
Provider Service Center

Harmony has a dedicated Provider Service Center (PSC) in place with established toll-free numbers. The PSC is composed of regionally aligned teams and dedicated staff designed to act as a single point of contact for providers in the resolution of provider issues.

A focus of the PSC is to resolve single claim issues in a timely manner but, more importantly, to investigate the basis for the issues and correct the root causes. The PSC partners with Provider Relations in resolving these issues.

In addition, the dedicated PSC telephone numbers enable providers to access the automated claims-status system as well as contact the Utilization Management, Pharmacy, Customer Service and Provider Relations departments.

Timely Claim Submission

Timely filing is six months from the date of service to the primary payers and 90 days to secondary payers, or as required by law. However, non-participating providers have up to one year from date of service to submit their claims. Refer to the **Rapid Reference Guide** for the appropriate mailing address.

Clean Claim

Providers are required to submit clean claims. A *clean claim* is one that can be processed without obtaining additional information from the provider who provided the service or from a third party. It does not mean a claim submitted by, or on behalf of, a provider who is under investigation for fraud or abuse, or a claim that is under review for medical necessity.

Prompt Payment

Clean claims must be paid within 30 days from receipt by the health carrier. Per Illinois Legislative Code 215 ILCS 5/368(a) clean claims paid beyond the 30-day time limit will be subject to interest payments beginning the 31st day, provided that interest amounting to less than \$1 need not be paid. Any required interest payments shall be made within 30 days after the payment of the claim.

**Claim
Submission
Format**

Claims may be submitted to the Plan in one of the following formats:

- Electronic Claims Submission (EDI)
- CMS 1500 form. Ensure you use the most current version. The footer should contain the following designation:

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05).

- UB-04 form (replaced the UB-92 form).

All providers are required to use the standard CMS codes for ICD9, CPT and HCPCS regardless of the type of submission.

The largest driver of payment turnaround time is the accuracy of the data on the claim, regardless of whether it is an electronic or paper claim submission. To assist providers in submitting the correct data in the correct fields on a claim, the Plan has prepared claim submission guidelines. These guidelines identify key fields the Plan requires to be filled for claims processing as well as the data source to complete the field.

**Provider ID and
NPI Requirements**

The Plan requires the use of the payer-issued tax ID and NPI on all claim submissions, both electronic and paper. However, the Plan-issued provider ID remains a key identifier on daily encounters with the Plan. For this reason, we highly recommend that it be included on your claim submissions.

- If submitting claims electronically, there is a required field in the file format for the Plan's provider ID number along with the referring, rendering or facility NPI numbers. Providers are encouraged to verify that their software management tool or clearinghouse has the correct provider ID and is placing it in the correct field.

- Providers submitting paper claims should include their Plan-issued provider ID or NPI on both CMS 1500 and UB-04 forms. Other forms of identification may be used in the absence of the provider ID or NPI number (see guidelines for CMS 1500 and UB-04 paper claims submission in this section).

National Provider Identifiers

Beginning May 23, 2007, standard transactions such as claims submitted electronically to the Plan must include the referring, rendering or attending, billing and facility provider's National Provider Identifier (NPI), per requirements put forth in HIPAA's NPI Final Rule Administrative Simplification.

The NPI and tax ID must be included with electronic claim submissions for proper adjudication. More information about NPI is available on the Centers for Medicare and Medicaid Services' (CMS) Web site.

HIPAA Electronic Transactions and Code Sets

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), which includes a series of administrative simplification provisions that require the Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions.

Since October 16, 2003, payers like Harmony are required by federal regulation to have the capability to send and receive all applicable HIPAA-compliant standard transactions and code sets.

For example, a payer must be able to electronically accept a HIPAA-compliant 837 (I and/or P) electronic claim transaction in standard format, and the provider must be able to send it to the payer in the required format for HIPAA-compliant 837 (I and/or P) electronic claim transactions.

Standard Code Sets

All providers are required to:

- Use the HIPAA Compliant codes, which include the standard CMS codes for ICD9, CPT and HCPCS; and
- Discontinue the use of all old HCPCS level III code sets, also known as local codes and/or home-grown codes, as they have been discontinued.

