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Billing procedures

Introduction

The Fallon Health Provider Manual billing section provides you with an overview of our billing requirements. This manual refers to commonly used codes supplied by the American Medical Association's Manual of current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS). Fallon Health is a customer driven organization that is dedicated to the prompt and accurate claims payment of our providers' claim submissions in accordance with regulatory and contractual requirements.

Fallon Health's commitment to quality:

Claims Department Quality Monitoring

Fallon Health is committed to giving our customers quality service. To ensure claims processing quality, our Claim Department monitors claims every month, verifying the accuracy of claims entry and adjudication. The data from this monitoring is used for additional training and for updating our procedures.

Claims Payment Integrity

To keep pace with ever changing medical technology and coding complexities, Fallon Health has enhanced its claim checking capabilities. Fallon Health payment integrity program exists to evaluate billing and coding accuracy on submitted claims. Fallon Health payment integrity program is guided by the coding criteria and protocols established by various sources including the Centers for Medicare and Medicaid Services (CMS), the CPT Manual published by the American Medical Association (AMA) and special society guidelines. Fallon Health continually evaluates, edits, and modifies the Payment Integrity program to accommodate Fallon Health payment methodology. Fallon Health performs routine upgrades to payment integrity software.

Billing procedures

Claims guidelines

Submitting a Claim:

Claims should be submitted with the Provider's National Provider Identifier (NPI) and Tax ID to Fallon Health in one of the following formats:

- Electronic file
- CMS 1500 claim form
- UB 04 claim form

Electronic claims have two methods offered for submission.

Direct submission to Fallon
Clearinghouse submission

Visit our website for additional information on these methods, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996: https://fallonhealth.org/en/providers/provider-tools/electronic-data-submission#direct

Paper claims should be submitted by mail to:
Fallon Health
Claims Department
PO Box 211308
Egan, MN 55121-2908

When shipping paper claims that are not deliverable to a P.O. Box, (via FedEx etc.), please send to the following address:
Fallon Health Claims- Smart Data Solutions
960 Blue Gentian Road
Eagan, MN 55121

Forms and Billing Guidelines
For the most up to date information on forms and use guidelines, visit CMS.gov: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans, with links to the following:

- CMS 1500 Professional Paper Claim Form and Instruction manual: National Uniform Claim Committee (NUCC), nucc.org
- UB-04/CMS 1450 Institutional paper claim form and Data Specifications Manual: National Uniform Billing Committee (NUBC), nubc.org

Helpful Billing Tips to ensure your paper claims submissions are processed expeditiously and efficiently:

- Please ensure your form meets NUCC/CMS guidelines
- Use black font and avoid light print to avoid data capture errors
- Do not submit handwritten claims

Billing procedures

- Font guidance
  - Use a 10-point font
  - Do not mix fonts or use italics, percentage signs, question marks, slashes, dashes, decimal points, dollar signs, or parentheses
  - Use UPPERCASE letters for alphabetical entries

- UB04 specific guidance
  - A claim must not exceed 450 lines
  - Total the claims on the last page only

Claims addresses for our vendor partners:

American Specialty Health (ASH)
Claims Administration
American Specialty Health
PO Box 509001
San Diego, CA 92150-9001

Care Centrix
PO Box 30722-3722
Tampa, FL 33630
For more information: https://fallonhealth.org/en/providers/criteria-policies-guidelines/sleep-studies

Carelon (formerly Beacon Health Options)
Fallon Health Plan Claims Department
P.O. Box 1866
Hicksville, NY 11802-1866
For more information: https://fallonhealth.org/en/providers/contact-us

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906
For more information: https://www.dentaquest.com/en/providers/massachusetts

EyeMed Vision Care
First American Administrators, Attn: Claims
PO Box 8504
Mason, OH 45040-7111

Zelis (appeals only)
Zelis Claims Integrity, Inc.
2 Crossroads Drive
Bedminster, NJ 07921
Attn: Appeals Department

Billing procedures

Balance Billing:

Balance billing Fallon Health members (other than deductibles, copayments or coinsurance) is not allowed for covered services. ACO and Navicare members do not have cost share and should never be billed for covered services.

Covering Providers:

When submitting claims to Fallon Health as a covering provider, the provider must identify him/herself as a covering physician on the CMS 1500 form. There are two options to submit these claims:

- Append Modifier Q5 to the E&M claim line will indicate the rendering is working in a covering capacity for the PCP. This can be done on paper or with electronic claim submissions.
- A paper claim can be submitted with "covering physician" indicated at the top and the name of the physician you are providing coverage for should be typed or written in box 17.

Reciprocal Billing/Locum Tenens Arrangements

- The reciprocal provider and locum tenens are responsible for adhering to the same Fallon Health's policies and procedures as the absentee physician. The absentee physician may submit the claim and receive payment for part B covered arrangements services under Locum Tenens and/or reciprocal billing arrangements.
- Services of a substituting physician are identified by entering modifier Q5 or Q6 in item 24d of the CMS 1500 claim form. The NPI number of the substituting physician must be reported on the claim submitted by the billing "absentee" physician in item 23 on the CMS 1500 claim form.
- The billing "absentee" physician's NPI number must be reported in item 33 on the CMS 1500 claim form for a solo practice and item 24j on the CMS 1500 claim form for group practice arrangements.

Filing Limits:

Contracted provider claims must be received within 120 days from the date of service. Non-Contracted providers must be received within one year from the date of service.

If…	**You should…**
You initially understood Fallon Health to be the secondary insurer, but Fallon Health is the primary insurer	Submit a paper claim to Fallon Health along with the other insurer's Explanation of Benefits (EOB). You must submit within 120 days of the date on the other insurers' EOB.

Billing procedures

The claim is related to a motor vehicle accident	Submit claims to Fallon Health after the Personal Injury Protection (PIP) is denied and submit a copy of the PIP letter.
The claim is related to Workers' Compensation-	Submit claims to Fallon Health with a copy of the workers' illness/injury compensation insurers' denial.

Note: Fallon Health members cannot be billed for claims denied due to late submissions. See the Adjustments and Appeals section for more information on appealing filing limits.

See Coordination of Benefits (COB) section for more information on COB.

Late Charges and Replacement Claims:

Late Charges will be accepted electronically for claims billed on a UB04 form type. The claim must be submitted with a frequency code of 5 (bill type ends in a 5).

Only submit charges not included on the original institutional/facility claim. Corrected claim lines must be submitted in accordance with adjustment guidelines; see Adjustment and Appeal section.

Replacement Claims are the preferred method to submit corrections, including late charges. A replacement claim will void/retract the original claim and replace those charges. All charges for the encounter should be submitted on the replacement claim, including the accurate original charges that do not require modification, corrected claim lines and additional charges. Standard filing limits apply.
Replacement claims will be accepted electronically for both institutional and professional charges.
Claims must be submitted with a frequency code of 7 to indicate a replacement. Claims billed on a UB04 form type may also be submitted on paper using a bill type that ends in a 7; a request for claim review form is not required.
Requests for claim review due to payment, authorization, filing limit, or other claim processing issues must be submitted in accordance with the Adjustment and Appeal guidelines; see Adjustment and Appeal guidelines.

Referrals and Prior Authorizations:

Primary care referrals:
A recommendation by which a Primary Care Provider (PCP) sends a member to another provider for services that are typically outside the PCP's scope of practice.

PCP referral process for Fallon Medicare Plus, NaviCare and Medicaid ACO members:

Referrals for specialty care are required for Fallon Medicare Plus (Central), Navicare and Mass Health ACO members.
Refer to the PCP referral and plan prior authorization process section of the provider manual.

Billing procedures

To ensure reimbursement to specialists and facilities:

- The specialist must verify the referral number through ProAuth prior to seeing the member. To sign up for Proauth https://www.fchp.org/Providertools/ProAuthRegistration/ProAuthRegContacts/Create
- There is no need to bill the approved referral number on the claim as Fallon will have this on file

If a specialist decides that a member needs a service that he/she cannot provide, the specialist must consult with the member's PCP, who will initiate a new referral to the appropriate specialist.

Please note that all services with non-contracted providers or facilities require a plan Prior Authorization.

