Billing for Services

Health Alliance requires all claims to be submitted within the timeframe stated in the provider contract. In general, outpatient services for Health Alliance members must be billed within 90 calendar days from the date of service, and inpatient services must be billed within 90 calendar days of the date of discharge. If the member has a different primary insurance or third-party payor, then Health Alliance must be billed within 90 calendar days of receipt of an explanation of benefits from the primary payor.

"Date of Service" (DOS) refers to the actual day you perform a service for your patient. The Health Alliance standard timely filing limit is 90 days. Self-funded plans may have their own timely filing limits that are different from the Health Alliance standard. This is not reflected in the provider contract. Health Alliance uses the DOS for claims purposes. When submitting claims for any service you provide, it must be within 90 calendar days of the DOS. If not, the claim will be disallowed. **For example, if you provide services to your patient on August 1, 2019, the claim must be received at Health Alliance before November 1, 2019.**

The standard HCFA 1500, UB04 or ADA dental claim forms must be used and must include standard code submissions (both principal and secondary), complete coding and CPT Modifiers. Failure to submit complete information may result in delay or loss of reimbursement.

If you have any questions about this process or the timeframes, please consult your PRS.

Electronic Claim Filing

Speed, accuracy, and ease of processing are just a few of the reasons filing electronic claims is so popular. Health Alliance accepts both physician and hospital claims electronically. Medical offices and hospitals that use electronic filing also save money. Electronic filing eliminates double data entry – your staff members are the only ones who enter claim information. Once the claim reaches Health Alliance, it is automatically loaded in our system, eliminating days of hand processing, sorting and scanning.

Ensure the most accurate, rapid claims filing turnaround times by using an electronic filing system to file your Health Alliance claims. **Please contact your billing system vendor and request they file your claims through Change Healthcare (formerly RelayHealth) under payor ID 77950 to make sure claims reach Health Alliance.** You can also call Change Healthcare directly at 1-877-411-7271 to discuss options for submitting your claims electronically to Health Alliance.

SECTION 9 CLAIMS

Health Alliance requires your ten-digit National Provider Identifier (NPI) for electronic claims. All electronic claims must comply with the HIPAA 5010 transaction set as required by CMS. If you have questions, please call the Health Alliance System Configuration Department at 1-800-851-3379, ext. 28936.

Electronic Funds Transfer

Health Alliance has partnered with Change Healthcare ePayment for electronic funds transfer (EFT) to providers. Enrollment in ePayment is completely free. For more information, you can access our Change Healthcare ePayment Flier and the ePayment Enrollment and Authorization Form by clicking the links here or at Your Health Alliance for providers under ePayment Forms & Fliers.

Electronic Claim Critical Error Message

Claims with Critical Errors will not automatically load into the Health Alliance claims system. These claims and the accompanying Critical Error Message are reported back to the clearing house which then sends them back to the provider for review. You have 90 days to resubmit a corrected claim.

The following is a summary of the most common critical errors when attempting to submit claims electronically:

- DRG Code not submitted or is invalid — The submission of the DRG is required even if the provider is not reimbursed by DRG. This error message is limited to inpatient claims because the DRG is a required field. This error indicates the DRG field was either blank or invalid (i.e., mis-key, old code).
- Provider not on file — Health Alliance requires your NPI for electronic claims. If this number is not submitted or does not find a valid match in our system, you will receive this error message. It is extremely important that your NPI is submitted in its entirety and is accurate, because an invalid submission may result in a match on another provider's identification number.
- Member not eligible-coverage group contract date error — This error message indicates the employer group or the member is no longer effective.
- Modifier not on file — The two-digit modifier submitted on the claim is either mis-keyed or invalid. The correct modifier must be submitted for the claim to load into the production system.

SECTION 9 CLAIMS

Paper Claim Filing

All claims are processed at the Health Alliance office in Champaign, Illinois. The mailing address for the submission of paper claims is:

Health Alliance Medical Plans
Attn: Claims Department
P.O. Box 6003
Urbana, IL 61803-6003

Invalid Claim Data Elements (electronic and paper)

When invalid claims data elements are submitted (e.g. diagnosis codes, CPT/HCPC codes, dates of service, member ID number, date of birth, etc.) claims are either rejected via a critical error report, letter to provider, or disallowed with descriptive messaging on the provider's remittance advice or HIPAA 835 transaction. Invalid claims submissions must be corrected and resubmitted within timely filing limitations for payment reconsideration.

