American Specialty Health

# Claims Submission

## *How to Submit Claims to ASH*

ASH strives to pay claims from Contracted Providers/Practitioners promptly and accurately to meet the requirements and expectations of Contracted Providers/Practitioners, our members, clients, and accreditation organizations. Your timely submission of claims for Covered Services rendered to ASH members following the guidelines below will contribute greatly to prompt payment of your claims. This section provides instructions for submitting claims for the reimbursement of Covered Services under a member's benefit plan. Completing the following steps will assist in the timely processing of your claims:

1. Verify that you have previously submitted a Medical Necessity Review Form (MNR Form), for all services beyond those indicated in your Clinical Performance System tier, if applicable for your specialty, as defined in the Clinical Performance System section of your Practitioner Operations Manual or the applicable Client Summary;
2. For any Covered Condition (diagnosis codes), all Covered Services (CPT Codes) under the applicable Client Summary are reimbursable when eligible within your Clinical Performance System tier or when verified by ASH as medically necessary.
3. Verify that you have received an MNR Response Form (MNRF) that confirms ASH has evaluated and verified Covered Services are Medically Necessary Services.
4. Submit all claims through ASHLink, our secure provider/practitioner website, an approved clearinghouse or on a CMS 1500 Claim Form (02/2012). (See Completing the CMS 1500 Claim Form (02/2012) section for instructions on how to submit your claim by mail.)
5. To prevent errors and omissions that may result in avoidably denied or returned claims:
   - Include the patient's correct birthdate.
   - Indicate the member's health plan name.
   - Indicate the correct member identification number.
   - Include accurate and valid diagnosis code(s). Diagnosis codes must be recorded to the highest level of specificity to the patient's condition in accordance with criteria set through the current ICD-10 Guidelines Manual in order to comply with HIPAA regulations.
   - In box #25, use the TIN in effect on the date of claims submission if different than the TIN in effect on the date(s) of service listed on the claim
   - If submitting a CMS 1500 Claim Form (02/2012), sign, type, or stamp your full name in box 31.
6. Refer to the applicable Client Summary and Fee Schedule for acceptable billing codes.
7. Enter each service separately listing your usual and customary billed charges.

8. Services must be billed according to the scope of licensure in your state.
9. If the claim is submitted with missing information, ASH will request the information from you. When the requested information is received, the claim is adjudicated accordingly. Notification to request additional information is made within 30 days of receipt and no longer than 5 days from determining a claim is not a clean claim. If the information requested is not received from you within 90 days, the claim will be denied. For Medicare claims, if the information requested is not received from you within 45 days, the claim will be denied.

Please note the following additional guidelines for claims submission may apply in certain circumstances. You will need to refer to the applicable Client Summaries to identify these exceptions and obtain further instructions:

1. If you are submitting a claim for services (which are not under the Clinical Performance System) and the member's benefit plan requires a referral from a primary care physician or treating physician (refer to applicable Client Summaries), fax a copy of the referral to 877.795.2746 when submitting your claim electronically through ASHLink or ASH Clearinghouse. Please be sure the treating practitioner's name and patient's identifying information are clear on the fax to allow ASH to match the referral to the appropriate transaction.
2. Some Client Summaries indicate that you are required to submit claims directly to the client.
3. Some clients require additional documentation to be attached to the claims. This additional information should also be faxed to 877.795.2746 when submitting your claim electronically through ASHLink or ASH Clearinghouse. Please be sure the treating practitioner's name and patient's identifying information are clear on the fax to allow ASH to match the additional documentation to the appropriate transaction.

## *Completing the CMS 1500 Claim Form (02/2012)*

The sections of the CMS 1500 Claim Form (02/2012) that need to be completed are described below. Only the red form version of the CMS 1500 Claim Form (02/2012) is accepted. Copies of the CMS-1500 should not be downloaded for submission of claims, since they may not accurately replicate colors included in the form. These colors are needed to enable automated reading of information on the form. Visit the U.S. Government Bookstore at https://bookstore.gpo.gov/ to order the form. You can view a sample of this form at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS1500.pdf.

