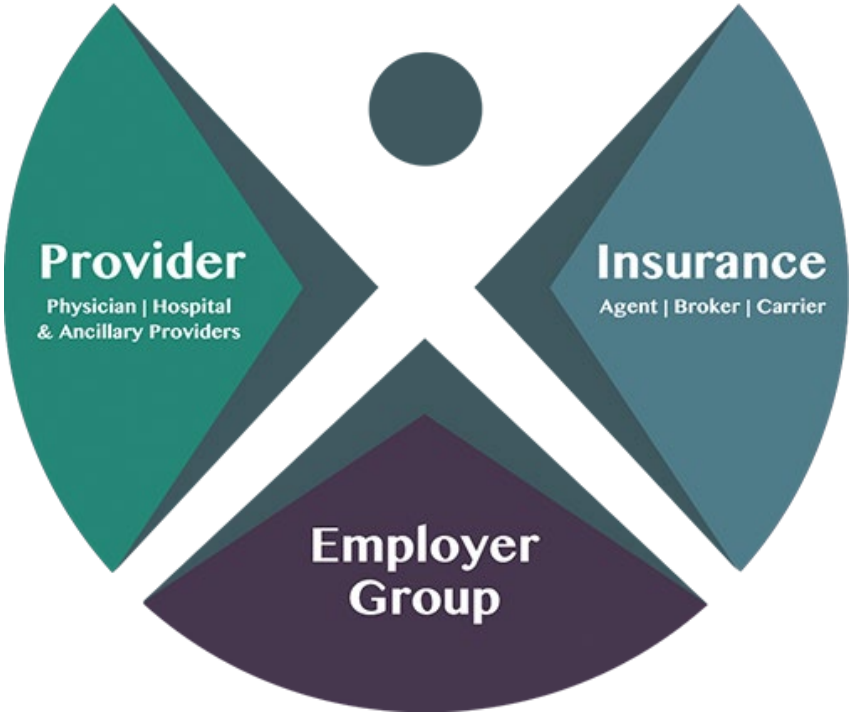
WPPA, INC.

# ProviDRs Care®




# 2021

Claims and Billing Manual

WPPA, INC.

# ProviDRs Care

## Contents

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# Introduction

## How to Use This Manual

The ProviDRs Care Claims and Billing Manual is published to assist healthcare providers and office staff in developing and maintaining a high quality working relationship with ProviDRs Care. Updates and revisions to this manual are available at **www.ProviDRsCare.net** and can also be provided electronically.

When questions arise regarding programs and plans associated with ProviDRs Care, we ask that you please check the appropriate section of the manual prior to calling customer service. If you are unable to find the answer, please check our website or contact the Provider Relations Department.

In addition, we are always searching for ways to improve service for our Providers. If you have any suggestions regarding improvement to this manual, please contact the Provider Relations Department.

## About ProviDRs Care

### Our Mission is...

- To sustain a comprehensive statewide network of physicians, hospitals and ancillary providers dedicated to delivering high-quality and cost effective medical care to covered members at a reasonable fee.
- To maximize the benefits of employee health care plans while controlling health care costs by partnering with insurance carriers, employers and our network of providers and facilities.

ProviDRs Care works in partnership with insurance agents, brokers and carriers to provide cost-effective, quality health care coverage to individuals, employers and groups ranging from 2 to 20,000 members. Our extensive network of physicians, health care providers and medical facilities helps employers maximize their plan benefits and gain control of their costs.

## How to Contact ProviDRs Care

Phone Number: (316) 683 4111 or (800) 801-9772
Fax Numbers: General (316) 683-6255 or Claims (316) 683-1271

Business hours are Monday through Friday, 8:30 am to 4:30 CST.

| | Phone Extension | Email Address |
|---|---|---|
| **Provider Relations** | (800) 801-9772, Option 4 | **ProviderRelations@ProviDRsCare.net** |
| **Claims Department** | (800) 801-9772, Option 4 | **Claims@ProviDRsCare.net** |

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## ProviDRs Care Network Reimbursement Policies

The ProviDRs Care Network allowances are designed to reimburse our ProviDRs appropriately while remaining competitive with other network reimbursements. Mid-level practitioners, occupational therapists, physical therapists, speech language pathologists and licensed dieticians are reimbursed at 85% of the Maximum Allowable Payment (MAP). Non physician behavioral health providers are reimbursed at 70% of the MAP. Providers rendering services at the following Places of Service are subject to a site differential:

- Inpatient Hospital (POS code 21);
- Outpatient Hospital (POS code 22);
- Emergency Room-Hospital (POS code 23);
- Ambulatory surgical center (ASC) (POS code 24);
- Skilled Nursing Facility (SNF) (POS code 31);
- Hospice – for inpatient care (POS code 34);
- Ambulance – Land (POS code 41);
- Ambulance – Air or Water (POS code 42);
- Inpatient Psychiatric Facility (POS code 51);
- Psychiatric Facility -- Partial Hospitalization (POS code 52);
- Community Mental Health Center (POS code 53);
- Psychiatric Residential Treatment Center (POS code 56); and
- Comprehensive Inpatient Rehabilitation Facility (POS code 61).

