BILLING AND CLAIMS

Instructions for Submitting Claims
The physician’s office should prepare and electronically submit a CMS–1500 claim form. Hospitals should prepare and electronically submit a UB04 claim form.

Electronic Claims Submission
Fidelis Care receives electronic claims submission. For a complete list of vendors, visit the Fidelis Care website at fideliscare.org. The unique payer ID for Fidelis Care is 11315 and is used for all submissions.

Direct Claims Submission

Providers can submit claims electronically for all lines of business directly. To submit directly to Fidelis Care, please complete the eCommerce Request Form.

Timely Filing
All claims must be submitted to Fidelis Care within the timeframes specified by your Fidelis Care provider contract. Claims for services provided to enrollees must be submitted within ninety (90) days. Acceptable reasons for a claim to be submitted late are: litigation, primary insurance processing delays, retro-active eligibility determination, and rejection of the original claim for reason(s) other than timely filing. Claims that are submitted must be accompanied by proof of prior billing to another insurance carrier or a letter that specifies an acceptable reason for the delay.

Fidelis Claims Editing Software

Fidelis Care uses TriZetto’s Claims Editing Software to automatically review and edit health care claims submitted by physicians and facilities.

Mailing Addresses for Paper Claims Submission:

<table>
<thead>
<tr>
<th>Essential Plans:</th>
<th>Metal-Level Products:</th>
</tr>
</thead>
<tbody>
<tr>
<td>UB-04 Institutional Claims</td>
<td>Fidelis Care</td>
</tr>
<tr>
<td></td>
<td>PO Box 806</td>
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<tr>
<td></td>
<td>Amherst NY 14226-0806</td>
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<tr>
<td></td>
<td>Fidelis Care</td>
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<td>Amherst NY 14226-0724</td>
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<tr>
<td>CMS-1500 Claims</td>
<td>Fidelis Care</td>
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<tr>
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<td>PO Box 898</td>
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<td></td>
<td>Amherst NY 14226-0898</td>
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<tr>
<td>All Coordination of Benefits Claims: CMS-1500 UB-04</td>
<td>All Claims Related to COB</td>
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<tr>
<td></td>
<td>Fidelis Care</td>
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<td>PO Box 905</td>
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<tr>
<td></td>
<td>Amherst NY 14226-0905</td>
</tr>
</tbody>
</table>
Claim Forms

Physician Services
Claims can be submitted electronically; please refer to section 12.1. Providers must submit claims and encounter information for services within ninety (90) calendar days of the date of service using the CMS-1500 claim.

Hospital Providers
Claims can be submitted electronically, refer to section 12.1. Claims for hospital services must be submitted on a UB04 claim form within ninety (90) calendar days of the date of service or the date of discharge.

Ancillary Providers
Claims can be submitted electronically; please refer to section 12.1. Providers must submit claims for home healthcare services, durable medical equipment (DME), respiratory care, physical, occupational and speech therapies on a CMS-1500 or UB04 claim form within ninety (90) calendar days of the date of service.

- For the following services, please attach the appropriate documentation to the claims:
  - Hysterectomies - Claims should include a copy of the consent form.
  - Any services defined as “By Report” must be submitted with an invoice to assist with adjudication and payment.
  - Supplies, drugs, and DME – Claims must include an unaltered manufacturer’s invoice* for HCPC codes that require a report.

*Claims Requiring Manufacturer’s Invoice
Claims that require a manufacturer’s invoice for payment consideration (e.g. “By Report” (BR) procedure) must be submitted with all of the following required information in order to be validated as an acceptable invoice:

- Manufacturer’s Name
- Provider Name
- Item with Description
- Acquisition Cost on the invoice
- Invoice Date

Some examples of unacceptable invoices are: altered manufacturer’s invoice, purchase orders, sales orders, order confirmations packing slips and delivery receipts.

Note, any claim received by Fidelis Care that requires an invoice and is missing an invoice, missing a required element (noted above), or is submitted with an unacceptable invoice, will be
Claims Procedures
Claims are processed Mondays through Fridays and clean claims are scheduled to be paid in accordance with New York State Insurance Law §3224-a. A "Clean Claim" is a claim for healthcare services that contains all the data elements required by Fidelis Care to process and adjudicate the claim including, but not limited to, all the data elements contained on Form 1500 published by CMS.

Please follow the guidelines below in completing and submitting claim forms for services rendered:

- Always include the National Provider Identifier and Tax Identification number on each claim.
- Complete a single claim form for each patient encounter.
- Submit a separate claim form for each Provider and for each site where services were rendered.

