Purpose: This chapter provides an overview of provider billing requirements and reimbursement considerations.

Topics

- Provider Reimbursement
- Claim Billing Instructions
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Overview
At Health Partners Plans, we provide services to individuals who are eligible for benefits through our participation in the HealthChoices Medical Assistance program (Health Partners), Private Coverage Option program (Health Partners Essential), Medicare Advantage (Health Partners Medicare) and the Children's Health Insurance Program (KidzPartners).

For Health Partners members, these payments are made at the lesser of billed charges or Medical Assistance rates unless otherwise contracted. For KidzPartners (CHIP) and Health Partners Essential members, payments are made at the lesser of billed charges or Health Partners Plans fee schedules. In either case, we consider such remittance to be payment in full.

Do not bill Health Partners (Medicaid) members for services.

Health Partners members are never responsible to pay participating providers any amount for covered medical services, other than approved copayment amounts as part of the member’s benefit package.

If you are participating in the Medical Assistance Program you may NOT seek reimbursement from the member for a balance due unless it is for a non-compensable service or one beyond his/her covered limits and the member is told by the provider, in writing, BEFORE the service is rendered.

If the member is dually eligible (Medicare/Medicaid) or has other insurance coverage, and the claim is for a coinsurance or deductible amount, please be aware that Health Partners Plans reimburses these amounts up to the applicable contracted or statutory limits.

Provider Reimbursement
The following sections provide an overview and guidelines for the reimbursement methods and requirements utilized at Health Partners Plans.

Primary Care Physician (PCP) Capitated Services
The following primary care services are covered under capitation:
- Office Visits
- Routine EKG and interpretation
- Venipuncture
- Vision screening for children
- Fitting and prescribing of family planning methods
- Local treatment of burns
- 24-hour per day, 7-day per week telephone coverage
- Telephone consultations
- Coordination of access to secondary, tertiary and specialty services
**Note:** All capitated services must be reported to Health Partners Plans on a CMS-1500 form or via electronic submission.

**PCP Fee-for-Service Reimbursement (Bill-aboves)**

PCPs are also eligible for compensation above capitation for certain services, as listed below:

- Suturing of minor wounds
- Removal of benign lesions
- Nail trimming and debridement, avulsion of nail plate
- Nebulizer treatment
- Audiometry/Tympanometry
- Administrations of immunizations (must bill related immunization code to receive payment)
- Inpatient visits to a hospital, skilled nursing facility, or rehabilitation facility
- Home visits
- Childhood (ages 0-20) weight management services (CPT codes 96150-96154, S9470, and T1015) and nutritional counseling (S9470)
- EPSDT visits (use appropriate preventive E&M code with EP modifier)
- Normal newborn care (Circumcision, inpatient newborn care, attendance at delivery)
- Lead screening
- Diabetes self-management training (G0108 & G0109).
- Smoking and tobacco use cessation

**Note:** Reimbursement for all non-capitated services requires completion of either the CMS-1500 form or electronic submission.

**Additional Compensation for PCPs (Medicaid Only)**

For the Health Partners Medicaid program, certain immunizations, pediatric preventive services and hospital visits to newborns are eligible for additional compensation to primary care physicians without further authorization from Health Partners Plans. Reimbursement for these immunizations and hospital visits is based on the completion and submission of the following form(s):

- EPSDT Encounter

  Providers should report the appropriate level Evaluation and Management CPT code, plus CPT code EP Modifier and all immunization CPT codes to properly report an EPSDT claim. Without this required coding, Encounters (claim services) will not be able to be reported to the Department of Human Services (DHS). If the encounter is unable to be reported, the provider may be subject to retraction of payments made for these services.

- Administration of immunizations when participating in the Vaccines for Children Program.

**Fee-for-Service Providers**

All specialists and PCPs on a fee-for-service agreement are compensated based on the then prevailing or contracted rates. For KidzPartners, this includes reimbursement for childhood immunizations. Examples of fee schedules are available on request through the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-13). ALL services must be reported to Health Partners Plans on a CMS-1500 form or via electronic submission in an ASC.
X12N-837 P format, using current HIPAA-standard coding. All facility services must be reported to Health Partners Plans on a UB-04 form.

Missed Appointments (Medicaid Only)
According to Pennsylvania Department of Human Services Medical Assistance Bulletin 99-11-14, a provider is not permitted to bill a member for a missed appointment. According to the Centers for Medicare & Medicaid Services (CMS), a missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider’s overall cost of doing business. As such, it is included in the MA rate and providers may not impose separate charges on Medicaid recipients. State Medicaid programs, including Pennsylvania’s MA Program, must comply with the CMS policy on this subject; therefore MA enrolled providers who render services to MA recipients may not bill recipients for missed appointments.

