Sunflower Health Plan

Regional Provider Workshop

Agenda & Objectives

- Third Party Liability (TPL) & Coordination of Benefits (COB)
  - Claims Submission Requirements Overview
  - Sunflower TPL & COB Claims Processing
  - Review Scenarios that cause Claim Denials
  - COB / TPL FAQs
- Claims Submission & Payment Timelines
  - Know Your Numbers
  - Timely Filing FAQs
- Present On Admission (POA) Indicators
  - Review Scenarios that cause Claim Denials
  - POA FAQs
- Billing with Modifiers
  - Review Scenarios that cause Claim Denials
  - Billing with Modifiers – Additional Tips
- Billing with Encounterable Codes
  - Review a Scenario that causes Claim Denials

Third Party Liability (TPL)
&
Coordination of Benefits (COB)

Claims Submission Requirements Overview

Definitions:

- Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan

- Coordination of Benefits (COB) is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. COB is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier, including other health insurance, retiree benefits, auto insurance, workers compensation, etc.

Claims Submission Requirements Overview

- COB & TPL
  - Sunflower is always the Payer of last resort
  - Tertiary medical claims must be billed on paper claim forms and mailed to:

    Sunflower Health Plan

    PO Box 4070

    Farmington, MO 63640-3833

- CMS-1500 forms field requirements
  - Fields 9 and 9A-D (Other Insured's Name) – If the beneficiary has secondary or supplemental insurance, complete Fields 9, 9a, and 9d. (Enter the primary insurance information in Field 11)
  - Field 11 and 11A-D (Insured's Policy Group or FECA Number)
  - Field 29 (Amount Paid)

Claims Submission Requirements Overview

- UB-04 forms field requirements
  - Field 50 (Payer Name) – Required
  - Field 54 (Prior Payments Payer) – Situational
  - Field 58 (Insured's Name) – Required
  - Field 59 (Patient's Relationship to Insured) - Required
    - Line A: Required
    - Line(s) B and C: Situational
  - Field 60 (Insured's Unique ID) – Required
    - Enter the 11-digit beneficiary number from the State of Kansas Medical Card on Line C.
    - If billing for newborn services, use the mother's beneficiary number. The mother's number should only be used if the newborn's ID number is unknown
  - Field 61 (Insured's Group Name) – Required, if group name is available
    - Enter the primary insurance information on Line A and Medicare on Line C
  - Field 62 (Insured's Group Number) – Required, when insured's ID card shows a group number

Sunflower TPL & COB Claims Processing

sunflower health plan

COB Algorithm

Sunflower processes professional and institutional Medicare-related claims using the same algorithm calculation applied to other third-party claims. If the other insurer paid more than Medicaid's allowed amount for that service, no additional reimbursement will be made. If a service is non-covered under Sunflower, no allowable amount will be computed for the service.

After calculation of the total Medicaid-allowed amount for the claim, comparison of what Medicaid-allowed to the OIC-allowed will be made (OIC paid plus coinsurance plus deductible). Non-covered OIC services are not included in this algorithm. These claims are processed using standard Medicaid pricing methodologies.

When the Medicaid-allowed amount is **greater** than OIC's paid amount (not including patient liability), Sunflower will make a payment. Sunflower's payment is the lesser of the:

- Patient liability amount *or*
- The difference between the Medicaid allowed amount and the OIC paid amount

Sunflower TPL & COB Claims Processing

FQHC, RHC & IHS providers COB Algorithm

Reimbursement should equal the Medicaid allowed amount minus other insurance payment. This includes Medicare crossover claims as well.

LTC COB Algorithm

LTC Claims are only coordinated when the member specifically has a Long Term Care policy. Reimbursement should equal the Medicaid allowed amount minus other insurance payment.

Note: *Exceptions may be made to the COB Algorithm based on State Policies, including but not limited to, Health Homes, IDD, Blanket Denials, preventative services, etc.*

Review Scenarios that Cause Claim Denials

Front End Billing Rejection:

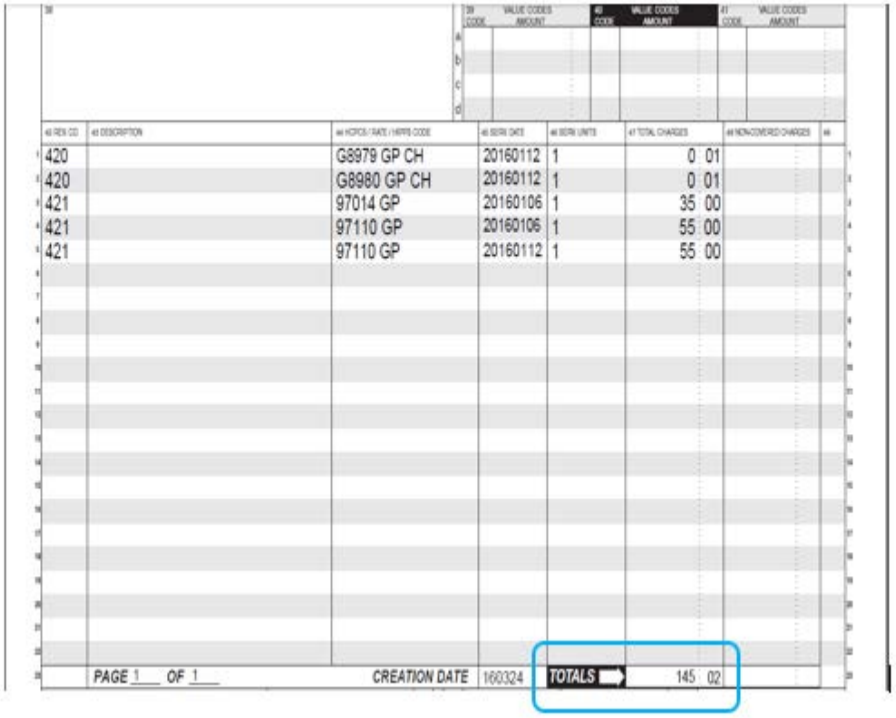
- COB Claim failed to balance : paid amount did not equal adjusted charge amount