Be sure to follow all referral policies and procedures for Coordination of Benefits (COB), Motor Vehicle Accident (MVA) or workers' compensation cases. For more details, please see the Coordination of Benefits section of this manual.
Members' coverage for services is subject to their eligibility based on their benefits, contract policies and exclusions.

Retroactive referrals may be submitted as follows:

Product	Timeline
Fallon Medicare Plus	Up to 90 days after Date of Service
NaviCare	Up to 90 days after Date of Service
Berkshire Fallon Care Collaborative Medicaid ACO	Up to 30 days after Date of Service
Fallon 365 Care	Up to 30 days after Date of Service
Fallon Health-Atrius Health Care Collaborative	Up to 90 days after Date of Service

PCP referral process for Community Care:
Referrals for specialty care are required for Community Care
Refer to the PCP referral and plan prior authorization process section of the provider manual.

To ensure reimbursement to specialists and facilities:
The specialist submits a claim to Fallon Health with evidence of a referral (the PCP's NPI number) from the member's PCP.
For CMS 1500 paper submitters:

- Box 17 – enter referring provider/PCP's name
- Box 17b – enter referring provider/PCP's NPI number

For Fallon Health direct claims submitters

- Loop 2310A Segment NM1 –enter the referring provider/PCP's name
- Loop 2310A Segment REF with the G2 qualifier – enter referring provider/PCP's NPI number

Billing procedures

Failure to include complete referral information (the referring provider's name and NPI number) on the claims will result in a denial.

PCP referrals will be accepted retroactively up to 120 days from the date of the Remittance Advice Summary (RAS). Should an initial claim be rejected for lack of a referral number (i.e., the PCP NPI number), the specialist has 120 days from the date of the RAS to resubmit a corrected claim with the provider NPI number.

If a member does not have a valid referral, but visits a specialist for services that require a PCP referral, the specialist should contact the member's PCP to obtain a PCP referral. If the PCP does not approve the referral, the specialist should inform the member of his or her financial liability and ask the member to sign a waiver of liability.

If a specialist decides that a member needs a service that he/she cannot provide, the specialist must consult with the member's PCP, who will initiate a new referral to the appropriate specialist.

Please note that all services with non-contracted providers or facilities require a plan Prior Authorization.

Provider must follow all referral policies and procedures for Coordination of Benefits (COB), Motor Vehicle Accident (MVA) or workers' compensation cases. For more details, please see the Coordination of Benefits section of this manual.
Members' coverage for services is subject to their eligibility based on their benefits, contract policies and exclusions.

Prior authorization process for all plans:
(with the exception of Summit ElderCare)

The prospective or concurrent review process used by Fallon Health to determine coverage of a particular medical service. Prior authorization involves the review of eligibility, level of benefits, servicing provider's participating status and medical necessity. Depending on the contract, some groups for some product lines might be delegated for this process. If this is a question, contact your Provider Relations Representative.

For services that require Prior Authorization, all contracted providers are responsible for ensuring that the appropriate authorization is in place prior to services being rendered. If medically necessary services are rendered to an eligible plan member and there is no Prior Authorization, the provider will not be reimbursed for related charges and the member cannot be billed.

To ensure reimbursement to specialists and facilities:

- The specialist must verify the prior authorization number through ProAuth or by calling care services prior to seeing the member.
- There is no need to bill the approved referral number on the claim as Fallon will have this on file.

Members' coverage for services is subject to their eligibility based on their benefits, contract policies and exclusions.

Coordination of benefits

Coordination of benefits is required when more than one insurance plan covers a service. This occurs when a person has coverage from more than one insurance company, or when Medicare, Workers' Compensation, or a motor vehicle accident (MVA) is involved. In order for services to be considered for payment as a secondary insurer, Fallon Health's policy and procedures for referrals and authorizations must be followed.

Why do the insurance plans coordinate benefits?
Payment are coordinated to prevent total payments from exceeding the total charges for the patient's health services.

How do I know where to send the claims?
All insurance companies use the same rules to determine the primary and secondary carriers. These rules are explained below. If another company is the primary carrier, you should first send the bills to that company. After you receive the other insurer's Explanation of Benefits, submit a copy of that document to Fallon Health with the CMS 1500 or the UB04 claim forms. Complete information on the other insurer must be shown on boxes 11 and 24j of the CMS 1500 claims form or box 50 on the UB04 claim form.

Are there limits on when a claim can be filed with Fallon Health?
Claims must be filed within 120 days from the date on the other insurance carrier's Explanation of Benefits (EOB). Remember to include the EOB from the other carrier with your claim when you submit to Fallon Health.

How is primary coverage determined?

More than one possible carrier	
Spouse	If the subscriber's spouse has other health insurance, that is the spouse's primary plan.
Dependent children	Claims are processed using the birthday rule. The primary carrier is the insurance of the parent whose birth date occurs first in the calendar year. When both parents have the same birth date, the primary carrier for the dependent child is the plan that has been in effect the longest.

Billing procedures

Special situations for dependent children	
Joint custody	If neither parent is specified as responsible for health insurance the birthday rule applies.
Court decree	If the court decree specifies that one parent is responsible for health coverage, that parent's plan is
Single custody	The following order applies: 1. Parent with custody 2. Spouse of parent with custody.

Medicare	
Rules are determined by Medicare Secondary Payer (MSP) Laws. These laws apply to age 65 or older active employees and their spouses who are enrolled in a group health plan of an employer with at least 20 employees. In these cases, the employee would have coverage through the group and also through Medicare.	
Subscriber is 65 or older and still working	Fallon Health is primary, Medicare is secondary
Subscriber is 65 or older and is retired	Medicare is primary, Fallon Health is secondary
Actively employed subscriber's spouse is 65 or older	Fallon Health is primary, Medicare is secondary
Retired subscriber's spouse is 65 or older	Medicare is primary, Fallon Health is secondary
Medicare entitlement due to end stage renal disease or disability	Special rules apply, call 866-275-3247 with questions

Billing procedures

How are motor vehicle accident (MVA) claims handled?	
Determining primary coverage	The automobile insurance company is primary for the first $2,000 in medical expenses under the Personal Injury Protections (PIP). If the member is covered under Fallon Medicare Plus, Medicaid ACO the automobile insurance is primary for $8,000 under the PIP. Fallon Health will adjust claims accordingly if it is determined that services are a result of an MVA after the claims have been processed.
Submitting claims	Use the CMS 1500 claim form or UB-04 claim form. Record name of auto insurance carrier or other responsible party in Box 9 of the CMS 1500 claim form or Box 50 of the UB-04 claim form. Indicate that the services are as a result of an MVA and include the following: • Auto claim number • Date of accident • PIP insurance carrier • Address of PIP carrier • Notice from the PIP carrier stating that benefits have been exhausted • Name of patient's attorney Fallon Health will process claims providing that the member completes an assignment of insurance payment form. If the member does not complete the form, claims will be held until the coordination of benefits with the automobile insurance or other responsible party is settled.
Filing limits	An MVA claim must be submitted to Fallon Health within 120 days or your contracted time frame from the date of the other insurance Explanation of Benefits. Please attach the Explanation of Benefits or PIP exhaustion letter from the other insurance carrier.
Referrals and authorization guidelines	In order for services to be considered for payment, Fallon Health Health's policies and procedures for referrals and authorizations must be followed.
Claims adjustments	Fallon Health will adjust claims accordingly if it is determined that services are result of an MVA after the claims have been processed.
Balance billing	Balance billing Fallon Health members is not allowed.

Billing procedures

How are workers' compensation claims handled?	
Referrals and authorization guidelines	Claims must be submitted to Fallon Health within 120 days or your contracted time frame from the date of the denial from the workers' compensation carrier.
	In order for services to be considered for payment, Fallon Health's policies and procedures for referrals and authorizations must be followed.

What is subrogation?	
Subrogation applies when a payment for a member's illness or injury may be the responsibility of a third party. Subrogation cases may be a result of an injury in a public place.	
Submitting claims	Please provide: • Date of accident • File number • Name of patient's attorney

Claim status checks

To check the status of your claims, contact the provider service line at 866-275-3247, prompt 2.