Claims Questions and Inquiries

Inquiries regarding claims payment can be directed to the Health Alliance Member Services Department or to our online Claims Reprocessing Inquires tool.

Member Services can be reached at 1-800-965-4022.

If you need help with our online Claims Reprocessing Inquiries tool, see section 4 of our YourHealthAlliance.org Overview for Providers and Office Personnel guide.

Claims Processing Guidelines

In most instances, Health Alliance adheres to Medicare guidelines. Please refer to the Medicare Claims Processing Manual- Chapter 12. Another helpful reference is found at CMS.HHS.gov/FeeScheduleGenInfo.

Adjustments
Claim adjustments (e.g. for duplicate payments, overpayments, etc.) are deducted from the provider's next claim payment. The Remittance Advice provides details of all claims being paid and any claims being adjusted.

Anesthesia

SECTION 9 CLAIMS

Health Alliance uses Medicare guidelines in regards to the base units. Anesthesia services are calculated in fifteen (15) minute time units, unless otherwise specified in your provider contract. Time is rounded to the nearest fifteen (15) minute time unit. If less than five (5) minutes no time unit will apply; five (5) minutes to fourteen point nine (14.9) minutes, one time unit will apply.

The Health Alliance calculation takes the base, time, modifiers and qualifying circumstances into consideration when calculating payments. The National Coverage Provisions for Anesthesia Services has established unique modifiers for anesthesia services that tell the payor if the services performed were medically supervised by a physician or performed without medical direction by/assistance from a physician. Those modifiers indicating that services were provided by both an anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA) will be entered in the modifier schedule at a 50 percent reduction. The system will take the appropriate reductions at the time of service.

The four modifiers that are updated to 50 percent are:

- AD – Medically supervised by a physician for more than four concurrent procedures
- QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QX – CRNA with medical direction by a physician
- QY – Medical direction by one CRNA or by an anesthesiologist

Annual Coding Changes

Effective January 1 of each year Health Alliance begins accepting new/revised CPT and HCPCS codes. ICD-10 additions, revisions and deletions are effective on October 1 of each year. To be compliant with HIPAA standards, there is no longer a 90-day grace period for discontinued codes. Resubmission of a new/more appropriate code will be required.

CES – Claims Editing Systems

Health Alliance utilizes claims editing systems that provide an extensive set of base rules that utilize historical data to audit claims for appropriate coding guidelines.

The editing systems identify coding errors related to unbundling, modifier appropriateness, mutually exclusive and incidental procedures, inappropriate billing and questionable coding relationships. The systems also edit across providers in the same group or specialty per Medicare guidelines. The systems do this by utilizing a knowledge base containing more than 9 million government and industry rules, regulations and policies governing health care claims. The editing rules are built upon nationally recognized and accepted sources, including American Medical Association CPT guidelines, CMS

guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards.

Charges

Full charges are to be included on the claim form. Health Alliance will process claims according to the member's benefit plan and provider payment terms. Adjustments will be detailed on the paper Remittance Advice or electronic HIPAA 835. ***Per your Participating Provider Agreement with Health Alliance, you may not charge Health Alliance members for covered services except standard copayments, coinsurance and deductibles.***

Claim Auditing

Provider acknowledges Health Alliance's right to conduct pre- and post-payment billing audits. Provider shall cooperate with Health Alliance's audits and forensic reviews of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, provider's charging policies, and other related data. Health Alliance shall use established industry claims adjudication and/or clinical practices, state, and federal guidelines, and/or Health Alliance's policies and data to determine the appropriateness of the billing, coding, and payment.

Explanation of Benefits (EOB)

EOB forms are available to members via the Health Alliance web portal. A sample Health Alliance EOB is included at the end of this section.

