Section 9
Claim Submission

Table of Contents—Claim Submission

Section 9

Claim Submission Process

After providing services to an eligible CDPHP member, the practitioner/provider's office is required to prepare and submit a claim form directly to the CDPHP claims department. All physician claims are to be submitted on either a CMS 1500 form or via a HIPAA compliant 837 transaction.

All paper claims must be submitted to: CDPHP, P.O. Box 66602, Albany, NY 12206-6602.

A single claim should be completed for each patient and submitted within the appropriate time frame. Also, please submit separate claim forms for each practitioner/provider, and for each set of services rendered. Please refer to page 9-5 for instructions on completion. All claims must contain the current required fields:

- (1a) CDPHP member ID # (including two-digit suffix number) as shown on patient's identification card
- (2) Patient's name: Last name, first name, middle initial
- (3) Date of birth and sex
- (4) Insured name: Last name, first name, middle initial
- (5) Patient's address
- (9) Other health insurance coverage (a – d)
- (10) Related conditions: Enter "X" in the appropriate box
- (17) Referring physician
- (17 A) Referring physician NPI #
- (21) Diagnosis: Enter current ICD-9 (or its successor ICD-10 effective October 1, 2015), diagnosis codes (up to 4)
- (24 A) Date(s) of service
- (24 B) Place of service: 11 – Physician Office, 21 – Inpatient Hospital, 22 – Outpatient, 12 – Patient's home , 32 – Nursing Home, 31 – Skilled Nursing Facility, 41 – Ambulance (land), 42 – Ambulance (air/water), 81 – Independent Lab, 24 – Ambulatory Surgical Center, 23 – Emergency Room, 12 – DME Supply Vendor, 99 – Other Location
- (24 D) CPT-4/HCPCS code(s), modifier if applicable
- (24 F) Itemized charges
- (24 G) Days or units
- (24 J) Rendering provider NPI #
- (25) Treating physician/provider tax ID #
- (28) Total charge
- (31) Signature of provider
- (32) Facility name and address
- (32 A) Facility NPI #
- (33) Billing provider name, address, and telephone number
- (33 A) Billing provider NPI #

- Ensure that claim print is dark enough with a font size of 10 or greater, for processing on CDPHP's image system.
- Check your CDPHP payment vouchers weekly to determine the claim status. When a claim appears, do not resubmit because this will cause duplication in the system.
- Requests for claims adjustments or review must be received by CDPHP within six months of the adjudication date.
- When submitting a procedure code ending in "99," please include medical records and a description of the services.
- Contact CDPHP's provider services department at (518) 641-3500 to obtain information regarding how your office can utilize HIPAA transactions to check claim status or member eligibility information.
- You can contact our provider services department for questions concerning your claim issues. To submit a claim appeal, fill out a *Provider Review Form* (one per claim), attach supporting documentation, and mail to:

  Provider Services Department, CDPHP, 6 Wellness Way, Latham, NY 12110

This information has been provided to you for informational purposes only. Coverage is always subject to the member's eligibility and specific contract benefits. For specific benefit coverage questions, please call our provider services department at (518) 641-3500 or 1-800-926-7526.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CDPHP®

P.O. Box 66602 • Albany, NY 12206-6602
(518) 641-3500 • 1-800-926-7526

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. ____ . ____ 3. ____ . ____ 2. ____ . ____ 4. ____ . ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.		33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.		

NUCC Instruction Manual available at: www.nucc.org ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CDPHP Health Insurance Claim Form

Instructions for Completion

Element **1a** **MEMBER IDENTIFICATION NUMBER:** Enter the nine-character ID number and the two-digit suffix as shown on the patient's member identification card.

Element **2** **PATIENT'S NAME:** Enter the patient's name as follows: last name, first name, middle initial.

Element **3** **DATE OF BIRTH:** Enter the patient's date of birth: month, day and year, in six-digit (MM/DD/YY) format. Please check appropriate box for male/female as well.

