

BILLING AND ACCOUNTS RECEIVABLE GUIDE

ELECTRONIC CLAIM SUBMISSION

- Process claims electronically through Availity to CSI in a batch format using our CSI payer ID #34186
- Confirm with your vendor/clearinghouse your software system has been set up to have the capability to upload batch files of X12 EDI transactions and can support an FTP (File Transfer Protocol) connection
- For Assistance with setting up electronic billing contact your EMR software vendor as well as your Clearinghouse and Availity @ 800-282-4548 or log onto Availity at www.availity.com
- Claims electronic format should be either (837P or 837I)
- If hard copy claims are needed until you are setup electronically you can email them to our Claims Resolution team at agencyclaims@optioncare.com include a log sheet listing patient's name, dates of service and billed amount

BILLING REQUIREMENTS

Please refer to your contract for payer specific billing requirements. All claims released to CSI must be complete with accurate information to be billable to the Payer.

- Setup your system with each payer specific rate following the rate sheet in your contract that has the corresponding revenue code and HCPC code and reimbursement rate for each service/discipline as fee for service or episodic indicated on payer's fee schedule
- Bill on either a UB04 or HCFA 1500 claim form – All Medicare Advantage and Anthem claims MUST be on a UB04
- Submit claims within **seventy-five (75) days** of the date of services rendered
 - Agencies can bill CSI daily, weekly, or bi-weekly we do not recommend going any longer than a month
- Submit claims with list price or contract amount
- CSI must have a referral on file with corresponding dates of service to bill claims
 - Be sure patient information on the claim matches the CSI authorization form to avoid claims rejecting for discrepancies, such as spelling of name, DOB, etc.
 - Confirm contracted codes, units, number of visits allowed, and date range correlates with your authorization form
 - If the admission/SOC date changes after the authorization has been secured, please send a portal mail message to notify the CSI Auth team of the revised SOC date
- Plans managed by Carelon; go to the Carelon portal to start your authorization process. CSI will capture that patient's data from a daily roster. To show on the roster you must choose CSI under Network Provider (tab 4) when securing your authorization
- Medicare Advantage claims must have a PDGM HIPPS code and value code 61 with appropriate 5-digit CBSA and Value code 85 with appropriate FIPS code
- All claims for HHA must include either SN or PT on the claim, this is a requirement of payers to ensure oversight of HHA visit
- BID visits should be on the same claim to avoid rejecting for duplicate, list on separate lines
- Skilled nursing use - RN G0299 or LPN G0300, SN IV 99601 and SN IV Hourly 99602 (if authorized)
- Bill with primary ICD-10 code pertaining to homecare services and up to five subsequent codes
- Referring physicians with their NPI must be on the claim and be PECOS certified for MDCR Advantage claims
- Availity is the intermediary and only passes the claim from the agency's software vendor to us. CSI does not receive reporting from Availity on any submitted claims
- Your agency will need to follow your released claims to ensure they are on the CSI report called the COF (Claims on File) or under the Rejected section on the EOP (Explanation of Payment)
- Fee for Service reimbursement- Do not bill two separate years of service on the same claim even when these services are within the same period of care **note- this does not apply to Episodic reimbursement*
- Additional billing requirements **for Hospice Claims**
 - Set up your system with each payer specific rate following the rate sheet/sheets which has the corresponding revenue code and reimbursement rate for each service as per diem as a daily rate or hourly for continuous in-home care
 - Each service should be on their own claim listed per service date -We have found when we bill different hospice types/codes on different claims, as well as itemized (one day per line), claims are adjudicated more efficiently and correctly
 - Value Code 61 is typically used for Routine Home Care and Continuous Home Care, indicating the Core-Based Statistical Area (CBSA) of the patient's residence
 - Value Code G8 is typically used for General Inpatient Care and Inpatient Respite Care, indicating the CBSA of the facility where care is delivered
 - Currently a NOE (Notice of Election) is not required

- Additional Billing Requirements for **Medical Mutual Medicare Advantage Claims (Episodic)**:
 - To be eligible to bill for services with this provider the MMO Amendment must be implemented.
 - Ensure the accurate HIPPS code is used (do not use a dummy HIPPS code)
 - Accurate Dx codes
 - Bill for each 30-day period of care
 - Use occurrence code 50 with the correct Assessment Date
 - Include value code 61 with the appropriate 5-digit CBSA code
 - Include value code 85 with the appropriate FIPS code
 - The revenue code must be compatible with the HCPCS code
 - Notice of Admission (NOA) is NOT required

