

# Billing Procedures

## Send Claims To:

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**MercyCare Insurance Company  
P.O. Box 2770  
Janesville, WI 53547-2770  
(800) 895-2421**

## Customer Service (800) 895-2421

### Claim Filing Procedures

All claims for **professional** charges should be itemized and submitted on HCFA 1500 forms with appropriate codes approved by MCIC (CPT-4 and ICD-9) for procedure and diagnosis showing Provider's regular billed charges and not the fee schedule amount for services rendered to Members.

Claims for **facility** charges should be itemized and submitted on UB92 forms with appropriate codes approved by MCIC (Revenue and ICD-9) for procedure and diagnosis showing Provider's regular billed charges and not the fee schedule amount for services rendered to Members.

Claims must be submitted on original HCFA or UB-92 claim forms. Claims that have been copied will not be accepted with the exception of claims submitted where MCIC is the secondary carrier and the EOB from the primary carrier is attached.

Claims that have been altered in any way such as whited out lines, hand written information, blacked out lines, etc., will not be accepted.

### Coding Requirements

Proper claim coding is important. Claims will be returned to the provider if forms and coding are incomplete and/or incorrect.

### Time Limit for Filing Claims

Primary claims must be filed within 90 days of the date of service. MCIC unaltered secondary claims must be filed within 90 days of primary carrier

determination. Secondary claims must be accompanied by supporting documentation of primary carrier determination in the form of an explanation of payment or formal letter of denial from the previously billed carrier.

### **HCFA 1500 Required Fields**

Claims must have complete information in all required fields. Claims submitted without this information may be returned to the provider.

**Bolded text indicates Required fields.**

<b>HCFA 1500 FIELD</b>	<b><u>DESCRIPTION</u></b>
<b>1A.</b>	<b>Patient's I.D. Number - to include correct 2 digit suffix</b>
<b>2.</b>	<b>Patient's Name</b>
<b>3.</b>	<b>Patient's Birth date/Sex</b>
4.	Insured's Name
5.	Patient's Address
<b>6.</b>	<b>Patient's Relationship to Insured</b>
7.	Insured's Address
8.	Patient Status
10.	<b>Is patient's Condition Related To:</b>
<b>11.</b>	<b>Patient's Policy Group Number</b>
<b>11D.</b>	<b>Is There Another Health Benefit Plan? (If yes, return to and complete items 9A - 9D and 11A - 11C)</b>
17.	Name of Referring Physician or Other Source
17A.	ID Number of Referring Physician (Referring physician's MCIC ID code, if known)
<b>21.</b>	<b>Diagnosis</b>
23.	Prior Authorization Number (When necessary)
<b>24A.</b>	<b>Date of Service, From/To</b>
<b>24B.</b>	<b>Place of Service</b>
<b>24D.</b>	<b>Procedure/Services/Supplies-CPT/Modifier</b>
<b>24E.</b>	<b>Diagnosis Code (Per CPT Line)</b>
<b>24F.</b>	<b>Charges</b>
<b>24G.</b>	<b>Days/Units</b>
<b>25.</b>	<b>Federal Tax ID Number and Suffix</b>
26.	Patient's Account Number
<b>28.</b>	<b>Total Charges</b>
<b>32.</b>	<b>Name and Address of Facility Where Services were Rendered</b>
<b>33.</b>	<b>Physician/Provider Billing Name, Address, Zip Code &amp; Phone number and MCIC Provider and Vendor Codes</b>

## **Claims Submission Requirements**

MCIC has developed claim submission rules. In addition to ensuring accurate claims transmission, claims submission rules will allow MCIC to provide timely, useful reports for each physician. As a result, the following claims submission requirements will be asked of **all MCIC providers**.

- 1) **Patient Member Number** -MCIC has found that there are many instances where the member number did not include the two-digit suffix, or the suffix belonged to the subscriber, not the patient. MCIC suggests that as patients come to the clinic for an appointment, the staff review the member's card and ensure the correct member number is keyed into the computer system. If providers submit claims under the wrong member number, claims will either be rejected or paid under the wrong member.
- 2) MCIC's provider code must be used for the **rendering physician**.
- 3) The referring physician's name should be indicated in the **referring physician** field when applicable.
- 4) A valid **procedure code** (and **modifier**, if applicable) must be used. If provider is submitting claims electronically, claims with a "22" modifier and unlisted procedure codes (XXX99) will reject. They must be submitted manually with the supporting information.
- 5) A valid ICD-9 **diagnosis code** must be used. Providers must indicate all diagnoses codes related to each line item in box 24e.
- 6) **Beneficiary's first and last name** must be specified.
- 7) **Sex code** must be "M" or "F".
- 8) **Beginning date of service** must be specified and must be a valid date.
- 9) If the **ending date of service** is specified, it must be a valid date. If not specified, the ending date of service will be the same as the beginning date of service.
- 10) A valid **place of service code** must be specified.
- 11) The **charge amount** must contain valid numeric data.
- 12) The **unit count** must contain valid numeric data.

## **Electronic Claims Submission Requirements**

In addition to the noted requirements, the following also applies when submitting claims electronically:

Claim types that cannot be submitted electronically include

- 1) Claims with incomplete information
- 2) Claims with MCIC as secondary (COB)
- 3) Claims for unusual services - 22 modifiers and unlisted codes (XXX99)

MercyCare Insurance Company has partnered with Netwerkes.com as our clearinghouse for electronic transactions to accept electronic billing. For more information, please access the following website – [www.netwerkes.com](http://www.netwerkes.com).

