Care1st Health Plan Arizona – Nov 2020

News you can use!

Billers' Corner

Provider Tips

Top 5 Denial Reasons and Reminders to Reduce Denials:

1. **Primary Insurance on file-Bill Primary Insurance:**
   - Verify coverage at each appointment
   - Use AHCCCS online to verify other coverage
2. **Duplicate Billing:**
   - Use the Care1st Web portal to confirm claim status at any time
   - Allow 45-60 days from the initial claim submission prior to resubmitting
   - Contact Claims Customer Service to assist with questions prior to submitting duplicates
3. **Patient Not Eligible on Date of Service:**
   - Confirm eligibility on AHCCCS online or Care1st Member Services prior to claims submission
4. **Provider Not Contracted – Auth Required:**
   - Refer all laboratory services to Sonora Quest (our exclusive lab)
   - Refer to the Prior Authorization Guidelines on the website
5. **Exceeds Timely Filing Guidelines:**
   - Initial claim submission must be received no later than 6 months from the date of service, or eligibility posting date, whichever is greater
     - Care1st secondary claims must be received within 6 months from the date of service/eligibility posting date, or within 60 days of the primary carrier's processing date as indicated on the EOB, whichever is greater
   - Resubmissions must be received within 12 months of the date of service, or eligibility posting date, whichever is greater

Care1st Health Plan Arizona
1870 W Rio Salado Parkway
Tempe, AZ 85281
Phone: 602.778.1800
Toll Free: (866).560.4042

Modifier Usage and Record Requirements

Our goal is to assist you in getting your claims paid on your initial submission. When applicable, the appropriate modifiers must be billed for claims payment. Records are required for some modifiers to override encounter edits at AHCCCS. Appropriate application of modifiers, with records submission when required, can mean the difference between a timely claim payment or a denial for invalid billing or records requested.

Below are a few common modifier reminders to assist you:

- **Modifier 50 - Bilateral Service:** Bilateral services are services performed during the same operative session by the same physician in either separate operative area (arms, legs, feet, etc.) or in the same operative area (nose, eyes, breast, etc.). Instead of billing LT and RT modifier to indicate performance on both side of the body, codes eligible for bilateral billing require the service to be billed on one line with a quantity of 1 and modifier 50 to ensure proper payment calculation.
  - Exceptions include codes that already specify bilateral or unilateral in the description or codes that are designated as not eligible for bilateral billing
- When billing a bilateral service, remember to include anatomical secondary modifiers as needed to help identify the specific location (fingers, toes, eyelids, etc.) where services were performed.

- **Modifier 59, XE, XS, or XU**
  - Modifier 59 indicates that a second billing of the CPT code is distinct from the initial service. Modifiers XE, XS, or XU provider greater detail to indicate the service is distinct:
    - XE - occurring during a separate encounter
    - XS - performed on a separate organ or site
    - XU - performed as a unique service that does not overlap usual components of the primary service
  - Modifier 59, XE, XS, or XU cannot be billed on the same service line as another modifier in this category.

- **Record Requirements or Other Modifier Billing**
  - Records are not required for modifier 50
  - Records may be required for modifier 59, XE, XS or XU.
    - Refer to the ***Care1st Provider Manual; Section XI, Billing, Claims, and Encounters –Modifiers*** for examples of codes or situations where records are required, or for modifiers not listed here.

As always, please reach out to Network Management or the Operations Account Representatives at the telephone number listed to the left if you have questions or concerns.