***Note: If claims are not billed in accordance with these guidelines, they will be rejected by CSI to be corrected and released again electronically**

MMO is processing episodic claims with information on incoming claim as well as additional details on the member in their system

MMO may appropriately process the episodic claim with a different HIPPS code than what was billed on the claim due to additional factors regarding that patient's care, or data on the claim itself (i.e. dx codes). If CSI determines payment is appropriate based on claim submission, we will adjust and identify this on the EOP with adjustment code D2 "Payment adjustment due to change in the HIPPS code as deemed by payer".

If you wish to appeal their decision following CSI's appeal process, be clear on the appeal form and corrected claim providing details that will support the change in HIPPS code. A change to the HIPPS code only will not result in different adjudication by MMO.

REPORTS

CLAIMS ON FILE REPORT (COF)

- This report can be set up to be sent to your agency weekly or bi-weekly by completing the Email Confirmation for Reports form and will be sent to the team members assigned to the reporting
- To change/add an email recipient, complete the Email Confirmation for Reports form, and send via email to your Contracting Representative or agencyupdategroup@optioncare.com
- Your agency should monitor this report to confirm all released claims from your clearinghouse are at CSI and released to the payer
- This report will also show all activity on the claim, balances, check dates and check numbers as well as partial payments and if an unpaid balance has been transferred to a secondary payer i.e., self-pay or another insurance plan. This is an ongoing report and can be manipulated, to show a specific period by using the drop down on the headers
- It is best to align your AR to the contract rates for the different payers for reimbursement, which will then match your COF report (column Q) labeled as AP invoice amount
- Claims that CSI rejects will not show on this report, they will show on your EOP (Explanation of Payment) they can be corrected and released again electronically to CSI providing it is within the payers' allowable time limit.
- If a claim is not on this report 10 days after your release date at the clearinghouse and is not on an EOP report check with your clearinghouse and release it again through Availity
- Different columns on your COF
 - **Column A** Report Type Shows whether the claim is presented at claim-level, or line-item level
 - All claims with a CSI billed date of 02/07/2025 will show as line-item level
 - **Column C** Line-item ID shows a unique internal ID for each line item to distinguish from the others
 - Will be blank for claim-level processing
 - **Column D** Primary Payer
 - **Column E** will inform you of a balance transferred to a secondary payer such as another payer, or patient responsibility. If uncollectable is noted, CSI is unable to bill the secondary, such as Medicare/Medicaid and the unpaid balance should be billed by your agency
 - **Column F** will inform you of denials or reason for the partial payments
 - **Column G** Displays the agency-contracted service codes for each line-item. Will be blank for claim-level processing
 - **Column N** Provides you with the date CSI billed the payer for that claim
 - **Column Q** Agency expected amount
 - **Column T** shows the unpaid balance
 - **Column U** will inform you of a check date and once processed Column V will provide the check number for that reimbursement
 - All other Column's will provide claims and patient information
 - Columns can also be altered to specific dates using the drop down on the headers
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EXPLANATION OF PAYMENT (EOP)

EOP (Explanation of Payment) Report are emailed weekly and correspond with the electronic check paid for that week. This report contains patient's name and DOB, CSI claim number, type of service with service date per line item.

There are (3) different sections on this report:

1. Processed with a payment or takebacks – Claims will show payments in full or partial pays with payer's adjustment code and takeback reasons
2. Denied by the Payer - If a Payer denies a claim as a whole, or partially the denial reason will show under the denied section of this report. If your agency believes the denial is in error, you can appeal by following the appeal process and completing a Provider Resolution Form. If the denial reason is exceeded authorization and the correct authorization approval has been used, most payers will not retro back authorization. Denied claims cannot be released again electronically
Denied claims cannot be released again electronically
3. Rejected by CSI – Claims your agency submitted to CSI that lack necessary information to be transmitted to the Payer. These claims can be corrected and re-submitted electronically to CSI provided they are within the payers' timely filing requirement
This is the only report that will show a REJECTED claim

These two reports, the COF and EOP, are how your agency can track your released claims with CSI: and should be reviewed weekly

COF- contains claims that were successfully transmitted to the payer

EOP rejected claim sections - Claims that lack data that can be corrected and released again electronically. Rejected claims do not show on the COF report until they are successfully accepted and processed at CSI, providing the service dates are within that payer's timely filing allowable limit.

