SECTION 9: Billing & Claims Processing

9.1 • Member Eligibility

Payment for services rendered is subject to verification that the member was enrolled in VNS Health at the time the service was provided and to the provider's compliance with the VNS Health's UM, Care Management, and prior authorization policies at the time of service. Claims submitted for services rendered without proper authorization will be denied for "failure to obtain authorization." No payment will be made. Providers must verify member eligibility at the time of service to ensure the member is enrolled in VNS Health. Failure to do so may affect claims payment. Note, however, that members may retroactively lose their eligibility with VNS Health after the date of service. Therefore, verification of eligibility is not a guarantee of payment by VNS Health.

In certain cases, a managed care plan member, including VNS Health members, may change health plans during a hospital stay. When this occurs, providers should bill the health plan to which the member belonged at the time of admission to the hospital.

9.2 • General Billing and Claim Submission Requirements

Instructions for Submitting Claims

Claims status is available through Provider Portal at: https://www.vnshealthplans.org/provider-portal/. Instructions for claims submission are available on our website. Service providers are responsible for submitting claims to VNS Health. Provider claims should be submitted either on a CMS-1500 form or UB-04 form or the related electronic format (837P or 837I). Claims for non-HIPAA covered services may be submitted on a nonstandard form at the approval of VNS Health. For exceptions to the standard form, please contact your Account Manager. Claims may be

submitted by mail to the VNS Health Claims Department at the address listed below and in the Provider Reference Guide , found in the Helpful Links on page 6 of this Manual.

- VNS Health MLTC/Total/EasyCare Plus/EasyCare/Select Health:
  P.O. Box 4498,
  Scranton, PA 18505
- For electronic submissions: Use VNS Health Payer ID# 77073.

9.3 • Time Frames for Claim Submission, Adjudication and Payment

Timely Filing and Prompt Payment of Claims

- Providers are expected to submit claims within the timelines specified in their contract.
- This will be applied to the date of service (or discharge for inpatient services.) Claims received after the Timely Filing Limit may be denied.
- "Clean Claims," those submitted fully according to VNS Health standards, will be paid, or denied according to State or Federal Prompt Payment requirements.
- For Medicare lines of business, other claims, including those with incomplete information from non-network providers, will be paid or denied within sixty (60) calendar days.
- Network providers will be paid according to the terms of their contract.
- Non-network providers will be paid according to CMS or New York State Medicaid regulations.
- The prompt payment of your claim is contingent on VNS Health's receipt of complete and legible claims information. Missing or incomplete information may delay payment.
- All claim submissions must include the providers National Provider Identification (NPI) and Tax ID number on the claim.

Late Claim Submission

In certain circumstances (see chart below), VNS Health will process claims submitted after the time required under the provider's agreement with VNS Health. Please note that "unclean" claims that are returned to the provider for necessary information are adjudicated according to the original date of service. They do not fall into the category of exceptions to the time required.

The following situations allow for special handling of claims. Claims must be submitted with a written explanation and appropriate documentation showing the date the claim came within the provider's control.

Reason for Delay	Time Frame for Submission
Litigation involving payment of the claim	Within ninety (90) calendar days from the time the submission came within the provider's control.
Medicare or other third-party processing delays affecting the claim.	Within Sixty (60) calendar days from the time the submission came within the provider's control
Original claim rejected or denied due to a reason unrelated to the 180-day rule.	Within ninety (90) calendar days of the date of notification (submit with original EOP)
Delay in member eligibility determination	Within ninety (90) days from the time of notification of eligibility (submit with documentation substantiating the delay)
Members' enrollment with VNS Health was not known on the date of service.	Within ninety (90) days from the time the member's enrollment is verified. Providers must make diligent attempts to determine the member's coverage with VNS Health

9.4 • Coordination of Benefits (COB)

If a member has coverage with another plan that is primary to VNS Health, please submit a claim for payment to the other plan first. The amount payable by VNS Health will be determined by the amount paid by the primary plan, Medicare secondary payer law and policies, or New York State Medicaid standards for coinsurance payments. Please submit a copy of the primary carrier's Explanation of Payment with your claim to VNS Health. Any cost sharing for a member that is considered Dual Eligible must be billed to Medicaid or other insurer.