Denial Reasons:

- EXL6 – DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB
- EXI1 – OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT

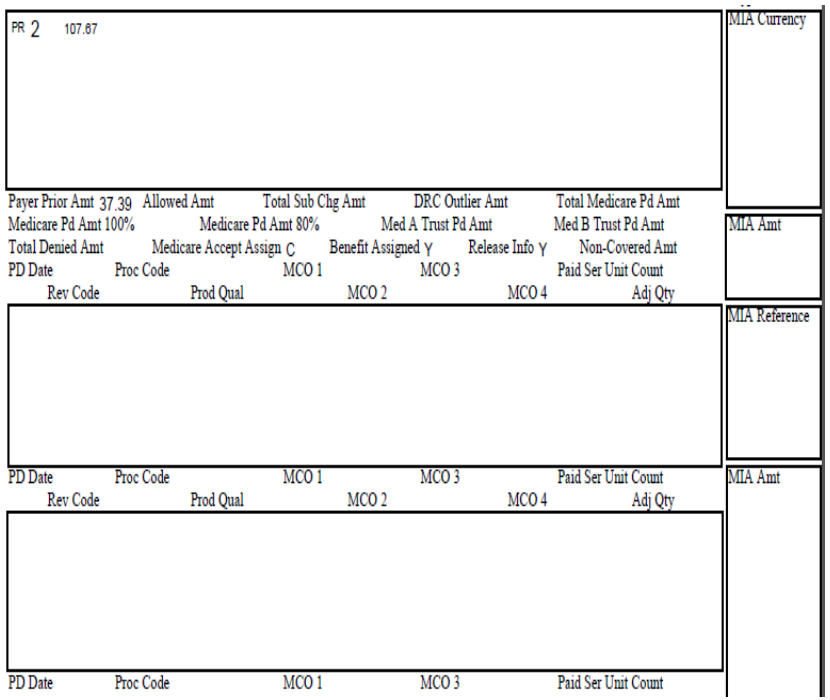
Review Scenarios that Cause Claim Denials

COB Claim Failed to Balance / Other Insurance EOB does not match



42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
420		G8979 GP CH	20160112	1	0 01	
420		G8980 GP CH	20160112	1	0 01	
421		97014 GP	20160106	1	35 00	
421		97110 GP	20160106	1	55 00	
421		97110 GP	20160112	1	55 00	

PAGE 1 OF 1 CREATION DATE 160324 TOTALS 145 02



PR 2 107.67

MIA Currency

Payer Prior Amt 37.39 Allowed Amt Total Sub Chg Amt DRC Outlier Amt Total Medicare Pd Amt
Medicare Pd Amt 100% Medicare Pd Amt 80% Med A Trust Pd Amt Med B Trust Pd Amt
Total Denied Amt Medicare Accept Assign C Benefit Assigned Y Release Info Y Non-Covered Amt
PD Date Proc Code MCO 1 MCO 3 Paid Ser Unit Count
Rev Code Prod Qual MCO 2 MCO 4 Adj Qty

MIA Amt

MIA Reference

PD Date Proc Code MCO 1 MCO 3 Paid Ser Unit Count
Rev Code Prod Qual MCO 2 MCO 4 Adj Qty

MIA Amt

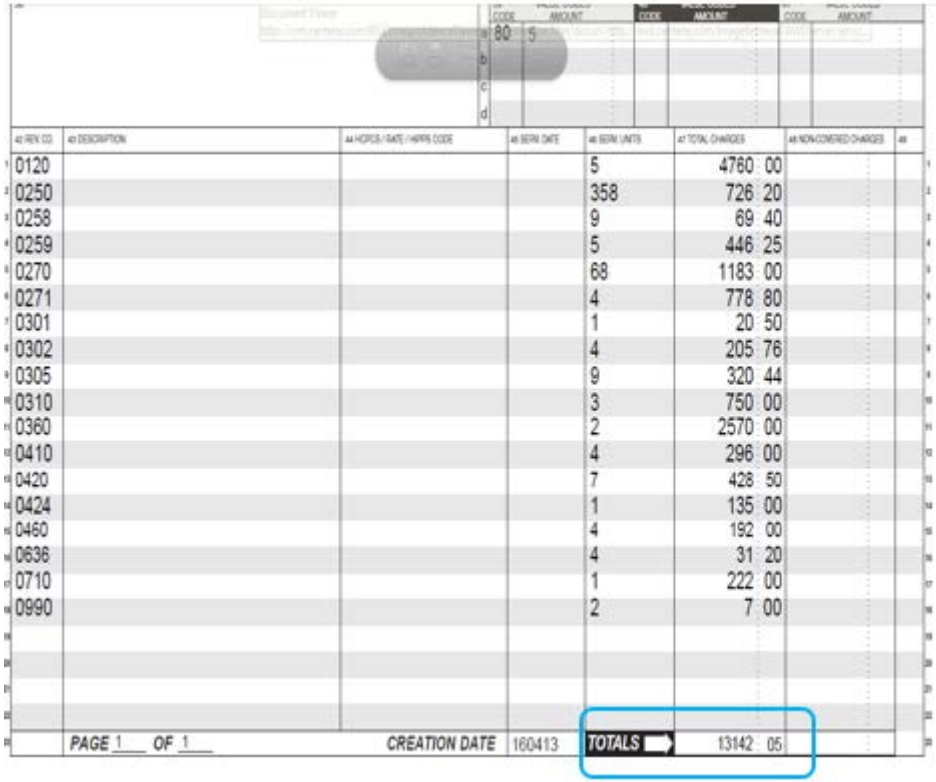
PD Date Proc Code MCO 1 MCO 3 Paid Ser Unit Count