Element **4** **INSURED NAME:** Last name, first name, middle initial.

Element **5** **PATIENT'S ADDRESS:** Street address, city, state, zip code.

Element **9** **OTHER HEALTH INSURANCE COVERAGE:** This information is necessary to assist us in determining if the patient has any other health insurance coverage, including Medicare. In the event there is other coverage, the name of the policyholder (insured) should be identified, as well as the name of the insurance carrier and the policy number. If there is no other coverage, enter "none."

Element **10** **RELATED CONDITIONS:** Enter "X" in the appropriate box, if applicable, to determine who is liable for the claim.

Element **17** **AUTHORIZING PHYSICIAN:** If you are the member's primary care physician, indicate "none" or "no authorization" in this space. Specialists should enter the full name of the physician who authorized the patient for services.

Element **17a** **NPI:** Enter the NPI of the referring physician in this field. If no referring physician, leave this field empty.

Element **21** **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:** Indicate ICD-9 (or its successor ICD-10 effective October 1, 2015) codes describing the medical condition or conditions for which the patient is being treated. Relate diagnosis codes 1–4 to item 24E (diagnosis code) by line.

Element **24A** **DATE OF SERVICE:** Enter the month, day, and year of services rendered. Individual dates of service need to be entered for **each** service provided. If "from" and "to" dates are shown here for a series of identical services, the number of these services should appear in Column 24G. **NOTE:** Days should be consecutive. If they are not, a breakdown of each date is required. **IMPORTANT: Claims must be submitted within established filing limits from date of service or payment will be denied and the member *cannot* be billed for these services.**

Element **24B** **PLACE:** Enter the place of service utilizing the numeric codes listed below.

PLACE OF SERVICE DESCRIPTION	POS CODE
Urgent Care Facility	20
Inpatient Hospital	21
Outpatient Hospital	22
Physician Office	11
Patient's Home	12
Nursing Home	32
Skilled Nursing Facility	31
Ambulance—Land	41
Ambulance—Air/Water	42
Independent Lab	81
Ambulatory Surgical Center	24
Emergency Room	23
DME/Supply Vendor	12
Other Location	99

Element **24D** **CPT/HCPCS CODE:** List the current five-digit CPT-4 procedure code or five-digit HCPCS code for the procedures and services that were performed.

Element **24D** **MODIFIER:** When applicable, please indicate.

Element **24F** **CHARGES:** Specify the amount charged per service in dollars and cents. (Please identify the charge **before** applicable copayment or before primary insurance payment if applicable.)

Element **24G** **DAYS OR UNITS:** Enter the number of times a given service has been performed on the same date of service. Or if billing "from" and "to" in date of service, indicate number of consecutive days the service was performed.

Element **25** **TREATING PHYSICIAN/PROVIDER TAX ID NUMBER:** Enter the rendering provider's nine-digit federal tax identification number.

Element **26** **PATIENT'S ACCOUNT NUMBER:** Will appear on the reimbursement voucher if billed on the claim form.

Element **28** **TOTAL CHARGE:** Enter the total of all charges from element 24F for the entire claim.

Element **31** **SIGNATURE OF PROVIDER OR SUPPLIER:** Claim forms must be legibly signed and dated by the rendering provider or supplier. A designated representative may sign the form on behalf of the provider or supplier if initialed accordingly.

Element **32** **FACILITY NAME AND ADDRESS:** If services are rendered in a hospital, clinic, laboratory, or any facility other than patient's home or the physician's office, enter facility's name and address.

Element **33** **PROVIDER/GROUP IDENTIFICATION NUMBER:** Enter the appropriate NPI number that has been individually assigned to you by CMS.

PHYSICIAN'S NAME, ADDRESS and TELEPHONE NUMBER: Element 33 is structured so that it may be completed by hand, typewritten, or rubber stamped. It should include the rendering provider's full name and address including zip code.