### Modifiers

The following modifiers may affect the repricing of your claims. The discounts derived from these modifiers are subject to network guidelines and cannot be billed to the patient.

| Modifier: | Description: | Repricing Methodology: | Applies to: |
|---|---|---|---|
| -22 | Increased Procedural Service | 115% of allowable. | Surgical procedures |
| -26 | Professional Fee Only | Professional allowable will be used. | Non-surgical services |
| -50 | Bilateral Procedure | 1½ times the Allowable. | Surgical procedures |
| -51<br>-59 | Multiple Procedure | 100% of allowable for the first procedure (which should not be marked with the modifier), 50% for the second procedure and 25% for the third and following procedures. | Surgical procedures |
| -52 | Reduced Service | 50% of allowable. | Surgical procedures |
| -53 | Discontinued Services | 50% of allowable. | All procedures |

| | | | |
|---|---|---|---|
| -54 | Surgical Care Only | 70% of allowable. | Surgical procedures |
| -55 | Postoperative Management Only | 15% of allowable. | Surgical procedures |
| -56 | Preoperative Management Only | 15% of allowable. | Surgical procedures |
| -62 | Co-surgeons | 125% of the Allowable is to be divided between the two surgeons. Each surgeon is to indicate what percent of the surgery he/she performed. When no indication is provided, ProviDRs Care will apply a default of 50/50. | Surgical procedures |
| -73 | Discontinued Outpatient Hospital/ASC Procedure prior to anesthesia | 60% of allowable. | Facility Fees |
| -74 | Discontinued Outpatient Hospital/ASC Procedure after anesthesia | 60% of allowable. (Anesthesiologists should bill indicating time and should be reimbursed according to standard Anesthesia guidelines) | Facility Fees |
| -80<br>-81<br>-82<br>-AS | Assistant Surgeon | 25% of the calculated allowable for approved assistant surgeon charges and approved assistant surgeons. | Surgical procedures |
| QX | NonPhysician Anesthetist with medical direction by a physician | Allow 50% of the allowable | Anesthesia |
| QY | Medical direction of one qualified nonphysician anesthetist by an anesthesiologist | Allow 50% of the allowable | Anesthesia |
| -TC | Technical Component | The technical allowable will be used. | Non-surgical services |

**Multiple Surgeries**

- The order of surgery reductions are determined using the RVU weight of the billed codes in combination with modifier 51 when applicable.

- Multiple surgery reductions apply even when the surgeries are billed on separate claims

- Add-on Codes and Modifier 51 Exempt Codes do not receive multiple surgery reductions
- Multiple units should be considered multiple surgeries
- Multiple Surgery reductions only apply to surgical procedures with an established allowable. Do not apply multiple surgery reductions on a surgical CPT Code that does not have an established allowable.

**Content of Service**

Content of service refers to specific services and/or procedures that are considered to be an integral part of previous or concomitant services or procedures to the extent that separate reimbursement is not recognized. Not all content of service issues are identified in the policies and procedures. ProviDRs Care may identify and classify specific coding and nomenclature issues as they arise. Examples of services that can be considered content of service are:

- Evaluation of tests or studies (i.e., radiology or pathology).
- Medical and surgical supplies.
- Therapeutic, prophylactic, or diagnostic injection administration provided on the same day as an office visit, home visit, or nursing home visit.

**Clinic Services In the Hospital Outpatient Setting**

For clinic visits and services performed in the hospital outpatient setting, ProviDRs Care does not allow split-billing of Provider-based clinic services. This applies whether the clinic is located in an on campus-outpatient hospital setting (POS 22), or an off campus outpatient hospital (POS 19), and whether or not the clinic uses the hospital tax identification number.

Do not split-bill clinic-based services, billing part of the service as a facility charge, and part of the service as a professional charge using POS 19 or 22 or a professional revenue code.

All professional services provided in an outpatient clinic setting are to be billed on a CMS1500 claim form or electronic equivalent, using POS 11 Office. Professional claims will be reimbursed according to the applicable professional fee schedule.