Total Billed charges on claim is **$145.02**

Patient Responsibility is $107.67
Payer Prior Amount is $37.39
Total Charges on EOB is $145.06

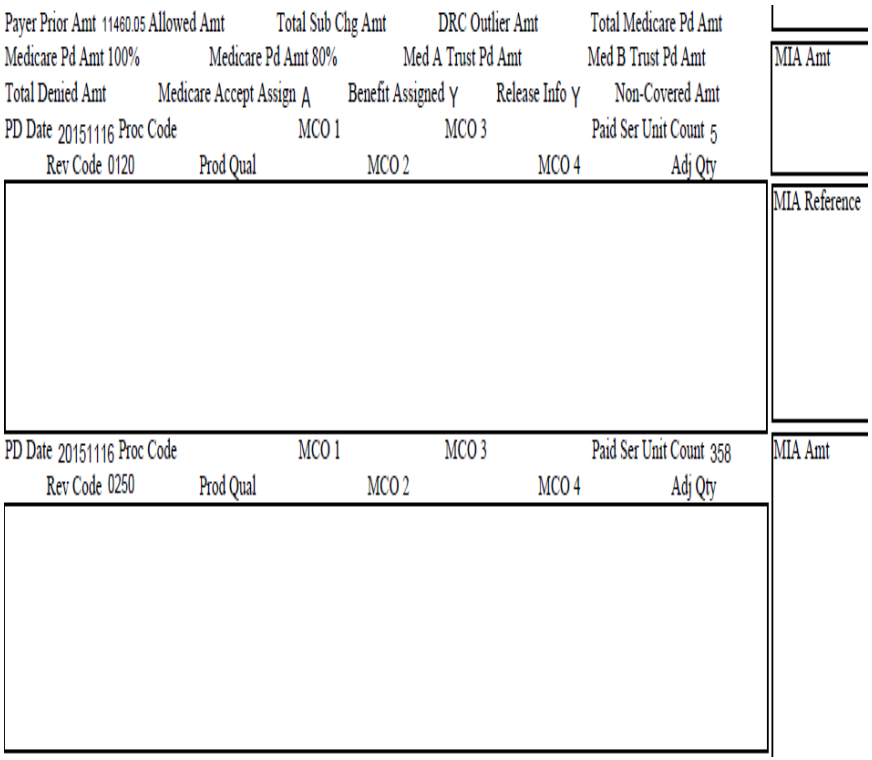
Review Scenarios that Cause Claim Denials

COB Claim Failed to Balance / Other Insurance EOB does not match



42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0120				5	4760 00	
0250				358	726 20	
0258				9	69 40	
0259				5	446 25	
0270				68	1183 00	
0271				4	778 80	
0301				1	20 50	
0302				4	205 76	
0305				9	320 44	
0310				3	750 00	
0360				2	2570 00	
0410				4	296 00	
0420				7	428 50	
0424				1	135 00	
0460				4	192 00	
0636				4	31 20	
0710				1	222 00	
0990				2	7 00	
	PAGE 1 OF 1		CREATION DATE 160413	TOTALS	13142 05	

Total Billed charges on claim is **$13,142.05**



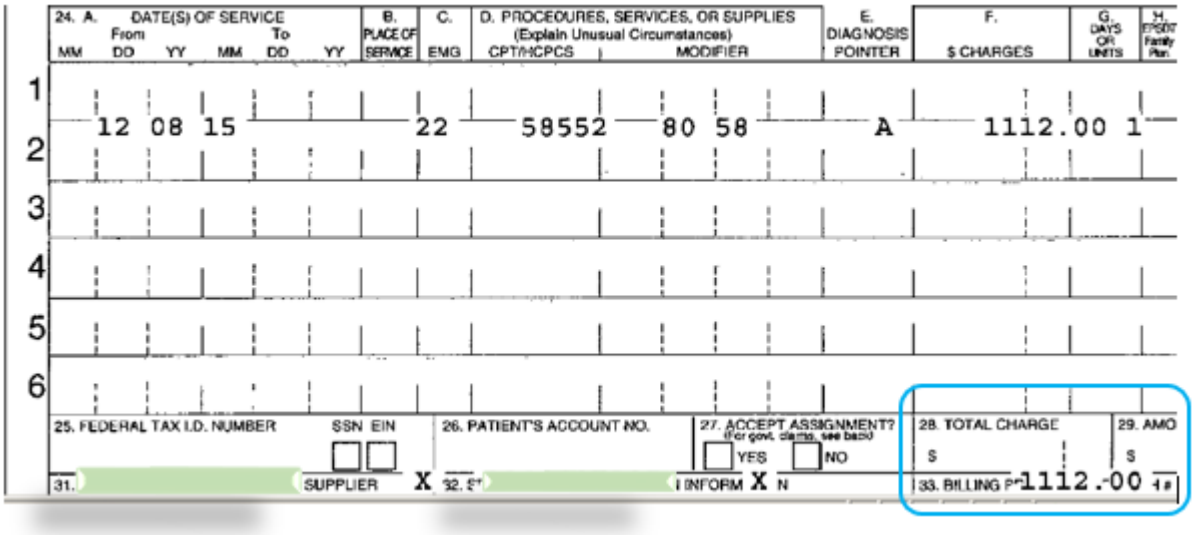
Payer Prior Amt 11460.05 Allowed Amt | Total Sub Chg Amt | DRC Outlier Amt | Total Medicare Pd Amt
Medicare Pd Amt 100% | Medicare Pd Amt 80% | Med A Trust Pd Amt | Med B Trust Pd Amt | MIA Amt
Total Denied Amt | Medicare Accept Assign A | Benefit Assigned Y | Release Info Y | Non-Covered Amt
PD Date 20151116 Proc Code | MCO 1 | MCO 3 | Paid Ser Unit Count 5
Rev Code 0120 | Prod Qual | MCO 2 | MCO 4 | Adj Qty | MIA Reference

