail charge divided by quantity administered
4. HCPCS codes that will require NDCs on professional claims: (submitted on the 837P format)

Tips for Submitting Paper Claims
Humana – CareSource uses optical/intelligent character recognition (OCR/ICR) systems to capture claims information to increase efficiency and to improve accuracy and turnaround time.

To Ensure Optimal Claims Processing Timelines
- EDI claims generally are processed more quickly than paper claims.
- If you submit paper claims we require the most current form version as designated by CMS, NUCC and the ADA.
- No handwritten (including printed claims with handwritten information) claims or super bills 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 to 14 point (capital letters preferred) in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- Federal tax ID number or physician SSN is required for all claims submissions.
- All data must be updated and on file with the KDMS MPL, including TIN, billing and rendering NPI, addresses and taxonomy codes.

Please mail or fax all Kentucky paper claim forms to Humana – CareSource at the following address:

Humana – CareSource
Attn: Claims Department
P.O. Box 824
Dayton, OH 45401-0824
Fax: 1-937-226-6916

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

Claims Processing Guidelines
- Providers have 365 days from the date of service or discharge to submit a claim. If the claim is submitted after 365 days, the claim will be denied for timely filing.
- If a member has other insurance and Humana – CareSource is secondary, the provider may submit for secondary payment within 365 days of the original date of service.
- If a provider does not agree with the decision on a processed claim, he or she has 365 days from the date of service or discharge to file an appeal.
- If the claim appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period. If the initial timely filing period has elapsed, the EOB must be submitted to us within 90 days from the primary payer's EOB date. If a copy of the claim and EOB are not submitted within the required timeframe, the claim will be denied for timely filing.
- All claims for newborns must be submitted using the newborn's Humana – CareSource ID number and the newborn's Kentucky Medicaid ID number. Do not submit newborn claims using the mother's identification numbers; the claim will be denied. Claims for newborns must include the birth weight.

Humana – CareSource established guidelines for payments to out-of-network providers for preauthorized medically necessary services. These services will be reimbursed at 65 percent of the Kentucky Medicaid fee schedule.

The following are exceptions to the January 1, 2014, reimbursement guidelines and will be reimbursed at 90 percent of the Kentucky Medicaid fee schedule:
- Emergency care (nonparticipating professional and facility services provided to members in an emergency room setting)
- Services provided for family planning
- Services for children in foster care

Searching for Claims Information Online
Claim status is updated daily on our provider portal and shows claims submitted in the previous 24 months. Searches by member ID number, member name and date of birth or claim number are available.

Additional Claims Enhancements on the Provider Portal:
- Reason for payment or denial
- Check number(s) and date
- Procedure/diagnostic
- Claims payment date

Procedure and Diagnosis Codes

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. Humana – 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 plan organizations. 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 by calling 1-202-512-1800 or faxing
  1-202-512-2250 and from 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 Procedures and Nomenclature. 2nd Edition (CDT-2). Available from the American Dental Association at
  1-800-947-4746 or www.ada.org
- National Drug Codes (NDC). Available at http://www.fda.gov/

Procedures That Do Not Have a Corresponding CPT Code

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

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

For example, 84999 is an unlisted lab code that requires additional explanation.

Additional Coding/Claim Submission Guidelines

- Drug injections that do not have specific J code descriptions (J9999 and J3490) and an assigned HCPC J code that are not listed on the Medicaid fee schedule require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Abortion sterilization and hysterectomy procedure claims submissions must have consent forms attached. (Please see the “Supplemental/Form” section of this provider manual for these forms.)
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report plus other documentation that will assist in determining reimbursement.
- Coordination of Benefits (COB) paper claims require a copy of the Explanation of Payment (EOP) from the primary carrier.
- COB electronic claims require a copy of the primary carrier’s payment information.

Code Editing

Humana – CareSource uses clinical editing software to evaluate the accuracy of diagnosis and procedure codes on submitted claims to ensure claims are processed consistently, accurately and efficiently.

