Provider Manual
Section 14.0
Provider Billing Manual

Table of Contents

14.1 Claim Submission
14.2 Timely Filing Requirements
14.3 Corrected Claims and Requests for Appeal and/or Refunds
14.4 Contact Information for Claims Questions

14.0 Provider Billing Manual

14.1 Claim Submission

14.1.1 Procedures for Claim Submission

Lighthouse is required by state and federal regulations to capture specific data regarding services rendered to its enrollees. The provider must adhere to all billing requirements in order to ensure timely processing of claims. When required data elements are missing or invalid, claims will be rejected by Lighthouse for correction and resubmission. The provider who performed the service to the Lighthouse enrollee must submit the claim for a billable service.

Claims filed with Lighthouse are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms;
- Verification that all diagnosis and procedure codes are valid for the date of service;
- Verification of the referral for specialist or non-primary care physician claims;
- Verification of enrollee eligibility for services under Lighthouse during the time period in which services were provided;
- Verification that the services were provided by a participating provider or that the "out- of-network" provider has received authorization to provide services to the eligible enrollee (excluding "self-referral" types of care);
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that Lighthouse is the "payer of last resort" on all claims submitted to Lighthouse;
- Verification that an authorization has been given for services that require prior authorization by Lighthouse; and
- Verification that the provider is enrolled with Florida Medicaid during the claim date of service and that the claim includes the appropriate NPI code and taxonomy code on file with Florida Medicaid.

In addition, Lighthouse uses claim edit applications following NCCI, AMA, and CMS guidelines:

- Procedure unbundling (billing two (2) or more CPT codes when one (1) CPT code exists for same procedure);
- Incidental procedures (procedures performed at the same time as a more complex procedure but requires little to no additional physician resources or is clinically integral to the performance of the procedure);
- Mutually-exclusive procedures (two (2) or more procedures that should not be performed or billed for the same enrollee on the same date of service);

- Multiple surgical procedures (surgical procedures are ranked according to clinical intensity and are paid following percentage guidelines);
- Multiple Procedure Payment Reduction (MPPR) for selected therapies (applies to multiple procedures and multiple units);
- Duplicate procedures (procedures billed more than once on same date of service);
- Assistant surgeon utilization (reimbursement and coverage determination);
- Evaluation and management service billing (review the billing of services with procedures performed); and
- ER evaluation and management services (review the billing for consistency with ACEP guidelines).

Claims for ER services will be subject to review for medical necessity and whether treatment was required for an Emergency Medical Condition as defined in paragraph 10.1.1 of this manual.

Any CPT/HCPCS level 1 or 2 codes that have been denied due to claims editing will be associated with the appropriate disposition code on the remittance advice.

As part of the agreement between Lighthouse and the provider, the provider agrees to cooperate with Lighthouse in its efforts to comply with all applicable Federal and State laws, including specifically the provisions of Section 6032 of the Deficit Reduction Act of 2005, PL-019-171, False Claims Act, Federal Remedies for False Claims and Statements Act, and s. 68.081, F.S. Lighthouse also complies with the applicable Prompt-Pay requirements found in s. 641.3155, F.S.

14.1.2 Rejected and Denied Claims

Rejected claims are defined as claims with invalid or missing data elements (such as the provider tax identification number) that are returned to the provider or EDI source without registration in the claims processing system. Since rejected claims are not registered in the claims processing system, the provider must re-submit corrected claims within 180 calendar days from the date of service. This requirement applies to claims submitted on paper or electronically. Denied claims are different than rejected claims and are registered in the claims processing system, but they do not meet requirements for payment under Lighthouse guidelines. For more information on denied claims, see Section 14.4 in this Provider Manual.

14.1.3 Claim Mailing Instructions

Lighthouse encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or the Change Healthcare (formerly Emdeon) Provider Support Line at (800) 845-6592 to arrange transmission.