Global Surgery Billing

Global surgery billing includes all necessary services normally furnished by the surgeon beginning with the day before surgery, the day of surgery, and the designated post-op period. Health Alliance follows the same guidelines as CMS. See section 40 of the Medicare Claims Processing Manual- Chapter 12 for more information.

Modifiers

Health Alliance accepts all current CPT and HCPCS modifiers for physicians and facilities.

Descriptive modifiers facilitate claims processing and often eliminate requests for additional documentation. Health Alliance reimbursement of modifiers is the same as Medicare with the exception of the AS and 80 modifiers. We reimburse the AS and 80 modifiers at 20 percent (with certain contracted exceptions).

Health Alliance follows Medicare guidelines regarding surgeons and global surgery. See section 40 of the Medicare Claims Processing Manual- Chapter 12 for more information.

Multiple Scope Billing
Health Alliance follows Medicare's various multiple procedure reduction rules paying a reduced amount for the second and subsequent procedures. The amount of the reduction is determined by the indicator within the "Multiple Procedure" column of the Medicare Physician Fee Schedule Relative Value file.

Primary Coverage
Claims for members with other primary coverage should be filed to the primary carrier first. Remaining balances should be filed to Health Alliance with the claim form and primary payor's EOB. Claims filed to Health Alliance without the primary payor's EOB will be returned to the provider for resubmission. Secondary claims can also be submitted electronically with appropriate HIPAA 837 COB loops and segments populated.

Remittance Advice
The Provider's Remittance Advice provides a detailed explanation of claim payments, denials to provider and/or member, code editing explanations (included on your ERA) and adjustments for each detail charge submitted. A sample remittance advice is included at the end of this section.

Timely Payment Guidelines
Health Alliance follows timely payment guidelines per state regulations. Interest payments will not be included on the same remittance advice as the original claim.

Venipunctures
Health Alliance considers the collection of venous blood to be incidental to performing the laboratory test. However, Health Alliance will reimburse for the venipuncture if the laboratory test is not performed in-house but sent to a reference lab. Health Alliance follows Medicare criteria for reference lab billing.

Refund Submission

When sending Health Alliance a refund, please make sure you provide the information needed to properly account for it. If Health Alliance has requested the refund, please make sure you include the information requested in the letter.

If you are sending a refund for a claim Health Alliance has not yet contacted your office about, please include the following information:

- Member name
- Health Alliance ID (if available)
- Date of service

- Health Alliance claim ID number
- Provider of services
- Detailed explanation of why you are sending a refund

Please send all correspondence regarding refunds to:

Health Alliance Medical Plans
Attn: Recovery Department
3310 Fields South Drive
Champaign, IL 61822

Timely Follow-up on Claims

If you have not received payment or notification from Health Alliance about a claim within 30 days of the submission date, please follow up with Health Alliance to check the status. You can check the status of a claim at Your Health Alliance for providers.

Recoupment Appeals Limit

Effective January 1, 2012, the State of Illinois set a time limit on recoupment appeals from providers. Provider/billing offices have 60 days after the receipt of a paper or electronic remittance advice to appeal recoupments or offsets.

Workers' Compensation Claims Submission

To allow payment of claims that may end up being denied by Workers' Compensation (WC) carrier, it is important that you follow the member's preauthorization process regarding services on the preauthorization list and referrals for secondary, tertiary and out-of-network providers.

You have 90 days to submit a WC claim and a copy of the denial notification for the claim to be processed.

Claims Submission Exceptions

Difficulty Obtaining Member Insurance Information

The provider must have supporting documentation demonstrating efforts to collect this information. The provider will be granted 90 days from the date the information is obtained, but no longer than 180 days from the date of service to submit the claim.

In Advance Request

SECTION 9 CLAIMS

A provider may contact Health Alliance in advance to request a temporary extension of the filing limit for just cause as determined by Health Alliance.

Liability Third-Party Claims

The submission timeframe for claims will be later when a third-party payor is involved (e.g. workers' compensation or other commercial insurance). Once the provider receives notification from the third party of payment or denial of the submitted claim, the provider then has 90 days to submit the appropriate information to Health Alliance for processing.

