EMHS Employee Health Plan

Provider Orientation

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Beacon Health

EMHS

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EMHS Employee Health Plan
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Medical & Behavioral Health

Website& Link to Portal

www.emhsemployeehealthplan.org

Pharmacy

Provider Portal:

www.NaviNet.net

Website:

www.thehealthplan.com

PORTAL TRANSACTIONS

Online transactions:

Eligibility and benefits inquiry

Claims

Claim Status Inquiry

Remittance Advice Inquiry

Claims appeals

Resource Center

Formulary Look up

Network Facility Search

Secure Messaging

WHO TO CALL

We have the same user friendly handout to help you identify your key contacts at the Health Plan, such as:

Claims/Customer Service Department

Medical Management

Account Management

GHP Pharmacy Customer Service

The Who-To-Call Card is located on the website.

MEMBERS

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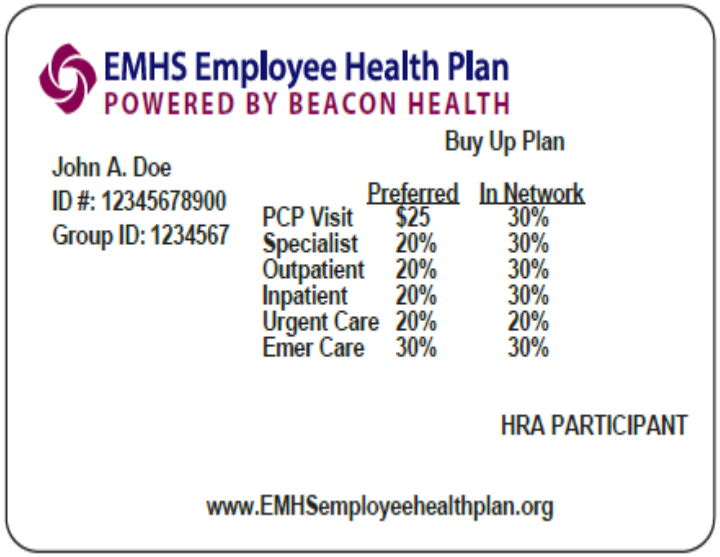
Contact the applicable Customer Service Team at the telephone number indicated on the reverse side of the member's identification card, to verify benefits and coverage prior to rendering services.



Health Savings Account

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EMHS employees enjoy the benefit of a Health Reimbursement Account. An HRA helps patients to pay first-dollar expenses.

- Evolent Health partners with ConnectYourCare for the administration of HRA services.
- All members have a health reimbursement arrangement that pay the first $1,000 single/$2,000 family coverage.
- The HRA can be used to pay deductible, coinsurances and the
- $25 in system rewards copayment.

HRA Process

1. EMHS provider sends claim to Evolent.
2. Claim is adjudicated.
3. Batches of adjudicated claims are sent weekly to CYC (each Friday).
4. CYC receives the claim and loads the claim the following Monday.
5. If the claim is eligible for payment from the employee's HRA, payment is sent to the provider in one of two ways:

A) Via an electronic ACH payment directly into the provider's designated

- checking account, or:

B) Via a paper check to the provider which includes an EOP.

HRA Process

6. If a provider receives a payment via electronic ACH payment, files are returned to Evolent the following Friday and a remittance is produced and sent to the provider approximately one week later in one of two ways.

   A)Through an electronic 835 remittance sent to the provider's designated clearinghouse, or:

   B) Through a paper remittance produced and mailed to the provider.

HRA Assistance

- Assistance with HRA questions:

- The CYC Customer Service Team has HRA Specialists who are dedicated to answering HRA-related questions.
- You can Access the HRA Specialists with any issues or concerns at (877) 292-4040

MEDICAL MANAGEMENT

Requires Coordination

The following services may require Facility/Provider coordination:

- Laboratory and Radiology Services
- Hospice, Infusion and Personal Care Facility Services
- Mental Health & Substance Abuse Services

PRIOR-AUTHORIZATION PROCESS

Who is responsible for obtaining prior-authorization?

•Admitting or ordering provider

What services require prior-authorization?

•A complete listing is available by visiting www.emhsemployeehealthplan.org

How do I obtain prior-authorization?