Provide all the information requested, including:
- Member name
- Date of birth
- Fidelis Care member ID number
- Accident or injury related indicator
- Authorization number on form
- All valid Diagnosis Codes by number (ICD-10)
- Present on Admission (POA)
- Date(s) of service
- Place of service
- Quantity/Units
- Valid Procedure Code (CPT 4 and HCPC)
- Charges
- Treating physician's name, address, telephone number
- National Provider Identifier (NPI)
- Taxonomy Codes
- COB information
- Federal Tax Identification Number (TIN)

Please note the following applicable place of service codes:

05 Indian Health Svc Free-standing Facility
06 Indian Health Svc Provider-based Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
11 Office Services
12 Home Services
15 Mobile Unit
20 Urgent Care
21 Inpatient Hospital
22 Outpatient Hospital
### Section Twelve

<table>
<thead>
<tr>
<th>Metal-Level Products and Essential Plans Provider Manual V17.0-8/18/17</th>
<th>Billing and Claims</th>
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<td>24 Ambulatory Surgical Center</td>
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<td>26 Military Treatment Ctr.</td>
<td>31 Skilled Nursing Facility (SNF)</td>
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<td>33 Custodial Care</td>
<td>34 Hospice</td>
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<td>42 Ambulance (Air or Water)</td>
<td>51 Inpatient Psych Facility</td>
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<td>53 CMHC Facility</td>
<td>54 Intermediate Care Facility</td>
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<td>56 Psych Res Trtmt Ctr</td>
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<td>81 Independent Lab</td>
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</tr>
<tr>
<td>49 Independent Clinic</td>
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</tbody>
</table>

### National Correct Coding Initiative Edits

The Center for Medicare & Medicaid Service (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate claim payment. These policies are based on coding conventions defined in the American Medical Association's (AMA) CPT Manual, National and Local Coverage Determinations (NCD and LCD), coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. These standards set the coding requirements that all plans and providers must follow in order to secure reimbursement for all lines of business. Claims that are found to be noncompliant with these guidelines may be returned and/or denied.

Please visit the sites below for additional information:

- AMA - [http://www.ama-assn.org/ama](http://www.ama-assn.org/ama)

### Claim Processing During Member Grace Period

**Metal-Level Products**

a) Government Subsidized Plans
Members receiving an Advance Premium Tax Credit (APTC) are entitled to a ninety (90) day grace period before coverage is terminated for premium delinquency. During the first thirty (30) days following nonpayment, claims for services will be processed and paid in accordance with this section. Claims for services rendered during the subsequent sixty (60) days will be pended by Fidelis Care; however members will continue to be responsible for copays, coinsurance, and deductibles. Pended claims will be processed if delinquent payments are received prior to the end of the grace period. If a member fails to pay their premium within ninety (90) days their policy will be cancelled and pended claims will be denied. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

Providers will be notified in writing if claims are pended for premium nonpayment. Additionally providers will be notified when eligibility is verified online or by calling Provider Services.

b) Nonsubsidized Plans
Members who do not qualify for an APTC, are entitled to a thirty (30) day grace period before coverage is terminated for premium delinquency. During the first thirty (30) days following nonpayment, claims for services will be pended by Fidelis Care; however members will continue to be responsible for copays, coinsurance, deductibles, etc. Pended claims will be processed if delinquent payments are received prior to the end of the grace period. If a member fails to pay their premium within thirty (30) days their policy will be cancelled and pended claims will be denied. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

Essential Plans

Members who fail to pay their premiums are given a 30-day grace period to pay their outstanding balance. During this time members are considered eligible for services and Fidelis Care will continue to pay claims for dates of service within the grace period. If the member fails to pay the amount owed by the end of the grace period, their coverage will terminate. Providers may seek payment from members for claims denied due to coverage termination for nonpayment.