New or Additional Information (including Corrected Claims)

New or additional information submitted in response to an initial coverage determination (e.g. claim denial) for a claim must be submitted within 90 days of the initial coverage notification date unless otherwise stipulated in the provider contract. Please include Frequency code 7 to indicate that it is a corrected submission and resubmit the correct claim in its entirety.

Resubmission Due to an Error

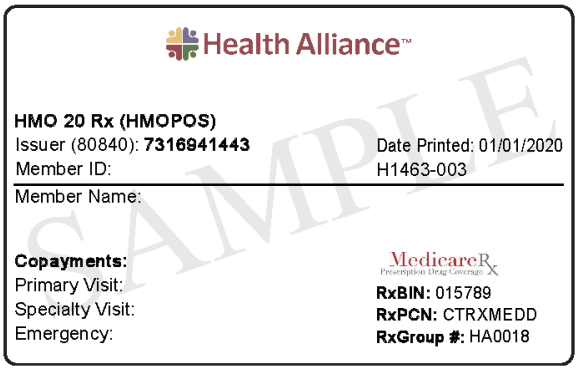
Claims that are resubmitted because of an error on the part of Health Alliance can be resubmitted up to one year following the date of the initial payment or denial.

Sample ID Cards

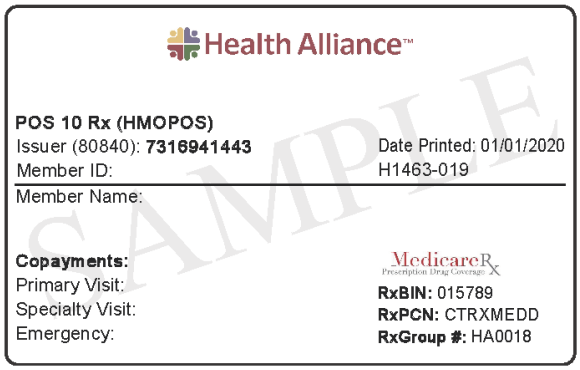
Health Alliance Legacy

SECTION 9 CLAIMS

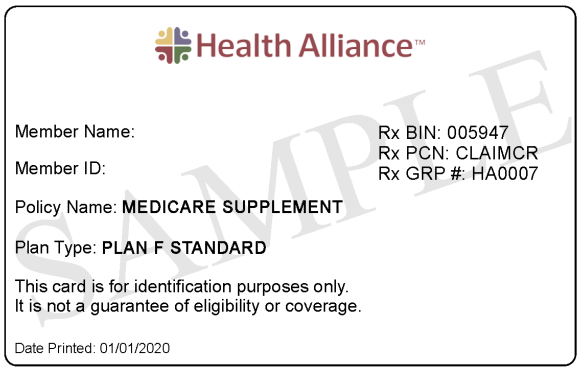
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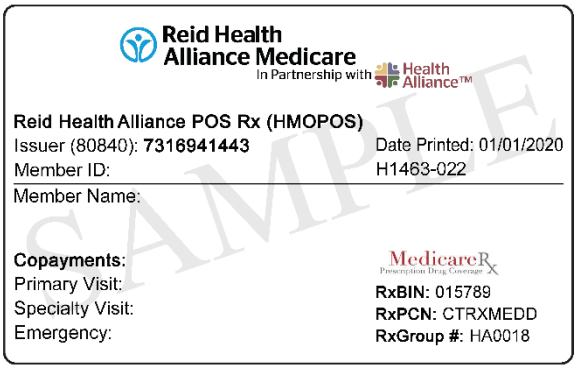
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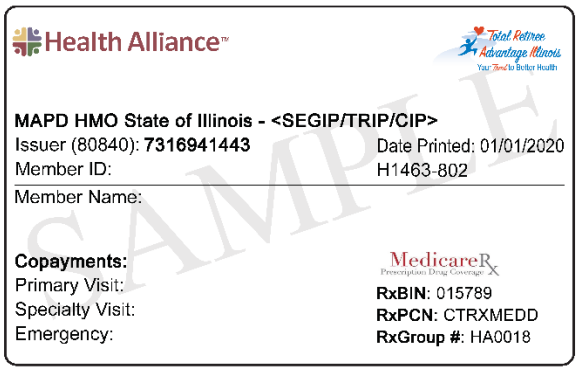
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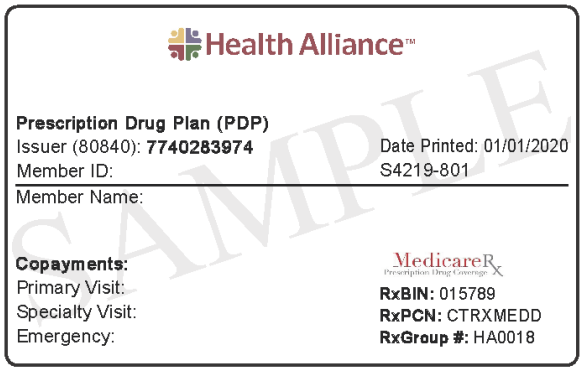
Reid



