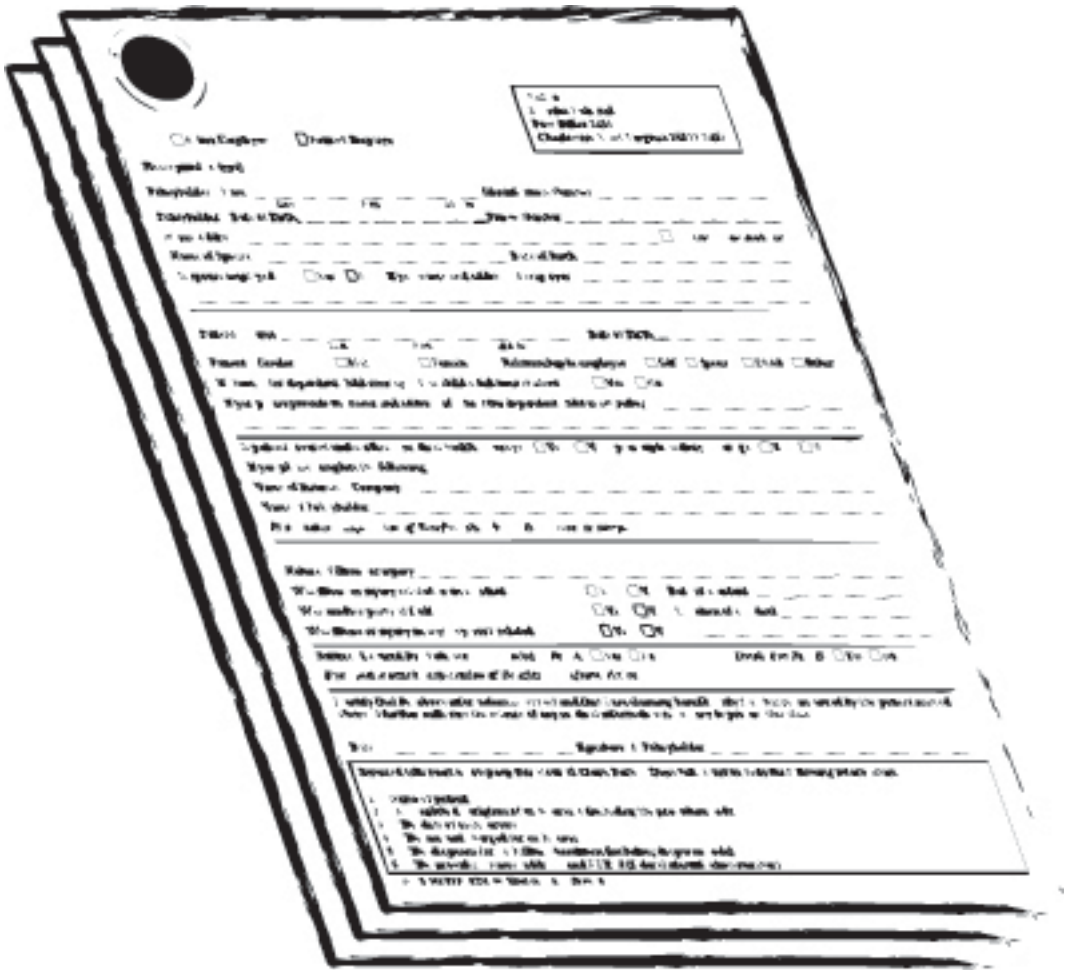
Section VI
Claims and Claims Disputes



Keystone First Claims Filing Instructions

The Keystone First Claims Filing Instructions can be found in the Appendix of the Manual or accessed online in the Provider Center at www.keystonefirstpa.com

The Claims Filing Instructions contains current information and is periodically updated as needed. If you prefer a hard copy of the Claims Filing Instructions, please contact your Provider Account Executive or call 1- 800-521-6007.

National Provider Identification Number

The National Provider Identifier (NPI) is a Federally-issued10-digit unique standard identification number that all Health Care Providers must use when submitting electronic claims.