Referrals, Authorizations & Encounter Data
The following sections provide guidelines regarding referrals, obtaining prior authorization for services (when necessary), and accurately recording member encounters.

Referrals
Referrals are not required for any Health Partners Plans line of business! Our members are permitted to “self-refer” for specialist care. This change went into effect in April 2015.

However, it is extremely important for the PCP to play an active role in the care of the member and we encourage members to seek the guidance of their PCP before choosing to self-refer to a specialist. In addition, it is equally important for the specialist to keep the member’s assigned PCP informed.

It is the responsibility of the rendering provider to verify eligibility prior to rendering care to a member and to verify authorization requirements prior to rendering any procedure.

The PCP is still asked to serve as the gate keeper. When coordinating care, the PCP should direct the member to a specialist who they believe can assist with the care needed. Health Partners Plans realizes that PCPs may occasionally need to direct members to a non-participating provider for some need or service not available through a participating provider. However, we require prior authorization before services can be rendered by a non-participating provider. If the PCP does not obtain prior authorization, reimbursement will be denied to the specialist.

If a member is not eligible with Health Partners Plans on the date of service, the physician will not be paid. To be sure, log on to HP Connect at www.HealthPartnersPlans.com or call Health Partners Plans (see Table 1: Service Department Contact Information on page 1-13) before the service is rendered.

The specialist is able to provide consultation and any additional services required to treat the condition for which the member was referred. If the additional services being ordered require prior authorization it is the specialist's responsibility to obtain the prior authorization.
If the specialist identifies the need to refer the member to another specialist, the PCP should be contacted to maintain a role in the member’s care and should always be given the opportunity to communicate with all treating specialists related to the care of the member.

In accordance with Pennsylvania law and the Department of Human Services requirements, Health Partners Plans will maintain procedures by which a member with a life-threatening degenerative or disabling disease or condition shall, upon request, receive an evaluation to determine if the member qualifies to select a specialist to act as his/her Primary Care Physician. This evaluation will include a written letter of medical necessity from the specialist and a determination by the Medical Director. If the specialist is designated as the primary care provider, he/she must be credentialed as a PCP.

**Prior Authorization**

Referrals to non-participating providers require prior authorization by calling Health Partners Plans’ Inpatient Services or Outpatient Services (see Table 1: Service Department Contact Information on page 1-13).

For Health Partners Plan members, prior authorization is required for:

- Elective hospitalizations
- Transfers to non-participating facilities
- Skilled nursing admissions
- Acute rehab admissions
- Inpatient hospice admissions
- Outpatient hospice
- Advanced radiology services (CT, MRI PET scans, stress echocardiography, echocardiography, cardiac nuclear medicine imaging, and radiation therapy)
- DME
- Non-emergent transportation
- Homecare services
- Outpatient Rehab therapies
- Prosthetics/Orthotics
- Services, procedures, items or drugs considered to be new or emerging technology
- Services/Procedures performed by non-participating providers
- Short Procedures (ASC and SPU) for KidzPartners only
- Pharmacy-specific drug prior authorizations (see Section 4, Health Partners Benefits or the website www.HealthPartnersPlans.com for more information)

Prior authorization is never required to provide emergency services. If an inpatient admission results following the provision of emergency/trafic care, clinical review policies and procedures apply. For a more detailed description of prior authorization requirements and guidelines, see Prior Authorizations on page 8-6.

All inpatient admissions require a clinical review. For DRG-contracted hospitals, reviews are required once the DRG trim point has been reached, and thereafter daily reviews are required.
through discharge. For per diem contracted hospitals, daily reviews are required from admission through discharge. If clinical reviews are not provided as required from admission through discharge, authorization and claim payment may be denied.

Providers must communicate all required information to Inpatient Services at Health Partners Plans. Unless complete prior authorization information is provided, unless appropriate concurrent review and discharge planning is conducted and unless a final determination of approved services is rendered, an “authorization” will not transfer to the claim processing system. Incoming claims will edit for a “no match on authorization” error due to the authorization data remaining in an incomplete (thus un-transferred) status and the claim will likely be denied. The elements required to accurately complete an authorization and successfully match and pay claims are:

- **Member ID**
  This is particularly important for newborns. Until the newborn is assigned a permanent Medicaid recipient number by DHS, authorizations will be set up under a temporary ID. The temporary ID is usually the baby's mother’s ID ending with Z and a sequential number at the end.

