



**CLAIMS AND BILLING
INSTRUCTIONAL MANUAL**

2007

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Paper Claims and Block Grant Submission Requirements
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- 1. Instructions for Completing the CMS 1500 Claim Form.** The information on the following pages must be completed or the claim may be zero-paid/initially denied on the summary voucher.

Field Number	Field Description	Data Type	Instructions
Member Information (Fields 1-13)			
1	Coverage	Optional	Show the type of health insurance coverage applicable to this claim by checking the appropriate box (e.g., if a Medicaid claim is being filed, check the Medicaid box).
1a	Insured's ID number	Required	List the Insured's identification number here. Verify that the identification number corresponds to the insured listed in item 4. The Member and the insured are not always the same person. Some payers assign unique identification numbers to each enrollee or dependent and require the number of the enrollee or dependent receiving services (the Member) instead of the insured's number in this item.
2	Member's name	Required	Enter the Member's last name, first name, and middle initial, if any. NOTE: If the Member has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name. Do not use any punctuation in this field.
3	Member's birth date and gender	Required	Enter the Member's birth date and sex. Use the eight digit format (MM DD CCYY) format for date of birth. Enter an X in the correct box to indicate the sex of the Member. Only one box can be marked. If the gender is unknown, leave blank.
4	Insured's name	Required	Enter the insured's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr, Sr) enter it after the last name, but before the first name.

Field Number	Field Description	Data Type	Instructions
5	Member's address, city, state, zip code and telephone number	Required	<p>Enter the Member's mailing address and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number.</p> <p>NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.</p>
6	Member's relationship to the insured	Required	<p>Check the appropriate box for the Member's relationship to the insured when item 4 is completed. Remember that the Member's relationship to the insured is not always "self".</p>
7	Insured's address, city, state, zip code and telephone number	Required	<p>Enter the insured's address (apartment/PO box number, street, city, state, zip code and telephone number with area code). When the address is the same as the Member's enter the word "same". Complete this item only when items 4 and 11 are completed.</p> <p>NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a none-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number.</p>
8	Member status	Required	<p>Check the appropriate box for the Member's marital status and whether employed or a student.</p>
9	Other insured's name	Conditional	<p>Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.</p>
9a	Other insured's policy or group number	Conditional	<p>Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.</p>

Field Number	Field Description	Data Type	Instructions
9b	Other insured's date of birth	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.
9c	Other insured's employer's name or school name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.
9d	Other insured's insurance plan name or program name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.
10a - c	Is the Member's condition related to: <ul style="list-style-type: none"> • Employment? • Auto accident? • Other accident? 	Required	Place an "X" in the box indicating whether or not the condition for which the Member is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question. NOTE: The state postal code must be shown if "yes" is marked in 10b for "auto accident". Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.
10d	Reserved for local use	Not required	Please leave blank.
11	Insured's policy group or FECA number	Optional	Enter the Insured's policy or group number as it appears on the insured's health care identification card.
11a	Insured's date of birth and sex	Conditional	Required if the Member is not the insured. Enter the insured's eight-digit birth date in the MMDDCCYY format and sex if different from item 3.
11b	Employer name or school name	Conditional	Enter the insured's employer's name, if applicable. If the insured is eligible by virtue of employment or covered under a policy as a student, enter the employer or school name.

Field Number	Field Description	Data Type	Instructions
11c	Insurance plan name or program name	Conditional	Enter the insured's insurance company or program name.
11d	Is there another health benefit plan?	Required	Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim.
12	Member's or authorized person's signature (Medicaid/other information release)	Conditional	<p>The Member <i>must</i> sign and date the claim <i>if</i> authorizing the release of medical information. If "signature on file" is indicated, the provider <i>must</i> maintain a signed release form or CMS-1500 (formally HCFA 1500).</p> <p>The Member's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment on the claim.</p>
13	Insured's or authorized person's signature	Conditional	The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature are acceptable. If there is no signature on file leave this item blank or enter "no signature on file".

Provider of Service or Supplier Information (Fields 14-33)

14	Date of current illness, injury or pregnancy	Not required	Not applicable.
15	If Member has had same or similar illness, give first date	Not required	Not applicable.
16	Dates Member unable to work in current occupation	Conditional	Required if the Member is eligible for disability or worker's compensation benefits due to this illness. Enter the "From" and "To" dates the Member was unable to work in MMDDYY or MMDDCCYY format.
17	Name of referring physician or other source	Conditional	Enter the name of the referring physician or other source if applicable.