Helpful Hints for Claims Submissions

When billing CDPHP, follow these helpful hints to increase your turnaround time:

- Confirm eligibility and ID number of the patient. Be sure to include the suffix on the ID number.
- Complete all required sections of the CMS 1500 claim form.
- Report valid ICD-9 diagnosis codes (or its successor ICD-10 codes effective October 1, 2015) on all claims.
- Indicate the valid and appropriate CPT-4 code and/or HCPCS code.
- Always bill CDPHP within the appropriate time frame.
- If more than one form is needed for a claim, please staple the claim forms together, and indicate total charges on first page.
- Do not use unlisted procedure codes without providing medical records or a comprehensive report detailing the item for which you are billing.
- When billing for an injection, you must indicate the medication that was being injected. If billing via 837, place info in "LIN" segment, not NTE segment.
- Make sure you indicate your NPI indicating office location when applicable on each claim form in the designated field.
- You must include the patient's full nine-digit identification number and the two-digit suffix.
- Include office records for members younger than 40 years of age when an EKG is done in the absence of symptomatic complaints.
- Please send medical records for a member seen twice on same date of service.
- Please send medical records for any CPT-4 or ICD-9 codes (or its successor ICD-10 codes effective October 1, 2015) that are potentially cosmetic in nature.
- Please send medical records for ligation/stripping varicose veins.
- Do not submit superbills.
- Ensure that claim print is dark enough with a font size of 10 or greater, for CDPHP's image system.
- Ensure that all claim information is lined up in the appropriate assigned fields, as instructed in this section.
- Be sure to review all CDPHP resource coordination policies that are provided to you. The most up-to-date policies can be accessed through the secure area of www.cdphp.com.

Coding of Claims

CDPHP requires all practitioners/providers submitting paper claims for medical services and procedures to bill CDPHP on a standard CMS 1500 form, or if appropriate, the UB-04 form.

CDPHP accepts only valid, standard CPT® and HCPCS procedure codes. These are a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians, and/or specialty practitioners/providers. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and an effective means for reliable nationwide communication among physicians, facilities, patients, and third parties. All services and procedures rendered should be adequately documented in the medical records.

As with procedural codes, CDPHP only accepts valid ICD-10 diagnosis and procedure codes.

In order to ensure claims are coded accurately and correctly, please follow proper coding guidelines as set forth by the following standard code sets:

Current Procedural Terminology (CPT4)
Healthcare Common Procedure Coding System (HCPCS)
International Classification of Diseases ICD-10

Billing the correct revenue code that reflects the actual site of service is important for facilities, and should match the place of service billed on the corresponding practitioner claim. For example:

- Minor surgical procedures not performed in the operating room or ambulatory surgery unit should be billed with the appropriate revenue code, indicating where the services were rendered (i.e., treatment room, ED, radiology, or other revenue codes, not revenue codes 0361 or 0490).
- Urgent care services, regardless of diagnosis codes, should be billed with revenue code 0456 in order for correct copayments to be applied, not ED revenue code 0450.
- Insertion of catheters (i.e. CPT 58340) performed in the ultrasound or radiology suite should be billed with revenue code 0402 or 0320, not an operating room or ambulatory surgery unit revenue code.

Modifiers

A modifier allows the reporting physician to report important specific circumstances related to a performed procedure. Please refer to your current AMA manual, *Current Procedural Terminology*, for appropriate use of these modifiers. Please bill with most current, valid modifiers. When submitting a claim with a modifier that describes a procedure that has been altered by a specific circumstance please include medical records.

Fraud

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty, the amount of which may vary by federal and state law, and the stated value of the claim for each such violation.