Provider Services is available to assist Monday through Friday from 8am-5pm.

Please note the following:

- Status requests can be mailed, faxed or telephoned in.
- Inquiries are limited to three per telephone call; all high volume requests should be mailed or faxed.
- Status checks should be made 45 days after submission of a claim to Fallon Health. This allows Fallon Health time to process you claim and for the provider to re-submit a claim prior to the filing limit.
- Clearly mark the claim “STATUS INQUIRY” in order to avoid duplicate entry.

Claim Status Check – Electronically

Fallon Health Supports EDI 276/277 Version 005010X212 for claim status requests and responses. Providers, billing services and clearinghouses are advised to use the ASC X12N 276/277 (005010X212) Implementation Guide as a basis for their submission of Claims Status inquiries. Additional information on this electronic Claim status enquiry can be found at our website: http://www.fchp.org/providers/provider-tools/electronic-data-submission.aspx

Provider Tools – Claim Metric Report

Fallon Health also supports to generate claim metric report for the registered users. This tool will let you view claim status for the claims submitted to Fallon Health during last 90 days. Additional details on this registration can be found at our website: http://www.fchp.org/providers/provider-tools/provider-tools-registration.aspx

Understanding your Remittance Advice Summary (RAS)

For specific details on electronic Remittance Advice Summaries, please refer to our companion guide: Health Care Payment/Advice ANSI X12 835 (Version 005010X221A1) Implementation Guide at:
http://www.fchp.org/providers/provider-tools/electronic-data-submission.aspx

Remittance Advice Summary — Field Definition
A Remittance Advice Summary (RAS) is a printed explanation of the adjudication of a claim. Here is a description of each field on the RAS. See the reference section for a detailed description of Fallon Health's adjudication codes.

	FIELD	DEFINITION
1	Provider	The name of the provider rendering services.
2	Member name	The name of the member to whom the service was provided.
3	Contract #	The member's ID number
4	Referral #	The number of the referral to which the claim is linked, if applicable.
5	Claim #	The number assigned by Fallon Health to the claim.
6	Post date	The date on which the claim was posted to the system.
7	Account number	The account number submitted by the provider.
8	Status flag (S/F)	Status flag: Y or N appears in this field, indicating if the claim is approved as statistical (reporting purposes) or non-statistical (fee for service). Statistical (Y) or non-statistical (N).
9	Procedure	The procedure code(s) and description(s) submitted on the claim.
10	Modifier (MOD)	The primary modifier code submitted on the claim.
11	Service dates	The service from and to dates, on the claim line.

Billing procedures

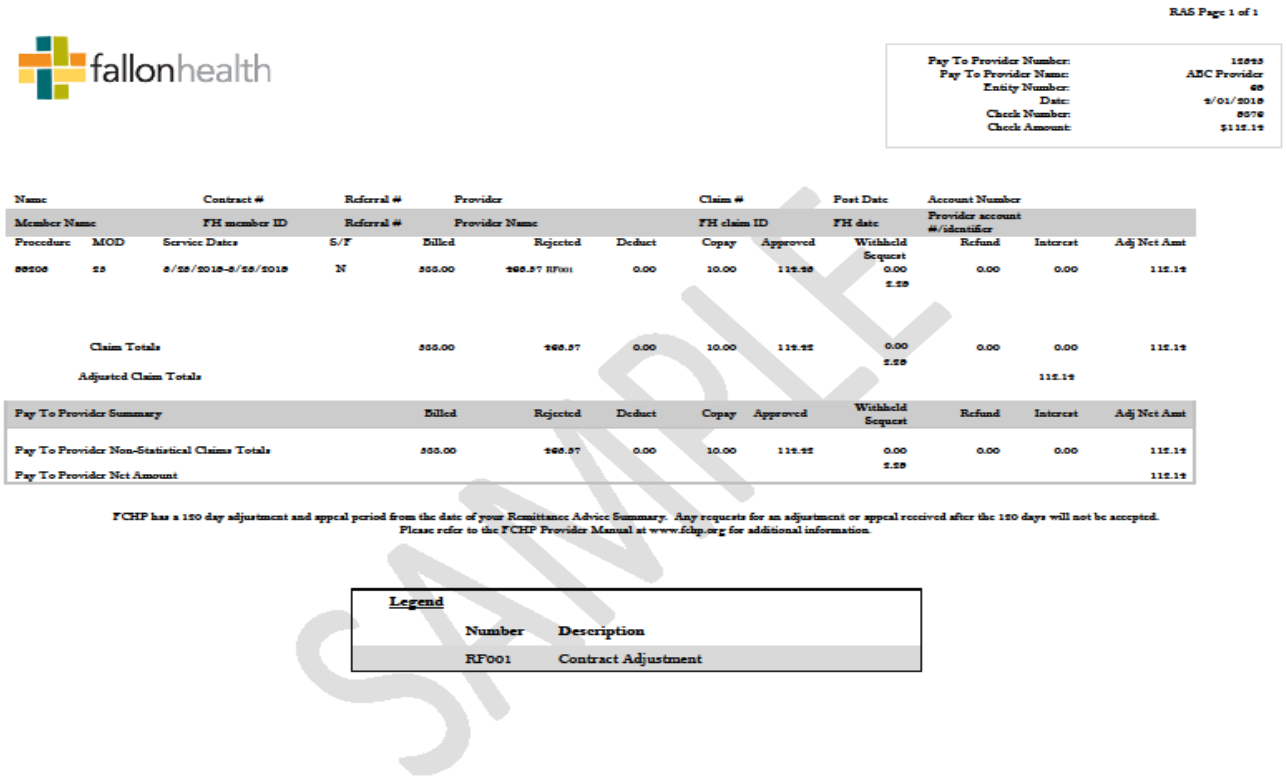
12	Billed	The total amount billed on the claim line.
13	Rejected	The total amount rejected on the claim line. Refer to legend for detailed explanation.
14	Deductible (Deduct)	The amount the member must pay towards his or her deductible and or coinsurance.
15	Copay amount	The amount the member must pay as a copayment and/or coinsurance.
16	Approved	The total approved amount on the claim line.
17	Withhold/sequestration	The total amount withheld based on the contractual agreement with the vendor/ sequestration, *see Sequestration Payment Policy.
18	Refund	The total amount of money received back from the provider and applied to the claim.
19	Interest	The total amount of money paid to the provider due to late payment by Fallon Health.
20	Net	The net amount, including all non-statistical approved dollars on the claim line.
21	Claim totals	Subtotal, by claim.
22	Notes	An information field is provided at the end of a claim. The purpose of this field is to provide helpful information for future billing, such as “Please update member’s ID #”.
23	Provider summary	Totals split out by statistical claim totals, non-statistical claim totals and negative balance amounts.
24	Provider net amount	The total amount of the check issues for this Remittance Advice Summary.
25	Legend	The legend indicates the claim line rejection disposition codes and their descriptions.

Billing procedures

A message section is provided on the last page of your RAS to notify you of important information or helpful facts.

Sample of RAS:

Double click on image to open.



RAS Page 1 of 1

fallonhealth

Pay To Provider Number:	12523
Pay To Provider Name:	ABC Provider
Entity Number:	60
Date:	5/01/2018
Check Number:	8076
Check Amount:	$112.12

Name	Contract #	Referral #	Provider	Claim #	Post Date	Account Number
Member Name	FH member ID	Referral #	Provider Name	FH claim ID	FH date	Provider account #/identifier

Procedure	MOD	Service Dates	S/T	Billed	Rejected	Deduct	Copay	Approved	Withheld Sequest	Refund	Interest	Adj Net Amt
88305	25	5/25/2018-5/25/2018	N	555.00	426.57 RF001	0.00	10.00	112.12	0.00 2.29	0.00	0.00	112.12
		Claim Totals		555.00	426.57	0.00	10.00	112.12	0.00 2.29	0.00	0.00	112.12
		Adjusted Claim Totals									112.12	

Pay To Provider Summary	Billed	Rejected	Deduct	Copay	Approved	Withheld Sequest	Refund	Interest	Adj Net Amt
Pay To Provider Non-Statistical Claims Totals	555.00	426.57	0.00	10.00	112.12	0.00 2.29	0.00	0.00	112.12
Pay To Provider Net Amount									112.12

FCHP has a 120 day adjustment and appeal period from the date of your Remittance Advice Summary. Any requests for an adjustment or appeal received after the 120 days will not be accepted. Please refer to the FCHP Provider Manual at www.fchp.org for additional information.