Revenue Codes 0510 – 0519 Clinic

Clinic charges (revenue codes 0510 – 0519) are facility fee split billing of clinic-based services. This split billing is not allowed, and revenue codes 0510 – 0519 are not reimbursable; charges will deny to facility/provider write-off. Participating providers and facilities may not balance-bill the patient.

These services are to be billed on a CMS1500 claim form or electronic equivalent, using POS 11 Office.

### Claims Edits

Accurate coding and reporting of services are critical aspects of proper billing. To promote national correct coding methodologies and to control improper coding leading to inappropriate payment, ProviDRs Care, consistent with industry standards, applies claim edits defined under the CMS National Correct Coding Initiative Guidelines (NCCI).

## Requests for Medical Records/Operative Reports

On occasion, ProviDRs Care will need to review a portion of the medical record to assure fair and accurate repricing. ProviDRs Care only requests records when necessary and is only used for purposes stated on the records request.

### Unit Limitations

ProviDRs Care follows Medicare's Medically Unlikely Edits (MUE) when determining the number of units any given code can be billed on a single date of service.

- **CMS MUE Edits**

### Wrong Surgical or Other Invasive Procedures

Providers will not be reimbursed for surgical or other invasive procedures that are erroneously performed by a healthcare provider. This policy applies to both UB-04 and CMS-1500 claim forms.

Erroneous procedures include:

- Surgical procedure performed on the wrong side or body part
- Surgical procedure performed on the wrong person
- The wrong surgical service or other invasive procedure rendered to a patient

In addition, Medica will not reimburse for services associated with the erroneous procedure. Associated services include:

- All services provided in the operating room that are related to the error
- Services provided by all providers in the operating room when the error occurred, who could bill individually for their services
- All related services provided during the same hospitalization in which the error occurred.

Providers may not balance bill the member for costs associated with erroneous procedures.

The following services (if covered) will be reimbursed regardless of whether or not they are related to the erroneous procedure:

- Services provided following discharge
- Performance of the correct procedure

ProviDRs Care follows CMS coding and billing guidelines:

Hospital Inpatient Claims
Hospitals are required to submit two UB-04 claims:

- A no-pay claim (Type of Bill 110) for all services associated with the erroneous procedure
- A separate claim for services unrelated to the erroneous procedure

Hospital Outpatient, Ambulatory Surgery Center (ASC), and Professional/1500 Claims
Outpatient, ASC, and practitioner claims must have one of the following modifiers appended to the surgical procedure code:

- PA: Surgical or other invasive procedure on wrong body part
- PB: Surgical or other invasive procedure on wrong patient
- PC: Wrong Surgery or other invasive procedure on patient

For claims billed on both the UB-04 and CMS-1500 form, one of the following diagnoses must be reported on the claim to identify the type of error that occurred:

ICD-10-CM on or after 10/1/2015:

- Y65.51 - Performance of wrong procedure (operation) on correct patient
- Y65.52 - Performance of procedure (operation) on patient not scheduled for surgery
- Y65.53 - Performance of correct procedure (operation) on wrong side/body part

Note: For the UB-04 claim type, the ICD-10-CM diagnosis codes listed above must be reported in diagnosis position 2-9.

## Durable Medical Equipment Pricing

Manually Priced Items

All manually priced DME, prosthetics and orthotics (P&O), and DME repair or maintenance will be priced according to the below criteria.

ProviDRs Care requires providers to follow current policy for DME and P&O. Current policy requires DME and P&O to be priced using the following tiered methodology:

1. ProviDRs Care Fee Schedule
2. Providers cost plus 10 percent
3. Manufacturer suggested retail price (MSRP) minus 15 percent

All DME and P&O claims must be accompanied by an official MSRP.

Providers actual cost and MSRP must be submitted with each claim on all manually priced DME/P&O items and codes. All documents submitted must be free of any altering, covering up, or blacking out of information, except to maintain HIPAA requirements.

All MSRPs must be official from the manufacturer. No handwritten MSRPs are allowed. MSRPs cannot be altered or blacked out in any way except to maintain HIPAA requirements.

Provider's cost is the actual cost the provider paid for the item. Any discounts the provider receives must also be submitted. An official invoice from the supplier/manufacturer must be supplied. Handwritten or DME provider-manipulated invoices are not allowed. Invoices cannot be blacked out or altered in any way except to maintain HIPAA requirements.

If an item is bought in bulk (or more than one at a time), the invoice showing the provider's actual cost and the number of units purchased must be submitted (per unit cost will be calculated). Costs of doing business (such as, employee's time, travel time and expenses, or office expenses) cannot be included in provider's cost.