CDPHP has a fraud hotline and email address to report health care fraud and abuse. Practitioners, office staff, and others may reach us at 1-800-280-6885 or specialinvestigationsunit@cdphp.com. All communications will be kept strictly confidential as well as anonymous. There is also a training program under "Fight Fraud" on www.cdphp.com. Please view it to gain a general understanding of fraud, waste, and abuse.

e-Options at CDPHP

CDPHP has made a commitment to the provider community to make available EDI (electronic data interchange) options for as many providers as is possible through electronic methods and technologies. Our goal is to allow access to pertinent member information through the Internet while maintaining Health Insurance Portability and Accountability Act (HIPAA) regulatory privacy and security guidelines.

Internet Communications

Secured Online Access

CDPHP offers a secure communications link for its providers/practitioners through the secure area of www.cdphp.com. This application allows 24-hour access to a host of CDPHP member and claim information, thereby allowing the practitioner opportunities to streamline and execute routine administrative tasks, increase productivity, and facilitate cost-effective procedures.

Users will find information regarding:

- Member eligibility
- Benefit/copayment data

- Claim status
- Prior authorization history
- Online version of *Provider Office Administrative Manual*
- Physician newsletters
- Pharmacy/Rx information
- Most up-to-date provider network information
- Out-of-pocket expense accumulator for High Deductible PPO members.
- Resource coordination policies
- Prior authorization guideline

There is a search function, allowing you to control much of the information you view. You simply need to define the information you want to view, how you want to see it, how you want it sorted (i.e., claim number, member name, service dates, etc.) and with a few clicks of the mouse, your query is complete.

CDPHP uses the industry standard 128-bit encryption to secure user access and information through the use of a Global Server ID. This means that you won't need to invest in software upgrades or any additional hardware. CDPHP automatically authenticates and secures 128-bit connections, as well as password protection. All member records are protected.

User access and participation will require registration and a signed confidentiality agreement by each user. To arrange for access, download and print security forms from www.cdphp.com. Fax inquiries to (518) 641-4305. You may also call (518) 641-4EDI or e-mail E_Transaction_Help@cdphp.com.

A self-guided tutorial of the secure site is also available on www.cdphp.com.

CDPHP.com

The CDPHP website also offers 24-hour access to a dedicated provider resource area containing administrative and technical materials.

No log-in is required to view:

- CDPHP, CDPHN, and CDPHP UBI product overviews
- Member identification card samples
- Up-to-date provider network information via Find-A-Doc
- Tip sheets specifically designed for primary care, OB/GYN, and specialist physician offices
- Pharmacy information on Providers tab (click on Formulary)
- Access to a variety of administrative forms, including adjunct and licensed practitioner credentialing applications
- Interactive web features providing health news and consumer information

837 Claim Files

CDPHP continues to accept paper claims as well as electronic claims (837 claim files).

CDPHP can accept claims directly from the provider or with the assistance of a third party clearinghouse. File submission formats include file transfer protocol (FTP) and Internet submissions. Claims received by 2 p.m. will be acknowledged and any rejected claims are returned to the submitter before the close of business the day of processing. This is facilitated via FTP or Internet depending on the original submission vehicle. It is important to review the reject reports, make the necessary corrections, and resubmit the corrected claims within the required filing limits.

CDPHP also works with a variety of practice management systems which help facilitate the formatting of files as well as auto-mating office processes.

Benefits of 837 Claims Submissions

- Electronic claims are entered into the claims processing system almost two days sooner than paper claims, and due to the nature of electronic submissions being "cleaner," there are fewer problems processing these claims than there are processing a paper claim.
- Claims received by 2 p.m. Monday through Friday are processed and loaded into CDPHP's claims processing system by the end of business that day.
- Claims submitted electronically on a Friday will enter that week's submissions and will be processed that week. Paper claims received on a Friday will not be entered into the CDPHP claim processing system until Monday and will not be processed until the following weekend. 837 Claims submissions allow for quicker turn-around of your claims.

- There are no claim volume requirements to submit electronically.
- There are no restrictions on time or frequency of submitting 837 claims. There are no pre-scheduled times to submits to the submitter can change the submitting schedule according to business needs.