Electronic claims submitted without an NPI will be rejected back to the provider via their EDI clearinghouse. Network Providers who submit claims via paper CMS 1500 or UB-04 are also required to include their NPI on their claims.

Keystone First strongly encourages Network Providers to continue to submit claims with their Keystone First provider ID, in addition to the required NPI number.

How to Apply for Your NPI
Health Care Providers may apply for their NPI in one of the following ways:

- Complete the web-based application at https://nppes.cms.hhs.gov. This process takes approximately 20 minutes to complete
- Call the Enumerator call center at 1-800-465-3203 or TTY 1-800-692-2326 to request a paper application
- E-mail customerservice@npienumerator.com to request a paper application
- Request a paper application by mail:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

NOTE: The most time-efficient method of getting an NPI is the web-based application process.

To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of providers (Code of Federal Regulations: 42CFR, §455.410), Providers participating with Keystone First must participate in the Pennsylvania Medical Assistance Program.

All providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

Important note: This applies to non-participating out-of-state providers as well.

This means all providers must enroll and meet applicable Medical Assistance provider requirements of DHS and receive a Pennsylvania Promise ID (PPID). The enrollment requirements for facilities, physicians and practitioners include registering every service location with DHS and having a different service location extension for each location.

DHS has expressed its intent to terminate Medical Assistance enrollment of all non-compliant providers. Keystone First will comply with DHS's expectation that non-compliant providers will also be terminated from our network, since medical assistance enrollment is a requirement for participation with Keystone First.

Enroll by visiting: http://provider.enrollment.dpw.state.pa.us/

The Department of Human Services (DHS) also requires that Providers obtain an NPI and share it with them. Further information on DHS's requirements can be found at www.DHS.state.pa.us.

Prospective Claims Editing Policy

Keystone First's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include, but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Claim Filing Deadlines

Original Claims

Original Claims must be submitted to Keystone First within 180 calendar days from the date services were rendered or date compensable items were provided.

Re-submission of Rejected Claims

Re-submission of **rejected Claims must occur within 180 calendar days** from the date of service or date compensable items were provided.

Re-submission of Denied Claims

Re-submission of previously Denied Claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date of service or date compensable items were provided. For more information on billing requirements, please see the Claims Filing Instructions in the Provider Center at www.keystonefirstpa.com.

Submission of Claims Involving Third Party Liability

If a Member has other insurance coverage in addition to Keystone First coverage, the other insurance carrier (the "Primary Insurer") must consider the Health Care Provider's charges before the Claim is submitted to Keystone First. Therefore, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill Keystone First for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. **Claims with EOBs from Primary Insurers must be submitted within 60 days of the date of the Primary Insurer's EOB.**

Please note – If a claim is paid and it is later discovered there was other insurance, Keystone First will recover all reimbursement paid to the Provider.

Failure to Comply with Claim Filing Deadlines

Keystone First will not grant exceptions to the Claim filing timeframes outlined in this section. Failure to comply with these timeframes will result in the denial of all Claims filed after the filing deadline. Late Claims paid in error shall not serve as a waiver of Keystone First's right to deny any future Claims that are filed after the deadlines or as a waiver of Keystone First's right to retract payments for any Claims paid in error.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than Keystone First. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as Keystone First, are always the **payer of last resort.** This means that all other insurance carriers (the "Primary Insurers") must consider the Health Care Provider's charges before a Claim is submitted to Keystone First. Therefore, before billing Keystone First when there is a Primary Insurer, Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill Keystone First for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the section above.

Reimbursement for Members with Third Party Resources

Medicare as a Third Party Resource

For Medicare services that are covered by Keystone First, Keystone First will pay, up to the Keystone First contracted rate, the lesser of:

- The difference between the Keystone First contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by Medicare and Keystone First will not exceed the Keystone First contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, Keystone First will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate.

For Medicare physical health services that are not covered by either Keystone First or the MA Fee-For-Service Program, Keystone First will pay cost-sharing amounts to the extent that the combined payment made under Medicare for the service and the payment made by Keystone First do not exceed 80% of the Medicare approved amount.