Claims priced under cost plus 10 percent or MSRP minus 15 percent will be paid at zero dollars on the initial claims submission. Providers should submit a corrected claim with the required supporting documentation for the correct allowance. Supporting documentation should be sent via fax, mail or email listed on page 3 to the Claims Department.

**Note:** All wheelchairs, wheelchair accessories, wheelchair repairs, and covered specialty walkers are exempt from this requirement. These items will be paid at 75% of MSRP or the current ProviDRs Care Fee Schedule rate.

### Ambulance Billing

Report 1 unit with HCPCs codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434

Report number loaded miles with HCPCs codes A0425, A0435 or A0436. Mileage must be reported as fractional units

- Miles totaling less than 100 miles: Report mileage units rounded up to nearest tenth of a mile. Submit fractional mileage using a decimal in appropriate place (e.g., 99.9). Mileage units reported as 99.99 will become 99.9

- Miles totaling 100 miles or greater: Report mileage rounded up to nearest whole number mile. Note: Contractors will truncate mileage units totaling 100 and greater that are reported with fractional mileage (e.g., 100.99 will become 100 after truncating the decimal places)

- Mileage totaling less than 1 mile, include a "0" prior to decimal point (e.g., 0.9)

### Drugs and Vaccine Billing

Some drug codes and vaccine codes require the provider to submit invoices to determine reimbursement. Providers that receive a reimbursement of $0 for either of these two services can email the following information to **Claims@ProviDRsCare.net** or **JeanneHingst@ProviDRsCare.net**:

- Claim DOS
- Patient name
- Claim charge amount
- NDC number for vaccine or drug
- If no NDC number available, submit cost invoice

### Claim Status Inquiries

ProviDRs Care Claims Repricing Department is available to assist with repricing status requests and problematic claims resolutions. Claims staff members are available Monday through Friday from 8:30 am to 4:30 pm Central Time. Providers in the Wichita, KS area should call (316) 683-4111; all others callers may use (800) 801-9772.

For your convenience, you may check claim repricing status online by clicking the link below:
**CLAIMS.ProviDRsCare.Net**

**Please note that ProviDRs Care does not pay claims and will not have information available regarding benefits or payment. For status of claims payment, please refer to the patient's identification card for the payer's telephone number. For more information on our prompt pay policy, see "Payment Turnaround Time".**

### Facility Rate Increases

Any facility with an escalator clause on their reimbursement schedule and all hospitals are required to provide advanced written notice of any annual or off-cycle chargemaster or rate increases. Those who fail to notify WPPA ProviDRs Care of annual rate increases are subject to a claims audit.

> ***Hospitals Only:*** Hospitals are limited to a maximum increase of three percent (3%) each contracting cycle (January 1-December 31) and are required to provide a written notice of any increases at least 60 days prior to the effective date unless otherwise stated in the reimbursement schedule escalator clause,

1. If written notice is received in accordance with the due date, Contracting staff calculates new reimbursement rates, including an offset should the rate increase exceed the maximum allowed increase (%), and effective date (January 1st unless otherwise stated in escalator clause).

2. If written notice is received *after* the due date, Contracting staff adjusts reimbursement rates to remove the impact of the rate increase. New reimbursement rates are effective the date of the increase.

3. If no written notice is received, approximately two (2) months after rate increase effective date (January 1st unless otherwise stated in escalator clause), Contracting staff performs a claims audit. Facility is notified of identified increases and any additional information requests. Reimbursement rates are adjusted, as applicable.

## Claims Filing & Collecting

### Collection of co-Payment and Co-Insurance

Providers may collect co-payments and co-insurance at the time services are rendered. Providers are expected to assist the patient in determining an appropriate co-insurance amount that considers the expected allowance and patient remaining out-of-pocket expenses.

### Timely Filing

Claims must be submitted within 180 days from the last day of the month in which services occurred. Keep in mind; however, the quicker the claim is filed, the quicker the payment can be received. Some self-funded plans have timely filing limits that prohibit claims payments that fall outside of the contract period. For this reason, it is critical to file claims as soon as possible after services are rendered.

Corrected claims should be filed within sixty (60) days after receipt of payment explanation from Group. If the claim is not filed promptly, the claim may be denied due to the plan limitations. At no time is the rendering provider allowed to balance bill the patient for denied claims filed after sixty (60) days.

### Payment Turnaround Time

Your payments will come from two sources: the payer and/or the patient. Contracting groups are required to pay or deny clean claims within thirty (30) business days of receiving the claim. In the event the claim cannot be processed timely, the group is required to issue a statement explaining the reason for the pending status.

