Palladian Muscular Skeletal Health

insight

The Palladian Health ® Provider Newsletter | Fall 2015

PREVENTING DUPLICATE CLAIM SUBMISSIONS

It is critical that you do not resubmit a duplicate claim until you know the status of your original submission.

Although, Palladian does not believe providers are deliberately trying to receive duplicate payment by submitting multiple claims for services, we must remind you that this is an **inappropriate billing practice**.

Additionally, National Government Services (NGS) is in the process of identifying providers and suppliers in several states including Connecticut, and New York, who continually submit multiple duplicate claims. Providers who have a high amount of duplicate claim submissions to NGS will be contacted in the next few weeks. These providers will be asked to explain the reason(s) for the duplicative billing and education will be provided to avoid excessive submissions in the future.

The definition of a duplicate claim submission is when a provider resubmits a claim either on paper or electronically for a single encounter and the service is provided by the same provider to the:

- same beneficiary; for the
- same item(s) or service(s); for the
- same date(s) of service.

Complications when submitting duplicate claims:

- May delay payment;
- Increases administrative costs;
- Could be identified as an abusive biller; or
- May result in an investigation for fraud if a pattern of duplicate billing is identified.

Check your EDI acknowledgment report to verify your claims were received and accepted or which claims may have rejected.

If you are unsure how to check these reports, contact the clearinghouse.
Check your software system to verify that your claims software system is **not set up for automatic re-bill** every 30 days or at any other set time intervals.

Ensure that your claims batching process is functioning properly.

Each software system may perform this process differently or use a different term for the process. A software product may allow you to inadvertently create a file with claims that have previously been batched and transmitted to the health plan.

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ICD-10 REQUIREMENTS

As of October 1, 2015 please submit updated Palladian Health Version 2.1 ICD-10 Compatible Treatment form and discard any copies of Version 1.5 of the Palladian Treatment form.

If the dates of service were after October 1, 2015, you must use an ICD-10 diagnosis.
Please update and correct the diagnosis if you have used ICD-9 for dates of service after October 1. A helpful website to convert ICD-9 codes to ICD- 10 is: http://www.icd10data.com/

The new ICD-10 Treatment form is available at the Provider Portal of the Palladian website or you may contact our Customer Service department Monday through Friday from 8:30am - 5pm to request copies.

GENERAL CLAIMS SUBMISSION

Claims for payment for GHI PPO enrollees must be sent directly to GHI for processing and payment. Palladian is not delegated to process and pay GHI PPO claims.

Verify your provider information to ensure that your provider address and other demographics are accurate and up-to-date.
Check that your claim for payment and authorization demographics match.

Verify that your patient's demographics have been updated and are correct if there has been a break in care or if you have not seen the patient for a period of time.

DIAGNOSTIC IMAGING GUIDELINES

Prior authorization requests for diagnostic imaging are reviewed based upon the Palladian Health guidelines. Pursuant to these policies, x-rays would be covered if the diagnosis is related to the primary region of complaint AND one of the following reasons were present:

- History or clinical suspicion of fracture
- History or clinical suspicion of spinal malignancy
- History or clinical suspicion of spinal infection
- History or clinical suspicion of systemic inflammatory disease
- History of spinal symptoms for at least 6 weeks with no response to conservative care

PROHIBITION ON BALANCE BILLING QUALIFIED MEDICARE BENEFICIARIES (QMBs)

Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs) – REMINDER
All Medicare providers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as "balance billing." QMBs have no legal obligation to make further payment to a provider for cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the State's discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and Mandatory Supplemental Benefits.
- **Regardless of whether the State Medicaid Agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits**.

Ways to Improve the Claims Process
Effective communications between you and State Medicaid Agencies can improve the claims process for all parties involved. Therefore, CMS suggests that you take the following four actions to improve communications with State Medicaid Agencies and better understand the billing process for services provided to QMB beneficiaries:

Determine if the State in which you operate has electronic crossover processes.
Recognize that you must meet any state-imposed requirements and may need to complete the provider registration process to be entered into the State payment system.
Understand the specific requirements for provider registration for the State(s) in which you work.
Contact the State Medicaid Agency directly to determine the process you need to follow to begin submitting claims and receiving payment.

For more information on the internet, please visit:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf
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