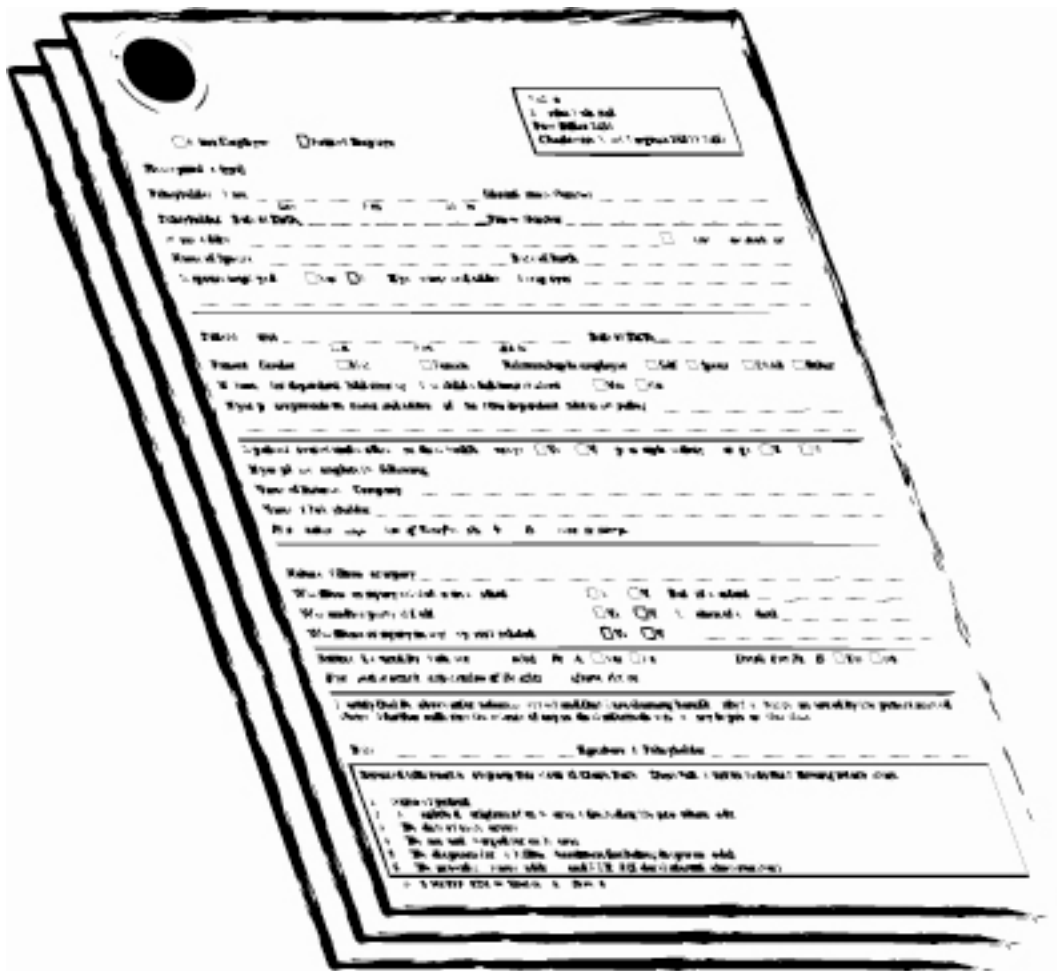


Section VI Claims and Claims Disputes



Keystone Mercy Claims Filing Instructions

The Keystone Mercy Claims Filing Instructions can be accessed online
In the Provider Center at

www.keystonemercy.com

The Claims Filing Instructions contains current information and is periodically updated as needed. If you prefer a hard copy of the Claims Filing Instructions, please contact your Provider Account Executive or call 1- 800-521-6007.

Claim Filing Deadlines

Original Claims

Original Claims must be submitted to Keystone Mercy within 180 calendar days from the date services were rendered or date compensable items were provided.

Re-submission of Rejected Claims

Re-submission of **rejected Claims must occur within 180 calendar days** from the date of service or date compensable items were provided.

Re-submission of Denied Claims

Re-submission of previously Denied Claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date of service or date compensable items were provided. For more information on billing requirements, please see the Claims Filing Instructions in the Provider Center at www.keystonemercy.com.

