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At a Glance

The MedStar Choice Plan pledges to provide accurate and efficient claims processing. To make this possible, MedStar Select requests that providers submit claims promptly and include all necessary data elements.

A key to controlling administrative costs is reducing excess paperwork, particularly paperwork generated by improperly completed claims.

- Type claims or submit them electronically. Handwritten claims may be returned. Make sure all data elements on paper claims appear in the appropriate boxes on the claim form.
- Claims with eraser marks or white out corrections may be returned. Do not use highlighters or red ink to draw attention to specific areas of the claim form.
- If a mistake is made on a claim, the provider must re-submit a new claim. Claims must be submitted by established filing deadlines or they will be denied.
- Corrected claims can be submitted electronically or on paper and should be identified as being a corrected version of a previously submitted claim.
- Only clean claims containing the required information will be processed within the required time limits. Rejected claims, those with missing or incorrect information, may not be resubmitted on the same form. A new claim form must be generated for resubmission.
- Services for the same patient with the same date of service may not be unbundled and submitted on separate claim forms. For example, an office visit, a lab work-up and a venipuncture by the same provider on the same day must be billed on the same claim.
- Resubmit claims only if the MedStar Select has not paid within 30 days and you have verified that we have not received the claim by checking our website or calling Provider Services.
- Use proper place of service codes for all claims.
- Use Modifier 25 when a provider performs a significant separately identifiable evaluation and management of a patient on the same date of service as the original visit and other modifiers as appropriate based on standard coding guidelines.
- Bill anesthesia claims with the correct codes from the American Society of Anesthesiologists with the appropriate anesthesia modifiers and time units if applicable.
- Submit only one payee address per tax identification number.
- Submit all appeals in writing within 90 business days of receipt for the notice indicating the claim was denied. Appeals should clearly state the reason you are requesting that the original processing decision be reviewed and the outcome you are expecting. Administrative appeals do not need medical records unless specifically requested, however they should contain all supporting documentation, up to and including notes from your practice management system, to support the reason you are filing the appeal. Clinical appeals should always contain medical records and if appropriate other supporting documentation.
Submission Guidelines

Electronic Filing
The MedStar Medicare Choice Plan’s claims processing system allows provider access to submitted claims information, including the ability to view claim details such as claim status (i.e., was there an error on submission?) and the claim number to be used as a reference indicator.

Electronically filed claims may be submitted in the following ways:

Individual Claim Entry
Individual claim entry is available to network providers with established Provider OnLine accounts. This feature allows direct submission of both professional (CMS-1500) and institutional (UB-04) claims via a user-friendly interface, using the Internet’s highest level of security to make the process safe and easy. In order to use Prelog, providers must complete a brief e-learning course and a short post-course assessment. Upon successful course completion, the provider’s office can enter claims and verify acceptance.

Electronic Data Interchange (EDI)
MedStar Medicare Choice also accepts electronic claims in data file transmissions. Electronic claim files sent directly to the MedStar Select Plan are permitted only in HIPAA standard formats.

Providers who have existing relationships with clearinghouses such as Emdeon, Relay Health and others (MedStar Medicare Choice Payer ID: 251MS), can continue to transmit claims in the format produced by their billing software. These clearinghouses are then responsible for reformatting claims to meet HIPAA standards and passing the claims on to the MedStar Select.

For all EDI submissions, the NPI (National Provider Identifier) number is required. When care is coordinated, the referring provider’s name and NPI are required.

Submission of Claims Directly to MedStar Medicare Choice
Providers are able to submit claims directly without incurring clearinghouse expenses. These claims are loaded into batches and immediately posted in preparation for adjudication. Via the Provider OnLine EDI tools, these batches can be viewed in several standard report formats.

In order to submit EDI files directly to MedStar Medicare Choice, providers must:

- Have an existing Provider OnLine account or register for a new provider or submitter account by filling out the application form at www.MedStarProviderNetwork.org.
- Use billing software that allows the generation of a HIPAA-compliant 837 professional or institutional file
- Have a sample 837 file exported from their billing system containing only MedStar Select claims
- Have a computer with Internet access
- Have the ability to download and install a free Active-X secure FTP add-on
- Complete testing with MedStar Medicare Choice.
Paper Claim Forms
CMS-1500 forms
These forms are for professional services performed in a provider’s office, hospital or ancillary facility. (Provider-specific billing forms are not accepted.)

UB-04 forms
These forms are for inpatient hospital services or ancillary services performed in the hospital. (Hospital-specific billing forms are not accepted.)

Deadlines
The MedStar Medicare Choice Plan accepts new claims for services up to 180 days after the date of service for MedStar Select.

When MedStar Medicare Choice is the secondary payer, claims are accepted with the explanation of benefit (EOB) from the primary carrier. This claim must be received within 180 days of the primary EOB remittance date or up to the new claim timely filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing.

Members cannot be billed for the MedStar Medicare Choice Plan’s portion of the claims submitted after these deadlines; however, they may be billed for co-payments, co-insurance and/or deductibles.