To expedite timely processing, ensure appropriate reimbursement, and prevent denial of your claim, it is important to provide complete and accurate information in the following fields:

**1a.** INSURED'S ID NUMBER: Enter insured's identification number as shown on insured's identification card for the payer to whom the claims are being submitted.

**2.** PATIENT'S NAME: Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr., Sr.) enter it after the last name and before the first name.

**3.** PATIENT'S BIRTH DATE, SEX: Enter the patient's 8-digit birth date (MM/DD/YYYY). Enter an X in the correct box to indicate gender of the patient.

**4.** INSURED'S NAME: Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr., Sr.) enter it after the last name and before the first name.

**5.** PATIENT'S ADDRESS: Enter the patient's mailing address and telephone number.

**6.** PATIENT RELATIONSHIP TO INSURED: Enter an X in the correct box to indicate the patient's relationship to insured.

**7.** INSURED'S ADDRESS: Enter the insured's mailing address and telephone number.

**8.** RESERVED FOR NUCC USE: This field is reserved for NUCC use.

**9.** OTHER INSURED'S NAME: If Item 11d is marked Yes, complete fields 9 and 9a-d, otherwise leave blank. When additional health coverage exists, enter other insured's full last name, first name and middle initial of the enrollee in another health plan.

**9a.** OTHER INSURED'S POLICY OR GROUP NUMBER: Enter the policy or group number of the other insured.

**9b.** RESERVED FOR NUCC USE: This field is reserved for NUCC use.

**9c.** RESERVED FOR NUCC USE: This field is reserved for NUCC use.

**9d.** INSURANCE PLAN NAME OR PROGRAM NAME: Enter the other insured's insurance plan or program name.

**10.** IS PATIENT'S CONDITION RELATED TO: When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. The state postal code must be shown if YES is marked in 10b for auto accident.

**10d.** CLAIM CODES (Designated by NUCC): When required by payers to provide the sub-set of Condition Codes approved by the NUCC, enter the Condition Code in this field. The Condition Codes approved for use on this 1500 Claim Form are available at www.nucc.org under Code Sets.

**11.** INSURED'S POLICY GROUP OR FECA NUMBER: Enter the insured's policy or group number as it appears on the insured's health care identification card.

**11a.** INSURED'S DATE OF BIRTH AND SEX: Enter the 8-digit date of birth (MM/DD/YYYY) of the insured and an X to indicate the gender of the insured.

**11b.** OTHER CLAIM ID (Designated by NUCC): Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC. The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number. Enter the qualifier to the left of the vertical, dotted line. Enter the identifier number to the right of the vertical, dotted line.

**11c.** INSURANCE PLAN NAME OR PROGRAM NAME: Enter the insurance plan or program name of the insured.

**11d.** IS THERE ANOTHER HEALTH BENEFIT PLAN? When appropriate, enter an X in the correct box. If marked Yes, complete 9, 9a and 9d.

**14.** DATE OF CURRENT ILLNESS. INJURY, OR PREGNANCY (LMP): Enter the 8-digit (MM/DD/YYYY) date of first date of the present illness. injury, or pregnancy.

**17.** NAME OF REFERRING PROVIDER OR OTHER SOURCE: Enter the name and credentials of the professional who referred or ordered the service(s) or supply(s) on the claim.

**17b**. Enter the NPI number of the referring practitioner, ordering practitioner, or other source.

**21.** DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Enter the applicable ICD indicator to identify which version of ICD codes is being reported: '0' for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than ICD-10-CM diagnosis codes. Relate Lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. **The first diagnosis code listed should be the primary diagnosis.** These diagnosis codes should match the diagnosis codes on the MNR Form and referenced on the MNRF.

**24A.** DATE(S) OF SERVICE: Enter date(s) of service, from and to, for each unique date of service in an eight-digit format (MM/DD/YYYY). It is important that you do not use date ranges.

**24D.** PROCEDURES, SERVICES OR SUPPLIES: Enter the appropriate CPT and HCPCS code(s) and modifiers(s) (if applicable) from the appropriate code set in effect on the date of service.