General Information Regarding 837 Claims Submissions

- A single claim cannot contain more than 97 service lines.
- A rejected claim is a claim that cannot be loaded into our processing system for the indicated reason on the reject report. Rejected claims must be corrected and can be resubmitted electronically in their entirety as long as they are within the timely filing requirements.
- If you are experiencing technical difficulties getting your claims through the clearinghouse, contact them before resubmitting your claim. This will avoid duplicate claims being received and processed.

If you are interested in exploring your e-claims options, please contact the CDPHP provider services department at (518) 641-3500 or the EDI department by e-mail at E_Transaction_Help@cdphp.com.

Benefits of 835/Health Care Claim Payment/Advice:

- Available on Tuesday by 12 p.m. EST; currently your paper voucher arrives between Wednesday and Friday.
- Files can be automatically processed through your billing source or practice management system (will require new process development).
- Eliminates the need to manually review a paper document to reconcile your accounts receivable information.

General information about 835/Health Care Claim Payment/Advice:

- Same information as on your paper voucher. The 835 will utilize the HIPAA-compliant codes.
- 835 reports back claims in a paid or denied status only (no pends).
- Upon selecting the 835 file, the paper EOP is discontinued. It is important to share this information throughout your organization, particularly to those areas that rely on this information.

270/271 Real Time Eligibility Inquiry/Response

CDPHP is now providing real-time inquiries on member eligibility and benefits utilizing the HIPAA standard 270/271.

The 270/271 is available via our vendors' web products or via a real-time integrated process by which the 270/271 is sent to and received from the vendors via the Internet.

Benefits of the 270/271 Eligibility Inquiry/Response:

- Available 24 hours a day, seven days a week, 365 days a year.
- Provides eligibility and benefits information at the point-of-service.
- Allows for the upfront collection of appropriate copayments.
- Provides information regarding benefit limits/maximums and up-to-date utilization (e.g., therapy visits, deductible dollars, etc.).

General information about 270/271 Eligibility Inquiry/Response:

- Questions regarding your options for utilizing the 270/271 transactions should be directed to the provider services department.

National Provider Identifier

National Provider Identifier (NPI) is a unique number that will be used to identify providers across the United States. NPI numbers can be obtained for individual practitioners, practice sites, group practices, and facilities. Centers for Medicare and Medicaid (CMS) has been designated to act as the NPI enumerator for all providers and organizations across the United States. Providers must apply to CMS to be issued an NPI number. CDPHP encourages the use of NPI at all levels, including the identification of the practice site.

For Medicaid-Select Plan and Medicaid-HARP, providers must comply, as applicable, with the requirements of the billing manual(s) and other procedural guidance published by New York State for certain mental health, substance use disorder services, health home and behavioral health home and community based services. More information is available at: https://www.omh.ny.gov/omhweb/bho/billing-services.html.

Health Insurance Portability and Accountability Act (HIPAA)

In part, HIPAA establishes standards for electronic transactions, codes sets, various national identifiers, security and privacy for the health care industry.

A goal of HIPAA's Administrative Simplification regulations is to facilitate the standardization of health care transactions through EDI (electronic data interchange) by using standards developed in part by the American National Standards Institute (ANSI) and the National Council for Prescription Drug Programs (NCPDP). For example, "home-grown" or local codes were replaced by October 16, 2003. CDPHP replaced its "home-grown" codes and instructed all network and business partners to use standard codes. Any use of "home grown" codes will cause the specific service to be denied.

In addition to standardizing codes and formats, HIPAA will require that steps be put in place to secure and protect the exchange of electronic health information.

For information regarding HIPAA regulations, refer to www.hhs.gov.