You may not bill a member for a non-covered service unless:

1) You have informed the member in advance that the service is not a covered service.
2) The member has agreed in writing to pay for the non-covered service.

The Provider shall not bill or collect any additional payment for services covered under Medicaid.

If a member loses their Medicaid eligibility while they are enrolled in a VNS Health "dual- eligible" plan, they will be deemed temporarily eligible to remain in the plan for up to six months because they may regain Medicaid eligibility. During this time, the member can receive the same benefits as any other member. If a participating provider receives a denial from Medicaid for such member's cost sharing for services provided during this period, the provider will look to the plan for reimbursement. Providers should contact Provider Services to initiate such reimbursement.

9.5 • Explanation of Payment (EOP) / Electronic Funds Transfer (EFT)

The EOP describes how claims for services rendered to VNS Health members were reviewed. It details the adjudication of claims, describing the amounts paid or denied and indicating the determinations made on each claim.

The EOP shall include the following elements:

- Name and address of payor
- Toll-free number of payor
- Subscriber's name and address
- Subscriber's identification (ID) number
- Member's name
- Provider's name
- Provider tax identification number (TIN)

- Claim date of service
- Type of service
- Total billed charges
- Allowed amount
- Discount amount
- Excluded charges
- Explanation of excluded charges (denial codes)
- Amount applied to deductible
- Copayment/coinsurance amount
- Total member responsibility amount
- Total payment made and to whom the EOP is arranged numerically by member account number. Each claim represented on an EOP may comprise multiple rows of text. The line number indicated below the date of service identifies the beginning and end of a particular claim. Key fields that will indicate payment amounts and denials are as follows:
- **Paid claim lines:** If the paid amount field reads greater than zero, the claim was paid in the amount indicated.
- **Denied claim lines:** If the not covered field is greater than zero and equal to the allowed amount, the service was denied.
- **Claim processed as a capitated service:** If the amount in the prepaid amount field is greater than zero, the service was processed as a capitated service.
- **End of claim:** Each claim is summarized by a claim total. If there are multiple claims for a single member, the EOP also summarizes the total amount paid for that member.

Electronic Claims Submissions

VNS Health encourages providers to submit clean claims to us electronically. Electronic claims submission can offer you the following benefits:

- More efficient claims payment
- Improved cash flow

- Increased convenience: one universal form to complete for all carriers
- Greater reliability than paper systems
- Decreased postage and mail time
- Reduced paperwork for office staff

9.6 • Claim Inquiries, Claim Disputes and Appeal Process

These documents are all available via the Provider Portal at: https://www.vnshealthplans.org/provider-portal/. If you have questions regarding the status of a claim or other inquiries, contact Provider Services at 1-866-783-0222, Monday to Friday, 8am – 5 pm. TTY users, call 711.

Please have the following information available:

- Provider's name and NPI
- Member's name and members identification number
- Date of service and date of claim submission

Difference between Claim Dispute and Claim Appeal

When to use the Provider Claim Dispute Form:

- Coding denials
- Underpaid/overpaid claims
- Invalid procedure code/revenue code/diagnosis code
- Incorrect modifier
- Charges previously considered/duplicate
- Claim denied as duplicate
- Authorization obtained and approved and claim denied

The form, instructions on how to use and more detailed Information about filing claim disputes and appeals is available on the VNS Health website at this link: https://www.vnshealthplans.org/provider-claims-dispute-form/

When to Submit a Claim Appeal:
If your claim is denied and you wish to challenge the decision, you can use the Grievance and Appeal Process. This will lead to an internal clinical or administrative review of the denial.

Examples of appealable denials include:

- Services were not authorized at time of authorization request
- Not medically necessary
- Non-covered service/benefit
- Benefit exhausted

For more information about appeals and the process, please refer to Section 10: Grievances & Appeals.