**24F.** $ CHARGES: Enter your usual and customary charge of each listed service.

**24J.** RENDERING PROVIDER ID #: Enter the 10-digit NPI of the treating practitioner.

**25.** FEDERAL TAX ID NUMBER: Enter the practitioner of service or supplier federal tax ID (employer identification number) or Social Security number on file with ASH. Enter an X in the appropriate box to indicate which number is being reported.

**28.** TOTAL CHARGE: Enter the total charges for the services billed.

**30.** RESERVED FOR NUCC USE: This field is reserved for NUCC use.

**31.** SIGNATURE OF PHYSICIAN OR SUPPLIER: Enter the legal signature, signature stamp or typed/printed name of an authorized agent of the corporation, partnership, or sole proprietorship. Include date the form was signed.

**32.** SERVICE FACILITY LOCATION INFORMATION: Enter the name, address, city, state and zip code of the location where the services were rendered. When more than one supplier is used, a separate CMS 1500 Claim Form must be used to bill for each supplier. Include **name of the practitioner who actually delivered the service(s) if different from box 33.** For example, if you are an employee or an associate of another practitioner and are billing under that practitioner's TIN you should list your name and address here and the TIN owner's name and address in box 33.

**32a.** Enter the NPI number of the service facility location.

**33.** BILLING PROVIDER INFO & PHONE #: Enter the practitioner's or supplier's billing name, address, zip code, and phone number. Item 33 identifies the practitioner that is requesting to be paid for the service rendered and should always be completed.

**33a.** Enter the NPI number of the billing practitioner.

The remaining fields are not required.

Mail your CMS 1500 Claim Form (02/2012) to:

American Specialty Health Group, Inc.
Claims Department
P.O. Box 509001
San Diego, CA 92150-9001

## *Claims Submission Timelines*

It is beneficial to you to promptly submit claims to ASH. Doing so results in timely reimbursement, avoids duplicate claims submission and adjustments, minimizes unnecessary customer service inquiries and decreases appeals. ASH and its contracted clients also utilize claim data for evaluation and analysis of their benefit programs. All claims must be submitted and received by ASH within one hundred eighty (180) days after the date of service unless otherwise noted in the exceptions below, on the Remittance Advice (citing state specific regulations) or on the Client Summary. ASH will use the received date of the claim when calculating the one hundred eighty (180) day timeline. Please be advised that submissions received by ASH outside of regular business hours will be considered as received the following business day. ASH business hours are 8 AM to 5 PM Pacific Time, Monday through Friday.

The following are exceptions to the one hundred eighty (180) day submission timeline:

1. If a claim is denied due to incorrect or incomplete information, you may re-bill within sixty (60) days of the date of an ASH Remittance Advice or one hundred eighty (180) days after the date of service, whichever is later.
2. If the claim is submitted and received within thirty (30) days from the MNRF date or within one hundred eighty (180) days after the date of service, whichever is later.

3. If ASH is the secondary client, you should submit the claim, along with a copy of the primary client's Explanation of Benefits (EOB), within one hundred eighty (180) days of the date of the primary client's EOB. If submitting your claim electronically through ASHLink or ASH Clearinghouse, fax a copy of the primary client's EOB to 877.740.2746 when submitting your claim. Please be sure the treating practitioner's name and the patient's identifying information are clear on your fax to allow ASH to match the EOB to the appropriate transaction. Your claim may be denied if you do not fax a copy of the EOB when submitting the claim.
4. If there is a third party liability and the third party denies reimbursement, submit the claim to ASH within one hundred eighty (180) days of the date of the third party denial.
5. If extraordinary circumstances exist and are demonstrated upon appeal.

## *ASH's Response to Claims Submission*

You should expect to receive a response to your claim submission from ASH within thirty (30) days. As an ASH Contracted Provider/Practitioner, you will receive Remittance Advices electronically through ASHLink. You can view the results of a claim submission on ASHLink and print a Remittance Advice if necessary. The Remittance Advice provides a summary of the ASH reimbursement for each date of service and CPT/HCPCS codes billed. The Remittance Advice will also include an explanation of the reimbursement and any amounts due from the member. Remember that a member is only responsible for those amounts that are identified as payable by the member on the ASH Remittance Advice. You can submit a question to ASH on ASHLink if you have any questions regarding ASH's determination of payment amounts.