Lighthouse Electronic Payer ID: 31828

If you choose to utilize paper claims, please submit to Lighthouse at the following address:

Lighthouse Health Plan
PO BOX 211156
Eagan, MN 55121

14.1.4 Claims Status Review

Providers may view claims status using any of the following methods:

- Online – Check eligibility/claims status by logging into Lighthouse's Provider Portal at www.lighthousehealthplan.com
- Telephone – You may also check eligibility and/or claims status by calling Lighthouse's IVR system at 844-243-5181
- Real-Time – Depending on your clearinghouse or practice management system, real-time claims status information is available to participating providers. Contact your clearinghouse to access:
    - Change Healthcare Products for claims status transactions; or
    - All other clearinghouses: Ask your clearinghouse to access transactions through Change Healthcare.

14.1.5 Notification of Denial via Remittance Advice

When a claim is denied because of missing or invalid mandatory information, the claim should be corrected, marked as a second submission or a corrected claim, and resubmitted within ninety (90) days of notification of payment/denial either electronically or to the general claim address:

Lighthouse Health Plan
PO BOX 211156
Eagan, MN55121

14.1.6 Claims Adjustment/Appeal Requests

If you believe there was an error made during claims processing or if there is a discrepancy in the payment amount, please call the PCSU at 844-243-5181. Lighthouse's representatives can help you resolve the issue, process a claim via the telephone, or advise whether a corrected claim or a written appeal needs to be submitted. Please submit Claims Issue Forms to the P.O. Box above.

Providers must return any overpayment to Lighthouse at the address set forth in this Manual within sixty (60) days after the date on which the overpayment was identified, as well as notify Lighthouse in writing of the reason for the overpayment. (42 CFR 438.608 (d)(2)).

The state cannot be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Lighthouse may request a return of any monies improperly paid to providers for non- covered services.

14.1.7 Claim Forms and Field Requirements

The link provides information on how to complete the required fields when submitting standard CMS-1500 or UB-04 claim forms.
http://www.cms1500claimbilling.com/p/proper-completion-of-cms-1500-for.html

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. All claims must be submitted within the timeframe referenced in the provider agreement.

Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

14.1.7.1 Claim Data Sets Billed by Providers

To facilitate timely and accurate claim processing, you must assure billing on the correct form for your provider type. The table below outlines the requirements as defined by Florida Medicaid:

	CMS-1500	**UB-04 (CMS-1450)**
Hospital - Acute Care Inpatient		X
Hospital – Outpatient		X
Hospital - Long Term Care		X
Inpatient Rehabilitation Facility		X
Inpatient Psychiatric Facility		X
Home Health Care		X
Skilled Nursing Facility		X
Ambulance (Land and Air)	X	
Ambulatory Surgical Center	X	
Dialysis Facility (Chronic)		X
Durable Medical Equipment	X	
Drugs (Part B)	X	
Laboratory	X	
Physician and Provider Services	X	
Federally Qualified Health Centers	X	
Rural Health Clinics	X	

14.1.8 CMS-1500 Claim Form and Required Fields

Use of the CMS-1500 form (02/12) was required as of April 1, 2014. Please see claim form instructions at 222.lighthousehealthplan.com. The form includes several fields that accommodate the use of your National Provider Identifier (NPI). More information can be found in the Physician part of our website www.lighthousehealthplan.com.

14.1.8.1 Procedures for Electronic Submission

14.1.8.1.1 Electronic Data Interchange (EDI) allows for faster, more efficient, and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claims submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof-of-claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about twenty-four (24) to forty-eight (48) hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Faster claim completion. Claims that do not need additional investigation are generally processed more quickly. Reports have shown that a large percentage of EDI claims are processed within ten (10) to fifteen (15) days of their receipt.

14.1.8.2 Requirements for Electronic Claim Filing

The following sections describe the procedures for electronic submission for hospital and medical claims, including descriptions of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

14.1.8.3 Hardware/Software Requirements

Providers may use different products to bill electronically. Providers may submit claims electronically as long as their software has the capability to send EDI claims to Change Healthcare (formerly Emdeon) through either direct submission or through another clearinghouse/vendor.

Change Healthcare has the capability to accept electronic data from numerous providers in several standardized EDI formats. Change Healthcare forwards the accepted information to carriers in an agreed upon format.