Field Number	Field Description	Data Type	Instructions
17a	ID number of referring physician	Conditional	<p>The CMS-assigned UPIN of the referring or ordering physician listed in Field 17. Enter only the seven-digit base number and the one-digit check digit.</p> <p>The other ID number of the referring provider, ordering provider, or other source should be reported in 17a in the shaded area. The qualifier indicating what the number represents should be reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers, since they are the same as those used in the electronic 837 Professional 4010A1:</p> <ul style="list-style-type: none"> • 0B – State license number • 1B – Blue Shield provider number • 1C – Medicare provider number • 1D – Medicaid provider number • 1G – Provider UPIN number • 1H – CHAMPUS identification number • EI – Employer’s identification number • G2 – Provider commercial number • LU – Location number • N5 – Provider plan network identification number • SY – Social Security number (The Social Security number may not be used for Medicare) • X5 – State industrial accident provider number • ZZ – Provider taxonomy – A list of the valid Taxonomy codes begins on Page 38.
17b	NPI	Required	<p>Enter the NPI of the referring or ordering physician listed in item 17 as soon as it is available. The NPI may be reported as of October 1, 2006.</p> <p>NOTE: Field 17a and / or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.</p>

Field Number	Field Description	Data Type	Instructions
18	Hospitalization dates related to current services	Conditional	Required if this claim includes charges for services rendered during an Inpatient admission. Enter dates in MMDDYY format.
19	Reserved for local use	Not Required	Not applicable.
20	Outside lab/charges	Not Required	Not applicable.
21.1-4	Diagnosis or nature of illness or injury	Required	Enter a valid ICD-9 diagnosis code, coding to the highest level of specificity (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Enter up to four codes in priority order (primary, secondary, etc.)
22	Medicaid resubmission code/original reference number	Conditional	List the original reference (claim) number for resubmitted claims.
23	Prior authorization number	Not required	Not applicable.
24a	Dates of service	Required	Enter "From" and "To" dates of service in MMDDYY or MMDDCCYY format. Line items can include no more than two dates of service for the same procedure code. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column C.
24b	Place of service	Required	Enter the appropriate place of service code from the list provided beginning on Page 19.
24c	EMG	Not required	Not applicable.
24d	Procedures, services or supplies CPT/HCPCS	Required	Enter a valid CPT or HCPCS code for each service rendered.

Field Number	Field Description	Data Type	Instructions
24d	Modifier	Conditional	<p>Enter a valid CPT or HCPCS code modifier for each service entered.**</p> <p><u>HIPAA: Billing Code Modifiers</u></p> <p>** When submitting a CPT or HCPC code with a modifier, it is critical that the modifier be placed in its appropriate allocation. HIPAA allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below:</p> <p>Modifier ONE: This field is dedicated for modifiers that affect or define the service (e.g., TG modifier to identify a ‘complex high level of care’)</p> <p>Modifier TWO: This field is dedicated for modifiers that identify pricing (e.g., HA modifier to identify ‘child/adolescent’ or HN modifier to identify ‘bachelors level’)</p> <p>Modifier THREE & FOUR: These fields are dedicated for modifiers that identify statistics (e.g., HV ‘funded by State Addictions Agency’)</p> <p>If you have any questions regarding the placement of Modifiers, please contact your State of Kansas Regional Provider Relations Representative for instructions.</p>
24e	Diagnosis pointer	Conditional	<p>Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, a 1, 2, 3 or 4, is shown. <i>Do not</i> enter the ICD-9 diagnosis code.</p>
24f	Charges	Required	Enter the provider’s billed charges for each service.
24g	Days or units	Required	Enter the appropriate number of units or days that correspond to the “From” and “To” dates indicated in Field 24a.

Field Number	Field Description	Data Type	Instructions
24h	EPSDT family plan	Conditional	If service was rendered as part of or in response to an EPSDT panel, mark an "X" in this block.
24i	ID Qual.	Conditional	If the provider does not have an NPI, enter the appropriate qualifier and identifying number in the shaded area. There will always be providers who do not have an NPI and will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported.
24j	Rendering Provider ID#	Required	Enter the NPI number in the un-shaded area of the field.
25	Federal Tax ID number and type: <ul style="list-style-type: none"> • Social Security Number or • Employer Identification Number 	Required	Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered.
26	Member's account number	Optional	Enter the unique number assigned by the provider for the Member. If entered, the Member account number will be returned to the provider on the Provider Summary Voucher.
27	Accept assignment?	Required	Enter an "X" in the appropriate box.
28	Total charge	Required	Enter the total charge for this claim. This is the total of all charges for each service noted in Field 24f.
29	Amount paid	Conditional	Enter the total amount paid by the Member for services billed on this claim.
30	Balance due	Conditional	Enter the total balance due for the services less any amount entered in Field 29.
31	Signature of physician or supplier including degrees or credentials	Required	Signature of physician or supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care <i>must</i> sign and indicate licensure level.
32	Name and address of facility where services were rendered	Required	Enter name and address where services are rendered.
32a	a.	Required	Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as October 1, 2006.
32b	b.	Not Required	Not Applicable

