healthfirst®
Health Insurance for New Yorkers

Licensed Home Care Services Agencies (LHCSA)

Billing and Authorization Guide

Introduction

The purpose of this guide is to assist providers in understanding and complying with Healthfirst's billing requirements for Licensed Home Care Services Agencies (LHCSA).

Billing guidelines are designed to promote accurate coding and to assist you when submitting claims to Healthfirst. Refer to your provider contract for compensation information and additional billing requirements that may apply to you.

Claims will be subjected to payment edits that are based on payment policies consistent with national standards established by Current Procedural Terminology (CPT), the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI), and specialty societies. We will keep our policies current with these respected sources as they make modifications.

Healthfirst will process all undisputed claims in accordance with New York State Prompt Payment regulations.

For additional information concerning requests for authorizations and claims submission, including clean claims requirements not included in this document, refer to the Healthfirst Provider Manual.

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Member Eligibility

Providers are responsible for verifying member eligibility and can do so by calling Healthfirst Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm.

Providers may also verify member eligibility online 24 hours a day, 7 days a week, by visiting the Healthfirst secure Provider Portal at **HFProviderPortal.org** and clicking on Provider Login.

New and existing users of the secure Provider Portal will need to register for the NEW 2018 secure Provider Portal at **HFProviderPortal.org** with a unique username that has not previously been registered. Additional instructions on how to navigate the enhanced Provider Portal are available under the "Provider Resource Center" under "Resources."

Authorization Requirements

All members require authorization for Personal Care Agency (PCA) services. All members are assessed in their home by a nurse to evaluate their need for PCA services and the extent of PCA services required. In addition, all members are reassessed every six months to one year, based on their medical condition and needs. For Senior Health Partners, Managed Long-Term Care Plan (SHP) and CompleteCare (CC), members are reassessed every six months.

A list of these services is provided in **Appendix A** of this guide.

To request authorization or for authorization inquiries, call the Care Coordination Unit (CCU) at **1-800-404-8778**, Monday to Friday, 8am–6pm; **TTY (English): 1-888-542-3821; TTY (Spanish): 1-888-867-4132**.

Appeals for denial of service may be mailed to:

Appeals and Grievances Department
P.O. Box 5166
New York, NY 10274-5166

- Approved services are authorized through the Care Management Team and detail the specific services by service code, duration, and date(s) that they are authorized to be rendered by the indicated provider
- Providers will receive a copy of the authorization
- To ensure payment, providers should render services only upon receipt of written authorization, except in the case of auto-enrolled members, who for the first 60 days may be billed without authorization.
- Services billed must match the services authorized and must have available units in order to receive payment. If the units are exhausted, or if authorized code, duration, or date does not match the billed service(s), the claim will be denied

You will receive a letter if the service request has been approved and authorized.
The letter will list the member name and ID#, requested dates of service, service procedures, and description. It will also include an authorization number.

Claims Processing

Claims Submission Timeframe

Claims must be submitted within **180 days** of the date of service.

All Personal Care Aide (PCA) provider services claims must be submitted to Healthfirst electronically using the **837(P)**, or on paper, using the CMS 1500 claim form. Effective 4/1/18, PCA providers are required to enroll in electronic funds transfer/electronic remittance advice (EFT/ERA) for payment processing. This will reduce administrative costs and result in quicker receipt of payment. To enroll in EFT/ERA, please contact your Network Management representative.

Submitting Clean Claims

Before being adjudicated, all claims are reviewed within the Healthfirst Claims department for completeness and correctness of the data elements required for processing payments, reporting, and data entry into the Healthfirst utilization systems. If any required data is missing from the claim, the claim is not "clean" and will be rejected. A listing of required fields is available in **Appendix C** of this guide.

Balance Billing

All payments for covered services provided to Healthfirst members constitute payment in full. Providers may not balance-bill members for the difference between their actual charges and the reimbursed amounts; any such billing violates the provider's agreement with Healthfirst and applicable New York State Law.

Clinical Claims Auditors Line

The Clinical Claims Auditors Line assists providers with denied claim issues.

Clinical Claims Auditors will verify whether an authorization is required for the type of service billed, will check CCMS to ensure authorization is in place for date of service (DOS) the provider is requesting, and will examine authorizations for completeness and accuracy.

