Attention: Billing Staff

August 6, 2021 **Bulletin 8.3, PCPs & Capped SPCs, Claim & Encounter Reminder**

Claim and Encounter Timely Submission

Prospect Medical has enhanced our processes for claim and encounter review for continued compliance with billing and payment guidelines. As part of our normal audit process, we may review prior claim and encounter submissions for quality and compliance purposes.

It is important that your office billing practices remain current with billing guidelines and requirements. **Please remind your billing staff to obtain Remittance Advice and/or 835 reports from Office Ally for electronic submitters or to check mail routinely. Capitation Summary Reports are available through the provider portal Aerial Care for current 3 months.** *Requests for report copies outside of Office Ally and Aerial Care may result in approximately 2 week or longer turnaround time from date of request.*

Billing and Coding Resources:
https://www.cms.gov/Medicare/Medicare.html
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
https://www.ama-assn.org/practice-management/cpt/finding-coding-resources

Electronic Submission:	Clearinghouse:	**Office Ally**
	Payor ID:	**PROSP**
	Website:	www.officeally.com
	Support:	**(866) 575-4120**
Submission via US mail:	Mailing Address:	**Prospect Medical Systems, Inc.** **P.O. Box 11466** **Santa Ana, CA 92711-1466**

- **Do NOT send claims for the following:**
  - Health Net Community Care – **bill directly to Health Net**
  - LA Care Medi-Cal – **bill directly to MedPoint**
- Electronic claims/encounters only accepted from ***Office Ally***.
- Must be submitted via a completed CMS 1500 Form or electronic equivalent.

Claim/Encounter Status

To determine if you claim/encounter has been received by Prospect and to check status of a claim/encounter, please log into the provider portal Aerial Care and search for the claim under the Claim Status feature.

Rejected claims should be reviewed frequently via the **Claim Fix** tool in ***Office Ally***. Correct your rejection reports sent via e-mail from Office Ally and resubmit in a timely manner. **Contact Office Ally at (866) 575-4120 if you need assistance.**

This publication is not intended to replace any contents in the Provider Manual or conflict with any requirements outlined in your signed agreement with Prospect Medical. If you have any questions or suggestions for our upcoming **PROVIDER** *focus*, please feel free to contact the Network Management Department at (800) 708-3230, prompt 1 then 7 or email to providerinfo@prospectmedical.com. This bulletin and previous versions of **PROVIDER** *focus* are also available at www.prospectmedical.com.

Common error reasons include:

- Not billing per CMS and NCCI Guidelines
- Invalid type/missing value on diagnosis or procedure code, use of ICD-9 Codes instead of ICD-10 codes
- Provider missing information/invalid information
- Rendering Physician NPI (Box 24J) is Required
- Invalid Billing Provider NPI Format (Box 33A)
- Patient not found
- Patient not covered

Corrected claims that are re-submitted because Prospect has contested the original claim for additional information (e.g. medical records, correct modifier, invalid ICD-10 code) **must be submitted to Prospect within 45 business days from date of determination** to be eligible for reconsideration. Corrected claims or claims submitted with additional information will be denied for untimely filing if received more than 45 business days after original claim's denial has been generated.

- **Corrected Claim: Box 22** should only be using a **7** if you are sending in a **corrected claim;** where the new claim is completely different from the original claim (DOS, CPT/HCPC codes/DX code, etc.).
- If the claim is exactly the same, then there should not be a value in box 22. Entering a value incorrectly in box 22 will result in incorrect edits within our system.
- **Replace Billing Code**: Complete box 22 (**Resubmission Code**) to include a **7** (the **"Replace" billing code**) to notify us of a **corrected or replacement claim**
- **Void Billing Code**: Complete Box 22 to include an **8** (the "**Void" billing code**) to let us know you are voiding a previously submitted **claim**. Enter the Blue Cross NC 'original' **claim** number as the Original Ref. Please see sample claim on next page.

Timelines for Submissions

Submit all claims and encounter data as soon as possible and per contractual requirements to facilitate performance metrics information.

- **Claims** must be submitted:
  - Contracted Providers: **within 90-days** from the date of service
  - Non-Contracted Providers: **within 180-days** from the date of service

- **Encounter Data** must be submitted **within 30-days** from the date of service