Keystone First's referral and authorization requirements are applicable if the services are covered by Medicare and the Member's Medicare benefits have been exhausted.

Commercial Third Party Resources

For services that have been rendered by a Network Provider, Keystone First will pay, up to the Keystone First contracted rate, the lesser of:

- The difference between the Keystone First contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by the Primary Insurer and Keystone First will not exceed Keystone First's contracted rate.

If the services are provided by a Non-Participating Provider or if no contracted rate exists, Keystone First will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance Fee-For-Service rate.

Health Care Providers must comply with all applicable Keystone First referral and authorization requirements.

Capitated Primary Care Practitioners (PCPs)

When services are rendered by a participating PCP or other capitated Network Provider, Keystone First considers the coinsurance, deductible and/or co-payment to be a component of the Network Provider's Capitation payment and does not make a separate payment in addition to the Capitation.

Fraud & Abuse

Under the HealthChoices program, Keystone First receives state and federal funding for payment of services provided to our Members. In accepting Claims payment from Keystone First, Health Care Providers are receiving state and federal program funds, and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to www.pacode.com/secure/data/055/partIIItoc.html for more information regarding Fraud or abuse, including "Provider Prohibited Acts" that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

Keystone First is dedicated to eradicating Fraud and Abuse from its programs and cooperates in Fraud and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Unit of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the HHS Office of Inspector General, as well as the Bureau of Program Integrity of DHS. As part of Keystone First's responsibilities, the Payment Integrity department is responsible for identifying and recovering claims overpayments. The department performs several operational activities to detect and prevent fraudulent and/or abusive activities.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered
- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement

Claims Overpayments or Errors

The Payment Integrity department is responsible for identifying and recovering claim overpayments. The department performs several operational activities to ensure the accuracy of providers' billing submissions.

The Payment Integrity department utilizes internal resources and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, providers may receive letters from

Keystone First, or on behalf of Keystone First, regarding recovery of potential overpayments and/or requesting medical records for review. Any questions should be referred to the contact information provided in the letter to expedite a response to questions or concerns.

The Claims Cost Containment Unit is responsible for the manual review of overpaid claims submitted by the Payment Integrity department for potential recovery. Claims submitted to the Claims Cost Containment Unit for review are outside of the Subrogation and Check Reconciliation areas. Some examples of identified "waste" include:

- Incorrect billing from providers causing overpayment
- Overpayment due to incorrect set-up or update of contract/fee schedules in the system
- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments
- Overpayments resulting from incorrect revenue/ procedure codes, retro TPL/Eligibility

The Claims Cost Containment Unit is also responsible for the manual review of provider initiated overpayments. Providers who self-identify claim overpayments may submit their inquires for review to the following address:

Claims Cost Containment
PO Box 7120
London, Kentucky 40742

Refunds for Claims Overpayments or Errors

Keystone First and DHS encourage Providers to conduct regular self-audits to ensure accurate payment. Medicaid Program funds that were improperly paid or overpaid must be returned. If the Provider's practice determines that it has received overpayments or improper payments, the Provider is required to make arrangements immediately to return the funds to Keystone First or follow the DHS protocol for returning improper payments or overpayments

1. Contact Keystone First Provider Claim Services at 1-800-521-6007 to arrange the repayment. There are two ways to return overpayments to Keystone First:
   - Have Keystone First deduct the overpayment/improper payment amount from future claims payments, or
   - Return the overpayments directly to Keystone First:
     - Use the Provider Claim Refund form when submitting return payments to Keystone First. A sample form can be found in the Appendix of the manual and is available on the Provider Center at www.keystonefirstpa.com under Forms.
     - Mail the completed form and refund check for the overpayment/improper payment amount to:

   Claims Processing Department
   Keystone First

PO Box 7115
London, KY 40742

Note: Please include the Member's name and ID, date of service, and Claim ID

2. Providers may follow the "*Pennsylvania Medical Assistance (MA) Provider Self-audit Protocol"* to return improper payments or overpayments. Access the DHS voluntary protocol process via the following web address:

   http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/

False Claims Act

The False Claims Act (FCA) is a federal law that prohibits knowingly presenting (or causing to be presented) a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved. When Keystone First submits claims data to the government for payment (for example, submitting Medicaid claims data to the Pennsylvania Department of Human Services), we must certify that the data is accurate to the best of our knowledge. We are also responsible for claims data submitted on our behalf from our subcontractors, and we monitor their work to ensure compliance.