PD Date 20151116 Proc Code | MCO 1 | MCO 3 | Paid Ser Unit Count 358 | MIA Amt
Rev Code 0250 | Prod Qual | MCO 2 | MCO 4 | Adj Qty

Payer Prior Amount is $11,460.05
Patient Responsibility / Contractual Write-Off amount was not provided; Sunflower is unable to coordinate the difference between what the primary paid and the billed amount

Review Scenarios that Cause Claim Denials

COB Claim Failed to Balance / Other Insurance EOB does not match



24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan
1 12 08 15			22	58552	80 58	A	1112.00	1
2								
3								
4								
5								
6								

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMO $

31. SUPPLIER X 32. INFORM X N | 33. BILLING P 1112.00

Total Billed charges on claim is **$1,112.00**

Service Information

Code	Date of Service	Modifier	Units	Billed	Allowed	Deductible	Copay/Coins	Paid	Reason Codes	Due
58552	12/8/2015	80	1	1112.00	1112.00	0.00	0.00	118.17		30.15
Total			**1**	**1112.00**	**1112.00**	**0.00**	**0.00**	**118.17**		**30.15**

Summary

Insurance	Billed	Not Allowed	Deductible	Copay/Coins	Paid	Due
MEDICARE	1112.00	0.00	0.00	0.00	118.17	30.15

Paid COB amount is **$118.17**
Due COB amount is **$30.15**
Total is $148.32

- Claim and COB charges do not match
- If the allowed was $1,112.00 and the Paid was $118.17, then the amount Due should have been the difference between the two *or* $993.83

COB / TPL FAQs

Q: I submitted the other insurer's EOB, so why was my claim denied?

A: If claim was billed on a CMS-1500, the other payer's payment amount must be listed at each detail line.

Q: I submitted both primary and secondary insurer's EOBs so why did Sunflower still over pay my claim? How can I get Sunflower to recoup the overpayment?

A: Sunflower is unable to process tertiary claims electronically or through the Secure Provider Portal. Claims and EOBs when Sunflower is the tertiary payer must be mailed to Sunflower Health Plan P.O. Box 4070 Farmington, MO 63640-3833.

A: Submit both insurer's EOBs, along with a copy of the Sunflower EOB or Remittance Advice (RA) to the address above and the claim will be adjusted according to the other two payers payments.

COB / TPL FAQs

Q: When I submit my COB Claims, should I include the patient's responsible amount (e.g., Client Obligation, Patient Liability or Spenddown)?

A: No, these amounts are automatically deducted from the final payment

Q: Will Sunflower ever make a payment when my patient has other insurance?

A: Yes, when Sunflower's allowed amount is greater than the other insurance's paid amount (not including the member's responsible amount)

COB / TPL FAQs

Q: The primary insurer denied my patient's claim for "No Authorization." Can I submit it to Sunflower for reimbursement?

A: No, Sunflower will not coordinate benefits when the primary insurer denies for administrative reasons, including No Authorization, Untimely Filing or Duplicate Denials

Q: The primary insurance denied my patient's claim because the service was Not Covered. Can I submit it to Sunflower for reimbursement?

A: Yes. Sunflower will cover non-administrative denials by the primary insurer, such as Non Covered and Benefit Exhausted denials. However, providers are required to ensure that Sunflower's Authorization requirements were met

COB / TPL FAQs

Q: Sunflower paid my claim but now another Insurer has also paid the claim and now I have a credit balance on the account. Where should I refund the credit balance or extra payment to?

A: When Sunflower has paid as the primary insurer and later another insurer also pays the services as primary, this is considered an overpayment by Sunflower. Overpayments must be returned to Sunflower, along with a copy of the both the primary payers EOB and the Sunflower EOB for those services within 30 days from the date of the Other Insurers payment to the following address:

Sunflower Health Plan

P.O. Box 955889

St. Louis, MO 63195-5889

COB / TPL FAQs

Q: What do I do if I've billed the primary payer but they have not responded?

A: If after 30 days* the primary payer has not responded (paid or denied the service), the provider can submit the claim within 12 months from the service date to Sunflower but must file a paper claim and include the following:

- Attestation for the date the information was sent to the primary payer and that a response has not been received
- Keep all related documentation on file and available on request

If the third-party requests additional information, providers must comply with the request. And if, after 90 days from the date of the original claim, there is still not response, providers may submit claims using the method above

*Exclusions apply to Self-Insured, Medicare/Medicare Supplements, Other Medicaid MCOs, Workers Compensation, Federal Employee Plans, Vision/Drug Plans, Disability, Claims Paid by Auto/Home Insurers

COB / TPL FAQs

Q: What if my services don't match because the primary payer requires me to bill differently than KanCare?

A: This information should be noted on the EOB

Q: What other forms of documentation are acceptable to submit if I don't have the primary payers EOP?