  A permanent ID can be assigned as early as ten days after the date of birth. The newborn's ID, whether temporary or permanent, can be confirmed through Provider Services at 215-991-4350 or 888-991-9023.

- **Dates of service**
  It is extremely important that discharge or service end date be provided so that authorizations can be closed. Often authorizations are left open-ended because the discharge dates or disposition is not known during preliminary discussions. Providers are responsible to follow-up on open/incomplete authorizations and to ensure accurate dates of services or admission and discharge dates are communicated to HealthPartners Plans Inpatient Services at the time of discharge along with disposition information. If the dates of service change after the authorization number is given, it is the provider's responsibility to contact Health Partners Plans with the new dates of service. Without exact dates, the claims submitted may deny or will only be paid for those dates matched between the claim and the authorization on file.

- **Provider ID**
  Unless a valid and accurate provider ID is incorporated in the authorization, the claim may not be matched and will subsequently be denied.

**Member Encounters**
Health Partners Plans PCPs, specialists, Ambulatory Surgical Centers, ancillary and allied health providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter with a Health Partners Plans member. All providers must submit this form within 180 days following the encounter date or payment will be denied. PCPs must report encounter data associated with EPSDT screens of Medicaid members within 180 days from the date of service.
Claim Billing Instructions

Health Partners Plans is required by State and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure that required data is captured, and that claims are processed in an accurate, timely manner.

Important Note for Medicaid Claims

Health Partners Plans is required to submit to the Department of Human Services (DHS), the Commonwealth of Pennsylvania department responsible for administering Medicaid, all necessary data that characterizes the context and purpose of each encounter between a Medicaid enrollee and a physician/practitioner, supplier, or other provider. State regulation requires services to Medical Assistance recipients be rendered by providers participating in Medicaid, except in emergent or urgent situations. DHS now uses encounter data to develop risk-adjusted ratings that tie to reimbursement for Managed Care Organizations (MCO). A provider's failure to submit complete, accurate and timely encounter data to Health Partners Plans as required may result in actions by Health Partners Plans including, but not limited to, payment delay or no payment at all, as well as possible exclusion from the network.

Billing Requirements and Guidelines

A mission of Health Partners Plans is to ensure timely and accurate claims processing. To that end, this section is intended to provide guidance to Provider Billing Offices so that complete and precise medical claim filing for payment consideration can be accomplished. These guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

Capitated, as well as fee-for-service claim (encounter) data, specifically the diagnosis and treatment codes, is used by DHS to develop a risk-adjusted reimbursement rate. DHS will reimburse Medicaid Managed Care Organizations according to the level of illness experienced by and service rendered to their members. As an extension, reimbursements to providers from Medicaid Managed Care Organizations will become dependent upon the quality of the data used in this reimbursement methodology. A provider's failure to submit to Health Partners Plans complete and timely encounter data, coded to the highest level of specificity, will have costly long-term effects. It is important that providers file all claims and encounters as required. Failure to do so could result in possible exclusion from the network.

Preventable Serious Adverse Events

Medical Directors will not approve services that are deemed harmful to our members, are of inferior quality, or are medically unnecessary (as may be the case with a serious and clearly preventable adverse event). In addition, based on CMS guidelines, financial compensation for any and all services rendered as a result of, or increased by, a preventable serious adverse event will be withheld or recovered.

Initial Claim Submission Procedures

Health Partners Plans has specific, established requirements for filing a notice of claim. These requirements include that the notice of a claim be valid and complete, furnished within a prescribed time, and be delivered to the correct business address. Failure to comply with any of these
requirements shall constitute a bar to filing a claim and shall preclude payment. To be accepted as a valid claim, the submission must meet the following criteria:

- Must be submitted on a standard current version of a CMS-1500, CMS-1450/UB-04 or in the ANSI X12-837 electronic format (current version)
- Must contain appropriate, current information in all required fields
- Must be a claim for a plan member eligible at the time of service
- Must be a claim for a Provider properly established on Health Partners Plans’ processing system for the time period and location (site) billed
- Must be an original bill
- Must contain correct current coding, including but not limited to CPT, HCPCS, DRG, Revenue and ICD-9 codes
- Must not be altered by handwritten additions or corrections to procedure/service codes and/or charges
- Must be printed with dark enough ink to be electronically imaged if submitted as a paper claim
- Must be received within 180 days from the date of service as measured by the date stamp applied by a Health Partners Plans representative who has agreed to and has the authority to accept claims at a Health Partners Plans business address by the system receipt date if filed as a paper claim through the correct claim post office box; or, by system receipt date after passing via an electronic data interchange gateway and through Health Partners Plans’ claim validation front-end editing

**Provider Numbers and Set Up**

All providers billing for services, whether participating or non-participating, must be established on the Health Partners Plans processing system with effective dates coinciding with the dates of services billed.