For claims where payment, denial or statement of pending status has not been received timely, the provider may request to have a prompt pay penalty applied to the claim. The provider may submit a request to rescind the network savings in writing via fax (316-683-1271) or mail:

Attn: Claims-Prompt Pay
ProviDRs Care Network
238 N Waco
Wichita KS 67202

The correspondence should include original date of claim submission, dates of resubmissions and copies of any correspondence sent or received. ProviDRs Care Network will contact the payer in an effort to reach a resolution within five (5) business days.

### Assignment and Claims Routing

As a ProviDRs Care Network participating provider, you have agreed to accept assignment and file claims for all services rendered to eligible patients.

Claims filing addresses vary by claim administrators. To ensure claims are filed to the accurate location, please refer to the patient's health identification card. You may also request a copy of our Payer/Client Repricing Report to assist you in determining the location for claims submissions. These requests may be sent to Claims@ProviDRsCare.Net.

Claims repriced by ProviDRs Care may be submitted via mail, fax or electronically. For more information on electronic submissions, see the next section; paper filing information is as follows:

Mailing address: 238 N Waco
Wichita KS 67202

Fax Number: (316) 683-1271

### Electronic Claims Filing

Electronic claims submission can significantly increase productivity within your practice. Not only will this reduce paper costs, but it also improves the repricing turnaround of your claims and improves accuracy by minimizing the chance of conversion errors. Please reference the list of Electronic Data Interchange (EDI) clearinghouses/vendors below for the most up-to-date status of connectivity with ProviDRs Care.

**http://providrscare.net/edi-vendor-connectivity-list/**

If you cannot locate your clearinghouse/vendor on the list, please contact **NikkiSade@ProviDRsCare.Net** to request a connection.

### Claims Service Locations

All claims filed (paper or electronic) are required to include the Service Facility location where services are rendered. On occasion, ProviDRs Care administers repricing for groups with benefit plans designed to increase continuity of care. To facilitate these plan designs, all providers participating in ProviDRs Care Network are required to provide the location of where the services were rendered. This also ensures the provider collects the proper co-pay and is reimbursed accordingly from the group. The following information is required:

Paper Claims HCFA: Box 32 (Service Facility Location)

Electronic Claims Professional v5010: Loop 2310C (Service Facility Location) is required when the location is different than the location in Loop 2010AA (Billing Provider).

## Corrected Claim Submission

### HCFA/Professional Claims

ELECTRONIC SUBMISSION: To submit a corrected HCFA claim electronically, please include a 7 (Replacement of prior claim) in the CLM05 Claim Frequency Type Code (AKA Claim Submission Reason Code).

PAPER SUBMISSION: To submit a corrected HCFA claim via paper:

- Option 1: Please include a 7 (Replacement of prior claim) in Box 22 (Resubmission Code).
- Option 2: Mark or Stamp “Corrected Claim” in a clear identifiable location on the paper claim.

**UB/Institutional Claims**

ELECTRONIC SUBMISSION: To submit a corrected UB claim electronically, please include a 7 (Replacement of prior claim) in the CLM05 Claim Frequency Type Code (AKA The third position of the Bill Type Code).

PAPER SUBMISSION: To submit a corrected UB claim via paper:

Option 1: Please include a 7 (Replacement of prior claim) as the third position of the Bill Type Code.

Option 2: Mark or Stamp "Corrected Claim" in a clear identifiable location on the paper claim.

## Claims Appeal

Providers are not required to call prior to submitting an appeal or request for assistance on a problematic claim. Requests may be sent with attention to Claims Appeals via the following:

- Mail:
  ProviDRs Care Network
  238 N Waco
  Wichita, KS 67202
- Fax: (316) 683-1271
- Email: **Claims@ProviDRsCare.net**

Examples of problematic claims include:

- Claims paid with incorrect ProviDRs Care Network allowance.
- Claims paid showing a participating provider as out-of-network in error, and vice-versa.

Claims can also be rejected for various reasons, including but not limited to the following:

- Tax identification number submitted on the claim is not on file with ProviDRs Care
- Not listing the practitioner name in box 31 of the HCFA
- Not listing the service facility location
- Not complying with provider data audits

If a claim is rejected, please reference the EOB or contact us at (800) 801-9772 if you have questions regarding rejected claims.

## Requests for Medical Records/Operative Reports

On occasion, ProviDRs Care will need to review a portion of the medical record to assure fair and accurate repricing. ProviDRs Care only requests records when necessary and is only used for purposes stated on the records request.