Legend

Number	Description
RF001	Contract Adjustment

SAMPLE

Fallon Health overpayments

What is an overpayment?
Overpayment occurs when Fallon Health sends you more money than we should have in the payment of a claim.

What should you do if this happens?
You should either return the Fallon Health check or issue a refund to Fallon Health. Your refund will be credited to your account.

Refund procedure:

When returning a Fallon Health check, include the following:

- The Remittance Advise Summary(RAS) that was received with the check
- The reason you are returning the check
- Name and phone number of the contact person at the office

When sending a refund check, include the following:

- Member name
- Membership number
- Member date of birth
- Date of Service or the RAS that was received with the check, highlighting the pertinent information
- The reason for the refund
- Name and phone number of the contact person at the office

Checks should be mailed to:

Fallon Health – Finance Department
10 Chestnut Street
Worcester, MA 01615-0121

Negative balances

Fallon Health periodically monitors claim payment activity to identify payments made to providers in error. Those payments made in error will be adjusted on the provider's account showing the amount overpaid as a negative amount originally paid in error.

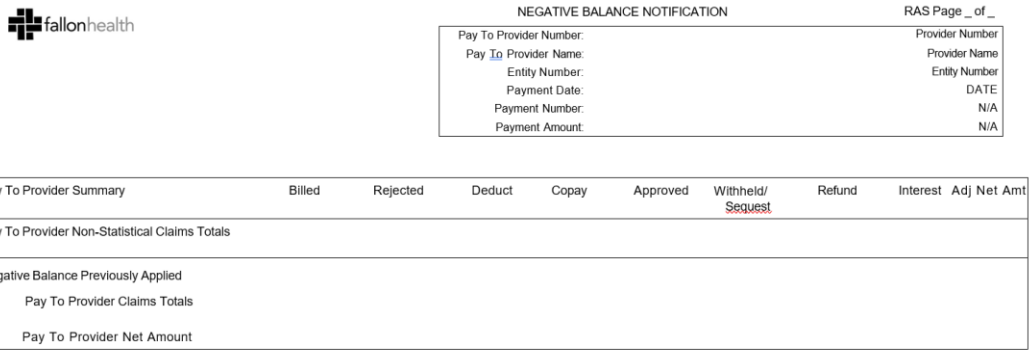
In some instances, a negative balance is generated when the total amount of adjusted claim dollars is greater than a provider's positive claim payment activity. If a provider is in a negative balance status with Fallon Health, the last page of your Remittance Advice Summary (RAS) will show the total amount due to Fallon Health. You will only receive the detailed patient claim information on the original negative balance RAS. Please be sure to keep this negative balance RAS as this will be needed to post your accounts.

If you anticipate the amount due Fallon Health will be cleared by future claim submissions, you may choose not to remit a refund to Fallon Health. However, if you wish to remit payment for the amount due, you may do so by making a check payable to Fallon Health and sending it to the address below. Please include a copy of the last page of your RAS.

Fallon Health
Attn: Finance Dept
10 Chestnut St.
Worcester, MA
01608

The Claims Department will send a report and a letter of explanation to the provider at intervals of 30/60/90 days from when the negative balance was created. Fallon Health will not issue any future payments until the negative balance is cleared. When sending your refund check, please enclose a copy of the letter and report sent to you.

Sample of RAS notification



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NEGATIVE BALANCE NOTIFICATION — RAS Page _ of _

Pay To Provider Number:	Provider Number
Pay To Provider Name:	Provider Name
Entity Number:	Entity Number
Payment Date:	DATE
Payment Number:	N/A
Payment Amount:	N/A

Pay To Provider Summary	Billed	Rejected	Deduct	Copay	Approved	Withheld/ Sequest	Refund	Interest	Adj Net Amt
Pay To Provider Non-Statistical Claims Totals									
Negative Balance Previously Applied									
Pay To Provider Claims Totals									
Pay To Provider Net Amount									

Billing procedures

FCHP has a 120-day adjustment and appeal period from the date of your Remittance Advice Summary. Any requests for an adjustment or appeal received after 120 days will not be accepted. Please refer to the FCHP Provider Manual at www.fchp.org for additional information.

Legend

Number	Description
DF064	Denied - no authorization or PCP referral
DF069	Denied-not paid separately
DF140	Denied-replacement claim received
MF20	Paid in accordance with to Medicaid outpatient hospital rates
RF001	Contract Adjustment
RF004	COB Applied

Billing procedures

Adjustments and Appeals

If you do not agree with a claim determination made by Fallon Health, you have the right to request a claim to be reviewed.

Claim Adjustments

The most efficient way to submit a correct claim to Fallon Health is to send electronically using industry standard 837 submissions within 120 days of the Remittance Advice Summary. Electronic corrections require the following information—indicating they are corrected/ replacement claims:

• Frequency code "7" for CMS 1500 claim forms

• Bill type "7" for UB claim forms

Written requests for provider corrections to a claim must be submitted within 120 days of the date of the Remittance Advice Summary (RAS) using a Request for Claim Review form.

Please mail or fax your adjustment request to:

Fallon Health
Claims Department: Adjustment Team
P.O. Box 211308
Eagan, MN 55121-2908
Fax: 508-368-9890

An adjustment or correction submission may be related to one of the following:

- Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.
- Corrected Claim: The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made and include **all the previous claim information** along with any corrected or additional information.
- Duplicate Claim: The original reason for denial was due to a duplicate claim submission.
- Retraction of Payment: The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).
- Correction to a claim denied for a Zelis edit

Claim Appeals

Provider appeals must be submitted within 120 days of the date of the Remittance Advice Summary (RAS) or initial denial. Provider claim appeals must be submitted in writing by using a Request for Claim Review form and include all pertinent information to substantiate your request.

Please mail or fax the form and supporting information to:

Fallon Health
Attn: Request for Claims Review/Provider Appeals
P.O. Box 211308
Eagan, MN 55121-2908
Fax: 508-368-9890

Billing procedures

An appeal submission may be related to one of the following:

- *Filing Limit:* The claim whose original reason for denial was untimely filing.
- *Payer Policy, Clinical:* The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
- *Payer Policy, Payment:* The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
- *Pre-Certification/Notification or Prior-Authorization or Reduced Payment:* The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
- *Referral Denial:* The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.
- *Request for additional information:* The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC Codes, Home Infusion Therapy).
- **Any appeal related to a Zelis edit should be submitted directly to Zelis**

    - By Mail:
      Zelis Claims Integrity, Inc. 2 Crossroads Drive Bedminster, NJ 07921 Attn: Appeals Department
    - By Fax: 1-855-787-2677

Submission Requirements
All claim review requests must be received within 120 days from the date of the initial claim denial/Remittance Advice Summary (RAS).

All claims must be completely processed by Fallon Health prior to the submission of a request for claim review.

A separate Request for Claim Review form must be supplied for each adjustment/appeal and all pertinent supporting documentation must be attached.

Please refer to the Request for Claim Review Reference Guide for examples of review types and required documentation for each review request.
Please note: Fallon Health will ensure that no punitive action is taken against a provider who submits an expedited request or supports an enrollee's appeal.

Submission Requirements for Non-Contracted Medicare Providers
All claims review (appeal) requests must be received in writing within 60 days from the date of the initial claim denial/Remittance Advice Summary (RAS) in order to be considered for review.

All claims must be completely processed by Fallon Health prior to the submission of a request for claim review.

A separate Request for Claim Review form must be supplied for each appeal and all pertinent supporting documentation must be attached.

Billing procedures

Please include a copy of the original claim, remittance showing the denial and any clinical records/documentation that would support the appeal.

Please refer to the Request for Claim Review Reference Guide for examples of review types and required documentation for each review request.

