

Billing Tips

Federally Qualified Health Centers

Sandra Bates, Provider Representative

Topics

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General Guidelines

Claims:

- Only one encounter per day per recipient.
- At least one RI Medicaid covered services must be performed/delivered to bill for the encounter.
- Medicare Crossover claims should be submitted using the coinsurance/deductible amounts as reported by Medicare.

Provider Manual:

- Currently in review by EOHHS

Timely Filing Guidelines

Rhode Island Executive Office of Health and Human Services (EOHHS) has a claim submission restriction of 12 months from the date of services provided to Medicaid clients.

- DXC Technology must receive a claim for services for Medicaid clients, with no other health insurance with 12 months of the date of service in order to process claims.
- Any claim submitted with a date greater than 12 months from the date of service will deny for timely filing.
- Adjustments and recoups are also subject to these guidelines unless they result in lesser reimbursement.



Bypass the Timely Filing Limit

Claims received more than 12 months after the date of service must meet one or more of the following qualifications to bypass the timely filing time limit:

- Retroactive recipient eligibility claims must be submitted within 90 days of the eligibility update.
- Claims with third party payer must be submitted within 90 days of the payers valid EOB date. Denials for timely filing or failure to comply with the primary payer are not included in this exception.
- Claims denied by DXC for reasons other than timely filing, must be submitted within 90 days from the process date on the remittance advice. This includes denials resulting from processing and/or recoupment errors.

Reminders:

- ✓ Any claims with a service date over one year and an EOB date from another payer or remittance advice from DXC over 90 days, will be denied for timely filing.
- ✓ Eligibility updates within 90 days from the approval date.
- ✓ Computer printouts are not considered acceptable proof of timely filing.
- ✓ Claims that meet the timely filing exceptions must be submitted on paper with the supporting documentation to your Provider Representative.

RI Medicaid as Primary Payer

RI Medicaid will pay the lesser of the billed amount or allowed amount (encounter rate)

Medical and Behavioral Health Fee-for-Service:

- a. Bill the encounter code T1015 on detail #1 at the encounter rate
- b. Subsequent details are the procedure codes for the RI Medicaid covered service(s) rendered during the encounter, billed at \$0.00


RI Medicaid as Secondary Payer

When there is other insurance to consider (excluding Medicare crossover claims):

- RI Medicaid will pay the difference between the total primary payment and the FQHC encounter rate.
- Paper Claims
 - You must send the valid primary EOB with your claim
 - EOBs that indicate that the primary payer's guidelines were not followed will be considered invalid and the claim cannot be processed for the balance of the encounter rate.
- Electronic Claim
 - Indicate "YES" to other insurance
 - Enter Adjustment Codes
 - Enter Group/Reason Codes and amounts
 - Codes should be entered as reported on the primary payers EOB

Rlte Share

- RI Medicaid will pay the difference between the total primary payment and the FQHC encounter rate.
- Claims for recipients enrolled in Rlte Share **must be submitted on paper, using the CMS 1500 form.**
- A valid EOB is required to process these claims.
- EOBs that indicate that the primary payer’s guidelines were not followed will be considered invalid and the claim cannot be processed for payment.



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)
GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK/LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY	STATE	7. INSURED'S ADDRESS (No., Street)	
ZIP CODE	TELEPHONE (Include Area Code) ()	8. RESERVED FOR NUCC USE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: 9. EMPLOYMENT? (Current or Previous)	
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY	

CARRIER ↑
RED INFORMATION ↓

Rlte Share

For encounter balance payment

- Bill the encounter code T1015 on detail #1 at your Encounter Rate.
- Subsequent details are the actual procedure codes for the RI Medicaid covered services rendered during the encounter billed at \$0.00
- Indicate “YES” to other insurance and the appropriate Carrier Code must be indicated in field 9D of the claim form along with the payer name.

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
 YES NO *If yes, complete items 9, 9a, and 9d.*

d. INSURANCE PLAN NAME OR PROGRAM NAME
Carrier Code Insurance Plan Name

- Carrier codes are found at:

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/carrier_code.pdf

- Complete instructions for the CMS 1500 are found at:

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/cms1500_directions.pdf

Medicare

If the Medicare payment is more than the RI Medicaid allowed amount (encounter rate),
no payment will be made.