The clinical Humana – CareSource editing software finds coding conflicts or inconsistent information on claims. For example, a claim may contain a conflict between the patient's age or gender and diagnosis, such as a pregnancy diagnosis for a male patient. Humana – CareSource software resolves these conflicts or indicates a need for additional information from the health care provider. Humana – CareSource clinical editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Humana – CareSource Provider Coding and Reimbursement Guidelines
Humana – CareSource strives to be consistent with KDMS, Medicare and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code/code set(s) submitted and related clinical standards for claims received either as hard copy or electronically. We apply HIPAA standards to all electronically received claims. Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, and ICD-9). Specific contract language stipulating the receipt, processing and payment of particular codes and modifiers are honored, as would be all aspects of a provider contract. When referenced in a contract, KDMS reimbursement rules (http://kymmis.com) are followed, depending on the state involved. In addition, the Center for Medicare & Medicaid Services (CMS) federal rules for Medicare and Medicaid coding standards are followed. Finally, generally accepted commercial health insurance rules regarding coding and reimbursement also
are used when appropriate. Humana – CareSource strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

To determine unit prices for a specific code or service, please refer to the following link for details: http://chfs.ky.gov/dms/fee.htm

Humana – CareSource uses coding industry standards, such as the AMA CPT manual, NCCI, and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Valid CPT/HCPCS code or modifier usage

Humana – CareSource seeks to apply fair and reasonable coding edits. We maintain a provider appeals function that will review, upon request, a claim that is denied based upon the use of a certain code, the relationship between two or more codes, unit counts or the use of modifiers. This review will take into consideration the previously mentioned commonwealth, Medicare, CCI and national commercial standards when considering an appeal. To ensure all relevant information is considered, appropriate clinical information should be supplied with the claim appeal. This clinical information allows the Humana – CareSource appeals team to consider why the code set(s) and modifier(s) being submitted differ from the standards inherent in our edit logic. The clinical information may provide evidence to override the edit logic when the clinical information demonstrates a reasonable exception to the norm.

Any specific claim is subject to current Humana – CareSource claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

Explanation of Payment (EOP)
EOPs are statements of the current status of claims that have been submitted to Humana – CareSource and entered into our system. EOPs are generated weekly. However, providers may not receive an EOP weekly, each time they are generated depending on claim activity. Providers who receive EFT payments will receive an electronic remittance advice (ERA) and can access a "human readable" version on the provider portal.

Information Included on EOPs
EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online
Please remember that you can track the progress of submitted claims at any time through our provider portal.

Other Coverage — Coordination of Benefits (COB)
Humana – CareSource collects Coordination of Benefits (COB) information for our members. This information helps us to ensure that we are paying claims appropriately and complying with federal regulations that Medicaid programs are the payer of last resort.

While we try to maintain accurate information at all times, we rely on numerous sources for information that is updated periodically, and some updates may not always be fully reflected on our provider portal. Please ask Humana – CareSource members for all health care insurance information at the time of service.

Search COB on the provider portal by:
- Member number
- Case number
- Medicaid number/MMIS number
- Member name and date of birth

You can check COB information for members who have been active with Humana – CareSource within the last 12 months.

Claims involving COB will not be paid until an EOB/EOP or EDI payment information file has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full ($0 balance) still must be submitted to Humana – CareSource for processing, due to regulatory requirements.

COB Overpayment
If a provider receives a payment from another carrier after receiving payment from Humana – CareSource for the same items or services, this is considered an overpayment. Humana – CareSource will provide 30 days written notice to the provider before any adjustment for overpayment is made. If a dispute is not received from the provider, adjustments to the overpayment will be made on a subsequent reimbursement. Providers also can issue refund

checks to Humana – CareSource for overpayments and mail them to the address below. Providers should not refund money paid to a member by a third party.
Humana – CareSource
P.O. Box 824
Dayton, OH 45401-0824

Workers' Compensation
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.

Member Billing Policy
State and federal regulations prohibit health care providers from billing Humana – CareSource members for services provided to them except under limited circumstances. Humana – CareSource monitors this activity based on complaints 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 Humana – CareSource.

Regulations on Billing Members
Please remember that government regulations state that health care providers must hold members harmless in the event that Humana – CareSource does not pay for a covered service performed by the provider. The only exception is if Humana – 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 notification must be done prior to providing the service and the member must sign and date the notification acknowledging his or her financial responsibility.

In compliance with federal and state requirements, Humana – CareSource members cannot be billed for missed appointments. Humana – CareSource encourages members to keep scheduled appointments and to call to cancel, if needed. Kentucky Medicaid may be able to offer transportation assistance to members for health care visits. For more information, please call 1-888-941-7433. Humana – CareSource provides emergency transportation as well as ambulance transportation to and from medical appointments when a member must be transported on a stretcher and cannot ride in a car. If you are concerned about a Humana – CareSource member who misses appointments, please call our case management department at 1-866-206-0272.

Providers should call provider services for guidance before billing members for services. You can reach provider services by calling 1-855-852-7005.