14.1.8.4 Contracting with Change Healthcare and Other Electronic Vendors

Providers without Change Healthcare EDI capabilities who are interested in electronic claims submission may contact the Change Healthcare Sales Department at (877) 469-3263, option 6. Providers may also choose to contract with another EDI clearinghouse or vendor who already has EDI capabilities.

After the registration process is completed and providers have received all certification material, providers must:

- Read over the instructions carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact their system vendor and/or Change Healthcare to initiate electronic submissions to Lighthouse. (Lighthouse's electronic payer identification number is 31828.)
- More information on electronic billing can be found in the Provider section of our website www.www.lighthousehealthplan.com

14.1.8.5 Plan Specific Electronic Edit Requirements - Exclusions

Certain claims are excluded from electronic billing. At this time, the following claims must be submitted on a paper claim:

- Letters of Agreement (LOA) or Single Case Agreements;
- Sterilization claims accompanied by appropriate MAP forms; and
- Providers contracted with vendors that are not transmitting through Change Healthcare.

Important: Requests for adjustments may be submitted by telephone to the PCSU at 844-243-5181 or by mailing to Lighthouse Health Plan at PO Box 211156, Eagan, MN 55121.

14.1.9. Submitting Enrollee Encounters

Lighthouse is required to submit encounter data to the AHCA. Provider assistance is an essential component of this requirement.

AHCA requires complete, accurate, and timely encounter data in order to effectively assess the availability and costs of services rendered to Medicaid enrollees. The data we provide affects AHCA's funding of the Medicaid Program, including Lighthouse.

Data regarding encounters is also used to fulfill the CMS required reporting in support of the Federal funding of State Medicaid plans.

According to Lighthouse policy, providers must report all enrollee encounters by claims submission either electronically or by mail to Lighthouse.

14.2 Timely Filing Requirements

Original claims must be submitted to Lighthouse within the timeframe identified in the provider agreement for services rendered or compensable items provided.

Resubmission of previously processed claims with corrections and/or requests for adjustments must be submitted within ninety (90) days of notification of payment/denial.

Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within the timeframe identified in the provider agreement. Rejected claims are not registered as received in the claims processing system.

14.3 Corrected Claims and Requests for Appeals and/or Refunds

If you would like to discuss claims payments, you may call the PCSU at 844-243-5181

Providers have the right to appeal the outcome of a claim. The appeal must be submitted in writing and received within two (2) years of the last process date and include supporting documentation. The Plan will respond to the appeal within thirty (30) days from the receipt date with a determination or status of the review.

The provider will receive written notification of the outcome of the appeal whether it is upheld or overturned. All upheld determinations will be sent to the provider in a letter with the reason the plan upheld the appeal. Any appeals overturned by the plan will be reprocessed, and the provider will receive an explanation of benefits (EOB) as notification.

Resubmitted claims should be resubmitted on paper. Corrected claims can be sent electronically. All corrected claims should have the corrected claim indicator (a 7) on the claim and the original claim number that you are correcting:

- Claims originally denied for missing/invalid information for inappropriate coding should be submitted as *corrected claims*. In addition to writing "corrected" on the claim, the corrected information should be circled so that it can be identified.
- Claims originally denied for additional information should be sent as a *resubmitted claim.* In addition to writing "resubmitted" on the claim, the additional/new information should be attached.
- Corrected and resubmitted paper claims are scanned during reprocessing. Please use blue or black ink only, and refrain from using red ink, white out, and/or highlighting that could affect the legibility of the scanned claim.

Corrected/Resubmitted paper claims should be sent to:

Lighthouse Health Plan
PO Box 211156
Egan, MN 55121

Following these instructions will roneous or duplicate claims and timely filing denials on second submissions.

When the need for a refund is identified, the provider should call the PCSU at 844-243-5181 to report the over-payment. Claim details will need to be provided, such as reason for refund, claim number, enrollee number, dates of service, etc. The claim will be adjusted, the money will be recovered, and the transaction will be reported on the Remittance Advice. There is no need to submit a refund check.

If Lighthouse recognizes the need for a refund, a letter outlining the details will be sent thirty (30) days prior to the recovery occurring. These adjustments will also be reported on the Remittance Advice.