



Billing Guidelines for Hospitals

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VERIFYING PATIENT ELIGIBILITY & BENEFITS

SCAN has an Interactive Voice Response (IVR) system for quick eligibility verification. The IVR toll free number is **(877) 778-7226**. Using the IVR system, the following information can be accessed 24 hours per day, 7 days per week:

- Member Name
- Effective Date
- Termination Date (if applicable)
- Primary Care Physician (PCP)
- Medical Group/IPA
- Plan/Benefit Code
- Office Visit Co-pay
- Emergency Room Co-pay

Transfer options to other SCAN departments are also available through the IVR.

Hospital benefits and co-pay amounts can also be verified by calling a Provider Eligibility Representative Monday through Friday, 7:00am to 6:00pm (excluding) holidays at:

(877) 906-1234

In addition, SCAN supplies member eligibility information to Insurance Benefit Spot Check, Inc. for those hospitals that have access to this system. For more information about the Spot Check eligibility verification system, call (800) 233-7768.



REQUIRED NOTIFICATION OF ADMISSIONS & DAILY SUBMISSION OF CENSUS REPORTS

Notification of Admissions 24 hours per day, 7 days per week: Please call SCAN's Utilization Management (UM) department or fax an admission face sheet as soon as a SCAN member is admitted to your hospital for inpatient admissions or outpatient surgery:

Telephone: (866) 813-1725

FAX: (800) 411-0671

In addition, you must also notify the member's Medical Group or IPA of the admission to receive authorization for the admission.

Daily Submission of Census Reports: In addition to all SCAN inpatient and outpatient admissions, SCAN requires hospitals to notify them daily of all discharge dates and discharge destinations. This will ensure that appropriate tracking/authorization numbers are generated and forwarded to both the hospital and SCAN's Claims department and in turn will facilitate timely and accurate payment of claims. Failure to notify SCAN's Utilization Management department of all pre-service, routine, urgent and emergent admissions may result in delayed claims payments and/or denials if unauthorized, non-emergent care is rendered.

The daily inpatient, outpatient and discharge censuses may be faxed to SCAN's Utilization Management office 24 hours per day, seven days per week, 365 days/year at (800) 411-0671.

Please include the name of a contact person or department on the cover sheet of the census reports in the event there are follow-up questions or problems with delivery.

DISCHARGE RESPONSIBILITIES

In addition to notifying SCAN of discharges on a daily basis, all SCAN members admitted to a Medicare approved facility must receive "The Important Letter from Medicare", which details discharge and appeal rights. If a SCAN member disagrees with the pending discharge, the hospital must issue the Notice of Discharge and Medicare Appeals Rights (NODMAR) as a part of the discharge appeal process. A copy of the NODMAR must be filed in the member's hospital record.



SUBMITTING CLAIMS FOR PAYMENT

All hospital claims for reimbursement of covered services must be submitted to SCAN within the timeframe set forth in the hospital's contract with SCAN. Claims must be submitted on CMS 1500 forms or UB 92 forms using Medicare fee-for-service claims submission guidelines (i.e., must pass Medicare fee-for-service edits). Please include the Medical Group or IPA authorization number and authorization copy or the SCAN UM Tracking Number on the claim. If claims are not submitted in the contracted timeframe and using the appropriate forms, SCAN reserves the right to deny payment for such claims. Claims should be mailed to:

SCAN Health Plan
Claims Department
P.O. Box 22698
Long Beach, CA 90801

APPEALING OR DISPUTING A CLAIMS PAYMENT

Appeals/Dispute Definition

A hospital appeal or dispute is a hospital's written notice to the health plan challenging, appealing or requesting reconsideration of a claim payment or denial of a claim.

Process for Filing a Claims Appeal/Dispute

Each claim appeal/dispute submitted must include the following:

1. Name of hospital;
2. Hospital's contact information;
3. The date(s) of service;
4. A clear identification of the disputed item(s), including:
 - A clear and concise explanation of the basis upon which the hospital believes the payment amount/denial is incorrect, the expected outcome, and appropriate documentation included.



All appeals/disputes must be submitted **in writing** to:

SCAN Health Plan
Claims Department / Provider Appeals
P.O. Box 22698
Long Beach, CA 90801
(877) 778-7226 – Option 3

SCAN's Process When Additional Information is Required

1. If it is determined by SCAN that there is not sufficient information to resolve the appeal/dispute, SCAN will send a letter to the hospital stating so and will request the additional documentation that is needed.
2. If the hospital fails to submit the requested information within 55 calendar days of the date of the letter, SCAN will consider the appeal/dispute closed and a closure letter will be sent to the hospital.

Timeframes

SCAN will strive to acknowledge receipt of a hospital's claim appeal/dispute within 15 calendar days. In addition, SCAN will strive to resolve the appeal/dispute and send an outcome/decision letter to the hospital within 60 calendar days of receiving complete information.