Field Number	Field Description	Data Type	Instructions
33	Physician's/supplier's billing: name, address, zip code and phone number	Required	Enter the appropriate billing information.
33a	PIN number	Required	Effective May 23, 2007, and later, enter the NPI of the billing provider or group.
33b	Group number	Not Required	Not Applicable after May 23, 2007

Valid Place of Service Codes for the Kansas Account (Field 24B)

Place of Service Code(s)	Place of Service Name	Place of Service Description
03	School	A facility whose primary purpose is education.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the Member receives care in a private residence.
21	Inpatient Hospital	A facility, other than a psychiatric facility, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to Members admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
51	Inpatient Psychiatric Facility	A facility that provides Inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Place of Service Code(s)	Place of Service Name	Place of Service Description
53	Community Mental Health Center	A facility that provides the following services: Outpatient services, including specialized Outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from Inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for Members being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
99	Other Place of Service	Other place of service not identified above.

State Requirements for Claims Turnaround Time

Clean Claims

Providers must file claims for covered services in the form and manner required by ValueOptions as specified below (herein referred to as a “clean claim”). Clean claims must be *received* by ValueOptions within 90 calendar days from the date of service.

ValueOptions will adjudicate 90% of Clean Claims (error-free claim) and adjustments within thirty (30) calendar days of receipt, and 99% percent of Clean Claims and adjustments will be processed within sixty (60) days of receipt.

Incomplete Claims Are Not Clean Claims

Claims with invalid or incomplete information will be **denied** with an Explanation of Benefit advising the provider of the incorrect or invalid information. The provider should send a “corrected” claim to ValueOptions providing the updated information for reconsideration. Corrected claims received more than 60 calendar days from the date on the Provider Summary Voucher will not be considered for payment.

If ValueOptions is unable to locate a Member’s ID number (e.g. Medicaid or Block Grant Member ID number) provided on the claim form, the claim will be denied, with an Explanation of Payment indicating the Member is unknown. If possible, ValueOptions will indicate the Member’s name in the Member account number field, shown on your Provider Summary Voucher. The necessary corrections should be made and a new claim sent for consideration. Please be sure to send all requested information within the account-specific timely filing guidelines.

Claims Appeal Process

If you feel ValueOptions has made an incorrect payment or processing decision on a claim, you may file a claim appeal in one of two ways:

- a. You may call ValueOptions at (866) 645-8216/ TTY# (888) 800-6791 where a Claim Customer Service Representative will collect the information from you,

or

- b. You may write a letter to ValueOptions and provide the reason you believe the claim should be reprocessed. In the letter be sure to include the Member’s name and ID number, date(s) of service, service, and provider’s name. Your letter and supporting documentation should be sent to the following address:

ValueOptions of Kansas
P.O. Box 1347
Latham, NY 12110
ATTN: Kansas Appeals Department

All appeals must be filed within 60 days of the date of the provider summary voucher (EOB) in which the claim was included.

Third Party Liability (TPL)

1. Providers must exhaust all avenues of other insurance coverage and payment prior to billing ValueOptions of Kansas for covered services.

2. ValueOptions of Kansas is typically the payer of last resort for Medicaid covered services, in the event any one or more third party payers are responsible for covered services provided to Members. This excludes those individuals that are covered under Senate Bill SB123.
3. ValueOptions' service authorization procedures outlined in the Clinical Section of the Provider Manual must be followed when providing services to a Member identified with TPL.
4. The Primary Carrier's Policies and Procedures must be followed in order for ValueOptions to coordinate benefits. For example, if the Primary Carrier requires pre-authorization and the claim was denied by the Primary Carrier because pre-authorization was not obtained, ValueOptions will not process the claim for payment.
5. For any eligible Member with reimbursable TPL, the third party insurance carrier must be billed prior to billing ValueOptions. Once the TPL carrier has responded, ValueOptions may then be billed. TPL claims for eligible Members must be submitted on a completed standard CMS 1500 or UB04 claim form. The claim form, along with a copy of the Explanation of Benefits or Summary Voucher received from the third party insurance carrier must be mailed to ValueOptions of Kansas.
6. All claims involving Third Party Liability must be submitted within ninety (90) days of the date of the other carrier's EOB or notification of payment / denial, to be considered for reimbursement.
7. If it is determined that an enrollee had relevant third party coverage after ValueOptions has been billed, the third party insurer must be billed. Once the EOB / Summary Voucher is received, an adjustment request for the applicable claim and a copy of the relevant ValueOptions and Third Party EOB / Summary Voucher must be sent to ValueOptions according to the procedures outlined the Adjustment / Reversal Requests section.