## **Provider ID Number**

Each physician providing services to MCIC members is assigned an individual provider code, which must be used on all claims submitted to MCIC.

When a new provider is added to your office, including physician assistants, resident physicians, etc., you must notify MCIC Provider Relations Representatives in order to initiate the credentialing process. New providers will not be assigned a MCIC provider code until they have been approved through our credentialing process.

MCIC Provider Relations will contact your office to confirm the new provider and inform you of the alpha or alpha/numeric provider code that must appear in box 33 of the HCFA 1500.

## **Place of Service Codes**

<b>Description</b>	<b>HCFA 1500</b>	<b>OBSOLETE CODES</b>
Office	11	O OR 3
Home	12	4 OR H
Inpatient Hospital	21	1 OR IH
Outpatient Hospital	22	2 OH
Emergency Room	23	E OR
Inpatient Psychiatric Facility	51	6
Day Care Facility (Psy)	52	5
Psychiatric Residential TX Center	56	C

Please use active valid codes on your claim forms.

## **Reimbursement**

Providers are reimbursed at least three times a month. An Explanation of Payment (EOP) will accompany each reimbursement check, indicating member name, member number, claim number, date of service, diagnosis code, amount billed, amount allowed, COB amount, non-covered amount, deductible amount, co-insurance amount, co-payment amount, discount amount, withhold amount, and amount paid to provider.

Provider may only bill members for any applicable deductible, co-insurance, co-payment and non covered amounts as indicated on the EOP.

## **Co-Insurance**

MCIC applies benefit plan specific co-insurance amounts on covered services to members. The co-insurance amount appears in the "Co-Ins" column of the Explanation of Payment (EOP), and providers are allowed to bill members directly. When a co-insurance is applied, the MCIC member receives an Explanation of Benefits (EOB) showing member liability amount.

## **Co-Payments**

MCIC applies benefit plan specific co-payment amounts when an MCIC member is charged for an office visit.

The rule of thumb is if a member sees a physician or physician extender, the member should pay their applicable co-payment at the time of the visit.

The co-payment amount appears on the member card, and MCIC recommends you collect co-payments at time of services.

The co-payment amount appears on the Explanation of Payment (EOP) in the "Copay" column. Providers are allowed to bill the member for any uncollected co-payments.

## **Deductibles**

Some MCIC benefit plans have deductibles. The claims should be filed in the usual manner, billing MCIC for the total amount.

During claims processing, the deductible will automatically be calculated and any applicable deductible will be charged on the EOP in the "Deduct" column. MCIC members are advised of their deductible liability on their EOB, providers are allowed to bill the member for any deductible amounts showing on their EOP.

## **Coordination of Benefits (COB)**

MCIC follows the birthday rule for determining coverage for dependents. As such, the dependent's primary carrier will be that of the parent/guardian whose birthday comes earliest in the year.

Coordination of Benefits (COB) is a procedure used when a member has coverage with two or more group health plans. It is intended to prevent duplication of benefits by determining primary coverage. All services provided to members enrolled in MCIC are subject to a Coordination of Benefit limitation. The Providers are encouraged to obtain "other insurance" information from the Member for COB and to indicate this information on referral forms and claims data submitted to MCIC.

## **COB with Medicare**

If a member presents with Medicare eligibility, please bill Medicare first. Medicare will then determine the order of payment.

## **COB with Other Insurance**

If MCIC receives a claim and is aware that another insurance is primary, both the member and the provider will receive an EOB/EOP from MCIC stating a copy of the Explanation of Benefit (EOB) is needed, if it was not already attached to the claim.

## **Request for Review of Claim Reimbursement or Resubmitted Claims**

These requests must be submitted in writing within 90 days of payment or denial. It is also acceptable to contact MCIC customer service by phone to request a review. When a diagnosis has been changed, or level of service increased, a copy of the office record must be attached to the resubmitted claim.

## **Refunds/Recoupment**

While MCIC has established quality standards for claims processing, occasionally overpayments, payments to the incorrect provider, or payments for an incorrect member are identified by the participating provider's office. In these instances the provider office should contact MCIC Customer Service Department.

Currently, the claims system will take a recoupment. A recoupment means the overpayment will be deducted from a future payment. Some providers

have found this method difficult to reconcile their records, however, it does eliminate the need to issue a refund check.

Usually this process works best for providers who have a high volume of MCIC claims. **This reversal is necessary to assure accuracy in the preparation of year end 1099 Income Forms.**

If you require a **refund**, please contact the MCIC Customer Service Department and your request will be reviewed.

**Please review your remit and each EOP you receive to verify whether any adjustments are due to recoupments taken or refund checks we have received from your office.**

### **Subrogation**

If a Member's illness/injury may be covered by a third party insurer (auto, homeowner, or liability), it is **required** for you to indicate on the claim form that the illness/injury is accident related and to include the name and address of the other insurance carrier on the claim by checking the correct box on the HCFA 1500 (box 10a, b or c.)

**MCIC will make payment on subrogated claims and will further investigate possible payment from other carriers. This in no way will affect your claims payment. MCIC pays and pursues these claims.**

### **Worker's Compensation**

The policy is not issued in lieu of nor does it affect any requirement for coverage by Workers' Compensation. If the member is eligible to receive Workers' Compensation for a bodily injury or sickness sustained in the course of any occupation or employment, that bodily injury or sickness is not covered under this policy. However, if MCIC covered such bodily injury or sickness, and MCIC determines that the member also received Workers' Compensation for the same incident, MCIC has the right to recover as described under the Right to Recovery provision of the Coordination of Benefits section of their certificate of coverage. The Plan will exercise the right to recover against the member.