A: Providers may submit the Other Insurer's EOB/EOP, Remittance Advice, any correspondence from the other insurer indicating payment/denial or a copy of the Accounts Receivable Ledger showing how the primary payment was applied to that visit

Q: How can I correct a claim and provide the Other Insurer's EOB?

A: Information can be submitted electronically (EDI), updated in the Secure Provider Portal or mailed via USPS

Claims Submission
&
Payment Timelines

Know Your Numbers

- **180 Days** – Providers have to submit claims from the Date of Service (DOS) or from the date of eligibility determination
- **180 Days** – Providers have to submit claims when the member has Other Insurance, from the date on the primary Payer's EOP**
- **30 Days** – Sunflower has to pay or deny Clean Claims
- **30 Days** – Sunflower has to pay or deny claims before Interest begins to apply
- **90 Days** – Sunflower has to pay or deny Non-Clean Claims
- **30 Days** – Providers have to refund Overpayments or establish a payment plan
- **365 Days** – Providers have to submit Corrected Claims**
- **90 Days** – Providers have to request a Reconsideration*
- **30 Days** – Sunflower has to pay or deny Corrected Claims & Reconsiderations
- **30 Days** – Providers have to request an Appeal
- **30 Days** – Sunflower has to respond to an Appeal*
- **30 Days** – Providers have to file a State Fair Hearing (SFH)*

*From the date on the last EOP or determination letter: Providers must complete a Reconsideration and Appeal steps before proceeding to a SFH

** These dates have been changed to reflect standardization of timely filing rules across all 3 MCOs

Timely Filing FAQs

Q: Does Sunflower grant exceptions to Timely Filing denials?

A: Yes, timely filing requirements may be evaluated in the event of one of the qualifying circumstances:

- Catastrophic events that substantially interfere with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster
- Mechanical or administrative delays or errors by Sunflower or the Kansas Department of Health and Environment
- The member was eligible; however, the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation ***only if all*** of the following conditions are met:
  - The provider's records indicate that the member refused or was physically unable to provide their ID card or information
  - The provider can substantiate that the provider continually pursued reimbursement from the patient until eligibility was discovered
  - The provider can substantiate that a claim was filed within 180 calendar days of discovering Plan eligibility
  - The provider has not filed a claim for this member prior to the filing of the claim under review

Timely Filing FAQs

Q: What if I submitted the claim timely, but it was rejected and I had to correct and resubmit it?

A: All claim records sent to Sunflower must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Sunflower. In these cases, the claim must be corrected and re-submitted within the required timely filing deadline of 180/365 calendar days from the date of service

It is important that you review the acceptance or claim status reports received from your clearinghouse in order to identify and

re-submit these claims accurately

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department

Timely Filing FAQs

Q: What is considered acceptable proof of timely filing?

A: Proof of timely filing must be a document indicating:

- Date the claim was submitted
- To whom it was submitted
- At least one additional date when the provider either,
  - 1) filed additional documentation for the claim or,
  - 2) called to check the status of this claim

Q: Do timely rules apply to recoupments?

A: Yes and No;

- Yes, when there are provisions in the provider's contract that provides a threshold for claim recoupments
- No, when a provider requests that we recoup claims due to overpayments
- No, when it is determined a payment error occurred that the provider was aware of and a refund was not received
- Yes, when Sunflower determines that a calendar year is financially closed for the reprocessing of any claims, e.g., 2013 DOS

Timely Filing FAQs

Q: What if my claim was originally denied in error by Sunflower (e.g., No Authorization on File, but I had an Authorization) and I've requested **more than one** Reconsideration, but now it's denying as Not Meeting Timely Filing?

A: If Sunflower verifies that the claim was not processed correctly and more than one Reconsideration has been filed, Sunflower will reprocess the claim correctly

Q: What happens if I don't submit a Refund within 30 days? Are there penalties?