If you are unclear about standard code sets, please call your Provider Relations representative.

Standard Transactions

All providers who submit electronic claims to the Plan must do so in the new format established by HIPAA.

The provider-focused HIPAA transactions are (*ANSI X12N):

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response
- 276/277–Health Care Claim Status Request & Response
- 278–Health Care Services Review – Request for Review and Response
- 835–Health Care Claim Payment/Advice
- 837–Health Care Claims

The X12N – 837 Claims Submission transactions replaces the manual CMS 1500/UB-04 forms.

All files submitted must be in the *ANSI ASC X12N format, version 4010A. Implementation Guides for all of the HIPAA transaction sets are available at <http://www.wpc-edi.com>.

**Electronic
Claim
Submission**

The plan accepts electronic claim submissions through Electronic Data Interchange (EDI).

Advantages of EDI

- Submitting claims electronically is less costly than billing with paper.
- In most instances, the Plan can process your electronic claim in half the time of a paper claim.
- Clearinghouses charge varying fees. The Plan has options with ACS, including connectivity and software, which are free. Contact the EDI department to see if you qualify for this service. You may also contact your clearinghouse or billing software vendor to see if they offer free options.

There are six primary clearinghouses through which we receive EDI transactions. Those companies are:

- ACS EDI Gateway, Inc.
- Availity
- Emdeon (former WebMD®)
- RelayHealth (McKesson)
- SSI Group
- ZirMed

Since most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, if other than those listed, to establish EDI with the Plan.

All files submitted to the Plan must be in the ANSI ASC X12N format, version 4010A. Implementation guides for HIPAA transaction sets are available at <http://www.wpc-edi.com>.

If you do not have a clearinghouse or have been unsuccessful in submitting claims through your clearinghouse, please contact our EDI team. The EDI team contact information can be found on the **Rapid Reference Guide**.

Payer ID

There are unique Payer IDs that must be used to identify our Plan on electronic claim submissions. The appropriate Payer IDs for each of the six clearinghouses through which Harmony claims may be submitted are listed below: (subject to change)

ACS EDI Gateway, Inc.

- 77004

Availity, Emdeon (WebMD®), RelayHealth (McKesson), SSI Group and ZirMed

- 14163

Paper Claim Submission Guidelines

Paper claims must be completed in full and include:

- The Plan member's name and his or her relationship to the subscriber;
- The subscriber's name, address and Social Security number;
- The subscriber's employer group name and number (when applicable);
- Information on other insurance or coverage for the Plan member;
- The name, signature, place of service address, billing address and telephone number of the physician or provider performing the service;
- The tax ID number; and
- Medicaid and/or Plan-issued provider ID number for the referring physician or provider performing the service as well as for the facility (when applicable) including its respective qualifier.

Qualifiers

Each form of identification should be accompanied by a qualifier which will correctly allocate the information when transferred into our databases. Proper qualifiers for identification numbers submitted to the Plan are:

ID	Qualifier
Tax ID	24
NPI	XX
Harmony ID	G2
Medicaid ID	1D
Taxonomy	ZZ
State License	0B

Notice that some form fields will include a box to submit the identification number's qualifier. In others, however, the box will not be available and the qualifier should be included by preceding the identification number with a hyphen (Ex. XX-XXXXXXXXXX).

- Appropriate ICD-9 codes;
- Standard CMS procedure or service codes (e.g., CPT-4 procedure codes and HCPC-I,II codes with appropriate modifiers, revenue codes);
- Number of service units rendered;
- Billed charges;
- Referring physician's name and NPI number;
- Date(s) of service;
- Place(s) of service and facility NPI (where applicable);
- Authorization Number (if applicable);

- NDC for drug therapy (if applicable); and
- Job related, auto or other accident information.

**CMS 1500
Paper Claim
Submission**

The Plan accepts the revised CMS 1500 forms printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the CMS 1500 form can be downloaded from the CMS Web site, copies of the form cannot be used for submission of claims since your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).

This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. OCR technology allows the Plan to record and process paper claims faster.

There are key fields that will properly identify and adjudicate claims information on a paper CMS 1500 form when submitted to our Plan. Below are guidelines identifying those fields to ensure timely and accurate processing of your claims.