**Non-Par Providers**

Non-participating providers, whether rendering emergency services or prior authorized and approved treatment, must provide the following information to be established on the Health Partners Plans system:

- W-9 tax form
- Pennsylvania Medicaid Provider Identification Number (in-state, Health Partners Plans Medicaid providers only)
- State Medical License Number and Expiration Date
- Social Security Number
- DEA (Drug Enforcement Administration) Number
- NPI (National Provider Identification) Number
- Provider Specialty
  - Specialist should declare their specialty
  - Facility
  - Allied Health Provider
  - Ancillary Health Care Provider (Home Health, DME, Transportation)
Note: Non-participating provider services (except for emergency services) require prior certification by calling Health Partners Plans Inpatient Services or Outpatient Services (see Table 1: Service Department Contact Information on page 1-13).

Information required in order to be established as a non-participating provider on the Health Partners Plans system can be sent to:

   Attn: Provider Reimbursement and Administration
   Health Partners Plans
   901 Market Street
   Suite 500
   Philadelphia, PA 19107

Or

   FAX to: 215-967-4486
   Attn: Provider Reimbursement and Administration

Participating Providers
Participating providers must be contracted and credentialed by Health Partners Plans. For electronic claim submission Providers must bill with their individual and billing NPI numbers or their claims will be denied.

Claim Mailing Instructions

For Health Partners Plans (Medicaid, PCO & Medicare) claims should be mailed to:
   Health Partners Plans
   P.O. Box 1220
   Philadelphia, PA 19105-1220
   For electronic claims use ID #80142.

For KidzPartners (CHIP), claims should be mailed to:
   KidzPartners
   P.O. Box 1230
   Philadelphia, PA 19105-1230
   For electronic claims use Emdeon payer ID #80142.

For claims reconsiderations:
   Claims Reconsiderations (Health Partners Plans – all lines of business)
   Health Partners Plans
   901 Market Street, Suite 500
   Philadelphia, PA 19107

Claim Filing Deadlines
Health Partners Plans allows 180 calendar days from the date of service or discharge date to submit and have accepted a valid initial claim.
A claim must be accepted as valid (as proven by entry into the Health Partners Plans claims processing system and assignment of a claim control number) to be considered filed. Paper claim submissions that cannot be entered into the claim processing system because of invalid member, provider or coding information are returned to the provider with a rejection notice (form letter or insert) explaining the reason for rejection.

Electronic claim submissions are rejected on electronic submission/error reports. The submission/error report(s) a provider's office receives depends on the billing service and/or electronic interchange vendor used. Because Health Partners Plans uses Emdeon as the gateway for all electronic submissions from other billing services and/or electronic interchange vendors, an acknowledgement of all claims accepted through Emdeon and submitted to Health Partners Plans is generated, as well as a first level rejection report of those claims not passing Emdeon edits. Once the Emdeon edits are passed, Health Partners Plans' system edits for member, provider and coding information, and these edits generate a second level of acceptance and/or error reports. Providers should check with their billing service and/or electronic interchange vendor to fully understand how the Health Partners Plans specific information is being provided.

During the 180 calendar day initial filing period, a provider may resubmit a non-accepted (invalid or EDI rejected) claim as often as is necessary to have it accepted. It is the provider's responsibility to ensure their claims are accepted. Once an initial claim is accepted, any subsequent (repeat) filing, regardless if it is paper or electronic, will deny as a duplicate filing. The initial claim, however, will be processed.

If the claim does not appear on an Explanation of Payment within 45 calendar days of submission as paid, denied, or as a duplicate of a claim already under review, and no rejection notice has been received, the provider must pursue the claim status to ensure it was accepted.

Claim status can be confirmed by calling the Provider Services Helpline at 215-991-4350 or 888-991-9023 or by accessing HP Connect on our website, www.HealthPartnersPlans.com.

An inquiry does not extend or suspend the timely filing requirement.

If, after resubmission, another 45 calendar days pass without the claim appearing on the Explanation of Payment (even as a duplicate denial), the provider should contact Health Partners Plans to discuss what could be preventing the claim from being accepted.

Claims that have been adjudicated (paid or denied) cannot currently be re-filed as though they were initial, unprocessed claims. Re-filing a previously adjudicated claim will cause automatic denial as a duplicate submission. To contest an incorrectly processed claim, see the Claims Inquiry and Reconsideration Section.