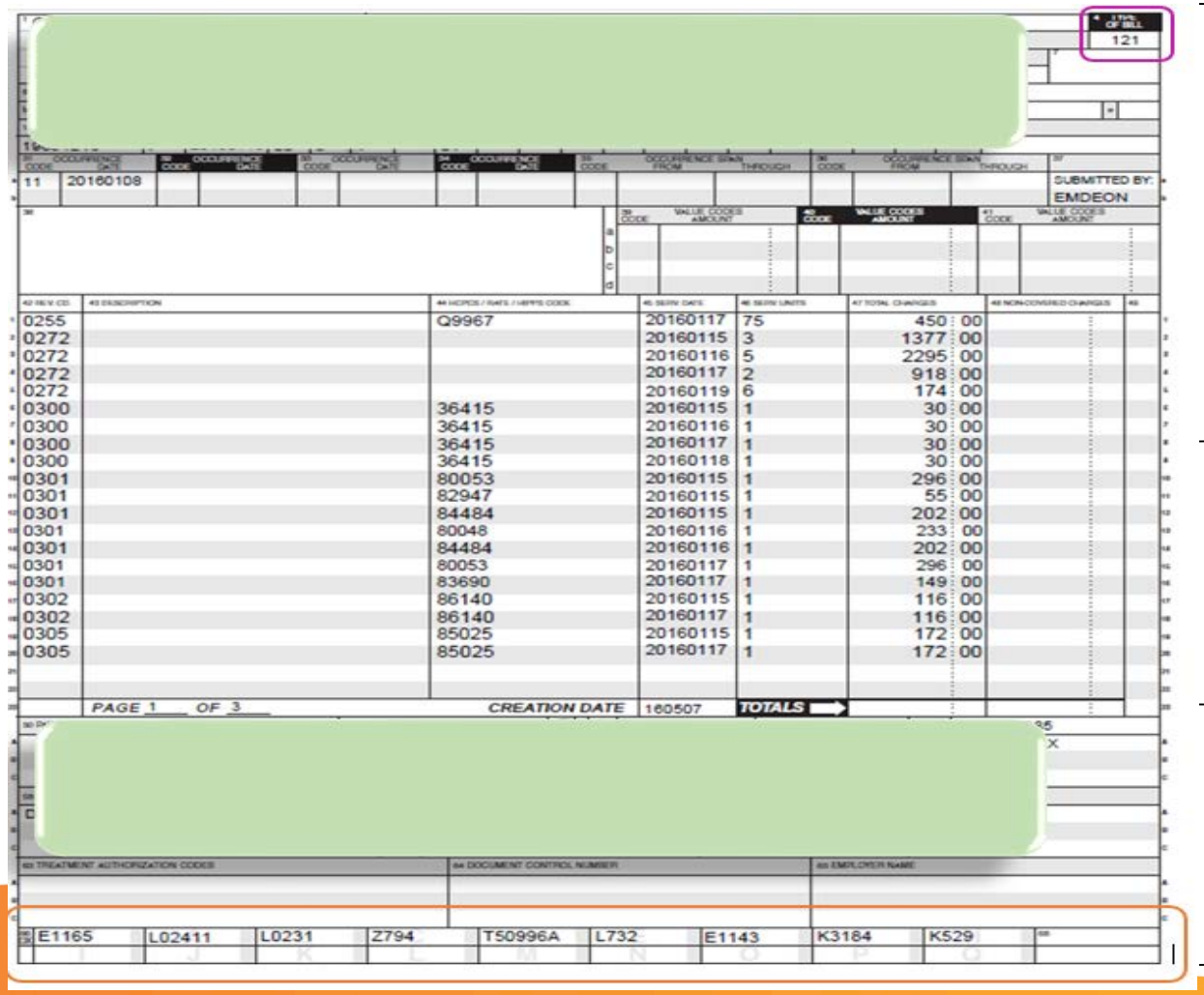
A: Sunflower Health Plan routinely conducts post-pay reviews and will recoup any overpayments identified. No, there are no penalties

Q: I submitted a claim on February 4; then submitted requested documentation on April 13. My claim was not paid until May 5. Why wasn't interest paid on my claim since more than 30 days had passed from the date I submitted my claim to the date the claim was paid?

A: Interest only applies to the date a Claim is determined to be clean; in this case, the clean claim date was the date the additional documentation was received on April 13

Present On Admission (POA) Indicators

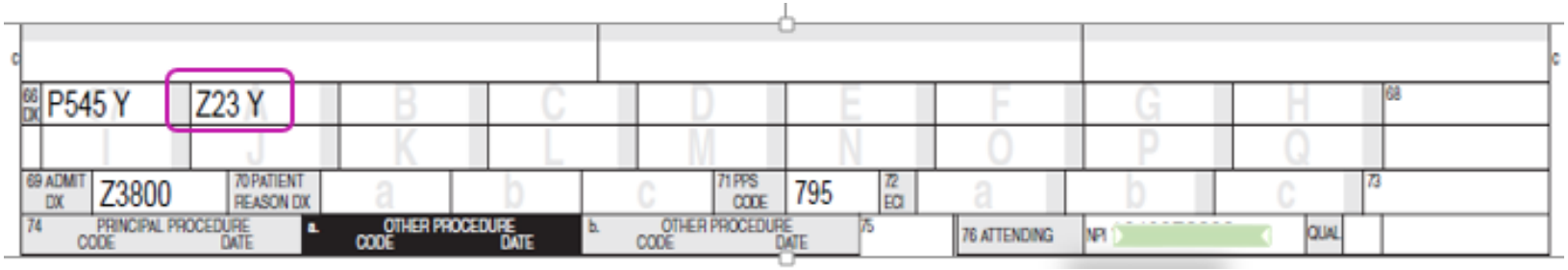
Review Scenarios that cause Claim Denials



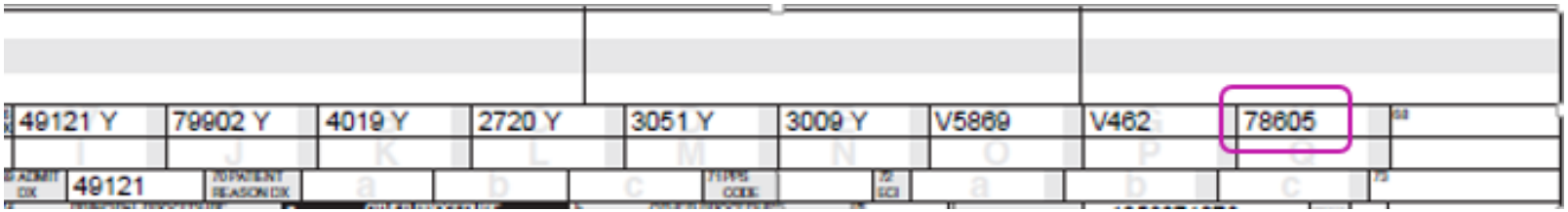
Claim submitted with *Type of Bill* 121, indicating inpatient part B services

All inpatient claims must be submitted with appropriate room and board line and Present On Admission (POA) indicators

Review Scenarios that cause Claim Denials



Diagnosis Z23 is on the “POA Exempt List”; therefore “Y” is not a valid value and this diagnosis should have been listed without an indicator



Diagnosis 78605 does not have a POA indicator on it and is not on the CMS Exempt List, so this diagnosis should have been listed with an indicator

Resources to verify POA requirements:

- 2014 SF Provider Bulletin SHPBN-040 http://www.sunflowerhealthplan.com/files/2014/11/SHPBN-040_POA-Indicators_110414_PV.pdf
- CMS POA Exempt List https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Coding.html

POA FAQs

Q: Why are POA indicators important / required?