CMS 1500 Guidelines for Paper Claims

- Block 17a: The referring provider's Harmony, Medicaid or tax ID number. Providers may also use their state license or taxonomy numbers should the others not be available.
- Block 17b: The referring provider's NPI number. Please ensure the 10-digit NPI number is accurate.
- Block 24i (lines 1-6): The ID qualifier for the rendering provider's Harmony, Medicaid or tax ID. Providers may also use their state license or taxonomy numbers should the others not be available. Refer to page 7 of this section for a list of qualifiers.

CLAIMS

Section 6

- Block 24j (lines 1-6): The rendering provider's Harmony, Medicaid or tax ID. Providers may also use their state license or taxonomy numbers should the others not be available.
- Block 25: The 9-digit federal tax ID number (TIN). The provider's tax ID must be included or the claim will be denied.
- Block 32: Facility contact information (name, address and telephone number). Include when applicable.
- Block 32a: Facility's NPI number. Please ensure the 10-digit NPI number is accurate.
- Block 32b: Facility ID Qualifier and respective ID number (Ex. xx-xxxxxxxx). Refer to page 7 of this section for a list of qualifiers.
- Block 33: Billing provider's (or billing vendor's) contact information. Include when applicable.
- Block 33a: Billing provider's NPI number. Please ensure the 10-digit NPI number is accurate.
- Block 33b: Billing provider's qualifier and respective ID number (Ex. xx-xxxxxxxx). Refer to page 7 of this section for a list of qualifiers.

UB-04 Paper Claim Submission

The Plan accepts UB-04 forms printed in Flint OCR Red, J6983, (or exact match) ink. Although a copy of the form can be downloaded from the CMS Web site, copies of the form cannot be used for submission of claims since your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).

This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner.

Photocopies cannot be scanned and therefore are not accepted.

There are key fields to properly identify and adjudicate claim information on a paper UB-04 form when submitted to our Plan. Below are guidelines identifying these fields to ensure timely and accurate processing of your claim submission.

UB-04 Guidelines for Paper Claims

- Block 56: Billing provider's NPI number is entered here. It is optional on paper claims.
- Block 57A&B: Use this field if an identification number other than the NPI is being reported for the billing provider such as a Medicaid or tax ID. Providers may also use their state license or taxonomy numbers.
- Block 57C: Billing provider's Harmony ID number.
- Block 71 PPS Code: Enter DRG code.
- Blocks 76-79 QUAL: Attending, operating or other physician's qualifier. Refer to page 7 for a list of qualifiers.
- Blocks 76-79: Enter the attending, operating or other physician's ID number related to the qualifiers listed above.
- Blocks 76-79 NPI: Include the attending, operating or other physician's NPI number whenever possible.
- Block 81CC: Enter the taxonomy codes corresponding to providers listed in fields 76-79.

**Encounter
Data Submissions**

If a provider's payment method is on a capitation basis, claims still must be submitted to the Plan.

This requirement is mandated to meet the reporting requirements of the Plan as well as those established by regulatory agencies and the Balanced Budget Act. Claims submitted under a capitation contract are usually referred to as encounter data. Encounter data can be submitted on CMS 1500 or UB-04 forms or through EDI following the same rules as standard claim submissions.

Note: Encounter data submitted using paper forms must include the billing provider's Medicaid ID or the claim submission will be rejected.

The Plan currently utilizes the six clearinghouses listed below to process the 837 Health Care Claims transactions. The encounter payer ID for all clearinghouses is **59354**.

- ACS EDI Gateway Inc.
- Availity
- Emdeon (former WebMD®)
- RelayHealth (McKesson)
- SSI Group
- ZirMed

The Plan will record all encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

Any capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.

**Coordination
of Benefits**

Coordination of Benefits (COB) is the procedure used to process health care payments when a person is covered by one or more insurers. Prior to submitting a claim to the Plan, providers must identify if any other payer has primary responsibility for payment of a claim.