Submission of Claims Involving Third Party Liability

If a Member has other insurance coverage in addition to Keystone Mercy coverage, the other insurance carrier (the “Primary Insurer”) must consider the Health Care Provider’s charges before the Claim is submitted to Keystone Mercy. Therefore, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill Keystone Mercy for the Claim by submitting the Claim along with a copy of the Primary Insurer’s EOB. **Claims with EOBs from Primary Insurers must be submitted within 60 days of the date of the Primary Insurer's EOB.**

Failure to Comply with Claim Filing Deadlines

Keystone Mercy will not grant exceptions to the Claim filing timeframes outlined in this section. Failure to comply with these timeframes will result in the denial of all Claims filed after the filing deadline. Late Claims paid in error shall not serve as a waiver of Keystone Mercy’s right to deny any future Claims that are filed after the deadlines or as a waiver of Keystone Mercy’s right to retract payments for any Claims paid in error.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than Keystone Mercy. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as Keystone Mercy, are always the **payer of last resort**. This means that all other insurance carriers (the "Primary Insurers") must consider the Health Care Provider's charges before a Claim is submitted to Keystone Mercy. Therefore, before billing Keystone Mercy when there is a Primary Insurer, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill Keystone Mercy for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.

Reimbursement for Members with Third Party Resources

Medicare as a Third Party Resource

For Medicare services that are covered by Keystone Mercy, Keystone Mercy will pay, up to the Keystone Mercy contracted rate, the lesser of:

- The difference between the Keystone Mercy contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by Medicare and Keystone Mercy will not exceed the Keystone Mercy contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, Keystone Mercy will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate.

For Medicare physical health services that are not covered by either Keystone Mercy or the MA Fee-For-Service Program, Keystone Mercy will pay cost-sharing amounts to the extent that the combined payment made under Medicare for the service and the payment made by Keystone Mercy do not exceed 80% of the Medicare approved amount.

Keystone Mercy's referral and authorization requirements are applicable if the services are covered by Medicare and the Member's Medicare benefits have been exhausted.

Commercial Third Party Resources

For services that have been rendered by a Network Provider, Keystone Mercy will pay, up to the Keystone Mercy contracted rate, the lesser of:

- The difference between the Keystone Mercy contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and Keystone Mercy will not exceed Keystone Mercy's contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, Keystone Mercy will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance Fee-For-Service rate.

Health Care Providers must comply with all applicable Keystone Mercy referral and authorization requirements.

Capitated Primary Care Practitioners (PCPs)

When services are rendered by a participating PCP or other capitated Network Provider, Keystone Mercy considers the coinsurance, deductible and/or co-payment to be a component of the Network Provider's Capitation payment and does not make a separate payment in addition to the Capitation.

Fraud & Abuse

Under the HealthChoices program, Keystone Mercy receives state and federal funding for payment of services provided to our Members. In accepting Claims payment from Keystone Mercy, Health Care Providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to www.pacode.com/secure/data/055/partIII/toc.html for more information regarding Fraud or abuse, including "Provider Prohibited Acts" that are specified in §1101.75.

Keystone Mercy is dedicated to eradicating Fraud and abuse from its programs and cooperates in Fraud and abuse investigations conducted by state and/or federal agencies, including the Medicaid Fund Control Unit of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the HHS Office of Inspector General, as well as the Bureau of Program Integrity of DPW.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement

Contact Information

To report or refer suspected cases of Fraud and abuse you may contact Keystone Mercy's Fraud and Abuse Hotline by:

Phone:
1-866-833-9718

Mail:
Manager, Special Investigations
Keystone Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113

OR

Contact The Pennsylvania Department of Public Welfare through one of the following methods:

Phone: 866-DPW-TIPS (866-379-8477)
On-line: www.dpw.state.pa.us/omap
E-mail: omaptips@state.pa.us
Fax: 1-717-772-4655, Attn: OMAP Provider Compliance Hotline
Mail: Bureau of Program Integrity
OMAP Provider Compliance Hotline
P.O. Box 2675
Harrisburg, PA 17105-2675

Claim Disputes and Appeals

Keystone Mercy's goal is to assure smooth transactions and interactions with our Provider Network community. There are some common reasons for rejection or denial of Claims and simple methods to correct them without initiating a Claims Dispute, which is described in more detail at the end of this Section. See the definitions below and instructions on the simplest method to correct/re-submit the Claim.

Common Reasons for Claim Rejections & Denials

Rejected Claims

Rejected Claims are defined as Claims with invalid or missing data elements. Some examples are illegible Claim fields or missing or invalid codes and/or missing or invalid Member or Provider ID numbers. Rejected Claims are returned to the Health Care Provider or EDI source without registration in the Claim processing system. Since rejected Claims are not registered in the Claim processing system, the Health Care Provider must re-submit corrected Claims within 180 calendar days from the date of service or date compensable items provided. This requirement applies to Claims submitted on paper or electronically. Rejected Claims are different than Denied Claims, which are registered in the Claim processing system but do not meet requirements for payment under Plan guidelines. Resubmit rejected Claims following the same process you use for original Claims - within 180 days of date of service or date compensable items provided.

