
SECTION 11: PROVIDER PAYMENT

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PROVIDER PAYMENT

To ensure timely and accurate reimbursement please note the following:

FORMS

W-9 Forms

To ensure the correct reporting of Provider income to the Internal Revenue Service and the California Franchise Tax Board Health Plan Advantage D-SNP must have an accurate and current W-9 form on file. The information on the W-9 provides Health Plan Advantage D-SNP with the following:

- The **entity** being paid.
- The full and complete **mailing address** where payments are to be directed.
- The **tax ID number** used to report income received from Health Plan Advantage D-SNP.

The critical sections of the W-9 are:

- **Legal Name:** The name of the individual and/or corporation that appear on the Provider's tax return.
- **Business Name:** The name under which the Provider does business (i.e., Doing Business As (DBA)).

Federal 1099 Forms

A 1099 form will be sent no later than January 31st of each year to Providers with payments of \$600 or more in the previous calendar year. Please contact the Provider Services Department at 1-888-361-7526 (TTY:711) or via email to Providerservices@hpsj.com to report an error in the information on a 1099 form received from Health Plan Advantage D-SNP.

FEE-FOR-SERVICE PAYMENT (FFS)

Providers interested in contracting with Health Plan Advantage D-SNP, are required to be enrolled in both the Medicare fee-for-service and the Medi-Cal fee-for-service (FFS) programs. Providers must also be credentialed by Health Plan Advantage D-SNP, meet all applicable screening and enrollment requirements and adhere to criteria outlined in regulatory Provider bulletins. FFS payments apply to any covered services provided by Providers. FFS payments are made when a claim is submitted and processed for payment in accordance with the Provider contract, national correct coding initiative (NCCI) edits, plan rules, and applicable Medicare and/or Medi-Cal guidelines. See Section 4: Provider Contracting – Becoming a participating provider for additional information.

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FFS payments are accompanied by a remittance advice identifying claims being paid and/or denied with an explanation reason.

Note: *Not all services are reimbursable. If services rendered require prior authorization and such authorization was not obtained, claims for contracted Providers will be denied. Claims from non-contracted Providers will be developed. See Section 10: Claims - Claim Development. No payment is made for non-covered benefits.*

ELECTRONIC REMITTANCE ADVICE (835)

Health Plan leverages Smart Data Solutions (SDS) for its 835 file delivery. This process will ensure that you receive your 835 files faster and more efficiently.

The process operates as follows:

Regular Check Run

After each check run, your 835 files are automatically generated and distributed to our clearinghouse partner, SDS.

To receive your 835 files, instructions are below:

- If you want to use SDS: Reach out to your existing clearinghouse vendor and ask them to add connection to SDS for Health Plan under Payer Enrollment using Payer ID: 68035 or visit <https://sdata.us/> and select the Provider Portal link at the top of the webpage. Once there, you can log in if you have an account or you can register for a new account.
- For the SDS Provider Portal Companion Guide, you can access it here <https://sdata.us/what-we-do/clearinghouse/smart-data-stream-provider-portal/>.

We have also partnered with another clearinghouse, TriZetto/Cognizant, who can deliver 835 files to those who are already signed up or choose to sign up with them as their clearinghouse.

- If you want to use TriZetto: You must be signed up with TriZetto before Health Plan can deliver your 835 files. For new users and to sign up, visit: www.trizettoprovider.com/health-plan-of-san-joaquin-new-user-form.
- For existing users, please contact TriZetto to arrange delivery of 835 files from Health Plan.

ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT) is a great way to receive payments from Health Plan Advantage D-SNP faster. You may contact the Provider Services Department at 1-888-361-7526 (TTY:711) or via email to Providerservices@hpsj.com for more information.

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CHECK TRACERS

If payment has not been received within 30 calendar days of the check issuance date, please contact the Provider Services Department at 1-888-361-7526 (TTY:711) or via email to Providerservices@hpsj.com to initiate a check tracer. The Provider Services staff will coordinate with Health Plan Advantage D-SNP's Finance Department to verify the check payment status.

If the check has been cashed or deposited, a copy of the canceled check will be provided. If the check has not been cashed or deposited, an affidavit form must be completed and returned to the Provider Services Department via email to [<Providerservices@hpsj.com](mailto:Providerservices@hpsj.com) request payment to be reissued. Affidavits must be notarized for payments greater than \$1,000.

Upon receipt of the completed affidavit, a stop payment order will be placed on the original check and Finance Department will process the reissued payment on the next scheduled payment date.

COORDINATION OF BENEFITS (COB)

When Health Plan Advantage D-SNP is the secondary payer, all claims must be submitted within 365 days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB must be attached to the claim if submitted via paper. COB data can also be submitted electronically if the claim is filed electronically. If the Enrollee's primary plan denies services and requests additional information, the information must be submitted to the primary insurance carrier before submitting to Health Plan Advantage D-SNP.

PAYMENTS TO OUT-OF-NETWORK PROVIDERS

Payments to out-of-network providers are made with the applicable Medicare pricing methodology for the type and location of services provided, including but not limited to, the Medicare Physician Fee Schedule (MPFS), Clinical Laboratory, Durable Medical Equipment (DME), and Average Sale Price (ASP) for Part B drug fee schedules. Facility-based services are reimbursed using the Inpatient and Outpatient Prospective Payment System pricers.

Prior authorization is required for out-of-network services unless:

- Services are emergent or urgent
- Dialysis services when member is temporarily out of the service area
- Continuity of Care exists (See Section 8: Utilization Management – Continuity of Care)
- Ambulance services dispatched through 911 or local equivalent

Note: See *Medicare Managed Care Manual Chapter 4 – Benefits and Beneficiary Protections* for additional information at:

<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf>

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FACILITY PAYMENTS

Health Plan Advantage D-SNP contracts with facilities within the service area and provides access to specialty facility services when needed outside of the service area. Each facility agreement/contract contains specific reimbursement information indicating payment methodologies.

Health Plan Advantage D-SNP will reimburse any Providers on staff within the facilities using the applicable Medicare fee schedule and/or contracted agreement.

Note: *Enrollees cannot be balance billed for services (See Section 10: Claims Submission – Enrollee Billing for details.)*

All facilities are expected to coordinate with Health Plan Advantage D-SNP's Utilization Management Inpatient Services for services that require prior authorization by providing the Enrollee information and medical documentation necessary to support high quality, timely, and cost-effective health care.

No Payment for Never Events, Hospital Acquired Conditions (HAC), and Provider Preventable Conditions (PPC)

CMS defines Never Events as “serious and costly errors in the provision of health care services that should never happen.” Never Events, HACs, and PPCs can be avoided through the application of evidence based clinical guidelines.

Institutional Providers are encouraged to take appropriate actions to reduce the likelihood of Never Events, HACs, and PPCs.

Facility Providers will not be reimbursed for covered services related to or resulting from Never Events, HAC, or PPC including reimbursement for additional inpatient days that would not have been incurred in the absence of such Never Event, HAC, or PPC. These events shall not be included in either APR-DRG calculations, per diems, or included in any stop loss calculations.

If a HAC or PPC event occurs, institutional Provider must submit a copy of the Enrollee's complete medical record with the claim and file the PPC with DHCS. PPC filing instructions are located at https://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx