Section Contents

For more detailed information on these programs, refer to the Authorization Section 5.

INTRODUCTION

The Claims Department processes medical bills submitted by participating physicians, as well as other medical providers. All claims are entered (or when available imported electronically) into our core system, then adjudicated according to contractual agreements and prior authorization requirements.

Reminder: It is very important that encounter data be submitted (electronic methods preferred) to the Claims Department, even if there is no direct reimbursement payment for that member encounter. All encounter data is required for the IPA to track utilization of services by its members.

Please Note: Timely and routine submission of encounter data within 90 days of date of service is also critical to the IPA's annual renegotiation efforts with contracted health plans. It is important to show all the services provided (including office visits) for which the PCP has received capitation payment, since this data will provide the IPA with information to determine needed changes to the capitation program.

IPA Claims Contacts

Claims Department	(408) 937-3620	FAX: (408) 937-3634
Claims Manager	(408) 937-3609	FAX: (408) 937-3634
TPL Coordinator	(408) 937-3629	FAX: (408) 937-3634

General Claims Inquiries

Please logon to our website **http://www.pmgmd.com** to verify claim status and payment information.

If you do not have Internet access or if you require additional assistance, please contact us (408) 937-3620. Claims Department Representatives are available to assist you.

Submitting Claims

Claims may be submitted either by mail or computer media. If you are submitting a claim which requires inclusion of medical notes, surgical notes or forms, please send a paper claim instead of an electronic claim. This will ensure the claim and the appropriate attachments are received by the Claims Department at the same time and avoiding it being incomplete (without records) at the time the claim is adjudicated.

About immunizations and injectables: Submit claims to either the appropriate Health Plan or PMG (EXCEL) for reimbursement. **Please see the attached Immunization Matrix.

Immunizations to be paid by the health plan:

- Please bill all immunizations along with the applicable administration codes. The immunizations will be paid by the health plans that are financially responsible and PMGSJ will pay the administration for the pediatric-specific immunization administration codes. **Administration reimbursement is for Commercial plans only.**

  - Bill the health plan for the reimbursement of the immunizations. PMGSJ will deny these as health plan responsibility and include on the EOB notes, reasons a) or b) below:

    a) All or part of your claim is not PMGSJ's responsibility. Because this is an electronic claim, we recommend that you follow-up with another billing to the health plan that is financially responsible.

    b) CHDP services are payable by the health plan. Because this is an electronic claim, we recommend that you follow-up with another billing to the health plan that is financially responsible.

Immunizations to be paid by PMGSJ:

- Please bill all immunizations along with the applicable administration codes. PMGSJ will pay the immunizations and the administration for the pediatric-specific immunization administration codes. **Administration reimbursement is for Commercial plans only.**

Paper/Mail Claim Submission

Mail claims (including all appropriate attachments) to:

Physicians Medical Group of San Jose
Claims Department
75 East Santa Clara Street, Suite 950
San Jose, CA 95113

Attn: *Specify Commercial or Medi-Cal/Healthy Kids*

Misdirected Paper Claims – Eligibility Issues

- Member has terminated with PMGSJ but are still eligible with the health plan directly or a new medical group, the claim will be forwarded onto the correct payer and will be noted on the EOB.

- Member is not with or never has been with PMGSJ, the claim will be sent back for verification of eligibility.

Electronic claim submission

Electronic claim submission saves postage, paper, human resources, and decreases the overall processing time.

For smooth uploading of electronic claims, be sure the patient's name, Date of Birth, and Insurance ID are entered exactly the same as they are shown on the member's Health Plan identification card.

Clearinghouse	Payor ID
ENS	PMGSJ
Emdeon	EXC01
Office Ally	EXC01
Proxymed	PMGSJ
WebMD	EXC01

E-Claims through Office Ally

- PMGSJ's procedure is to upload e-claims every work day (not weekends or holidays).

  - AB1455 Time limits: Acknowledgement of claims shall be provided within 2 working days of the receipt of an electronic claim and 15 working days of the receipt of a paper claim. Please confirm receipt of e-claims within 2-3 working days on PMGSJ's website: www.pmgmd.com.

  - If the claim is not on the website, please call for status to verify if the claim was received.

Direct submission of electronic claims

For PMGSJ providers who do not use a clearing house to submit claims electronically, we would like to still encourage them to submit electronic claims directly to EXCEL MSO if their practice management software can produce the claims file in the HIPAA X12-837 format. Call (408) 937-3607 for more info.

CLAIMS PROCESSING
For All Professional Services

It is preferred that all services provided by IPA physicians be submitted electronically. Otherwise, services are to be billed on a CMS1500 form. Instructions for mailing are described in the following procedure section. A sample of the CMS1500 form is included in the Appendix of this section.

Referral services rendered by outside contracted providers and facilities should be appropriately billed on either the standard CMS1500 form or UB92 form, with a copy of the authorization attached or the authorization number hand-written on the claim.

Electronic submission of claims and encounter data is preferred. All (mailed) claims and/or encounter data should be submitted to:

Physicians Medical Group of San Jose
Claims Department
75 East Santa Clara Street, Suite 950
San Jose, CA 95113

Attn: *Specify Commercial or Medi-Cal/Healthy Kids*

Since different claim types are processed by designated claims processing units, separating the Commercial claims from Medi-Cal/Healthy Kids Claims is important to us. This will aid us in routing the claims to proper processing unit in a timely manner. You may send them in separate envelopes (with Commercial or Medi-Cal). If you include these mixed claims in the same envelope, separate by a labeled sheet of paper or rubber band the batches together.

For more information on how to submit your claims electronically, please contact Provider Services at (408) 937-3604.

Misdirected E-Claims – Eligibility Issues

- Member has terminated with PMGSJ but are still eligible with the health plan directly or a new medical group, the claim will be denied and advised of such on the EOB.

- Member is not with or never has been with PMGSJ, the claim will be rejected and will not come through the e-claim download process. Office Ally will send notification of the rejected claims.

Claims Processing
For All Professional Services

Payment or *denial of payment* for services rendered by non-contracted providers will be generated within 45 working days of receipt.

Payment or *denial of payment* for services rendered by contracted providers will be generated within 45 working days of receipt.

Payment for claims pended for authorization or additional information required will be generated within 60 to 90 days of receipt by the IPA.

Claims Inquiries

Claims submitted and processed by the IPA may be viewed through the **doctor's login** application on the **http://www.pmgmd.com** website. *Please allow a minimum of two weeks for claims to appear in the system after submitting them by mail.*

If you do not have Internet access, or if you have additional questions about the claims viewed on-line, please contact the Claims Department at (408) 937-3620. Be prepared to provide the Provider name, member name, date of service, and a summary of your question in order for our IPA Coordinators to provide efficient and expedient service.

Completing the Claim

The IPA would like to remind all providers to fill out each claim form as completely as possible - - - especially the name of the health plan. **This is very important because the IPA is mandated to have the health plan (name) listed on the form. When claims are audited, they are done by health plan.** Thank you to those providers who are already doing this.

Refer to the checklist below for claim submissions.

1. List the name of the health plan (e.g. Health Net) on the claim form. *For example, for the CMS1500 put the name of the health plan either in Box 11 or somewhere on the claim form.*
2. Separate the Commercial claims from the Medi-Cal claims.
3. Include the member's accurate Insurance ID number.
4. Include the member's correct date of birth. *There are numerous members with similar names. The correct birthday will help distinguish the correct member.*
5. For Blue Cross/Medi-Cal claims, put both the new CIN number and Social Security Number for established members.

Due to large volumes of claims, the IPA (EXCEL) will not be able to process any incomplete claim. If you have any questions, please contact the Claims Department at (408) 937-3620.

Reminder: Please submit your claims in a timely manner. Submission of claims more than ninety (90) days after the date of service may be denied for untimely submission.

CAPITATION SERVICES

Each member is required to select a Primary Care Physician (PCP) at the time of enrollment with a health plan. PCPs are paid a monthly capitation fee based on the member's selection of them as his/her PCP.

Submission of Encounter Data

When the PCP treats an assigned member for capitated services, he/she must submit an "Encounter Record" of those services even if there is no reimbursement involved.

Eligibility Verification

When an assigned health plan member is going to have services at the PCP office, verify his/her eligibility as outlined in the "Eligibility Procedures for the Primary Physician's Office" section of this manual.

The Physician provides the necessary treatment to the member and claims are submitted. The information submitted on this claims shall be the same information as is required to process a fee-for-service claim.

- **Member encounters (required for member utilization tracking) <u>Instructions:</u> Submit claims to PMG** <u>Electronic submission is preferred</u>**.** However, a CMS1500 Form is acceptable for submitting this information if submitted by mail. Encounter Data should be submitted promptly for each member visit, within the month that the service occurred.

<u>Note:</u> Fee-for-service claims (services beyond capitation services)
Fee for service claims will be submitted on a CMS1500 Form to either the HMO or the IPA. This is important to note since the IPA has different contracts with the respective health plans. If there are any changes, all providers will be notified.

RECOMMENDED ACCOUNTING PROCEDURE FOR RECORDING CAPITATION PAYMENTS

Briefly outlined below is a suggested procedure for recording capitation payments and encounter services.

Capitation Payments

Capitation payments are received each month for the health plan members who have chosen each physician as their PCP. The contracted capitation rate is paid per member per month (pmpm) and is issued the 25th of each month. Capitation rates are defined in each Physician contract.

Posting Capitation Payments

We suggest that a distinct account be established for capitation. An account or ledger card should be set up for "Capitation Payment" services.

Many offices have tried to apply the amount paid per individual to separate accounts or ledger cards for each assigned health plan member. This is not necessary or desirable.

Each month the capitation payments received from the IPA should be posted in total to this account. Then to offset the credit balance, a capitation adjustment should be posted to the same account; leaving a zero balance.

Health plan member encounter services, which are the services provided to health plan members for whom you received capitation payments, should be posted to the individual member's account. In order for this system to work efficiently, you must have a way to keep track of the capitated services you render on a monthly basis. Offsetting adjustments should be made to credit the services off the individual member's account when you receive the capitation check and eligibility list. This offsetting adjustment process will allow your office manager or accountant along with the IPA to evaluate your office's experience with capitation.

Reimbursement of Additional Special Services Provided by Primary Care Physicians

The following services will be paid per health plan or IPA fee schedule, in addition to capitation, when provided by the Primary Care Physician (PCP):

1. All Adult and Pediatric Immunizations, when medically appropriate and covered by the health plan.

   Instructions: Submit to the appropriate Health Plan or to PMG. Please note that some immunizations require prior authorization (i.e. Hepatitis A and B).

2. EKG's

3. X-rays (X-rays in the office only if performed on an emergent basis or prior authorized)

4. Inpatient care for eligible inpatient admission including newborn care visits in hospital.

   - All newborn claims for inpatient evaluation management and discharges should always be billed under the mother's name and ID# in Box #2.

   - Add the notes "newborn claim – DOB" in field Box #19. This will flag the claims processors to match the delivery authorization to the newborn inpatient charges and pay the claim under the mother's insurance ID#.

   - If payment is not received after 3 weeks of electronic claims submission you may check the website www.pmgmd.com to verify if the claim was received. If the claim(s) is not on the website, please call for status for verification of receipt.

   - If a paper claim is submitted, please expect payment after 5 weeks of submission.

5. For any service the PCP wants to be considered for "special reimbursement", the PCP should submit an Authorization Request Form (A Referral Request Form may be submitted through the electronic authorization system on **http://www.pmgmd.com** or by fax.)

COORDINATION OF BENEFITS (COB)

"Coordination of benefits" is a method of calculating reimbursement when a member has more than one insurance plan. The EXCEL-affiliated IPA coordinates benefits with other medical insurance carriers. The first rule is "the employee is always primary". Another rule, the "Birthday Rule" is applied for dependent children to determine which carrier is primary in the cases of dependent coverage.

If insurance is carried by both spouses, under the Birthday Rule the primary carrier is responsible for the coverage carried by the person whose birthday is the earliest in the year.

> For example, if a husband and wife both have family coverage through two different employers and they have one child, the child would be covered by the Father's health plan if the Father's birth date was April 15th and the Mother's birth date was July 4th. This is because the Father's birth date is earlier in the year than the Mother's.

When you are providing care to a member, and both adult family members are working, please check for double insurance coverage. It is very important that any additional carriers be reported on your claim form. If you collect any amounts from the primary insurer, please provide documentation of the amount collected. These amounts will be considered when calculating your secondary payment.

Coordination of Benefits (continued)

Coordination of Benefits for Medi-Cal Managed Care Members

- The IPA will coordinate benefits with all other carriers including Medicare.
- The Medi-Cal managed care plan is always secondary to any other coverage that the member may have.
- Other coverage information must be completed on Boxes 9a through 9d on the CMS1500 form used to submit claims.
- Since Medi-Cal managed care plan is always secondary, the provider must submit the claim to the other carrier before submitting the claim to the IPA.

THIRD PARTY LIABILITY (TPL)

The IPA coordinates benefits with third party liability carriers. When an IPA physician is treating a member suffering from an accident, injury, or illness that may have arisen from an accident, the member must sign a **Third Party Lien/Assignment Form** for third party liability.

For your convenience, a copy of the **Third Party Lien/Assignment Form** is provided in the Appendix of this section.

Instructions:

1. Member completes a copy of the **Third Party Lien Assignment Form.**

2. Make a copy of the completed **Third Party Lien/Assignment Form** for your office records.

3. Send the **original** signed **TPL Assignment Form** along with your claim, and we will process these claims in accordance with our general claims processing policies.

4. The IPA will coordinate and pursue the action with the third party carrier. *Any recoveries received directly by the provider must be refunded to the extent of our payment.*

See Appendix for Third Party Liability Forms.

MEDI-CAL MANAGED CARE CLAIMS AND ENCOUNTER SUBMISSIONS

The following applies to all IPA Member Claims and Encounters (except for CHDP billing guidelines, which are provided on the next page).

Send claims for services and encounters on CMS1500 Forms.

Send claims to:

Physicians Medical Group of San Jose
Claims Department
75 East Santa Clara Street, Suite 950
San Jose, CA 95113
(Specify whether Commercial or Medi-Cal)

To check status of a claim, view information using **http://www.pmgmd.com using your User name and password from PMG ONLINE.**

If you do not have Internet access, call or fax the Claims Department at (408) 937-3620.

Child Health and Disability Prevention (CHDP) Services

Billing information for CHDP Providers only

CHDP reimbursement comes directly from the health plans.

- For **Santa Clara Family Health Plan** members, attach the completed CMS1500 form to the top two (white and yellow) copies of the CHDP Form PM160 and send to: **Santa Clara Family Health Plan, P.O. Box 5550, San Jose, CA 95150**

- For **Blue Cross of California** members, attach the completed CMS 1500 form to the top copy only of the PM160 form, and send to: Blue Cross of California, P.O. Box 9054, Oxnard, CA 93030-9044

  BCC Notes:
  (1) Use J Codes for billing
  (2) Send the yellow copy of PM160 to:
  CHDP Program office
  976 Lenzen Ave
  San Jose, CA 95126

Claims and Encounter Submission for Medi-Cal Programs

California Perinatal Services Program (CPSP) Claims

- Only CPSP-certified providers may provide CPSP services to the IPA members.

- Please refer to the DHS CPSP manual for all program standards.

California Children Service (CCS)

For a complete overview of the CCS program and claims, please refer to the California Children Services (CCS) in the Utilization Management section of this manual.

CODING MEDI-CAL MANAGED CARE CLAIMS

Claim forms must be coded using:

- CPT Codes (refer to the *Physicians' Current Procedural Terminology Manual* published by the American Medical Association)

- HCPCS (refer to *Common Procedure Coding System* published by the Centers for Medicare and Medicaid Services' [CMS]

- **Modifiers** - When appropriate, modifier codes must be used, according to the guidelines of the EDS *Provider Manual.*

- **Authorization Number** - Pre-authorized claims must include the authorization number on Box 23 of the CMS1500 form.

- **License Number** - The Physician's State-issued license number must also be included on the claim.

- When providers other than the member's Primary Care Physician (e.g. Specialist Consultants, Emergency Department, School Based clinics, etc.), perform services, including those but not limited to services that are considered self-referrals, these providers must forward documentation of care and consult notes to the Primary Care Physician (PCP) in a timely manner.

PROFESSIONAL EMERGENCY SERVICES AND URGENT CARE SERVICES

Claims submitted to the IPA for professional services during treatment of an emergency condition must be billed on a CMS1500 form using appropriate CPT, HCPC, or Medi-Cal codes.

Viewing Claims On-Line

To view claims already submitting to EXCEL, use our website and your user name and password. Please call Provider Services at (408) 937-3612 or 937-3604 if you need additional assistance.

Explanation of Benefits

An explanation of Benefits includes the following information:

Field	
CARRIER/PLAN:	REFERRAL #:
REND PHY: (rendering physician)	CLAIM #:
REFERRED BY:	CHECK #:
ACCOUNT #:	CHECK DATE:
PATIENT NAME:	PATIENT ACCOUNT #:
DIAGNOSIS: 1: 2: 3:	

Claim detail includes:

MSG	*Messages*
DATE OF SERVICE	*The date the service was performed*
PROC CODE	*Procedure code*
MODIFIERS	*Procedure modifiers*
GROSS CHARGES	*Dollar Amount*
NET PAY	*Dollar Amount*
ADJ REASONS:	*Adjustment reason code and description.*

See the following page for a complete listing of reason code explanations.

NOTES:

EOB Explanation Codes

Code	Reason
0D	On call for a capitated provider, please seek reimbursement from that provider
0E	In Between Eligibility with Medi-Cal HMO Plan
1D	Our records do not indicate that you are a CPSP provider
1E	Postdates Eligibility with the Medi-Cal HMO Plan
2C	Invalid / Deleted Code
2D	Paid according to the Letter of Agreement on file
2E	Infertility Services are not a covered benefit
3C	Denied, Lab services should be done by QUEST Diagnostics
3D	Payment can not be made without the actual anesthesia time on claim
3E	Appeals Additional Payment
4D	Payment for Newborn child using Mothers ID#
5C	Processed according to contract / Agreement
5D	Please submit claim to Workers Compensation Carrier
6D	Services are out of area, please bill the Health Plan directly
7D	Services rendered are not covered by Medi-Cal
8C	Paid at the current Medi-Cal rates
8D	Patient not eligible with Physicians Medical Group of San Jose after DOS
9D	Two visits by the same provider are not billable on the same date of service
AC	Please resubmit paper claim with medical records for processing
AD	CHDP services are payable by the Heath Plan, a copy of your claim has been forwarded
B	Charges are included in the global fees
BC	Cost Invoice needed
BD	Duplicate Service, claim previously processed
-C	COB applied to payment
CC	Paid at the Medicare charge limit, do not bill member
CD	Denied for untimely claim submission
D	Down Coded per Medical Review
DC	Services denied as non life threatening, nor emergent
DD	Denied No Authorization - No member liability, DO NOT BILL MEMBER
EC	Please rebill with a copy of the primary insurance carrier EOB
ED	Denied, services are payable by CCS
FC	Services rendered are not a covered benefit
FD	Primary insurance payment exceeds allowed amount
GC	Additional Payment
GD	Charges are included in the office visit
HC	Patient not eligible with Physicians Medical Group of San Jose prior to DOS
HD	Denied payment, waiting for TPL information from member
IC	Incorrect coding, resubmit with the correct CPT/HCPC/MEDI-CAL code
ID	The charges on this claim should be reimbursed by the rendering hospital
JC	$30 Access Plus copayment applies
JD	This claim has been paid at 50 percentile of the reasonable and customary fee for Santa Clara county
KC	All or part of your claim is not PMGSJ's responsibility, we forward to Health Plan for processing
KD	Claim paid per contracted case rate
LD	Urgent Care Facility fees are included with professional fee reimbursement
M	Medicare assignment accepted, do not balance bill patient
MD	This service is being processed as a separate claim under the correct authorization

N	Assistant surgeon, paid at 20% of the primary surgeons reimbursement
NC	Capitated service, payment is not available
ND	Predates Eligibility with Plan
OD	In between Eligibility
PD	Postdates Eligibility with Plan
QD	Service Postdates Member's Death
RD	Chiropractic Services are not a covered benefit
SD	Acupuncture Services are not a covered benefit
TD	Appeals Interest Payment
UD	Payment on your claim can not be made at this time. Payment of this claim is pending CCS review
VC	Denied, services not authorized
VD	Services rendered are covered by Calif. Children Services. Please redirect your claim to CCS
WC	Exceeds allowed number of pre natal visits, charges included as part of total OB
WD	No authorization on file for these services, member has a POS
XC	Inpatient days denied per Utilization Management
XD	Worker's Compensation is responsible for payment, please rebill correct insurance company
YC	Interest payment
YD	Medical records requested were not received
ZC	Legislation requires a signed copy of the PM330 be attached to the claim
ZD	Predates Eligibility with Medi-cal HMO Plan

CLAIMS APPEALS

Claims Settlement Practices and Dispute Resolution

The Department of Managed Health Care promulgated regulations related to claim settlement and dispute resolution practices of health plans and their delegated IPAs/Medical Groups ("AB1455 Regulations"). Among other things, the AB 1455 Regulations requires IPAs/Medical Groups that are delegated for claims processing and dispute resolution to send a notice to their downstream contracted providers outlining the IPA/Medical Group's claim settlement and dispute resolution practices ("AB1455 Notice"). A copy of this document was sent to all PMG Physicians in December 2003.

A copy of Physicians Medical Group (PMG) of San Jose's AB1455 Notice is in the Appendix of this section. This notice includes detailed information on how to submit claims and disputes to Physicians Medical Group of San Jose as well as information on its claim overpayment process.