Please note, Fallon Health will ensure that no punitive action is taken against a provider who requests an expedited request or supports an enrollee's appeal.

In addition, non-contracted providers must include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal. This form must be accompanied with the claims review(appeal) request.

Please mail or fax the forms and supporting information to:

Fallon Health
Attn: Request for Claims Review/Provider Appeals
P.O. Box 211308
Eagan, MN 55121-2908
Fax: 508-368-9890

Filing Limit Appeals
All claim review requests must be received in writing within 120 days from the date of the initial claim denial/Remittance Advice Summary (RAS). All claims must be completely processed by Fallon Health prior to the submission of a claim review request. Any request received after this timeframe will not be considered for review.
Filing Limit Appeal Requirements

- Submit a separate Request for Claims Review Form for each appeal.
- Copy of Fallon Health Claims Metrics Report or Copy of original Fallon Health RAS
- CMS-1500/ADA/UB claim form
- Supporting Documentation

Supporting Documentation

Paper Claims
If you are requesting a filing limit claim review of a claim that was submitted on paper, the following are acceptable proofs of timely submission.

- Copy of patient account ledger which indicates the patient's name, date of service, and the date the claim was submitted to Fallon Health.
- If the member or another insurer had been previously billed, include proof that the member or another carrier had been billed (ledger).
- Clinical notes, medical records, discharge summary (should the filing limit denial pertain to services such as an inpatient admission or outpatient observation
- RAS from another insurer

Billing procedures

EDI Claims

If you are requesting a filing limit claim review of an EDI claim, submitted either through a clearinghouse, billing agency, or directly to Fallon Health, the following are the only acceptable proofs of timely submission.

- 999 Report
- EDI Clearinghouse or billing agency report indicating that the claim was accepted by Fallon Health within the filing limit

Additional information regarding EDI Claims

Fallon Health does not routinely waive the filing limit for EDI claims. It is the responsibility of a provider's office staff or billing service to process their EDI reports as well as Remittance Advice Summaries on a regular basis and resubmit rejected/problematic claims within the filing limit. Due to the availability of these reporting and tracking tools, it is unusual for the Fallon Health Claims department to expect late claim submission. Please resubmit any claims in question immediately. If the claim cannot be resubmitted electronically, office staff should reprocess the claims on paper and send them directly to Fallon Health within your contractual time frame.

Mail or fax your filing limit appeal request to:

Fallon Health
Attn: Request for Claims Review/Provider Appeals
P.O. Box 211308
Eagan, MN 55121-2908
Fax: 508-368-9890

Provider Appeal Determinations

Following receipt of a completed request for claim review, Fallon Health will research the request and notify the provider of the determination. When the original claim denial is upheld, a letter will be sent explaining the review determination. When a review is approved, the Remittance Advice Summary or 835 file will indicate the message of Approved per Provider Appeals.

All claim review determinations will be final and binding and in keeping with the provisions of your contract with Fallon Health.

Please note: Fallon Health will ensure that no punitive action is taken against a provider who submits an expedited request or supports an enrollee's appeal.

Billing procedures

Claims reference

Payment Policy guidelines:

Fallon Health has an extensive list of service specific payment policies
https://fallonhealth.org/providers/criteria-policies-guidelines/payment-policies

Place of service codes

Place of Service codes please visit: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Type of Bill (TOB)

TOB visit: CMS Chapter 1 General Billing Requirements: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf

New, Revised and Deleted codes

Each year, the American Medical Association and CMS review the CPT and HCPCS codes to determine whether codes should be added, revised or deleted. Fallon Health adheres to the standard coding guidelines of the American Medical Association in conjunction with Medicare guidelines. To make sure that contract documents and payment mechanisms remain current with industry standards, Fallon Health will add new codes for covered benefits to our claims payment system as contract language allows. Codes for new technology must first be reviewed by Fallon Health to determine whether the procedure is a covered benefit. Codes deleted by the AMA will be deactivated from our system effective January 1st of each year.

Unlisted Procedure Codes

Unlisted procedure codes should never be used when a more descriptive procedure code is available.

Community Care Qualifying Payment Amount (QPA) for Non-contracted Providers

Fallon Health is paying out-of-network claims for the Community Care product pursuant to the federal No Surprises Act. The allowed amount for out-of-network claims covered by the No Surprises Act will be set at the Qualifying Payment Amount (QPA).

- Fallon Health is working with our vendor partner ClearHealth to identify claims subject to the No Surprises Act and to determine the appropriate QPA.
- For any claims paid in accordance with the No Surprises Act, the Fallon Remittance Advise (RAS) will note at a claim line level “Paid according to the qualifying payment amount (QPA), as defined by the No Surprises Act Regulations.” A Provider Adjustments and Appeals letter with additional details will be included with the RAS.
- If an out-of-network provider or facility wishes to initiate a 30-day open negotiation period for purposes of determining the amount of final payment to the provider or facility, they may contact ClearHealth via the secure portal https://provider.clearhs.com or by calling (866) 722- 3773.

Billing procedures

Disposition codes

reasonid	reasontype	reporttext
DF001	REMIT	Denied-above invoice cost
DF002	REMIT	Denied-above authorization limit
DF003	REMIT	Denied- valid admission source required
DF004	REMIT	Denied-admit type required
DF005	REMIT	Denied-age invalid per medical policy
DF006	REMIT	Denied-age/procedure conflict
DF007	REMIT	Denied-appeals review
DF008	REMIT	Denied-assistant surgeon not necessary
DF009	REMIT	Denied-authorization line not approved
DF010	REMIT	Denied-authorized services do not match billed
DF011	REMIT	Denied-benefit has age restriction
DF012	REMIT	Denied-benefits no longer administered by FCHP
DF013	REMIT	Denied-bill as observation
DF014	REMIT	Denied-claim document or information not received
DF015	REMIT	Denied-clinical trial
DF016	REMIT	Denied-co surgeon not allowed
DF017	REMIT	Denied-detail supply code needed
DF018	REMIT	Denied-diagnosis invalid per medical policy
DF019	REMIT	Denied-discharge status required
DF020	REMIT	Denied-duplicate claim line
DF021	REMIT	Denied-exceeds review time limit
DF022	REMIT	Denied-gender invalid per medical policy
DF023	REMIT	Denied-gender/procedure conflict
DF025	REMIT	Denied-hospice primary
DF026	REMIT	Denied- diagnosis code invalid for dos
DF027	REMIT	Denied-diagnosis code required
DF028	REMIT	Denied-ICD procedure code invalid for dos
DF029	REMIT	Denied-ICD diagnosis code/CPT code mismatch
DF030	REMIT	Denied-incidental to other procedure
DF031	REMIT	Denied-included in admission
DF032	REMIT	Denied-included in global fee
DF033	REMIT	Denied-incorrect bill
DF034	REMIT	Denied-incorrect date of service
DF035	REMIT	Denied-incorrect medical notes
DF036	REMIT	Denied-incorrect number of units billed
DF037	REMIT	Denied-incorrect place of service
DF038	REMIT	Denied-incorrect provider
DF039	REMIT	Denied-invalid REV code
DF040	REMIT	Denied-invalid condition code on dos
DF041	REMIT	Denied-invalid CPT/HCPCS for dos
DF042	REMIT	Denied-invalid diagnosis code for benefit
DF043	REMIT	Denied-invalid mod/CPT combo
DF044	REMIT	Denied-invalid modifier for dos
DF045	REMIT	Denied-invalid occurrence code on dos
DF046	REMIT	Denied-invalid occurrence span code on dos

