

## SPRING 2004

### APS HEALTHCARE BILLING AND AUTHORIZATION INFORMATION UPDATE

- **WHAT FORMS SHOULD I USE TO FILE A CLAIM?** Please file all outpatient claims on an original CMS 1500 (formerly HCFA 1500) or inpatient and facility claims on an original UB 92. Using the original red bar forms and entering the data in typewritten form allows our system to automatically scan the document into the claims system, thereby speeding the claims processing time for your claims.
- **WHAT DIAGNOSIS CODES SHOULD I USE?** Your claim will process more quickly if you use ICD-9 codes. While most DSM-IV-TR codes are identical to ICD-9 there are some differences. If you need to access ICD-9 codes please go to [www.eicd.com](http://www.eicd.com) and choose eICD Online. This is a website that requires registration but is a free service.
- **WHY HAS APS PAID MEMBERS FOR MY OUTPATIENT SERVICES?** APS' new claims system is designed to pay claims based on Medicare, Medicaid and/or state specific claims payment guidelines and regulations. In order to pay providers for services rendered the member must assign their payment of benefits to the provider. The claims payor is notified of the members' intent to pay you directly for your services by signing Box 13 on the CMS 1500 or providers, with the member's assent, may enter "Signature on File" in Box 13. Failure to complete Box 13 may result in payments made to members.
- **WHY CAN'T I HAVE MY PAYMENTS SENT TO MORE THAN ONE ADDRESS?** APS' new claims system only recognizes one remit address per SSN or EIN.
- **WHY DID I RECEIVE A DENIAL OR REDUCED PAYMENT STATING I AM OUT OF NETWORK?** APS' new claims system was implemented to increase the speed and accuracy of claims payment to our providers. These goals are accomplished through the use of claims scanning technology which allows a clean claim to auto adjudicate. In other words, the system can pay the claim without manual intervention. The most common reasons that claims deny or pay at a lesser amount are:
  - a.) The name and credentials you have supplied in Box 31 do not match your credentialed file information;
  - b.) Box 31 is blank;
  - c.) Box 31 contains the phrase "Signature on File" instead of the rendering providers' name and credentials;
  - d.) The tax ID information in Box 25 does not match the data you have supplied to APS; or
  - e.) The tax ID number has fewer or greater than 9 digits
- **DID YOU CHANGE YOUR AUTHORIZATION LETTERS?** Yes. Our new system allows us to assign one reference (authorization) number per member per type of service. You will not receive a new authorization number each time you receive additional authorizations. APS' new authorization letters allow you to see the cumulative total of authorizations you have received for a specific member between January 1 and December 31 of each year. If you received authorization for 7 visits initially and an additional 5 visits as the result of submitting an OTR, your first authorization letter will show 7 visits. The second authorization letter will show 12 visits; i.e., the initial 7 plus 5 visits.

APS hopes you find these tips helpful. Beginning in May 2004, we will be adding useful claims and authorization information to the Behavioral Health Providers area of our website at [www.apshealthcare.com](http://www.apshealthcare.com). If you have questions about any information contained in this document please contact APS Provider Relations staff at (877) 490-6854.