When sending requests to Clinical Claims Auditors, please provide the following:

- Provider name
- Name of contact at provider
- Telephone number

Clinical Claims Auditors Line
Phone: 1-212-519-8170
Monday to Friday, 8am–5pm
Email: **ClinicalClaimsAuditors@Healthfirst.org**

Claims Appeals and Reconsiderations

Healthfirst provides a two (2)-level process for providers to appeal a claim denial or payment which the provider believes was incorrect or inaccurate.

Corrected Claims—Corrected claims must be marked **"Corrected"** and should be submitted within **180 days** of the date of service. All corrected claims must include the original Healthfirst claim number being corrected. For electronic corrected claim submission, claim frequency type must be a 7.

Failure to indicate corrected claims may result in a duplicate denial. **Please note, a change to an authorization is not considered a corrected claim** and must be submitted as a Review and Reconsideration or Provider Appeal (as appropriate) or it will result in a duplicate denial.

First-Level Appeal Requests

Reviews and Reconsiderations—Providers who are dissatisfied with a claim determination made by Healthfirst must submit a **written** request for review and reconsideration, with all supporting documentation, **within ninety (90) calendar days** from the paid date on the provider's Explanation of Payment (EOP). Written requests, including attachments, must be mailed to the applicable location below.

Providers with questions about the outcome of claims may contact their Network Representative for assistance. Before contacting your Network Representative, please reconcile your Explanation of Payment (EOP) against your records. You may then submit your reconciled EOP with the highlighted claims numbers in question to your Network Representative to facilitate further review. Network Representatives cannot accept a provider's accounts receivable or internal billing statements.

You may also access the secure Provider Portal at **HFProviderPortal.org** to check claim status. These requests are accepted through the Healthfirst secure Provider Portal or may be mailed to:

Healthfirst Claims Correspondence Unit
P.O. Box 958438
Lake Mary, FL 32795-8438

Senior Health Partners Claims Correspondence Unit
P.O. Box 958439
Lake Mary, FL 32795-8439

Second-Level Appeal Requests

Provider Claims Appeals—Providers may appeal the outcome of a review and reconsideration in writing, with supporting documentation, **within sixty (60) calendar days** from the date listed on the reconsideration letter. Appeals should be mailed to:

Healthfirst Provider Claims Appeals
P.O. Box 958431
Lake Mary, FL 32795-8431

Senior Health Partners Provider Claims Appeals
P.O. Box 958432
Lake Mary, FL 32795-8432

Reprocessing and resubmission of claims to correct errors is not a guarantee of payment.

Claims and/or claims correspondence are not accepted via certified mail. Certified-mail receipts, overnight-mail receipts, or documentation from internal billing software is not valid evidence of timely filing.

Billing Requirements for LHCSA/PCA Services

The service codes and associated rates, along with required modifiers, will be provided on contract rate sheets and, if applicable, on rate sheet amendments. Refer to the Service Code Summary table on page 13 for descriptions of these codes and how they should be billed. In addition:

- Make sure that the total of the authorized units is equal to what you are billing—if you bill for more units, your claim can be denied
- Make sure you are billing for services within the correct date range—billing for services outside of the approved date range will result in a denied claim
- Make sure you are billing for the right number of units based on the code submitted
  - When hourly services are approved, bill 1 unit for codes that represent 15-minute increments
    Example: T1019, U1 "Personal Care Services, per 15 minutes"
    8 hrs. two times per week approved = 8 hrs. x 2 days x 4 units = 64 units
- For per diem codes:

  Example: T1020 "Personal Care Services, per diem"
- For split shift
  - 96 units are equal to two 12-hour shifts (one split shift) and should be billed on one line of the CMS-1500 form.
    Example: T1020, U2; T1019, U2; "Personal Care Services, per 15 minutes"
- Skilled Nursing Services are not reimbursable to LHCSAs. These services have been transitioned to CHHAs (Certified Home Health Agencies) effective September 1, 2014, according to the NYSDOH DAL release

Single Patient Agreements

Single Patient Agreements (SPAs) are required for providers that are out-of-network (OON).

After the provider has requested authorization for services, they must reach out to a Healthfirst and/or SHP Ancillary Contractor to request a SPA.