If the Medicare payment is less than the encounter rate, the following payment logic is used:

- RI Medicaid Allowed Amount (-) Medicare Payment = \$X.XX
- Medicare Reported Coinsurance (+) Deductible = \$X.XX
- RI Medicaid Payment = Lesser of #1 and #2

Billing Medicare Crossover Claims

– Electronic Submission

- Indicate “YES” to other insurance
- Enter Adjustment Codes
- Enter Group/Reason Codes and amounts
- Codes should be entered as reported on the Medicare EOB only

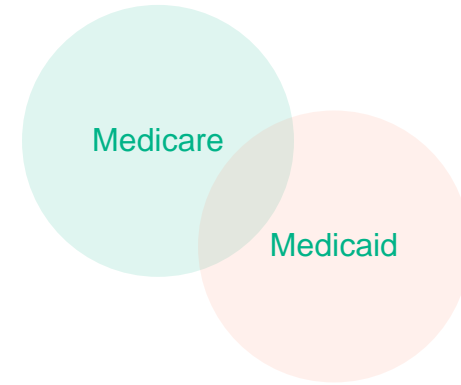
– Paper Submission

- Indicate “YES” to other insurance and enter appropriate Carrier Code for the Medicare plan in field 9D with the plan name if applicable.

d. INSURANCE PLAN NAME OR PROGRAM NAME

Carrier Code Medicare Plan Name

- See CMS1500 Claim form instructions on the EOHHS website for complete instructions.
- A valid EOB is required
- EOBs that indicate that Medicare guidelines were not followed will be considered invalid and the claim cannot be processed.



Dental Services

Dental Fee for Service

- Bill the encounter code T1015 on detail #1 at your Encounter Rate.
- Subsequent details are the ADA procedure codes for the RI Medicaid covered services rendered during the encounter, billed at \$0.00.

RIte Smiles or Commercial Primary (encounter balance payment only)

- Bill the encounter code T1015 on detail #1 at your Encounter Rate.
- Subsequent details are the ADA procedure codes for the RI Medicaid covered services rendered during the encounter, billed at \$0.00.



Billing Dental Services with Other Insurance

Billing on Paper

- Indicate “YES” to other insurance
- Enter the Carrier Code and name of primary payer in field 11 of the ADA 2012

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
28A Rhode Island Dental

- Complete instructions can be found at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/dental_form_inst.pdf
- Valid EOB is required to process claim
- EOBs that indicate the primary payer’s guidelines were not followed will be considered invalid and the claim cannot be processed for balance of the encounter rate.

Billing Electronically

- Indicate “YES” to other insurance
- Enter Adjustment Codes
- Enter Group/Reason Codes and amounts
- Codes should be entered as reported on the primary payers EOB

Denture Fabrication Billing

Two Appliances Delivered on the Same Date of Service

- A maximum of 4 encounters may be billed to Medicaid
- Appropriate appliance D code should be included on dental claim form only once for the appliance on the date it is delivered to the patient.
- Additional encounters for adjustments should include:
 - D0999 (unspecified diagnostic procedure, by report) on the claim form
 - A note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance



Denture Fabrication Billing

Single Appliances

- A maximum of 3 encounters may be billed to Medicaid
- Appropriate appliance D code should be included on dental claim form only once for the appliance on the date it is delivered to the patient
- Additional encounters for adjustments should include:
 - D0999 (unspecified diagnostic procedure, by report) on the claim form
 - A note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance

Denture Fabrication Billing

Note:

- Exceptions to these limitations require prior authorization.
- Valpast dentures may be fabricated for Medicaid recipients, reimbursed at the usual Medicaid allowable amount. They must be billed to Medicaid using:
 - D5110 (complete denture-maxillary)
 - D5120 (complete denture-mandibular)
 - D5211 (partial denture-maxillary)
 - D5212 (partial denture-mandibular)

Thank you

Sandra Bates
sandra.bates@dxc.com