DF047	REMIT	Denied-invalid or missing admission date
DF048	REMIT	Denied-invalid REV/CPT code combo
DF049	REMIT	Denied-missing or invalid value code
DF050	REMIT	Denied-invoice required
DF051	REMIT	Denied-itemization required
DF052	REMIT	Denied-late charges/corrections
DF053	REMIT	Denied-max benefit limit exceeded
DF055	REMIT	Denied-medical criteria not met
DF056	REMIT	Denied-medical notes required
DF057	REMIT	Denied-medical visit not paid separately
DF058	REMIT	Denied-member not enrolled on dos
DF059	REMIT	Denied-modifier is invalid or missing per medical policy
DF060	REMIT	Denied-modifier missing
DF061	REMIT	Denied-modifier on claim does not match contract term or modifier not billed and contract requires modifier
DF062	REMIT	Denied-motor vehicle accident
DF063	REMIT	Denied-mutually exclusive service
DF064	REMIT	Denied - no authorization or PCP referral
DF065	REMIT	Denied-no available bed days on auth
DF066	REMIT	Denied-no response.
DF067	REMIT	Denied-no supporting documentation
DF068	REMIT	Denied-not a covered benefit
DF069	REMIT	Denied-not paid separately
DF070	REMIT	Denied-NPI invalid format
DF071	REMIT	Denied-NPI missing
DF072	REMIT	Denied-NPI not matched
DF073	REMIT	Denied-OP notes required
DF074	REMIT	Denied-original bill in review
DF075	REMIT	Denied-other agency may be responsible for payment
DF076	REMIT	Denied-other insurance primary
DF077	REMIT	Denied-over submit date
DF078	REMIT	Denied-paid by other insurance
DF079	REMIT	Denied-PHCS repricing applied in error
DF080	REMIT	Denied-physician specialty is invalid for medical policy
DF081	REMIT	Denied-place of service invalid per medical policy
DF082	REMIT	Denied-prior authorization not approved
DF083	REMIT	Denied-provider specialty not appropriate for service
DF084	REMIT	Denied-provider type is invalid per medical policy
DF085	REMIT	Denied-provider type not appropriate for service
DF086	REMIT	Denied-readmit related DRG
DF087	REMIT	Denied-readmit same DRG
DF088	REMIT	Denied-rebill initiating hospital for transport
DF089	REMIT	Denied-rebill with anesthesia CPT code
DF090	REMIT	Denied- Tax ID Number Does Not Match Billing Provider
DF091	REMIT	Denied-rebill with referring physician's NPI
DF092	REMIT	Denied-rebill with rendering physician
DF093	REMIT	Denied-rebundled
DF094	REMIT	Denied-referring provider not PCP

DF095	REMIT	Denied-retro review request
DF096	REMIT	Denied-send ambulance trip sheet
DF097	REMIT	Denied-send ER record
DF098	REMIT	Denied-services not on provider contract
DF099	REMIT	Denied-submit on 1500 form w rendering physician
DF100	REMIT	Denied-submit to ASHN
DF101	REMIT	Denied-submit to Beacon Health Options
DF102	REMIT	Denied-submit to dental vendor
DF103	REMIT	Denied-submit to Lifetrac Network
DF104	REMIT	Denied-submit to skilled nursing facility
DF105	REMIT	Denied-submit to United Behavioral Health
DF106	REMIT	Denied-team surgeon not allowed
DF107	REMIT	Denied-too many units billed for service
DF108	REMIT	Denied-units exceeded per medical policy
DF109	REMIT	Denied-workers compensation
DF110	REMIT	Denied-excluded service provider liable
DF111	REMIT	Denied-E&M code not valid for established patient
DF112	REMIT	Denied-member penalty no precertification
DF113	REMIT	Denied-anesthesia time required
DF114	REMIT	Denied-incorrect procedure code after OP-Note Review
DF115	REMIT	Denied-paid in error
DF116	REMIT	Denied-invalid from or thru date of service
DF117	REMIT	Denied-incorrect bill type
DF118	REMIT	Part D-Submitted to Pharmacare
DF119	REMIT	Denied-maximum approved units of service exhausted
DF120	REMIT	Denied-not a preferred provider
DF121	REMIT	Denied- Incorrect billing according to Medicare guidelines
DF122	REMIT	Denied- Incorrect billing according to Medicare OPPS guidelines
DF123	REMIT	Denied-missing end date on claim
DF124	REMIT	Denied-claim submitted to beacon for review
DF125	REMIT	Denied-incorrect procedure code
DF126	REMIT	Denied-referring physician not within member's HCO
DF127	REMIT	Denied-referring physician NPI is invalid
DF128	REMIT	Denied-state supplied vaccine no reimbursement
DF129	REMIT	Denied -incorrect or missing modifier
DF130	REMIT	Denied -incomplete notes
DF131	REMIT	Denied -submit with code
DF132	REMIT	Denied-sds service requires cpt/hcpc code
DF133	REMIT	Denied-claim total billed does not equal claim lines
DF134	REMIT	Denied-place of service incorrect for billed service
DF135	REMIT	Denied- documentation required for mod 22
DF136	REMIT	Denied-submit to Interlink
DF137	REMIT	Denied-CPT/HCPCS code required
DF138	REMIT	Denied-member lost eligibility during date span
DF139	REMIT	Denied-rebill on UB04
DF140	REMIT	Denied-replacement claim received
DF141	REMIT	Services excluded for provider specialty-denied member liable
DF142	REMIT	Denied-resubmit to Optum

DF143	REMIT	Denied-resubmit to Cigna
DF144	REMIT	Denied-invalid diagnosis pointer on service line
DF145	REMIT	Denied-over the rental period
DF146	REMIT	Denied notes received past review time
DF155	REMIT	Denied-U modifier required for code 96110
DF156	REMIT	Denied-FCHP reimbursed member directly
DF157	REMIT	Denied-notes not received timely
DF158	REMIT	Denied-Submit to Caremark
DF159	REMIT	Denied-Corrected claim received
DF160	REMIT	Part D - Submitted to Caremark
DF161	REMIT	Resubmit with primary carrier's paid date
DF162	REMIT	Denied-submit to EyeMed Vision Care
DF163	REMIT	Denied-referring NPI not matched
DF164	REMIT	Denied-serious reportable event
DF165	REMIT	Denied-Provider preventable condition
DF166	REMIT	Denied-Incorrect member id
DF167	REMIT	Denied-lack of medical necessity determined. Please submit medical records for redetermination.
DF168	REMIT	Denied-NDC code required for payment
DF169	REMIT	Denied-request requires appeal and medical notes to be submitted
DF170	REMIT	Denied-Resubmit claim with PPA
DF171	REMIT	Denied-submit to Sleep Management Solutions
DF172	REMIT	Denied- DHP commission paid in error
DF173	REMIT	Denied-Expiration of run out period
DF174	REMIT	Denied- ASO Escheatment Process
DF176	REMIT	Claim not processed. Op Note required. Please fax op notes to 508 368 9094.
DF177	REMIT	Denied-Member has met OOP max
DF178	REMIT	Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, this service. Please resubmit with this code.
DF179	REMIT	Denied-invalid or mismatched EOB submitted.
DF180	REMIT	Denied-Medical Records Not Received
DF181	REMIT	This drug is not covered by the plan administered by Fallon Health. To obtain this drug, please contact CVS Caremark Specialty Pharmacy at 800 237 2767
DF182	REMIT	Denied-Provider is not state certified
DF183	REMIT	Denied-Bill as Same Day Surgery
DF184	REMIT	Denied-Tax ID Missing
DF185	REMIT	Denied - Submit to MedCost
DF186	REMIT	Denied-assist not paid at teaching facilities
DF187	REMIT	Denied-Add on code denied as primary code not billed
DF188	REMIT	Denied-incorrect bill corrected claim required
DF189	REMIT	Denied-date of service billed does not match date of service authorized
DF190	REMIT	Denied-not separately reimbursed per Medicare guidelines
DF191	REMIT	Denied-Missing billing provider information
DF192	REMIT	Denied- Provider Not Credentialed
DF193	REMIT	Denied– CPT not supported in documentation
DF194	REMIT	Denied Reversed in PBM
DF195	REMIT	Denied Reimbursed to PBM
DF196	REMIT	Denied - service not covered under the MLTC benefit. Bill to NY state Fee for service Medicaid
DF197	REMIT	Denied – Provider is Non-Participating approval was not obtained for this service