Claims Denied for Missing Information

Claims that pass the initial pre-processing edits and are accepted for adjudication but DENIED because required information from the Health Care Provider is missing must be resubmitted for correction. Some examples are a missing Tax ID number, incomplete information or incorrect coding. These are Claims that can be resubmitted and re-adjudicated once missing information is supplied. Health Care Providers have 365 calendar days from the date of service or date compensable items were provided to re-submit a corrected Claim.

Claims denied for missing information can be re-submitted to the following address. Please clearly indicate “Corrected Claims” on the Claim form:

**Corrected Claims/Adjusted Claims
Keystone Mercy Health Plan
P.O. Box 7115
London, KY 40742**

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and can often be corrected over the phone. Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the Network Provider has an authorization number. **If a Network Provider has Claims needing adjustment and there is a manageable volume of Claims (five or less), the Network Provider can call Keystone Mercy's Provider Claim Services Unit (PCSU) at 1-800-521-6007 to report payment discrepancies.** Representatives are available to review Claim information and make on-line adjustments to incorrectly processed Claims.

Emergency Department Payment Level Reconsideration for Participating Providers

In certain cases, it is not necessary for a hospital Provider to appeal a Claim decision when they are not in agreement with Keystone Mercy's level of payment for Emergency Room services. If a Claim has been reimbursed at the lower degree of acuity rate, and the original Claim submission did not include medical records or the Emergency Room summary, the hospital Provider may resubmit the Claim along with medical records (or Emergency Room Summary) for payment level reconsideration. Keystone Mercy's clinical staff will review the medical records and render a decision based on the nature of treatment rendered to treat presenting symptoms. These Claims should be submitted to the Claims Medical Review Department at the following address:

**Claims Medical Review Department
Keystone Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113**

Hospital Providers will be notified via the remittance advice of any decisions to pay at the higher degree of acuity rate. If review of the medical records does not indicate services should be paid at the higher degree of acuity rate, a letter will be sent to the hospital Provider upholding the

original Claim determination. If the hospital Provider disagrees with this determination, the hospital Provider may file a Formal Provider Appeal for further reconsideration of the level of payment. For information on how to file, please refer to Formal Provider Appeal procedures outlined in Section VII.

Payment Limitations

No payment will be made for Emergency Room services if:

- The Member is not eligible for benefits on the date of service
- The Member is admitted to an SPU, Observation or Inpatient setting within 24 hours of the Emergency Room stay. In such cases, Emergency Room charges should be reported on the SPU, Observation or Inpatient bill. See the Emergency Admissions, Surgical Procedures and Observations Stays topic in Section II for notification requirements

If your Claim issues are not resolved following the steps outlined above, the following procedures may be followed.

Claims Disputes

Claims Disputes include Claim denials, payments the Network Provider feels were made in error by Keystone Mercy, or involve a larger volume of Claims than can easily be handled by phone. Network Providers must submit these Claims Disputes to Keystone Mercy within 365 days from the date of service, or the date compensable items were provided, with a written explanation of the error to:

**Keystone Mercy Health Plan
Provider Network Management
200 Stevens Drive
Philadelphia, PA 19113
ATTN: Provider Solutions Specialist**

For accurate and timely resolution of issues, Network Providers should include the following information:

- Provider Name
- Provider Number
- Tax ID Number
- Number of Claims involved
- Claim numbers, as well as a sample of the Claim(s)
- A description of the denial issue

If numerous Claims are impacted by the same issue, Keystone Mercy has developed a spreadsheet format for submission of larger Claims projects. The spreadsheet format can be found in Appendix VI or online in the Provider Center at www.keystonemercy.com. If several Claims have been denied for the same reason, these may all be included in a single letter/E-mail with an attached list of Claims or spreadsheet. **An electronic version of the spreadsheet is highly preferred. Do not combine multiple denials for different reasons in the same letter/spreadsheet.**

All disputed Claims will be acknowledged, researched and the decision conveyed to the Network Provider within 60 days following procedures as outlined in Section VII. If the Network Provider remains unhappy with Keystone Mercy's Dispute decision, the Network Provider may file a Formal Provider Appeal.

Repeated re-submission of a Claim does not preserve the right to Appeal if the 365 day timeframe is exceeded.