Claims Dispute Process:
Please go to our Claims, Billing and Payments page on our website: vnshealthplans.org/health-professionals/claims-billing-and-payments health-professionals-overview/claims-billing-and-payments/

Please go here for complete instructions for submitting a Provider Claim Dispute: https://www.vnshealthplans.org/provider-claims-dispute-form

1. When submitting a disputed claim(s), you must include an excel attachment with all claims within one spreadsheet. Download the Provider Payment Dispute Template (find the link in the expandable section labeled "How to File a Claims Dispute") and use that Excel sheet to enter the information listed in each column. We will need it to process your payment dispute. (Note: if you do not see the template right away, check your browser's download status bar or the download file on your computer.)

2. Attach the file in the field labeled "File upload" when you submit your dispute using this Claim Dispute Form: https://www.vnshealthplans.org/provider-claims-dispute-form
3. Look for an email confirmation of your submission.

Rebuttal Claim Dispute Process

The project submitter or account manager has 30 calendar days from the date of the PDPI determination letter to file a rebuttal.
To initiate the rebuttal process, the submitter must provide the original analysis spreadsheet provided with the determination of the Claims Dispute project (PDPI), along with detailed comments specifying the items being contested.

For documentation and tracking, the date of receipt and any subsequent actions will be recorded within the PDPI that is being challenged.

If the submitter presents **new** or supplemental information not included in the initial review, a new PDPI submission must be entered through the claims dispute portal for analysis.

The following applies to claims for all health plans.

Type	Submission Timeframe	Necessary Information to be Provided (in writing*)
Standard reconsideration request of a denial of payment or medical necessity	Please refer to your provider contract	▪ Copy of Denied Claim ▪ Copy of Remittance ▪ Any requested or substantiating documentation not previously provided

*Appeals may be faxed or mailed to the address indicated in Section 10 on page 103 of this manual.

In addition the following applies to VNS Health MLTC claims.

Appeal Type	Submission Timeframe	Necessary Information to be Provided (in writing*)
Requests for a denial of payment due to no authorization, non-covered, benefit exhausted, duplicate submission, etc.	Please refer to billing/claims contact number in the Introduction.	Any requested or substantiating documentation not previously provided.

9.7 • Overpayments

VNS Health periodically reviews payments made to providers to ensure the accuracy of claim payment pursuant to the terms of the provider contract or as part of its continuing utilization review and fraud control programs. In doing so, VNS Health may identify instances when we have overpaid a provider for certain services. When this happens, VNS Health provides notice to the provider and recoups the overpayment consistent with Section 3224-b of the New York State Insurance Law.

VNS Health will not pursue overpayment recovery efforts for claims older than 24 months after the date of the original payment to a provider unless the overpayment is

1) Based upon a reasonable belief of fraud, intentional misconduct, or abusive billing
2) Required or initiated by the request of a self-insured plan
3) Required by a state or federal government program

In addition, we may at times apply the procedures described in this section to recoup duplication claims payments but reserve the right to use other

procedures to do so. In addition, if a provider asserts that VNS Health has underpaid any claim(s) to a provider, VNS Health may offset any underpayments that may be owed against past underpayments made by VNS Health dating as far back as the claimed underpayment.

If VNS Health has determined that an overpayment has occurred, VNS Health will provide written notice to the provider of the overpayment and request repayment (30 days notice for Medicaid related claims, 60 days notice for Medicare related claims. This notice will include the member's name, service dates, payment amounts proposed adjustment, and a reasonably specific explanation of the reason for the overpayment and the proposed adjustment. In response to this notice, the provider may dispute the finding or remit payment as outlined below. Upon the receipt of a request for repayment, providers may voluntarily submit a refund check made payable to VNS Health within 30 days from the date of the overpayment notice.

Providers should further include a statement in writing regarding the purpose of the refund check or include the Overpayment Notice with the refund check to ensure the proper recording and timely processing of the refund.

Refund checks should be mailed to:
VNS Health
220 East 42nd St, 3rd Floor New York, NY 10017
Attention: Claims Payment Integrity/Recoveries

If a provider disagrees with VNS Health's determination concerning the overpayment, the provider must submit a written request for an appeal within 30 days from the date of the overpayment notice and include all supporting documentation in accordance with the provider appeal procedure described above in the previous topic to VNS Health, P.O. Box 445, Elmsford, NY 10523.