Additional TPL Billing Instructions

1. One copy of the Explanation of Benefits / Summary Voucher should be attached to each applicable claim.
2. Ensure the level of detail on the claim corresponds to the EOB / Summary Voucher from the primary carrier.
3. If there are multiple third party carriers, all relevant EOBs / Summary Voucher should be attached to the claim.

Adjustment / Reversal Requests

1. Claims requiring reconsideration of payment amounts for any reason must be resubmitted to ValueOptions on an Adjustment Request Form within sixty (60) days from the date of the Summary Voucher. Electronic submissions of this form will not be accepted.
2. The Adjustment Form can be found on page 24 of this section. One form must be completed for each original claim being adjusted. All items on the form are required. Incomplete forms will not be processed and will be returned. Please mail completed forms to:

ValueOptions

ATTN: KS Adjustment Unit
P.O. Box 1290
Latham, NY 12110

Or

fax to (757) 459-5404.

3. A copy of the Provider Summary Voucher page on which the original claim appears must be included with the Adjustment Form.
4. Any reduction in payment will be applied to the payment cycle following the processing of the form.
5. Instructions for completing the Adjustment Form:
 - a. **Provider Information:** Enter the name, provider number, and address of the provider to whom the payment was made.
 - b. **Member Information:** Enter the Member's name and Member ID Number as it appears on the Provider Summary Voucher.
 - c. **Claim Information:** Enter the claim number and date as listed on the Provider Summary Voucher.
 - d. **Reason for Adjustment:** Place an "X" on the line that best describes the reason for requesting the Adjustment and enter the required information. If "Other, Please Explain" is marked, describe the reason for the Adjustment request.
 - e. **Provider Signature and Date:** An Adjustment request cannot be processed without a typed, signed, stamped, or computer-generated signature and the date that the form was completed.

ValueOptions

ValueOptions of Kansas Adjustment Form

Adjustment Reversal Payment Increase Payment Decrease

Provider Name:	Member Name:
Provider Number:	Member ID Number:
Provider Address:	Claim Number:
	Paid Date:

Reason for Adjustment

Member Name/Member ID #:
 Correct Member: _____ Correct ID # : _____

Date of Service:
 Incorrect Date: _____ Correct Date: _____

Billing Code Error:
 Incorrect Code: _____ Correct Code: _____

Units Incorrect:
 Incorrect Units: _____ Correct Units: _____

Provider / Vendor Paid:
 Incorrect Provider #: _____ Correct Provider #: _____
 Incorrect Vendor #: _____ Correct Vendor #: _____

Other Reimbursement Received:
 Source: _____ Amount: _____

Authorization Extended:

Authorization Number: _____

Other: (Please Explain)

If there are any questions regarding this adjustment request, please contact ValueOptions' Claim Department at (866) 645-8216/TTY# (888) 800-6791.

Provider Signature: _____
Date: _____

ValueOptions Use Only		
Processor: _____	Code: _____	Date _____

Resubmissions

Incomplete Claims

1. Claims may be "zero-paid" or receive an initial denial by ValueOptions in the case of incorrect or incomplete required data elements.
2. ValueOptions will notify the provider via the Provider Summary Voucher, of those data elements requiring completion or correction. The required data elements and other claim submission requirements are outlined in Sections C1 and C2 of this manual. Electronic Media Claims (EMC) submission guidelines are contained in the ValueOptions EDI Specifications Manual.

Re-submissions

1. Claims "zero-paid" or initially denied due to incorrect or incomplete required data elements must be resubmitted for payment consideration within sixty (60) days form the date on the Summary Voucher.



2. Providers may resubmit corrected claims (which were zero paid for incomplete or incorrect required data elements) by mail or EMC.
3. Corrected claims should have a clear indication on the claim that the claim is a “Corrected Claim”.

Refunds and Voids

In order to process refunds and voids, please forward your check, summary voucher and any other information to the address listed below. If additional information is required please contact the Claims Department.

ValueOptions
240 Corporate Blvd
Norfolk, VA 23502
ATTN: Finance Department