DF198	REMIT	Denied - Incorrect billing according to Medicaid guidelines
DF199	REMIT	Denied - Not a covered service by Fallon Health -bill Mass Health
DF200	REMIT	Denied - Services require valid referring PCPs NPI within Members HCO
DF201	REMIT	Benefits for this service are managed by American Specialty Health. Claim has been forwarded to ASH for processing.
DF202	REMIT	Benefits for this service are managed by Beacon Health Options. Claim has been forwarded to Beacon for processing.
DF203	REMIT	Benefits for this service are managed by Sleep Management Solutions/CareCentrix. Claim has been forwarded to SMS/CCX for processing.
DF204	REMIT	Benefits for this service are managed by dental vendor. Claim has been forwarded to dental vendor for processing.
DF205	REMIT	Benefits for this service are managed by EyeMed. Claim has been forwarded to EyeMed for processing.
DF206	REMIT	Denied - Modifier is missing invalid or not covered per medical policy
DF207	REMIT	Denied-modifier not supported in documentation
DF208	REMIT	Denied - Documentation provided does not support service billed
DF209	REMIT	Denied - Documentation does not support medical necessity of service billed
DF210	REMIT	Denied - Documentation requested and not received
DF211	REMIT	Denied - Documentation submitted not sufficient to determine service was provided
DF212	REMIT	Denied- unable to validate services performed BLS provider is responsible for payment of paramedic intercept services.
DF213	REMIT	Please bill BLS provider
DF214	REMIT	The services/drugs you received from this provider are not covered by your medical plan. Call your Express Scripts Prescription plan at 1-800-922-8279 for coverage and claims submission details
DF215	REMIT	Denied - Split claim in accordance with member's enrollment
DF216	REMIT	Denied - Benefits for this service are processed as member reimbursement only. Member is liable for charges and may request reimbursement from the plan up to the max benefit limit.
DF217	REMIT	Denied-provider liable-excluded provider
DF218	REMIT	Contact Contract Manager for single case agreement
DF219	REMIT	Denied - External NCCI/MCE edit applied
DF220	REMIT	Denied -Code does not represent a physician service
DF221	REMIT	Denied-Services not covered when related to SRE or OPPC
DF222	REMIT	Denied-Principal diagnosis invalid as discharge diagnosis
DF223	REMIT	Denied-Invalid DRG
DF224	REMIT	Denied-Not a Covered Service
DF225	REMIT	Denied-Invalid or missing zip code
DF226	REMIT	Denied - Provider requested retraction or void of this claim
DF227	REMIT	Denied- CMS does not provide rate for this code in the DMEPOS fee schedule
DF228	REMIT	Denied - Procedure Code Not Payable Per MassHealth
DF229	REMIT	Deny - Clinical Trial Diagnosis Code Missing
DF230	REMIT	Deny - NCT Identifier Missing
DF231	REMIT	Deny - IDE Number Missing
DF232	REMIT	Deny - Clinical Trial Condition Code Missing
DF233	REMIT	Deny - Clinical Trial Modifier Missing
DF234	REMIT	Denied-Resubmit active NDC code and appropriate unit of measure
DF235	REMIT	Denied - This service is not covered by your Benefit Bank plan benefits. Review your Evidence of Coverage for more information.

DF236	REMIT	Denied - You submitted your request past the allowed time frame. Requests must be received within 90 days from the end of the calendar year. Review your Evidence of Coverage for more information
DF237	REMIT	Denied - Your request is missing required information. Please resubmit your request with all required documentation in a legible format
DF238	REMIT	Denied - There was an issue when you swiped your card. If you are still experiencing issues, please call Customer Service.
DF239	REMIT	Denied - You need to activate your card. Call the number on the back of your card to activate it.
DF240	REMIT	Denied - You attempted to use your Benefit Bank card benefits at a merchant or provider outside the benefits covered by the card. Review your Evidence of Coverage for more information
DF241	REMIT	Denied - The balance on your card is less than the total charge. The charged amount cannot exceed your available balance. Check your card balance by going to the portal at fallonhealth.org/myfallon-medicare or by calling Customer Service.
DF242	REMIT	Denied - This is a duplicate request for reimbursement.
DF243	REMIT	Denied - This provider is excluded from participating with Medicare. This means we cannot pay this claim. Call Customer Service if you have any questions.
DF244	REMIT	Denied -Not an approved Telehealth service for Member's Program
DF245	REMIT	Denied - The request is for an item not covered by your fitness reimbursement benefit. Review your Evidence of Coverage for more information.
DF246	REMIT	Denied - The request is for a non-preventive dental service. Preventive services are cleanings, x-rays, fluoride treatments and oral exams. Review your Evidence of Coverage for more information.
DF247	REMIT	Denied - Your plan does not include a dental reimbursement benefit. Review your Evidence of Coverage for more information about covered benefits.
DF248	REMIT	Denied - Your plan does not cover eyewear from out-of-network providers. Review your Evidence of Coverage for more information about covered benefits.
DF249	REMIT	No payment due. Item provided without cost to provider, supplier or practitioner
DF250	REMIT	Denied-diagnosis is inconsistent with the patient's birth weight
DF251	REMIT	Denied professional service is included in hospital global rate
DF252	REMIT	Denied-COVID admin requires COVID vaccine on same claim
DF253	REMIT	Denied - Invalid HIPPS code. Resubmit a valid HIPPS code with revenue code 0023
DF254	REMIT	Per CMS, type of bill 320 indicates that the HHA expects full denial of services billed. No payment is made on this claim
DF255	REMIT	Denied - This is a RAP/NOA. RAP/NOA was submitted must not be checked
DF256	REMIT	Denied - This required occurrence code 50 is missing
DF257	REMIT	Denied - A non-RAP claim must have skilled visits unless condition code 54 is reported on the claim
DF258	REMIT	Denied - for non-RAP with more than 4 visits, a HIPPS is needed
DF259	REMIT	Denied - HCPCS code Q5001 is reported with revenue code that is not 042X,043X,044X,055X,056X or 057X
DF260	REMIT	Denied - Item or 30illabl is not 30illable under TOB 034X
DF261	REMIT	Denied - Dates of service span two calendar years. Calendar year overlap is not allowed for this type of bill 034X
DF262	REMIT	Denied - Claim spans eligible and ineligible periods of coverage. Rebill separate claims
DF263	REMIT	Denied - RAP/NOA received date is missing
DF264	REMIT	Denied - Invalid HCPCS for DOS
DF265	REMIT	Denied-invalid NDC for submitted CPT/HCPCS code

DF266	REMIT	Denied - No Rate per MA Medicaid Outpatient Pricing
DF267	REMIT	Denied - not separately reimbursed for all codes that pertain to these services. Contracted and non-contracted providers must not seek further reimbursement from the member for these services
DF268	REMIT	Denied - The Required FIPS code is missing or invalid
DF269	REMIT	Denied - Claim is being sent to the pharmacy benefit administrator for review. Contact your provider if you receive a bill.
DF270	REMIT	DMR dismissed. AOR not on file
DF271	REMIT	Denied - Missing or Invalid Admission Date
DF272	REMIT	Denied - Missing or Invalid Value Code
DF273	REMIT	Denied - Item is a packaged Service
DF274	REMIT	Denied - Patient Height is invalid or missing
DF275	REMIT	Denied - Patient Weight is invalid or missing
DF276	REMIT	Denied - Procedure can not be billed on AKI claim
DF278	REMIT	Denied - Incorrect Billing of Principle Diag Code
DF279	REMIT	Denied - Ambulance Service to a Physician office is not covered
DF280	REMIT	Denied - Inappropriate use of Q codes
DF282	REMIT	Denied - Diag Inconsistent with Patient Age
DF283	REMIT	Denied - Diag Inconsistent with Patient Sex
DF284	REMIT	Denied - POA indicator missing or invalid
DF300	REMIT	Zelis Edit Procedure code is obsolete
DF301	REMIT	Zelis Edit Co-Surgeon or Team Surgery not appropriate
DF302	REMIT	Zelis Edit Inappropriate Use of Modifier
DF303	REMIT	Zelis Edit Already paid in part or full on another claim or provider
DF304	REMIT	Zelis Edit Add-on Code: Primary procedure not found
DF305	REMIT	Zelis Edit Not allowed separate payment with procedure {0}
DF306	REMIT	Zelis Edit Incidental or packaged proc no separate payment warranted
DF307	REMIT	Zelis Edit Assistant surgery not appropriate
DF308	REMIT	Zelis Edit In global fee period for procedure {0}
DF309	REMIT	Zelis Edit Too many new patient codes replace with code {0}
DF310	REMIT	Zelis Edit Inappropriate initial admission or discharge facility visit
DF311	REMIT	Zelis Edit Too many ICU visits on same service date
DF312	REMIT	Zelis Edit Other office visit ({0}) on same service date
DF313	REMIT	Zelis Edit Inappropriate use of HCPCS code CPT code exists
DF314	REMIT	Zelis Edit Not allowed payment with procedure {0}
DF315	REMIT	Zelis Edit Diagnosis does not qualify procedure or frequency of proc
DF316	REMIT	Zelis Edit Medical records do not support procedure billed
DF317	REMIT	Zelis Edit Denied due to lack of medical necessity
DF318	REMIT	Zelis Edit Ambulance charge denied due to lack of medical necessity
DF319	REMIT	Zelis Edit Laboratory charge denied due to lack of medical necessity
DF320	REMIT	Zelis Edit Exceeds clinical guidelines
DF321	REMIT	Zelis Edit Rebundled with other procedure(s) into procedure {0}
DF322	REMIT	Zelis Edit Too many procedures of this type billed
DF323	REMIT	Zelis Edit Duplicate procedure
DF324	REMIT	Zelis Edit Procedure has been processed for another provider
DF325	REMIT	Zelis Edit Service/procedure upcoding, audit will allow payment for {0}
DF326	REMIT	Zelis Edit Procedure is inconsistent with the patients age
DF327	REMIT	Zelis Edit Procedure is inconsistent with the patients gender
DF328	REMIT	Zelis Edit Diagnosis is inconsistent with the patients age
DF329	REMIT	Zelis Edit Diagnosis is inconsistent with the patients gender
DF330	REMIT	Zelis Edit Not allowed for this provider