## *Claims Follow-up*

If you have not viewed the results of your submitted claims or the ASH Remittance Advice is not available online within thirty (30) days of claim submission, you may use any of the following steps to assist in follow-up:

1. Logon to your ASHLink account to check the status of the claim in question. You will also be able to submit an inquiry to ASH through your ASHLink account login.
2. Call Customer Service at 800.972.4226, option 2.
3. Submit a claims tracer on ASHLink or a copy of the CMS 1500 Claim Form (02/2012) noting Tracer by fax or mail. ASH will respond with a Remittance Advice or Tracer Response form.
4. Submit a completed Claims Tracer Request form by fax or mail. ASH will respond with a Tracer Response form or a Remittance Advice. (A copy of the Claims Tracer Request form is available through your ASHLink account login on the *Resources* > *Forms* page.)

Mail claim correspondence to:

American Specialty Health
Claims Department
P.O. Box 509001
San Diego, CA 92150-9001

## *Reimbursement Guidelines*

The Reimbursement Guidelines described below provide general information about ASH's claims reimbursement process, coordination of benefits, and third party liability. It is important to review the member's applicable Client Summary for specific information about how a claim will be processed and by whom.

## *Reimbursement by Clients*

Claims Processing and Reimbursement procedures may vary depending on the member's client. In most cases, ASH has been given responsibility for processing and payment of claims for a client; however, this is not always the case. The claim will be processed in one of the following methods:

1. Your claims will be processed and paid directly by ASH.
2. Your claims will be re-priced by ASH and forwarded to the client for direct reimbursement to you.
3. Your claims will be re-priced by ASH and forwarded to the client for adjudication. The client will submit payment to ASH who will release payment directly to you according to the client's adjudication results.

It is important to note that reimbursement may vary between clients. Please refer to the appropriate Client Summaries for eligible CPT and HCPCS Codes and Fee Schedule reimbursement amounts for member benefit plans

## *Coordination of Benefits*

Coordination of Benefits (COB) applies when a person is covered under more than one group health benefit program. Payment of benefits is coordinated between the clients to provide the maximum allowable benefit to members and to eliminate duplication of benefit payments for the same service.

## *Determination of Primary/Secondary Coverage*

The following guidelines should assist you in determining which client should be billed as the primary client.

1. If the injury/condition is related to or caused by work or an auto accident, then Workers' Compensation or the Auto Insurer may be primary.
2. If a husband and wife are both employed, have elected their own insurance coverage, and cover each other on their policies, then the primary coverage is through the patient's employer. The spouse's coverage would then become secondary.
3. If a child is covered under both parents' insurance policies, the parent with the birth month earliest in the year is primary.
4. If the member is 65 or older and actively employed, the Client is primary rather than Medicare.

## *Reimbursement of Primary/Secondary Coverage*

The ASH reimbursement is determined, in part, by whether ASH is the primary or secondary coverage client. The following guidelines should assist you in establishing reimbursement expectations and provide instructions for claims submissions.

1. **ASH or Client is Primary:** Reimbursement will be made consistent with the applicable Client Summary, the Fee Schedule Amounts reduced by any applicable member payments. Submit your claim directly to ASH or other address listed in the Client Summary.
2. **ASH or Client is Secondary:** Reimbursement will be made consistent with the applicable Client Summary. ASH will reimburse the difference between the amount paid under primary coverage and the ASH allowable Fee Schedule Amount in the applicable Client Summary.
3. **ASH is both Primary and Secondary:** Reimbursement will first be made consistent with the primary coverage Client Summary. Through Coordination of Benefits, ASH will reimburse the difference between the amount paid under primary coverage and the ASH allowable Fee Schedule Amount in the applicable Client Summary. It will not provide duplicate coverage for the visits if they were reimbursed under the primary coverage. If the primary coverage allows more visits than the secondary coverage, the member will be responsible for the copayment or coinsurance of those additional visits. If the secondary coverage allows for more visits, the member will be responsible for the co-payment or coinsurance for the additional visits covered by the secondary coverage.
4. **Medicare is Primary and ASH is Secondary:** ASH will reimburse based on its fee schedule up to the Medicare allowable amount. If Medicare does not cover services rendered, the ASH allowable amount, based on the fee schedule in the applicable Client Summary, would then apply.