Standard Transactions

Following are some of the standard required transaction sets that will be utilized for the appropriate electronic transactions:

1. **837: Health care claim or encounter—**Required information needed to be transmitted will depend on the 837 transaction companion document published by the Plan.
2. **835: Claim payment and remittance advice—**The 835 transaction will be sent to the practitioner or submitting facility or clearinghouse provided the electronic transaction can be accepted from the payer.
3. **276/277: Health care claim status**—Electronic claims tracking could replace e-mail or telephone status inquiries. The uniformity of this transaction greatly improves follow-up routines.
4. **270/271**: **Eligibility for a health plan**—Eligibility transactions will work much like today's functions, except that they will be electronic instead of the current telephone, fax and mail.
5. **278: Referral certification and authorization—**Will handle prior authorizations and specialty referrals.
6. **834: Enrollment and dis-enrollment in a health plan—**Utilized by employer groups to transmit their employee and dependent information to appropriate payers.
7. **820: Premium payments—**Utilized by employer groups to transmit premium payments to payers.

Example of HIPAA regulated transaction:
Once a provider has captured all the data needed to complete an eligibility check, the computer system would automatically query the appropriate plan/CDPHP for eligibility information. The plan/CDPHP would have eligibility information on file and return the eligibility information to the provider, who could then proceed with the administration of care to the member/patient.

6 Wellness Way • Latham, NY 12110

TIP SHEET FOR ELECTRONIC CLAIM SUBMISSION

Electronic Data Interchange Access Information

(518) 641-4EDI (4334) . . . . . E_Transaction_Help@cdphp.com

Here are some guidelines to follow whether you are contemplating electronic claim submission or you are a current EDI submitter.

History of EDI

Although the business computer enabled companies to store and process data electronically, companies needed an expedient method to communicate the data. This method was realized by the widespread use of computer telecommunications. Using telecommunications, companies could transmit data electronically over telephone lines, and have the data input directly into a trading partner's business application. These electronic interchanges improved response time, reduced paperwork, and eliminated the potential for transcription errors.

Claim Submission Vehicles

Direct Submission:

- 837 claim files can be submitted via file transfer protocol (FTP) and the Internet.
- 837 claim files received by 2 p.m. Monday through Friday are acknowledged and any rejected claims are returned to the submitter before the close of business the day of processing. This is either facilitated via FTP or internet depending on the original submission vehicle.
- EDI analysts will review rejected claims and work with you if your rejected claim percentages are higher than 10 percent. CDPHP reserves the right to reject entire claim files if the reject percentage repeatedly exceeds 10 percent where there is no indication errors are being addressed. HIPAA requirements are mandated, all non-compliant HIPAA transactions will be rejected.

Third Party Submission:

- 837 claim files also are submitted through the assistance of a third party generally referred to as a clearinghouse.
- 837 claim files can also be submitted via third parties acting as billing services for provider(s).
- Acknowledgements and any rejected claims are returned to the third party by the same day the file processed.
- Review the reject reports, make necessary corrections, and resubmit corrected claims within the required filing limits.

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General Information:

- Claims received by 2 p.m. Monday through Friday are processed and loaded into CDPHP's claim processing system by the end of each business day.
- There are no claim volume requirements to submit electronically regardless of the vehicle of submission.
- Claims submission frequency is based on individual business needs. There are no restrictions on time or frequency. There are no pre-scheduled times, so the submitter can change needs depending on business variations. Multiple same-day submissions also can be accepted.
- A single claim cannot contain more than 97 service lines.
- A rejected claim is a claim that cannot be loaded into our processing system for the indicated reason provided on the reject report. Rejected claims must be corrected and can be resubmitted electronically in their entirety as long as they are within the timely filing requirements.
- Secondary (COB) claims can be submitted electronically.

When to Call:

- If you are experiencing technical difficulties getting your claims to a third party vendor, contact them before re-sending your claim file repeatedly. This will avoid duplicate claims being received and processed.
- If you are missing claims, first verify that all reports have been retrieved in conjunction with CDPHP or your third party vendor's procedures. If a problem still exists, EDI analysts can assist in researching claim receipt at CDPHP.