Coordination of Benefits (COB)

If a Fidelis Care member has more than one health plan, Fidelis Care will coordinate the benefits with the other carrier(s) to ensure that Fidelis Care's liability does not exceed more than 100% of Fidelis Care's allowable expenses. This effort involves coordinating coverage and benefits for illnesses, injuries, and accidents covered by:

- Personal Automobile coverage
- Workers' Compensation
- Veteran's Administration
- No Fault
- Other Health Insurance Plans

Payments Involving COB
In the event a claim is initially filed with Fidelis Care for which another carrier is determined to be the primary payer, the provider will be notified on a remittance advice to file with the primary insurer.
All participating providers agree to provide Fidelis Care with the necessary information for the collection and coordination of benefits when a member has other coverage. The provider will be required to do the following:

- Determine if there is duplicate coverage for the service provided;
- Recover the value of services rendered to the extent such services are provided by any other payor; and
- File the claim with Fidelis Care along with the primary carrier's Explanation of Benefits (EOB) attached for reconsideration within ninety (90) calendar days of receiving the primary carrier’s explanation of benefits.

Fidelis Care will coordinate benefits up to Fidelis Care's allowable as secondary payer. Fidelis Care is not responsible for payment of benefits determined to be the responsibility of another primary insurer.

**Mailing Address for all Claims Related to Coordination of Benefits Submission:**

<table>
<thead>
<tr>
<th>UB-04 or CMS-1500</th>
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<tbody>
<tr>
<td>Coordination of Benefits</td>
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<tr>
<td>Fidelis Care</td>
</tr>
<tr>
<td>PO Box 905</td>
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<tr>
<td>Amherst NY 14226-0905</td>
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</tbody>
</table>

**Billing requirements for Assistant Surgeon & Surgical Assist Claims**

Participating surgeons may utilize the services of an assistant surgeon when the complexity of the surgical procedure deems it appropriate. Assistant surgeon is only permitted when the service is recognized as allowing an assist. When multiple complex surgeries are being performed, the surgeon can be the primary surgeon on some of the surgeries and the assist on others. These services can be billed on the same claim.

- A surgeon may not assist on his/her own surgery.

**Assistant Surgeon performed by a physician:**

- Modifier 80, 81 or 82 should be used.
- The assistant surgeon should be billed on a separate CMS-1500 claim form.
- When multiple complex surgeries are being performed, the assistant surgeon can be the assistant surgeon on some of the surgeries and the primary surgeon on others. These services can be billed on the same claim (they will be identified as different CPT codes).
- These modifiers must be billed by a physician. They cannot be billed by physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist.

**Surgical assist performed by a PA, NP or other qualified health professionals:**

- Must be billed by the physician. Claims submitted by the PA, NP, or clinical nurse specialist will be denied.
- Modifier AS should be used.
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Billing and Claims

- Only one (1) claim line should be billed with the surgical CPT code and AS modifier.
- Medicare Only – The AS modifier should be billed by PA, NP or other Qualified Health professionals for Medicare Claims using their own NPI.

Payments and Reimbursements

Fidelis Care reimburses providers for services that are billed correctly to Fidelis Care on a weekly basis. Clean claims are paid within the guidelines stipulated by Section 3224-a of the New York State Insurance Law.

Payments to Specialty Providers

Each specialist provider will receive a check reflecting payment for covered services provided to eligible members and correctly billed to Fidelis Care. The check may be made payable to the individual provider or to a designated medical or professional group. Multiple Specialty Providers should submit taxonomy code when submitting claim forms.

NOTE:

Any changes in a provider's status, address, corporate name, or other changes should be reported to Fidelis Care immediately to ensure prompt and accurate reimbursement.

Remittance Advice

Electronic Remittance Advice and 835 are available. For providers who have a user ID/password on the Secure File Delivery system, a Remittance Advice should be obtained by going to fideliscare.org. Click on the Quick Navigation Link and search for Provider Access Online or go to the site's Provider section and locate the link for Provider Access Online. Providers may also connect directly to https://secure.fideliscare.org/files/logon.aspx. For providers who have not established a user id/password, please contact your local provider relations representative for assistance.

The Remittance Advice identifies which members and services are covered by a particular check. Claims are listed in alphabetical order according to the member’s last name. Each item in the listing includes the following:

- Fidelis Care claim number as assigned by Fidelis Care
- Member's name
- Member's Fidelis Care ID number
- Provider's name
- Date of service
- Procedure code
- Patient account number
- Denied amount
- Allowed amount
- Member deductible, copay and coinsurance amounts if applicable

The Remittance Advice should be examined to reconcile payments from Fidelis Care with accounts receivable records.
Electronic Fund Transfer (EFT)
Providers can request to receive payments electronically if they've met the following criteria:

- Participating provider
- Submitting claims electronically for at least two months
- Receiving remittances and/or rosters electronically
- Agrees to receive all payments in an EFT format; claims, capitation and QCMI (if applicable)
- Agrees to receive other communication electronically

Suggestions to Expedite Claims

- Have correct and complete information on the claim form.
- Verify member eligibility
- Do not submit duplicate claims. Initiate an inquiry if payment is not received within forty-five (45) days after billing date.
- Provide Coordination of Benefits information before claim is filed.
- Include your NPI and TIN on all claims submitted.
- Electronic submission is the best way to expedite claims (refer to section 12.1 in this manual). However, if you must submit paper claims, please mail claims routinely. By mailing claims routinely throughout the month, you will assure faster turnaround and avoid an end of the month backlog.
- Include the Authorization Number on the claim and/or attach authorization claims form.