9.8 • Submitting Claims for Non-Credentialed Practitioner in a Group Arrangement or for a Non-Credentialed Substitute Practitioner

All providers who are part of a VNS Health contracted medical group – and individually credentialed providers who have a non-contracted provider as part of their group and share a TIN, NPI, specialty/taxonomy code – are considered contracted providers for the purposes of claim payments and are considered "Substitute Practitioners." Claims for Substitute Practitioner services should be billed by the medical group or by the regular participating practitioner and will be reimbursed at the regular participating practitioner's contracted fee schedule.

Substitute Practitioners are not required to enroll with the health plan and should not bill the health plan directly.

- Please note the following to ensure your claims for the Substitute Practitioner's services are documented correctly.
- Claims that include services provided by a Substitute Practitioner must include the credentialed provider's billing name, address, and national provider identifier (NPI) in Block 33 of the claim form.
- The name and mailing address of the Substitute Practitioner must be documented in Block 19, not Block 33.
- When billing for a service provided by a Substitute Practitioner physician, the modifier Q5 or Q6 must follow the procedure code in Block 24D for services provided by the Substitute Practitioner.

9.9 • Claims from a Network Hospital Associated with a Non-Network Health Care Provider

VNS Health will not immediately process claims from a network hospital as out of network solely on the basis that a health care provider who is not participating with VNS Health treated the member.

9.10 • Claims from a Network Health Care Provider Associated with a Non-Network Hospital

VNS Health will not arbitrarily process claims from network health care providers as out of network solely because the hospital is not participating with VNS Health.

9.11 • Facility Claim Requirements

Ambulatory Patient Group (APG) Rate Codes

VNS Health pays claims billed with Ambulatory Patient Group (APG) rate codes (and their corresponding CPT codes) for services covered by APG reimbursement. The APG system is the New York State mandated payment methodology for most Medicaid outpatient services. APGs will pay hospital outpatient clinic, ambulatory surgery, and emergency department services when services are reimbursed at the Medicaid rate. APGs will not be used for services that are carved out of Medicaid managed care. Medicaid APG claims should be submitted:

- APG and non-APG services on separate claims
- Report a value code of 24 and an appropriate rate code
- Report CPT codes for all revenue lines

Claims without proper coding will be returned for correction prior to adjudication.

More information on APGs can be found at the New York State Department of Health's website at health.state.ny.us/health_care/medicaid/rates/apg/ as well as the DOH's Policy and Billing Guidance.

Ambulatory Patient Groups (APGs) Provider Manual

health.ny.gov/health_care/medicaid/rates/apg/docs/apg_provider_manual.pdf

For documentation on known APG issues and HIPAA APG requirements, go to eMedNY's website emedny.org/apg_known_issues.pdf and .https://www.emedny.org/hipaa/5010/transactions/eMedNY_Transaction_Information_CAQH-CORE_CG_X12_version_5010.pdf

"Present on Admission" Indicator for Hospitals

The Deficit Reduction Act of 2005 mandates hospitals to report all diagnosis on a UB-04 (paper claims) or ASC X12N 837 Institutional (837I electronic transmissions) for Medicare and Medicaid patients. To comply with this government program, VNS Health requires a "present on admission" (POA) indicator for the following claims:

- Acute care hospital admissions
- All medical inpatient services
- Substance abuse treatment
- Mental health admissions

Note: Patients considered exempt by Medicare must also have POA indicators noted. If the diagnosis is exempt, enter a value of "1."

Because the HAC-POA payment applies to IPPS (Acute Inpatient Prospective Payment System) hospitals, all the hospitals below are exempt:

- Critical access hospitals
- Inpatient rehabilitation facilities
- Inpatient psychiatric facilities
- Maryland waiver hospitals
- Long term care hospitals
- Cancer hospitals
- Children's hospitals
- Hospitals paid under any type of prospective payment system (PPS) other than the acute care hospital PPS

A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the ICD-10-CM Official Guidelines for Coding and Reporting, by the Centers for Medicare & Medicaid Services [CMS] and the National Center for Health Statistics [DHHS]) and the external cause of injury. CMS does not require a POA indicator for the external cause of injury unless it is being reported as an "other" diagnosis.