If determination is made that another payer is primary:

- The primary payer should be billed prior to billing the Plan;
- Any balance due after receipt of payment from the primary payer should be submitted to the Plan for consideration; and
- The claim must include information verifying the payment amount received from the primary plan as well as a copy of their Explanation of Payment (EOP) statement with the name of the primary payer and the member's primary subscribed ID number.

Upon receipt of the claim, the Plan will review it using the COB rule or other, as applicable.

Prohibition on Billing Plan Members

Your agreement with the Plan requires providers to accept payment directly from the Plan. Payment from the Plan constitutes payment in full, with the exception of applicable co-payments, deductibles, co-insurance and any other amounts listed as member responsibility on the Explanation of Payment/Provider Remittance Advice.

Providers may not bill Plan members for:

- The difference between actual charges and the contracted reimbursement amount;
- Services denied due to timely filing requirements;
- Covered services for which a claim has been returned and denied for lack of information;
- Remaining or denied charges for those services where the provider fails to notify the Plan of a service that required prior authorization;
- Payment for that service will be denied; and

- Covered services that were not medically necessary, in the judgment of the Plan, unless prior to rendering the service, the provider obtains the member's informed written consent and the member receives information that they would be financially responsible for the specific services.

Non-Covered Services

Plan members may be billed for non-covered services, such as cosmetic procedures and items of convenience (i.e. televisions).

Covering Physician Reimbursement

In the event a covering physician agrees to act on behalf of another network physician, the following applies:

- The covering physician that is providing services to the network physician's Plan members agrees to accept payment under the network physician's agreement with the Plan.
- If covering for a network physician who is reimbursed on a capitation basis, the covering physician will be required to seek payment for services provided to Plan members from the network physician and not the Plan.
- Covering physicians will not be able to seek payment from the Plan or the Plan member, with the exception of those services for which the network physician would have been permitted to collect from the Plan pursuant to their contractual agreement.

Professional and Technical Component Payments

The Plan covers the professional and technical components of global CPT procedures. Therefore, the appropriate professional component modifiers and technical component modifiers should be used on the claim form.

Explanation of Payment

An Explanation of Payment (EOP) is issued for each claim submitted. The EOP contains all of the information that was submitted on the claim form. The EOP will show all reimbursement information along with any specific messages regarding the claim.

Provider Complaint Process

The provider complaint process allows providers to make complaints verbally, or in written correspondence through faxes, Web site inquires, E-mails and projects.

In order to resolve claims issues a verbal or written request by participating providers must be received by the Plan within 60 calendar days from receipt of the Plan's explanation of payment (EOP) and non-participating providers have 365 days from receipt of the explanation of payment (EOP).

The provider complaint process can be used for the following claim issues: Delays in claims payments, denial of claims, claims not paid correctly and any aspect of the Plan's claims functions, including proposed actions.

The Plan will review the claim or claim related issue for resolution and respond to the provider within 45 calendar days of receiving a verbal or written request with an additional 14 calendar day extension if the Plan justifies the need.

A log is maintained of all filed provider claim complaints. The logged information includes the provider's name, date of the complaint, nature of the complaint and disposition.

Claim Appeals

The process to appeal a denied claim is as follows:

- Submit a written request to the Plan's Claims department to reconsider the denied claim along with a copy of the denied claim. The Plan will not consider claim appeals by telephone;

CLAIMS

Section 6

- Outline the reason(s) why the denial should be reversed;
- Supply specific, pertinent documentation that supports the need for and the appropriateness of services on the claim;
- Include all medical records that apply to the service on the claim;
- Send the appeal and accompanying documentation to the claim appeal mailing address found on the **Rapid Reference Guide**.

Physicians and hospitals must appeal denied claims within 90 days of the date on the EOP. The Plan will pay all overturned claim denials within 30 days of the resubmitted claim.

Delegated Entities

All participating providers or entities delegated for Utilization Management are to use the same standards as defined in this section. Compliance is monitored on a monthly basis, and formal audits are conducted annually. Failure to pass all annual audits will result in action by the Plan.

Delegated entities are subject to all state, Illinois Department of Healthcare and Family Services (HFS), the Centers for Medicare and Medicaid Services (CMS), federal guidelines and all accreditation and Harmony standards related to delegated claims functions.