The SPA will include the authorization for services being rendered to members and must be used when billing claims. If the SPA is not used when billing the claim, the services will be paid at a reduced charge.

Electronic Claims

Submit claims electronically and enjoy the following benefits:

- Faster submission of claims
- Faster tracking of claims
- Improved cash flow
- Improved business relationships

For all electronic claims, Healthfirst utilizes the Emdeon clearinghouse and MD On-Line, a free online service for providers who do not have claims submission software.

To sign up for electronic billing with Emdeon, providers must contact their software vendor and request that their Healthfirst claims be submitted through Emdeon. Providers can also direct their current clearinghouse to forward claims to Emdeon.

Providers who sign up for electronic billing may also sign up for electronic funds transfer/ electronic remittance advice (EFT/ERA) by contacting their Network Management representative. Electronic claims must include:

- Healthfirst Payor ID Number 80141
- Member ID Number
- Provider Name, Tax ID Number, and NPI
- Authorization Number

Submitting claims on paper:
All paper claims should be submitted to:

Healthfirst Claims Department
P.O. Box 958438
Lake Mary, FL 32795-8438

All paper claims should include the National Provider Identifier (NPI).

Note for group practices and facilities: When submitting claims, please ensure the facility NPI is entered into the appropriate field.

A claim submitted electronically receives a status report indicating whether it is accepted, rejected, or pending, and the amount paid on the claim once it has been finalized.

Claims submitted electronically must include:

1. Healthfirst Payor ID Number **80141** on each claim.
2. Complete **Healthfirst Member ID Numbers** (see Member ID card or monthly enrollment roster).
3. A National Provider Identifier (NPI) should reside in:
   - 837 Professional (CMS-1500 HCFA) - Loop 2310B Rendering Provider Identifier, Segment/Element NM109. NM108 must qualify with an XX (NPI).

EFT/ERA

The benefits of Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA):

- Reduction in mailing costs – the electronic exchange of money occurs directly from one account to another
- No stuffing of envelopes – helps save on staff resources
- EFT/ERA is safe, secure, and efficient
- EFT money is available right away with direct deposit to a checking account
- No lost checks

Effective 4/1/18, long-term providers in the HF network are required to utilize EFT/ERA to receive payment. To sign up for EFT/ERA, please reach out to your Network Management representative.

MD On-Line

Submit Claims Electronically to Healthfirst for FREE

Healthfirst has partnered with **MD On-Line, Inc.** (now part of Ability), a leader in electronic all-payer claims solutions, to offer you a FREE solution for submitting your Healthfirst paper claims electronically.

Why use MD On-Line?

- Three easy steps: enroll, submit, get paid
- Electronic claims submission for practices with/without practice management software
- ICD-10 codes & CMS-1500 form changes (version 02/12) – MD On-Line is ready to accommodate, and is in full compliance with, these upcoming industry transitions, to be supplemented by the development of added features
- Instinctive Data® – Leverages your claims data to securely deliver valuable educational messaging and financial analysis relevant to your practice
- Fully integrated PM/EMR, medical transcription, revenue cycle management, electronic remittance advice, real-time eligibility, patient statements, credit card processing, and patient reminders

To enroll for this service, log on to **www.healthfirstmdol.com**, or call MD On-Line at **1-888-499-5465** and mention "**Healthfirst promotion**." Representatives are available Monday to Friday, 8:30am–6:00pm.

Claims Submission and Encounter Data

Healthfirst is required to report—to New York State, CMS, and other regulatory agencies—encounter data which lists the types and number of healthcare services members receive. Encounter data is essential for claims processing and utilization reporting, as well as for complying with the reporting requirements of CMS, New York State, and other governmental and regulatory agencies. Further, for some Healthfirst providers, such reporting will impact the provider's eligibility for bonuses paid for certain programs. It is essential that this information be submitted in a timely and accurate manner.

For participating providers who are paid on a fee-for-service basis, the claim usually provides the encounter data Healthfirst requires. In addition, participating Healthfirst providers reimbursed on a capitated basis are still required to submit claims so that encounter data is reported to Healthfirst.