If a condition cannot be coded or reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, the POA indicator should not be billed.

ERM care hospitals

- Cancer hospitals
- Children's hospitals
- Hospitals paid under any type of prospective payment system (PPS) other than the acute care hospital PPS

A POA indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the ICD-10-CM Official Guidelines for Coding and Reporting, by the Centers for Medicare & Medicaid Services [CMS] and the National Center for Health Statistics [DHHS]) and the external cause of injury. CMS does not require a POA indicator for the external cause of injury unless it is being reported as an "other" diagnosis.

If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA indicator would not be reported.

Present on Admission (POA) Indicator List	
Code	Description
Y	Yes. The condition was present at the time of inpatient admission.
N	No. The condition was not present at the time of inpatient admission.
U	Unknown. The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.

Note: Hospitals which are considered exempt by Medicare must also bill a POA indicators. If the diagnosis is exempt, enter a value of "1"-exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A.

Issues related to inconsistent, missing, conflicting or unclear documentation must be resolved by the practitioner.

More information and coding instructions, including the POA Fact Sheet, can be found on the CMS website https://www.cms.gov/medicare/payment/feefor-serviceproviders/hospital-aquiredconditionshac/coding#:~:text=To%20group%20diagnoses%20into%20the,UB% 2D04%20a nd%20837%20Institutional.

9.12 • Taxonomy Codes: Definition and Claims Use

Taxonomy codes are administrative codes set for identifying the practitioner type and area of specialization for health care practitioners. Each taxonomy code is a unique 10-character alphanumeric code that enables practitioners to identify their specialty at the claim level.

Taxonomy codes are assigned at both the individual practitioner and organizational practitioner level.

Taxonomy codes have three distinct levels: Level I is the Practitioner Type, Level II is Classification, and Level III is the Area of Specialization. A complete list of taxonomy codes can be found within the Health Insurance Portability and Accountability Act (HIPAA).

Taxonomy codes are self-reported, both by registering with the **National Plan and Provider Enumeration System (NPPES)** and by electronic and paper claims submission.

Taxonomy Codes registered with NPPES at the time of NPI application are reflected on the confirmation notice document received from NPPES with the provider's assigned NPI number. Current taxonomy codes registered, including any subsequent changes, may be obtained on an inquiry basis by visiting the NPI Registry website.

A practitioner can have more than one taxonomy code, due to training, board certifications, etc. It is critical to register all applicable taxonomy codes with NPPES and to use the correct taxonomy code to represent the specific specialty when filing claims. This will assist VNS Health in a more accurate and timely processing of claims.

Please provide Taxonomy codes on all VNS Health claims. The absence of these codes may result in incorrect payment.

Taxonomy codes on **electronic claim submissions** with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level and segment PRV03 and loop 2420A for the rendering level.

For paper CMS-1500 professional claims, the taxonomy code should be identified with the qualifier "ZZ" in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the "ZZ" qualifier for the billing level.

9.13 • HHAeXchange for Home Health Services

VNS Health has engaged HHAeXchange, a web-based software solution, for scheduling, communication, and billing of Home Health Services. The HHAeXchange Portal provides a direct connection from the agency to VNS Health for:

- Electronic case broadcasting, authorizations, plan of care management and entering confirmed visits
- Real-time two-way messaging
- Free EVV solution for time, attendance, and duty tracking
- Electronic billing

Billing Options

Based on how your agency currently works with the Plan, below are the options you have in working with the HHAeXchange portal:

- Option 1: Entering data directly into the Plan: After requesting to be linked to HHAeXchange, you will be able to enter data directly into the HHAeXchange portal.
- Option 2: Currently using another third party solution: Interface specifications will be available at no charge, enabling you to bring your data into the HHAeXchange portal.

Simple Claims Billing and EVV Implementation for VNS Health

VNS Health will be processing claims via a clearinghouse. VNS Health utilizes Availity.com for claims adjudications.

Participation and Additional Information

If you are interested in integration, please reach out to your assigned VNS Health Account Manager. Participation is optional. Additional information is located at: hhaexchange.com/vnshealth.org/