

Biller's Webinar Q&A

January 22, 2009

Q: Does the original Remittance Advice need to be attached to a corrected claim, even if the original claim number is being included in box 22 of the 1500? Furthermore, if the units are being altered, does modifier 59 need to be included on the corrected claim?

A: Yes, the KHS Remittance Advice should be submitted with the correct red 1500 claim form with the appropriate units (not additional) that was intended to be billed, so that a recoupment can be completed on the original, and the new claim can be entered and adjudicated. A claim that has more services in the same day (such as a patient being seen twice in one day) should be submitted as a new claim with modifier 59 to distinguish a separately identifiable service. If you are only billing more units, modifier 59 is *not* appropriate. Please reference the services listing within the Provider Notice 1.8, December 2007 for appropriate modifier 59 billing combinations.

Q: When will we be able to adjust our own claims? When will Phase III of Online Adjustments be available?

A: Other changes are being implemented into eCura to prepare it to handle Phase III. We are expecting Phase III to be implemented in the March-April timeframe.

Q: When sending COB claims, does KHS look at the primary EOB for the paid date in order to override timely filing?

A: See page 76 of the Biller's Manual...yes, if the notification date from the primary insurance is within 90 days, we will override timely filing.

Q: If KHS denies no EOB, can a claim be resubmitted *without* declaring "Corrected Claim" at the top of the 1500 form?

A: Yes, if the claim was fully denied. "Corrected claim" is used for claims that have had some payment made.

Q: Is there an estimated delivery date for COB to be acceptable through Provider Connect?

A: This is part of Phase III.

Q: What updates are being added to the eCura system tomorrow night, January 23, 2009?

A: A summary of the changes can be found on the Provider Connect Welcome Page.

Q: What is the status of the diagnosis pointer issue in 837 submissions? Will the claims that need re-adjudicated be done automatically, or will providers need to take action for resubmission?

A: This issue involves the editing of 837 claims within Provider Connect, which will be corrected soon. Any 'edited' claims through Provider Connect that denied in error will be re-adjudicated by KHS.

Q: What progress has been made in regards to the Crisis codes being denied for no authorization inappropriately?

A: For crisis code units exceeded denials, our investigations have found that the system handled the claims appropriately.

Q: Will KHS be able to accept/consider for payment the V diagnosis groupings for Initial Intake interviews?

A: This is currently a system limitation where only V71.09 is a covered diagnosis. We recommend that billers submit the claims for denial to avoid timely filing issues, in case this process is altered in the future. Steve Richards is discussing this issue with SRS.

Reminder...if a claim has COB involved, please do not edit on Provider Connect, due to the COB module not working at this time.