Fidelis Care Claim Inquiry

To status claims submitted over thirty-five (35) days please go to fideliscare.org to access Provider Access Online. You can also contact the Provider Call Center at 1-888-FIDELIS (1-888-343-3547) Monday through Friday, 8:30AM to 5:00PM.

Stop payment and reissue of checks

To request a stop payment and reissue of a check, the request must be sent in writing to the following address:

Attn: Finance Department
Fidelis Care
95-25 Queens Blvd
Rego Park, NY 11374

The written request must have the following information:

- A completed and notarized affidavit (affidavit form, refer to Section 12B of this manual)
- The contact person and phone number
- Verification of the correct remittance address for the check
- Who the check was made payable to, if known

Please note that if the check has been cashed, an additional Affidavit form will need to be obtained, signed, and notarized.

Corrected Claim

Corrected claims must be submitted within sixty (60) days of the remittance advice for that claim.

A Corrected Claim is a claim that has any changes made to an original claim previously submitted that include but not limited to a change of the following:

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- Date of Service
- Place of Service
- Procedure Codes - including adding or removing modifiers
- Diagnosis Billed
- Units per service
- Dollar amounts
- Provider status changed
- Provider specialty change
- Provider tax id# change

Electronic Submission of Corrected Claims
When submitting a Corrected Claim electronically, the original claim number must be submitted and the claim frequency type code must be a 7 (replacement of prior claim) or 8 (void if original payment). Please go to Fidelis Care’s website for additional information.

Overpayments/Underpayments
If your claim is overpaid/underpaid, please request an adjustment by submitting an Administrative Review Form (Section 12A) and a copy of the payment voucher that indicates the payment. If Fidelis Care agrees with your request for adjustment due to an overpayment, the overpayment will be withdrawn from a future payment. Do not return the check containing the overpayment.

If Fidelis Care identifies that an overpayment has been made to a provider, Fidelis Care shall provide a thirty (30) calendar days written notice to physicians (unless otherwise noted) before engaging in additional overpayment recovery efforts. Such notice will state the member name, service date, payment amount, proposed adjustment, and a reasonable specific explanation of the proposed adjustment.

If a provider disagrees with the payment determination, please attach documentation supporting additional payment along with an Administrative Review form (Section 12A) and submit your request within sixty (60) days of the remittance advice.

No payment
If a provider disagrees with the no payment determination, please attach documentation supporting payment along with an Administrative Review form (Section 12A).

Coding
Billing with the appropriate procedure and diagnosis codes aids in accurate and timely payment reimbursement.

Quick Guide to Claims Processing

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>PROFESSIONAL AND FACILITY SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do I direct billing questions?</td>
<td>1-888-FIDELIS</td>
</tr>
<tr>
<td></td>
<td>Provider Services Department</td>
</tr>
<tr>
<td>Where do I submit claims?</td>
<td>Refer to the Fidelis Care website at fideliscare.org for information about submitting claims electronically</td>
</tr>
</tbody>
</table>
### Section Twelve

#### Billing and Claims

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| Which forms may be used for billing?                                    | Professional - CMS 1500  
                         Facility - UB04                                                      |
| Which patient identifier(s) should be used?                             | Fidelis Care Identification Number                                      |
| What is the time frame for submitting the claim?                        | Ninety (90) days                                                        |
| How do I check on the status of a claim?                                | To status claims please go fideliscare.org to access our secure Provider Portal |
| What is the time frame for payment of a completed and clean claim?      | Thirty (30) days after receipt of a clean claim submitted electronically  
                         Forty-five (45) days after receipt of a clean claim submitted via paper  
                         (In accordance with NY Insurance Law Section 3224-a)                |
| What is the appeal process if you believe a claim has been underpaid or wish to appeal a denied claim? | Please refer to Section 13, PROVIDER APPEALS                           |