Health care entities that violate the Federal FCA can be subject to imprisonment and civil monetary penalties ranging from $10,781 to $21,563 for each false claim submitted to the United States government or its contactors, including state Medicaid agencies, as well as possible exclusion from Federal Government health care programs. These minimum and maximum penalties have been updated to reflect the Civil Monetary Penalties Inflation Adjustment Interim Final Rule by the Department of Justice published on June 30, 2016, with an effective date of August 1, 2016.

The Federal FCA contains a "qui tam" or whistleblower provision to encourage individuals to report misconduct involving false claims. The qui tam provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The FCA protects individuals who report under the qui tam provisions from retaliation that results from filing an action under the Act, investigating a false claim, or providing testimony for or assistance in a Federal FCA action.

The Fraud Enforcement and Recovery Act of 2009 (FERA) was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the False Claims Act (FCA). Penalties for violations of FERA are comparable to penalties for violation of the FCA. FERA does the following:
• Expands potential liability under the FCA for government contractors like Keystone First
• Expands the definition of false/fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like Keystone First

• Expands the definition of false record to include any record that is material to a false/fraudulent claim
• Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations

Reporting and Preventing Fraud, Waste and Abuse (FWA)

If you, or any entity with which you contract to provide health care services on behalf of Keystone First beneficiaries, become concerned about or identifies potential fraud, waste or abuse, please contact Keystone First by:

- Calling the toll-free Fraud Waste and Abuse Hotline at 1-866-833-9718;
- E-mailing to FraudTip@keystonefirstpa.com; or,
- Mailing a written statement to Special Investigations Unit, Keystone First, 200 Stevens Drive, Philadelphia, PA, 19113.

Below are examples of information that will assist Keystone First with an investigation:

- Contact Information (e.g. name of individual making the allegation, address, telephone number);
- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected fraud, waste, and abuse to:
Keystone First's Fraud and Abuse Hotline by:

Phone:
1-866-833-9718

Mail:
Corporate and Financial Investigations
Keystone First
200 Stevens Drive
Philadelphia, PA 19113

OR

Contact The Pennsylvania Department of Human Services through one of the following methods:

Phone:	866-DHS-TIPS (866-379-8477)
On-line:	www.dhs.pa.gov/learnaboutdhs/fraudandabuse/
E-mail:	omaptips@state.pa.us
Fax:	1-717-772-4655, Attn: MA Provider Compliance Hotline
Mail:	Bureau of Program Integrity MA Provider Compliance Hotline P.O. Box 2675

Harrisburg, PA 17105-2675

Claim Disputes and Appeals

Keystone First's goal is to assure smooth transactions and interactions with our Provider Network community. There are some common reasons for rejection or denial of Claims and simple methods to correct them without initiating a Claims Dispute, which is described in more detail at the end of this Section. See the definitions below and instructions on the simplest method to correct/re-submit the Claim.

Common Reasons for Claim Rejections & Denials

Rejected Claims

Rejected Claims are defined as Claims with invalid or missing data elements. Rejected Claims are returned to the Health Care Provider or EDI source without registration in the Claim processing system. Since rejected Claims are not registered in the Claim processing system, the Health Care Provider must re-submit corrected Claims within 180 calendar days from the date of service or date compensable items provided. This requirement applies to Claims submitted on paper or electronically. Rejected Claims are different than Denied Claims, which are registered in the Claim processing system but do not meet requirements for payment under Plan guidelines. Resubmit rejected Claims following the same process you use for original Claims - within 180 days of date of service or date compensable items provided.

