CSINetworkServices®
An Option Care Health Company

BILLING AND ACCOUNTS RECEIVABLE GUIDE

ELECTRONIC SUBMISSION

Process claims electronically through Availity to CSI in a batch format using our CSI payer ID #34186

- Check with your clearinghouse to see if a crosswalk has been setup in their system to pass claims from Availity to CSI
  - 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), no manual entry
  - Availity is the intermediary and only passes the claim from the agency's software vendor to us. CSI does **not** get reporting from Availity on any submitted claims
- Electronic Billing Advantages
  - Proof of timely submission
  - Secure delivery of invoices
- 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

Please refer to your contract for payer specific billing requirements of fee for service or episodic

- Agencies can bill CSI daily, weekly, or bi-weekly we do not recommend going any longer than a month
- CSI must have a referral on file with corresponding dates of service to bill claims (refer to our portal guide)
- Plans managed by Carelon do not need entered onto the CSI portal follow the authorization guide be sure to choose CSI under Network Provider **(tab 4)** when securing your authorization

RELEASING CLEAN CLAIMS TO CSI

All claims released to CSI must be complete with accurate information to be billable to the Payer

- Submit claims within seventy-five (75) days of the date of services rendered
- Check patient's information for accuracy, name, date of birth, and address including insurance (payer) identification information
- Bill on either a UB04 or HCFA 1500 claim form – All Medicare Advantage claims MUST be on a UB04
- Confirm contracted codes, units, number of visit's allowed, and date range correlates with your authorization (if required)
- 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
- All Medicare Advantage claims must have a current PDGM HIPPS code on the claim (example 2XX22 one number followed by two letters than two numbers)
- Submit claims with list price or contract amount
- Referring physician with their NPI must be on the claim and be PECO certified for MDCR Advantage claims
- Agency's complete name and address with NPI
- **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 listed on separate lines
- Do not bill two separate years of service on the same claim even when these services are within the same episode of care

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Reports for Reconciling Claims

CLAIMS ON FILE REPORT (COF)

- This report can be setup to send to your agency weekly or bi-weekly by completing the Email for Confirmation form and 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 manipulates, 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 M) labeled as AP invoice amount
- Claims that CSI rejects will not show on this report, however 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 after 10 days from your released 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 **D** will inform you of denials or reason for the partial payments
  - Column **C** 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 **J** Provides you with the date CSI billed the payer for that claim
  - Column **Q** will inform you of a check date and once processed Column R will provide the check number for that reimbursement
  - Column **P** shows the unpaid balance

EOP (Explanation of Payment)

❖ **The EOP reports are emailed weekly and correspond with the electronic check paid**

- **This Report Contains 3 types of claims**
- **Processed claim by the Payer**- Will show claim payments, adjustments such as takebacks and partial denials and show claim balances due from the payer
- **Rejected claim -**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 if they are within timely filing requirements**
- **Denied Claims** – claims that CSI has accepted and billed to the Payer, that the Payer denies in whole or part. If your agency wishes to appeal a claim that the payer denies, you must follow the appeal process by completing a Provider Resolution Form These claims cannot be rebilled electronically to CSI
- Reconcile your payments/cash posting to this EOP

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CLAIMS STATUS INQUIRES

Once you have 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 J 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 partially paid and more information is needed that's not on the COF (column D) report
- Claim Status form is located on the portal under Forms and can be submitted through the portal or email to agencyclaims@optioncare.com
- Once our Resolution Team has completed their review your Claims Status form will be returned via email with our finding. Please allow 14 days for the team to complete

APPEAL PROCESS FOR DENIED CLAIMS

- Denied claims from the payer will show on the EOP Report, CSI will appeal a denied claim on your behalf if requested
- Follow the appeal process instructions to request an appeal on a denied claim, complete the Provider Resolution Form and email the form with the documentation needed to agencyclaims@optioncare.com
- CSI will adjust you're A/R on the COF report once a 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

- Review your contract for terms of Patient Responsibility Collections- Any claim that has a self-pay balance and CSI is deemed as the collector; CSI will bill the patient for three consecutive billing cycles before turning the patient over to a third-party collector. If this happens CSI will send you a **letter** and advise that we will be adjusting off the patient balance on the COF report and if/when the third-party is able to collect, CSI will reverse the paid amount and send a payment to your agency
- If CSI is not deemed as the collector, we will take our margin from monies paid or future payments to your agency.

Remember When Reconciling Claims

- 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 services are without 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