- Use the provider web portal
- Complete the prior authorization form & fax form
- Phone medical management

REQUIRES PRIOR-AUTHORIZATION

The following require prior-authorization by the Health Plan:

Planned inpatient admission, including rehabilitation admissions

Skilled level of care admissions

Outpatient rehabilitative services (PT/OT/ST)

Home Health/Hospice Services by Home Health Provider

PRIOR-AUTHORIZATION REQUIREMENTS

Planned admission require prior-authorization no less than 2 business days prior to date of admission. No more than thirty (30) business days prior to the date of admission.

Observation Services expected to exceed 23 hours require the Participating Provider to initiate a request for prior-authorization

CLAIM SUBMISSION REQUIREMENTS

Claim Submission Time Limits

Time Limits

- Initial submission of any claim must be received by the Health Plan:
  - within **120** days from the date of service for outpatient claims; or
  - within **120** days from the date of discharge for inpatient claims.
- Any claim which the Health Plan has previously paid or denied may be resubmitted and must be received by the Health Plan for reconsideration:
  - within **60** days from the date indicated on the EOP from the Health Plan that the claim was paid or denied.

CLAIMS SUBMISSION REQUIREMENTS

All services rendered should be reported:

Using a UB04 or a CMS1500 claim form

Submission through electronic format

Include summarization by revenue code, which may include CPT-4® and/or HCPCS procedural codes with applicable modifiers

Include the then current ICD-10 diagnosis coding to the highest level of specificity, as applicable, for all services and procedures

Include NPI number in Box 33a of the CMS1500 Claim Form

BILLING INFORMATION MODIFIERS

59 Modifier – Distinct Procedural Service - used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

- Documentation must accompany the claim

BILLING INFORMATION MODIFIERS

25 modifier - used to report a significant, separately identifiable E & M service performed by the same provider on the same day of the procedure or other service.

Use 25 modifier when the E/M service is separate from that required for the procedure and is a clearly documented, distinct and significantly identifiable service was rendered.

Use 25 modifier on an E/M service on the same day as procedure, the E/M service must have the key elements (history, examination, medical decision making) well documented.

Documentation should accompany the claim.

BILLING INFORMATION MODIFIERS

50 modifier – bilateral procedures

Number of units = 1

Reimbursement calculated using 150% of the Health Plan payment schedule unless multiple surgery reduction applies

80, 81, or 82 modifiers – assistant surgeons

If such services are reported, the following information must be on the claim:

Name of supervising physician in field 31 of the CMS 1500 form.

Modifier AS must be submitted for these services.

Include 80, 81, 82 to represent a non-physician assistant at surgery.

CLAIM SUBMISSION REQUIREMENTS – OUTPATIENT REHABILITATION

Outpatient Rehab. Providers are required to utilize the applicable modifiers; GN, GO, GP, etc.

GP – services delivered under a physical therapy plan of care

GO – services delivered under an occupational therapy plan of care

GN – services delivered under a speech-language pathology plan of care

Physical medicine/rehabilitation encounter based CPT® codes (i.e. 92507, 97001, 97003) are designed to be reported with one (1) unit per date of service regardless of the length of visit/treatment time.

CLAIM SUBMISSION REQUIREMENTS – OUTPATIENT DIAGNOSTIC TESTING

When reporting outpatient diagnostic testing the ordering provider information must be completed in Box 17 on the CMS1500 Claim Form and/or Box 82 on the UB92 Claim Form.

The referring physician's name and NPI number must be included in Box 76 "attending phys.id" on the UB04 Claim Form

CLAIMS APPEAL

- Health Plan has 45 days to review and process appeals

- Please utilize the Provider Portal for appeal submission

ELECTRONIC CAPABILITIES

Take advantage of these electronic capabilities:

EDI – is the electronic claims transactions

EMHS Employee Health Plan Payor ID = 16565

Electronic funds transfer and electronic remittance advise

Register with InstaMed at www.instamed.com/eraeft or by completing the InstaMed Network Funding Agreement (available online).

To begin using these capabilities, please submit the appropriate on-line forms using the link on our website at: www.emhsemployeehealth.org

PROVIDER NETWORK MANAGEMENT

PROVIDER Customer Service

Customer Service is available to assist you with any of the following issues:

Policy questions

General questions

Demographic changes (i.e., change in office locations, addition and/or termination of a physician, change in Tax identification number) – go to website: www.emhsemployeehealthplan.org and use form provided

QUESTIONS?

Thank You!

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