A: On February 8, 2006, the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the Secretary to identify conditions that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.

Q: What diagnoses are considered to be a POA Indicator?

A: POA is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA.

POA FAQs

Q: Which claims are these indicators required for?

A: All claims involving inpatient admissions to general acute care hospitals will require submission of POA indicator(s).

Q: Is there an effective date for this requirement? What if I'm a Critical Access Hospital or Nursing Facility?

A: Effective with dates of service on and after July 1, 2013, POA and Health Care Acquired Conditions (HCAC) requirements apply to all inpatient settings, including critical access, long-term care, cancer, and children's hospitals as well as freestanding psychiatric and rehabilitation facilities.

Billing with Modifiers
(for Outpatient Hospitals)

Review Scenarios that cause Claim Denials

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0424		97001	20160310	1	237 25			1
2									2
3									3
4									4
5									5

97001: *Physical Therapy Evaluation* requires that a modifier be billed in conjunction with the procedure code

Resources to verify modifier requirements:

- KMAP Coding Modifiers Table https://www.kmap-state-ks.us/Provider/PRICING/CodingModifiers.asp

GP		Submit this modifier with services delivered under an outpatient physical therapy plan of care. KMAP has determined it is appropriate to use modifier GP on the following codes: 64550, G0281, G0283, G0329, 0019T, 0029T, 0183T, 90901, 92520, 92506, 92507, 92508, 92526, 92597, 92605, 92606, 92607, 92608, 92609, 92610, 92611, 92612, 92614, 92616, 95831, 95832, 95833, 95834, 95851, 95852, 96105, 96110, 96111, 96125, 97001, 97002, 97003, 97004, 97010, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97597, 97598, 97602, 97605, 97606, 97750, 97755, 97760, 97761, 97762 and 97799. KMAP will deny the service if this modifier is billed with any code other than those listed.

- Sunflower Health Plan Provider Manual,
  - Appendix X: Billing Tips and Reminders
    - Modifiers: GN, GO, GP Modifiers – therapy modifiers required for speech, occupational and physical therapy
  - Appendix II: Common Causes of Claim Processing Delays and Denials
    - Procedure or Modifier Codes entered are invalid or missing - This includes GN, GO, or GP modifier for therapy services

Review Scenarios that cause Claim Denials

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0300		G0477		1	117 50		
2	0306		87480		1	22 16		
3	0306		87491 GZ		1	68 67	68 67	
4	0306		87510		1	22 16		
5	0306		87591 GZ		1	68 67	68 67	
6	0306		87660		1	22 16		
7								
8								

This claim is billed with 87491 and 87591, both billed with GZ Modifiers

Resources to verify modifier requirements:

- KMAP Coding Modifiers Table https://www.kmap-state-ks.us/Provider/PRICING/CodingModifiers.asp

GZ		Medicare will automatically deny any service with modifier GZ appended as not medically necessary. The denial will reflect a claim adjustment reason code (CARC) of 50 and a group code of contractual obligation (CO) to show provider/supplier liability because an Advance Beneficiary Notice was not issued to the beneficiary. Medicaid will also follow Medicare policy and begin automatically denying any services with a modifier GZ appended as not medically necessary with a CARC of 50 and a group code of CO.

Review Scenarios that cause Claim Denials

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0301		80053		1	156 00		
0301		84484		1	180 30		
0305		85025		1	67 80		
0306		87086		1	71 70	71 70	
0307		81001		1	91 60		
0324		71010		1	268 20		
0450		96360		1	289 50		
0450		96361		6	869 40		
0450		99284 25		1	1037 50		
0637		A9270		10	75 90	75 90	
0730		93005		1	225 00		
0972		71010 26		1	18 00		
0981		99284		1	424 30		

71010: *Radiologic exam, chest; single view* is not allowed to be billed with a 26 modifier when billed by a hospital

Resources to verify modifier requirements:

- KMAP Coding Modifiers Table https://www.kmap-state-ks.us/Provider/PRICING/CodingModifiers.asp

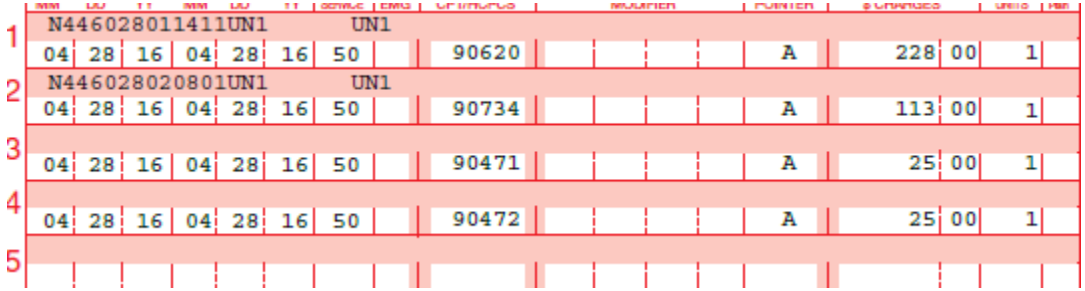
26	50, 62, 66, TC	If billing for the global component (professional & technical) of a procedure, modifiers 26 and TC should not be used. Modifier 26 can only be used by professional providers. It should not be used by a hospital. KMAP uses the Medicare Physician Fee Schedule Relative Value file to determine which procedures are appropriately billed with modifier 26. KMAP uses the PT/TC indicator field on the file as a basis to determine proper usage of modifier 26. The following determination has been made based on the individual indicators. • This modifier should not be used on procedures which have a PC/TC indicator equal to 0, 2, 3, 4, 5, 8, and 9 on the Medicare Physician Fee Schedule Relative Value file. Any procedure billed to Medicaid that has been assigned one of these indicators will be denied unless Medicaid has instructed differently through provider bulletins and/or manuals. Complete definitions of the PC/TC indicators are available on the CMS website. Once within the document, perform a word search for MPFSDB Record Layouts and look for the particular year in question (such as 2008, 2009).