Healthfirst submits encounter and claims data monthly to the NYSDOH Office of Managed Care Medicaid Encounter Data System (MEDS). MEDS serves as the information warehouse by which the state has the capacity to monitor, evaluate, and continuously improve its managed care programs. It is essential that providers submit claims promptly for all services, including capitated services. MEDS is the standard by which the performance of Healthfirst and other managed care organizations is measured. To meet the state mandate, Healthfirst requires its providers to satisfy MEDS requirements when submitting claims and encounter information. Please refer to the Claims section for the specific requirements when submitting claims or encounters. Please refer to each reporting measure as described in this section for specific measure requirements.

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Appendix A – List of Services that Require Authorization

This table outlines PCA Provider Services that will require authorization, effective 1/1/18.

Service Code	Modifier	Units	Description
S5125		Per 15 minutes	HHA
S5130	**U1**	Per 15 minutes	PCS Level I
S5130	**U1, TV**	Per 15 minutes	PCS Level I Weekend/Holiday
T1019	**U1**	Per 15 minutes	PCS Level II Basic
T1019	**U2**	Per 15 minutes	PCS Level II Basic Two Client
T1019	**U6**	Per 15 minutes	CDPA Basic
T1019	**U1, TV**	Per 15 minutes	PCS Level II Basic Weekend/Holiday
T1019	**U2, TV**	Per 15 minutes	PCS Level II Basic Two Client Weekend/Holiday
T1019	**U6, TV**	Per 15 minutes	CDPA Basic Weekend/Holiday
T1019	**U7**	Per 15 minutes	CDPA Two Consumer
T1019	**U7, TV**	Per 15 minutes	CDPA Two Consumer Weekend/Holiday
T1019	**U9**	Per 15 minutes	CDPA Two Consumer Enhanced
T1020	**U6**	Per diem (13 hours)	CDPA Live In
T1020		Per diem (13 hours)	PCS Level II Live In
T1020	**U2**	Per diem (13 hours)	PCS Level II Live in Two Client
T1020	**TV**	Per diem (13 hours)	PCS Level II Live In
T1020	**U2, TV**	Per diem (13 hours)	PCS Level II Live In Two Client Weekend/Holiday
T1020	**U6, TV**	Per diem (13 hours)	CDPA Live In Weekend/Holiday

Appendix B – Claims Forms

Form CMS-1500

SAMPLE SAMPLE SAMPLE SAMPLE

HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): ABCDE7G

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT'S BIRTH DATE MM 11 DD 11 YY 31 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1st Place

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Bronx STATE: NY

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 10473 TELEPHONE (Include Area Code): (718) 222-1122

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE 10/25/15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. 714.00 B. C. D.

E. 357.1 F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	01	15	01	10	15	12		T1019	U1	1,2	55.50	12		NPI	11111111111
2															NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 222-22-222

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 55.50

29. AMOUNT PAID $

30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED 10/25/15 DATE

32. SERVICE FACILITY LOCATION INFORMATION
Care For Life
100 Pond Avenue
Bronx, NY 10461

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )
Care For Life
100 Pond Avenue Bronx, NY 10461
Bronx, NY 10461

a. 1111111111 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Appendix C – Required Data Elements for Clean Claims

Data Element	CMS 1500
Patient Name	X
Patient Date of Birth	X
Patient Sex	X
Subscriber (Member) Name/Address	X
Healthfirst Member ID Number (including Client Identification Number [CIN] for all newborn babies, when applicable)	X
Coordination of Benefits (COB)/Other Insured's Information	X
Date(s) of Service	X
ICD-9 Diagnosis Code(s), including 4th and 5th Digit When Required (ending 9/30/2015) ICD-10 Diagnosis Code(s), including 4th, 5th, 6th, and 7th Digit When Required (beginning 10/1/2015)	X
CPT-4 Procedure Code(s)	X
HCPCS Code(s)	X
Service Code Modifier (if applicable)	X
Place of Service	X
Service Units	X
Charges per Service and Total Charges	X
Provider Name	X
Provider Address/Phone Number	X
National Provider Identifier – NPI (Healthfirst does not accept legacy provider ID numbers submitted on HIPAA standard transactions)	X
Tax ID Number	X
Healthfirst Provider Number – **For Paper Claims Only**	X
Healthfirst Payer ID Number 80141 – **For EDI Claims Only**	X
Healthfirst Authorization Number	X

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