State of Illinois MAPD

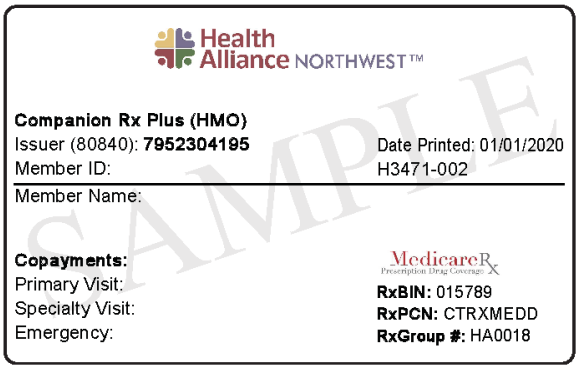


Prescription Drug Plan

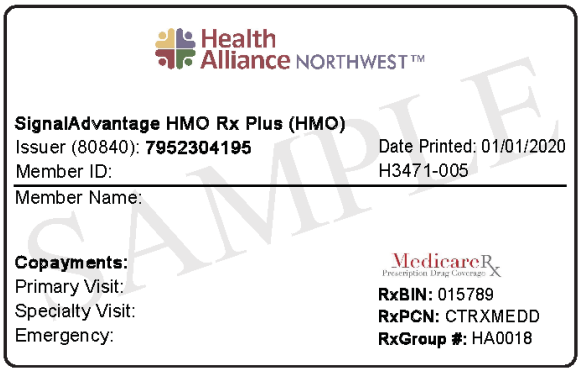


Health Alliance Northwest

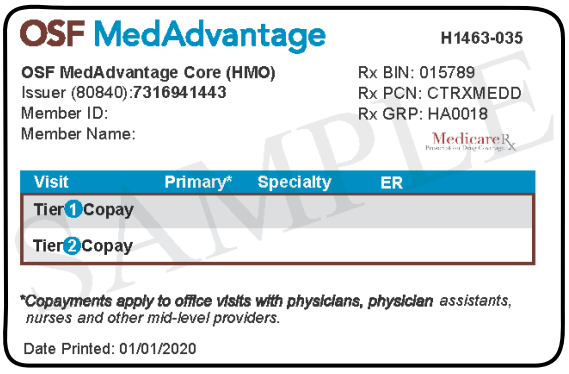
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SignalAdvantage (Yakima)

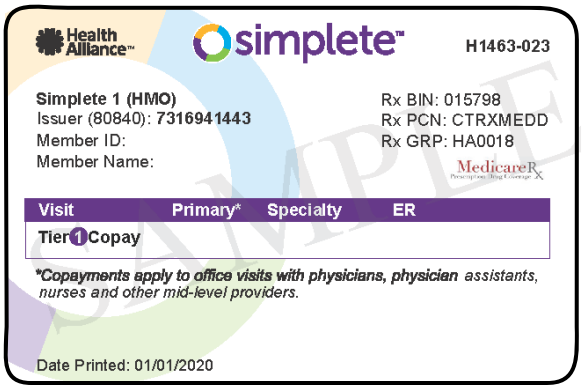


OSF MedAdvantage



Simplete

Simplete HMO



Simplete POS