Claims Denied for Missing Information

Claims that pass the initial pre-processing edits and are accepted for adjudication but DENIED because required information for payment under Plan guidelines is missing must be resubmitted for correction. These are Claims that can be resubmitted and re-adjudicated once missing information is supplied. Health Care Providers have 365 calendar days from the date of service or date compensable items were provided to re-submit a corrected Claim.

Claims denied for missing information can be re-submitted to the following address. Please clearly indicate "Corrected Claims" on the Claim form:

Corrected Claims/Adjusted Claims
Keystone First
P.O. Box 7115
London, KY 40742

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and can often be corrected over the phone. Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the Network Provider has an authorization number. **If a Network Provider has Claims needing adjustment and there is a manageable volume of Claims (five or less), the Network**

Provider can call Keystone First's Provider Claim Services Unit (PCSU) at 1-800-521-6007 to report payment discrepancies. Representatives are available to review Claim information and make on-line adjustments to incorrectly processed Claims.

Emergency Department Payment Level Reconsideration For Participating Providers

In certain cases, it is not necessary for a hospital Provider to appeal a Claim decision when they are not in agreement with Keystone First's level of payment for Emergency Room services. If a Claim has been reimbursed at the lower degree of acuity rate, and the original Claim submission did not include medical records or the Emergency Room summary, the hospital Provider may resubmit the Claim along with medical records (or Emergency Room Summary) for payment level reconsideration. Keystone First's clinical staff will review the medical records and render a decision based on the nature of treatment rendered to treat presenting symptoms. These Claims should be submitted to the Claims Medical Review Department at the following address:

Claims Medical Review Department
Keystone First
P.O. Box 7180
London, KY 40742

Hospital Providers will be notified via the remittance advice of any decisions to pay at the higher degree of acuity rate. If review of the medical records does not indicate services should be paid at the higher degree of acuity rate, a letter will be sent to the hospital Provider upholding the original Claim determination. If the hospital Provider disagrees with this determination, the hospital Provider may file a Formal Provider Appeal for further reconsideration of the level of payment. For information on how to file, please refer to Formal Provider Appeal procedures outlined in Section VII.

Payment Limitations

No payment will be made for Emergency Room services if:

- The Member is not eligible for benefits on the date of service
- The Member is admitted to an SPU, Observation or Inpatient setting within 24 hours of the Emergency Room stay. In such cases, Emergency Room charges should be reported on the SPU, Observation or Inpatient bill. See the Emergency Admissions, Surgical Procedures and Observations Stays topic in Section II for notification requirements
- The service was provided outside of the United States or its territories.

If your Claim issues are not resolved following the steps outlined above, the following procedures may be followed.

Claims Disputes

Claims Disputes include Claim denials, payments the Network Provider feels were made in error by Keystone First, or involve a larger volume of Claims than cannot easily be handled by phone. Network Providers must submit these Claims Disputes to Keystone First within 365 days from the date of service, or the date compensable items were provided, with a written explanation of the error to:

Keystone First
Claims Disputes
P.O. Box 7115
London, KY 40742

For accurate and timely resolution of issues, Network Providers should include the following information:

- Provider Name
- Provider Number
- Tax ID Number
- Number of Claims involved
- Claim numbers, as well as a sample of the Claim(s)
- A description of the denial issue

If numerous Claims are impacted by the same issue, Keystone First has developed a spreadsheet format for submission of larger Claims projects. The spreadsheet and accompanying claims should be sent to the Providers assigned Account Executive. If several Claims have been denied for the same reason, these may all be included in a single letter/E-mail with an attached list of Claims or spreadsheet. **An electronic version of the spreadsheet is highly preferred. Do not combine multiple denials for different reasons in the same letter/spreadsheet**.

The spreadsheet format can be found in the appendix or online in the Provider Center at www.keystonefirstpa.com.
All disputed Claims will be acknowledged, researched and the decision conveyed to the Network Provider within 60 days following procedures as outlined in Section VII. If the Network Provider disagrees with Keystone First's Dispute decision, the Network Provider may file a Formal Provider Appeal.

Repeated re-submission of a Claim does not preserve the right to Appeal if the 365 day timeframe is exceeded.