Claims Address
Claim forms should be submitted to the following address:

MedStar Medicare Choice Claims
P.O. Box 1200
Pittsburgh, PA 15230-1200
Diagnosis Codes
Claims must be submitted with a diagnosis code, indicating the member’s medical condition or circumstances necessitating evaluation or treatment. The diagnosis codes submitted on claim forms must correlate to the documentation contained within the member’s medical record and reflect or support the reason services have been provided.

Follow these guidelines to avoid the most common claims coding problems:

- New POA (Present on Admission Indicator)
- Diagnosis should be coded using ICD-9-CM. Make sure the diagnosis code is valid and complete (i.e., includes all digits).
- The primary diagnosis should describe the chief reason for the member’s visit to the provider.
- When a specific condition or multiple conditions are identified, these conditions should be coded and reported as specifically as possible.
- For coding of services provided on an outpatient basis, do not code the diagnosis as “rule out,” “suspect” or “probable” until such time as the condition is confirmed. Code the condition to the highest degree of certainty, such as symptoms, signs, or abnormal test results.
- When addressing both acute and chronic conditions, assign codes to all conditions for which the member is seeking medical care.
- When coding ongoing or chronic conditions, do not assume the code used at a previous visit is appropriate for a current visit.
- In coding diabetes, be certain to identify the current status of the member’s condition as Type I or Type II, controlled or uncontrolled, referring to the direction of ICD-9-CM.
- Use caution in coding injuries, identifying each as specifically as possible.
- Refer to guidelines throughout ICD-9-CM for “late effect” coding and sequencing.
- “Well” vs. “sick” visits — If a preventive visit was scheduled, but symptoms of illness or injury exist at the time of the visit, code the primary diagnosis as “preventive.” The condition(s) for which the member is being treated should be coded as a secondary diagnosis.
- V-codes are used for circumstances affecting a member’s health status or involving contact with health services that are not classified under ICD-9 codes 001–999. In general, they do not represent primary disease or injury conditions and should not be used routinely. V-codes used to describe personal and/or family history of medical conditions are covered when used for a screening procedure; however, V-codes that pertain to mental health, learning disorders or social conditions are not covered.

Claims Resubmission
Claims may be resubmitted if MedStar Medicare Choice has not paid within 30 days of the initial submission. These claims can be a photocopy or a reprinted claim.
Claims Documentation

Clean vs. Unclean Claims
The MedStar Medicare Choice Plan defines a “clean” claim as one with no defects or improprieties. A defect or impropriety may include, but is not limited to, the following:

- Lack of required substantiating documentation
- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim
- Any required fields where information is missing, incomplete, or illegible.
- Invalid, incorrect or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes)
- A missing explanation of benefits (EOB) for a member with other coverage
- Claims requiring medical review before payment
- Claims requiring authorization that was not obtained
Reimbursement

The MedStar Medicare Choice Plan processes all clean claims within 30 days from the date they are received. Applicable state regulations stipulate that a claim is paid when MedStar Medicare Choice mails the check.

Explanation of Payment (Remittance Advice)

The Explanation of Payment (EOP), referred to on the statement as a “remittance advice,” is a summary of claims submitted by a provider. It shows the date of service, diagnosis and procedure performed as well as all payment information (i.e., money applied to the member’s deductible or copayment, and denied services.)

For additional questions pertaining to the EOP, contact Provider Services at (855) 222-1042.

Process for Refunds or Returned Checks

The MedStar Select Plan accepts overpayments two ways:

1. Providers may refund additional money directly to MedStar Medicare Choice, or
2. MedStar Medicare Choice will take deductions from future claims.

Refunds

If MedStar Medicare Choice has paid in error, providers may return the check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund and the explanation of benefits (EOB) from other insurance carriers, if applicable.

Refunds should be sent directly to the General Accounting Department at this address:

Attn: General Accounting
MedStar Medicare Choice
24th Floor
600 Grant Street
Pittsburgh, PA 15219

Overpayment

If the MedStar Medicare Choice Plan has paid in error and the provider has not sent a refund or returned the check, money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount.

Claim Follow-Up

To view claim status online go to www.MedStarProviderNetwork.org. Existing users can log in through Provider OnLine. New users will be asked to register. For log-in information, contact Provider Services at (855) 222-1042 or email Provider_Support@TogetherForYourHealth.com.

To check the status of a claim without going online, call Provider Services at (855) 222-1042 from 8 a.m. to 5 p.m., Monday through Friday.
Denials & Appeals

All denied claims are reported on the EOP, referred to on the statement as a “remittance advice.” This indicates whether the provider has the right to bill the member for the denied services and/or if the member is financially responsible for payment.

If a provider disagrees with the MedStar Medicare Choice Plan’s decision to deny payment of services, the provider must appeal in writing to the appeals coordinator within 90 business days of receipt of the denial notification. The request must include the reason for the appeal and any relevant documentation, which may include the member’s medical record. More detailed information on this subject can be found in the Provider Standards & Procedures section of this manual. Appeals should be submitted to:

MedStar Medicare Choice
Provider Appeals
PO Box 269
Pittsburgh, PA 15230-0269

All appeals undergo MedStar Medicare Choice's internal review process, which meets all applicable regulatory agency requirements. The provider will receive written notification in all situations in which the decision to deny payment is upheld.