Billing with Modifiers – Additional Tips

- **Modifier 27** is used to identify multiple outpatient hospital E&M encounters on the same date. **This modifier is not to be used by physician practices. It was created exclusively for hospital outpatient departments.** For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E&M encounters performed in multiple outpatient hospital settings on the same date can be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E&M code(s). This modifier cannot be used for physician reporting of multiple E&M services performed by the same physician on the same date. This modifier is valid for the following *CPT*® code ranges: 99201 – 99239, 99241 – 99255, 99281 – 99299
- Submit **modifier GN** to indicate the services were delivered under an outpatient speech language pathology plan of care
- Submit **Modifier GO** to indicate services delivered under an outpatient occupational plan of care
- Submit **Modifier GP** with services delivered under an outpatient physical therapy plan of care
- Submit **Modifiers PA, PB, or PC** when a surgical or other invasive procedure is considered to have been performed on the wrong body part if it is inconsistent with the correctly documented informed consent for that patient including surgery on the right body part but the wrong location on the body. This includes left versus right (appendages and/or organs) or at the wrong level (spine). Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate Type of Bills (TOBs) are required to append one of the following applicable National Coverage Determinations (NCD) modifiers to all lines related to the erroneous surgery(s)
- KMAP has determined only the following codes can be billed with **Modifier ET:** 99281-99285, 99291, and 99292. **No reimbursement will be made to hospitals for base codes 99281-99285 or 99291-99292 without modifier ET** since this signifies physician charges. Accordingly, physicians and mid-level practitioners should use codes 99281-99285 and 99291-99292 for emergency room visits without modifier ET

Billing with Encounterable Codes (for RHCs and FQHCs)

Review a Scenario that causes Claim Denials



1	N446028011411UN1					UN1											
	04	28	16	04	28	16	50		90620				A	228	00	1	
2	N446028020801UN1					UN1											
	04	28	16	04	28	16	50		90734				A	113	00	1	
3																	
	04	28	16	04	28	16	50		90471				A	25	00	1	
4																	
	04	28	16	04	28	16	50		90472				A	25	00	1	
5																	

In this example, vaccines and administrations codes are being billed without the presence of a face-to-face visit

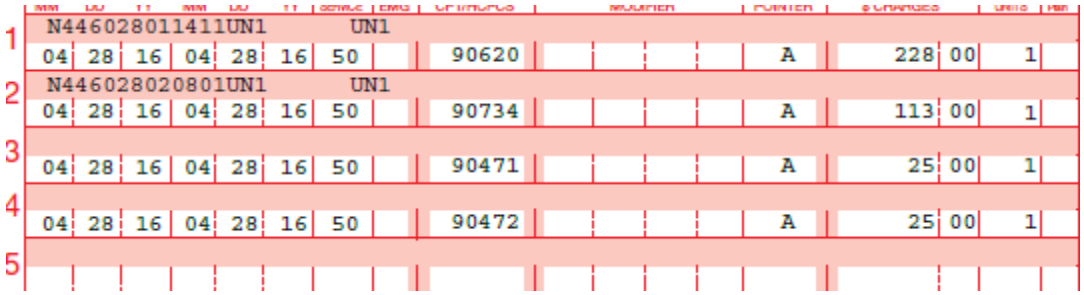
Per the KMAP RHC-FQHC Manual:

Visit or Encounter

A covered RHC or FQHC “visit” means a face-to-face encounter between a clinic/center patient and a clinic/center health care professional or practitioner (listed below) during which a covered RHC/FQHC service or dental service is rendered:

- Physician
- Physician assistant (PA)
- Advanced registered nurse practitioner (ARNP)
- Nurse midwife
- Dentist (for FQHCs only)
- Clinical psychologist
- Clinical social worker
- Registered nurse (RN), for KBH nursing screen only, bill with modifier TD
- Visiting nurse (if the conditions listed under “visiting nurse services” are fulfilled)
- Registered dental hygienist, extended care permit (RDH ECP)

Review a Scenario that causes Claim Denials



1	N4460280114	11UN1			UN1										
	04	28	16	04	28	16	50		90620				A	228	00	1	
2	N4460280208	01UN1			UN1										
	04	28	16	04	28	16	50		90734				A	113	00	1	
3																	
	04	28	16	04	28	16	50		90471				A	25	00	1	
4																	
	04	28	16	04	28	16	50		90472				A	25	00	1	
5																	

When a service is covered it does not automatically mean it is a billable/covered *visit*. If an encounter does not involve one of the previously listed practitioners, it is not a covered RHC/FQHC visit and **should not** be billed.

If an examination of the patient is not performed during a face-to-face encounter, it does not constitute a covered RHC/FQHC visit and **should not** be billed. For example, a visit for the sole purpose of obtaining or renewing a prescription (need for which was determined previously) without a medical examination of the patient is **not** a covered encounter.

Questions?