CLAIMS STATUS INQUIRES

Once you reconcile your AR against the COF and EOP your agency can utilize the Claim Status Inquiry form to request CSI Resolution team to review claims further if needed. Transfer the claim data from the COF and provide the reason you believe claim has not processed correctly

- If a claim has had no resolution after 35 days, from the billed date (column N on the COF) it can be added to this form to have CSI Resolution team review the status with the payer
- A claim that has been partially paid and more information is needed that is not on the COF (column E) report
- Claim Status form is located on our website <https://optioncarehealth.com/csi> under the **contact us page** navigate to **Forms**, email completed form to agencyclaims@optioncare.com
- Once our Resolution Team has completed their review your Claims Status form will be returned via email with our findings. You can expect to receive a response on most claims within 10 business days

APPEAL PROCESS FOR DENIED CLAIMS

- Denied Claims from a payer will show on the EOP Denial section of the report, when requested by your agency, CSI will appeal a denied claim on your agency's behalf
- Follow the appeal process instruction /form located on our website: <http://optioncarehealth.com/csi> located under the **contact us page**, then navigate to **Forms**. Once the Provider Resolution form is completed it can be email to agencyclaims@optioncare.com with the documents that support the reason for a reconsideration. It is the payer decision to overturn a denial
- CSI will adjust the A/R on the COF report once the claim has been denied, if the payer reverses the denial once CSI receives the funds, we will reverse the adjustment on the COF and pay your agency

PATIENT RESPONSIBILITY/SECONDARY PAYERS

- Review your contract terms for Patient Responsibility Collections- Any claim that has a self-pay balance and CSI is deemed as the collector; CSI will bill the patient for at least three consecutive billing cycles before turning the patient over to a third-party vendor. If this happens, your agency will be notified via a denial on the EOP and CSI will adjust off the unpaid balance on the COF report under Column F for the claim/line item with the date of this transaction with the adjustment code **688** and description "Patient balance sent to 3rd party collections W/O". Any payments collected by our third-party vendor as a whole or partial, CSI will reverse that adjusted amount on the COF and a payment will be sent to your agency.
- If CSI is not deemed as the collector for patient responsibility, CSI will deduct our margin from the payment received for the claim/line item. When a payment does not cover CSI's margin or if no payment is made, CSI will deduct our margin from the balance of the check or future checks. Column F will have code **570** with the description "Patient balance-agency to bill direct" with the date of the transaction, Column R will show the AP adjusted amount of patient responsibility deemed by the primary payer.
- If CSI is not in-network to bill a secondary plan, and a claim/line-item balance remains, column F will have code **569** with the description "Agency should bill secondary payer on file" with the date of the transaction, Column R will show the AP adjusted amount needed to collect from the secondary plan as deemed by the primary payer. When payment from the primary does not cover CSI's margin or if no payment is made, CSI will deduct our margin from the balance of the check or future checks.
- When a Hospice balance remains and the payer reimbursement does not cover CSI's margin- or if no payment is received. CSI will deduct our margin from the balance of the check or future checks. Column F will have code **568** with the description "Hospice patient balance- agency to bill direct" with the date of the transaction, Column R will show the AP adjusted amount of patient responsibility deemed by the primary payer
- Your COF should reflect on all transactions against your EOP. With any scenario that CSI margin is not collected from the primary reimbursement there will be a negative amount on column S on the COF for your AP reporting.

HELPFUL TIPS

- Manage your Accounts Receivable (AR) monthly at minimum by reviewing your COF (claims on file), EOP (Explanation of payment). Any claim that has been submitted to CSI and we were able to successfully submit it to the payer will be on the COF and once processed will be on the EOP report
- If service lines are missing required authorization, you can submit the claim to CSI to bill to the payer, the payer will determine if the claim is payable without an authorization. It will be up to the payer if an appeal can be accepted
- Contracts do contain multiple fee schedules with unique rates, billing units, and billing code requirements, requesting authorizations and submitting claims under the incorrect fee schedule may result in incorrect payments on your account receivable against the COF reporting
- Go to our website <https://optioncarehealth.com/csi> for contact information for our different departments and to access and upload needed forms