When ASH is secondary, you should first bill the member's primary Client. When you receive an EOB from the primary Client, you should then submit the claim to ASH with the primary Client's EOB attached. If submitting the claim through ASHLink, fax the primary EOB to 877.740.2746 when submitting your claim. Please be sure the t reating practitioner's name and the patient's identifying information are clear on the fax to allow ASH to match the EOB to the appropriate transaction. Submission of a claim for reimbursement by ASH as the secondary Client needs to be received within one hundred eighty (180) days of the date of the primary Client's EOB. Remember to submit a copy of the primary Client's EOB and CMS 1500 claim form within one hundred eighty (180) days of the date of primary Client's EOB to be eligible for reimbursement when ASH is secondary.

## *Third Party Liability (TPL)*

Third-party liability claims are claims that are the financial responsibility of an entity other than a traditional medical insurance plan (i.e. workers compensation or property and casualty). TPL claims include, but are not limited to Workers' Compensation and automobile related injuries. Instructions for submitting claims when TPL is involved are listed below:

1. If the member's condition is believed to be to the responsibility of a third party, then payment should be sought from the third party.
2. Please delay billing ASH for any services rendered and believed to be the responsibility of a third party, until you receive a payment response from the third party. If you receive a denial, you may then bill ASH. You will need to submit your claim within one hundred eighty (180) days from the date of the third party denial letter unless otherwise specified in the applicable Client Summary. Refer to the Submitting MNR Forms section in your Practitioner Operations Manual for instructions on submitting MNR Forms under third party liability. Please note that Workers' Compensation MNR Forms or claims received without the Third Party Liability determination letter/EOB are subject to denial, pending the Third Party Liability Determination.
3. Alternatively, for Third Party Liability claims that are not related to Workers' Compensation, you may choose to bill ASH for services rendered. If there is a settlement by the third party, you will need to reimburse ASH for the services previously paid by ASH.
4. If there is not a settlement, ASH's payment will be payment in full.

The above guidelines apply for all third-party liability cases, except as otherwise required by state law. Check the applicable Client Summary for any specific requirements in processing third-party liability cases other than those described above.

## Claims Adjustments

Occasionally, a claim may be processed erroneously due to incorrect information received from Clients or due to an examiner oversight. This may result in an overpayment or under payment to you. When identified by you or your staff, ASH and/or Client, ASH and/or Client will adjust the claim accordingly. In the case of an underpayment, ASH and/or Client will reprocess the claim provide additional payment for the balance due, and post an accompanying Remittance Advice online. In the case of an overpayment, ASH will, in accordance with state laws or regulations, either request a direct reimbursement from you, or may recover the amounts due from future claim payments. Any such recovery will include documentation regarding the reason for the offset. Please be assured that these offsets are not frequent.

## Direct Deposit

The easiest, fastest and most convenient way to receive payments from ASH is through direct deposit. Advantages of direct deposit are:

- Easy to Sign up. Complete and submit the Direct Deposit Authorization Form available through your ASHLink account login on the *Resources* > *Forms* page.
- Faster Claims Payments. Funds are directly deposited in your bank account, no waiting for a check in the mail.
- Convenient. No more handling checks, trips to the bank, worries about lost or stolen checks, or waiting up to four (4) weeks for check replacement.
- Go Green. Save trees and save paper.
- Earn incentives by using direct deposit. ASH pays you an additional 1% for using direct deposit for claims payment; this is in addition to the incentives you may earn for using ASHLink for other transactions such as eligibility, MNR, and claims submission. See Attachment J of your Practitioner Services Agreement for details.

## Provider Appeals

- You may appeal any non-approved or partially approved service or any non-payment of a claim. All appeals must be submitted within 365 days after the notice of partial or non-approval by ASH. For additional information, please refer to the Appeals & Grievances section of the Provider Resources page.