Billing procedures

DF331	REMIT	Zelis Edit Deemed ineligible when performed in an ASC setting
DF332	REMIT	Zelis Edit Procedure not compatible with diagnosis
DF333	REMIT	Zelis Edit As per NCCI, not allowed separate payment with procedure {0}
DF334	REMIT	Zelis Edit No corresponding surgeon charge on file - ineligible for processing
DF335	REMIT	Zelis Edit Incomplete Diagnosis Code
DF336	REMIT	Zelis Denial DME code not compatible with diagnosis
DF337	REMIT	Zelis Denial DME modifier missing or invalid
DF338	REMIT	Zelis Denial Unspecified laterality diagnosis code
DF339	REMIT	Zelis Edit CPT and/or HCPCS code is not effective on DOS
DF340	REMIT	Zelis Edit CPT and/or HCPCS code(s) submitted is invalid
DF341	REMIT	Zelis Edit Denied - Therapy code was received with more than one therapy modifier.
DF342	REMIT	Zelis Edit Denied - Assistant therapy code requires additional modifier.
DF343	REMIT	Zelis Edit Denied - Assistant therapy code requires additional modifier.
DF344	REMIT	Zelis Edit Denied - Therapy code was received with more than one therapy modifier.
DF345	REMIT	Zelis Edit Denied - Therapy code was received with more than one therapy modifier.
DF346	REMIT	Zelis Edit Denied - ST code with inappropriate modifier/REV code pairing.
DF347	REMIT	Zelis Edit Denied - OT code with inappropriate modifier/REV code pairing
DF348	REMIT	Zelis Edit Denied - PT code with inappropriate modifier/REV code pairing.
DF349	REMIT	Zelis Edit Denied - Therapy modifier with inappropriate REV code pairing.
DF400	REMIT	Magellan - deny itemization needed
DF401	REMIT	Magellan - deny NDC number blank or invalid
DF402	REMIT	Magellan - deny non par no authorization on file
DF403	REMIT	Magellan - deny drug cannot be billed with JW modifier
DF404	REMIT	Magellan - deny clinical department denial
DF405	REMIT	Magellan - deny multiple E modifiers billed for one service
DF406	REMIT	Magellan - deny health plan denied
DF407	REMIT	Magellan - deny incorrect unclassified drug code billed
DF408	REMIT	Magellan - deny NDC submitted not FDA approved
DF409	REMIT	Magellan - deny duplicate prev submit and processed or still in process
DF410	REMIT	Magellan - deny units per day exceed amount allowable
DF411	REMIT	Magellan - deny units exceed amount allowable for time period
DF412	REMIT	Magellan - deny units per day exceed amount allowable for dx combination
DF413	REMIT	Magellan - deny RX over amount of units authorized
DF414	REMIT	Magellan - deny NCCI procedure to procedure
DF415	REMIT	Magellan - deny OCE dx/age conflict
DF416	REMIT	Magellan - deny OCE dx/gender conflict
DF417	REMIT	Magellan - deny par provider no authorization on file
DF418	REMIT	Magellan - deny JW-modifier billed same line
DF419	REMIT	Magellan - deny DX not eligible for code
DF420	REMIT	Magellan - deny unclassified drug code-valid code available
DF421	REMIT	Magellan - deny procedure and dos does not match authorization
DF422	REMIT	Magellan - deny procedure code does not match authorization
DF423	REMIT	Magellan - deny OCE 50-statutory exclusion list
DF424	REMIT	Magellan - deny external causes of morbidity dx can't be primary dx
DF425	REMIT	Magellan - deny units exceed amount allowable for time period w/in authorization
DF426	REMIT	Magellan - deny rebundling-procedure code changed
DF427	REMIT	Magellan - deny patient has exceeded authorized number of visits

DF428	REMIT	Magellan - deny date of service does not match authorized date span
DF429	REMIT	Magellan - deny units per day exceed amount allowable within authorization
DF430	REMIT	Magellan - deny procedure code and/or modifier invalid for patient age
DF431	REMIT	Magellan - deny invalid procedure code/modifier combination
DF432	REMIT	Magellan - deny place of service does not match authorization
DF433	REMIT	Magellan - deny drugs billed w/out modifier
DF434	REMIT	Magellan - drug billed w/incorrect modifier
DF435	REMIT	Magellan - not appropriate for drug billed
DF436	REMIT	Magellan - deny NDC submitted not valid w/procedure code
DF437	REMIT	Magellan - deny NDC unit of measure and/or quantity missing
DF438	REMIT	Magellan - deny medically unlikely edit (MUE)
DF439	REMIT	Magellan - deny drug is not covered or preferred drug

Zelis

Fallon Health uses an integrated claims editing tool offered by Zelis to further evaluate claims for adherence to industry-recognized edits and guidelines, and to ensure compliance with payment policies and standard coding practices.

If a claim line denies for a Zelis edit, providers will find a message on the Remittance Advice Summary (RAS) and the Electronic Remittance Advice (835 file) indicating an edit was applied by Zelis.

Questions surrounding these Zelis edits should be directed to Zelis at 1-866-489-9444.

Appeals related to a Zelis edit should be sent to Zelis within 120 days of the original RAS at the following address:

Zelis Claims Integrity, Inc.
2 Crossroads Drive
Bedminster, NJ 07921
Attn: Appeals Department
Fax: 1-855-787-2677

Zelis appeals require:

- A completed Request for Claim Review form explaining the reason for the dispute, including contact information and a fax number
- A copy of the original claim billed
- A copy of the RAS including the denial
- All pertinent medical records and or reports necessary for reconsideration of the claim

Claim Adjustments related to a Zelis edit should be sent to Fallon Health.
The most efficient way to submit a correct claim to Fallon Health is to send electronically using industry standard 837 submissions within 120 days of the Remittance Advice Summary. Electronic corrections require the following information—indicating they are corrected/ replacement claims:

- Frequency code “7” for CMS 1500 claim forms
- Bill type “7” for UB claim forms

Written requests for provider corrections to a claim must be submitted within 120 days of the date of the Remittance Advice Summary (RAS) using a Request for Claim Review form and the corrected claim with all claim lines submitted to the following address:

Fallon Health
Claims Department: Adjustment Team
P.O. Box 211308
Eagan, MN 55121-2908
Fax: 508-368-9890