**Filing Period Exceptions**

The only exceptions to the 180-calendar day filing period are:

- If the delay was caused by a third-party resource filing. Third-party resource claims must be submitted within 60 calendar days of the initial determination notification from the primary carrier.
• If Health Partners Plans' Enrollment department verifies a problem determining a member's eligibility.
• Non-par Medicare providers must submit claims within 27 months of the date of service.

Claim Form Filing Requirements
Claim form completion requirements for both CMS-1500 and UB-04 forms are on pages 12-25 and 12-28, respectively, of this section. Each field is listed by number and include a description of the data needed along with an “R”, “A” or “O” field code. If the field is coded “R” (required) the data must be completed on every form submitted. If the field is not complete or contains invalid data, the claim will not be considered for payment.

If a field is coded “A” (when Applicable), the data is required only for claims submissions where the field is directly related to the billed services for that record type. However, if the information is not included but is applicable to the billed services, the claim will not be considered for payment. Only claims completed as outlined will be eligible for payment consideration.

A field coded “O” is optional.

Common Reasons for Claim Rejections or Denials include but are not limited to:

• Incorrect Member Identification number.
  Do not use the Medicaid ACCESS card number when submitting claims. Use of this number will cause a claim rejection. Until DHS has assigned a permanent Medical Assistance number, newborn claims may be billed using their temporary Health Partners Plans identification number, which is usually Mother's identification plus a 'Z' and a number at the end. This identification number will be provided by Health Partners Plans when the provider obtains the authorization. Providers must validate that the newborn's permanent identification number has not been assigned before billing. Once the permanent number is assigned, claims will reject if submitted under the temporary number.

• Incorrect Provider Identification number.
  For electronic claims a provider must use both the individual and the billing NPI number. For paper claims providers can bill with either their individual NPI or the Health Partners Plans legacy number. If these numbers have not been established on the Health Partners Plans processing system it may cause a provider to appear as non-participating, thus requiring authorization for services. Without an authorization, or a valid legacy provider number all claims will be denied.

• Authorization and claim service dates do not match.
  Providers are responsible for communicating all service dates, beginning/admission through ending/discharge. If the scheduled service date is canceled or rescheduled, providers must call Inpatient Services or Outpatient Services to update the authorization to reflect the change. Any service dates not included in the authorization will be denied.

• Invalid procedure and/or diagnosis codes.
  Claims must be coded with the most current procedure codes and diagnosis codes at the highest level of specificity. Unless claims are properly and completely coded, they will be rejected if invalid or denied if obsolete.
- Referrals to non-participating providers. Except for emergency services, all non-participating providers require prior authorization. (Please call Health Partners Plans Inpatient and Ancillary Services.) Without proper authorization nonparticipating provider claims will be denied.

- Health Partners Plans billed as primary when other insurance exists. Providers must verify coverage every time a member is seen for services. Health Partners Plans can be contacted to review other insurance information on file. If Health Partners Plans is billed before the primary carrier has made a determination, the claim will be denied.

- Explanation of Payments/Benefits (EOP/EOB) from primary insurers not submitted for secondary payment. Health Partners Plans will only pay up to our allowable fee schedule or contracted rate, minus what the primary payer did or would have paid as demonstrated on the EOP attachment. The claim will be denied until the required EOP information is submitted.

- Member benefit limitation has been exceeded. Certain benefit packages have limitation to the number of services allowed. Health Partners Plans will only pay for those services covered under their respective benefit package and will only reimburse the allowable portion of the claim, i.e., coinsurance and deductible.

**Electronic Data Interchange (EDI)**

Health Partners Plans offers providers the speed, convenience and lower administrative costs of electronic claims filing or Electronic Data Interchange (EDI). EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative cost. The plan uses Emdeon Transaction Services (also may be known as NEIC, ENVOY or WebMD ENVOY) as our claims clearinghouse.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs.
  - EDI eliminates the need for most paper claim submissions.

- Faster transaction time for claims submitted electronically.
  - An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received by Health Partners Plans. Many electronically submitted claims, because of the “clean data” embedded within the claim, can be auto-adjudicated.

- Validation of data elements on the claim form.
  - By the time a claim is successfully received electronically, information needed for processing has been pre-screened for required elements and, if passed, will be accepted as submitted. This reduces the chance of data entry errors that occur when completing paper claim forms.

For all claims (837Institutional and 837Professional) submitted electronically through the Emdeon clearinghouse, Health Partners Plans can electronically return detailed status information through Emdeon.
The status message will show which claims were accepted, rejected and/or pending, and provide the amount paid on the submitted claim once it has been finalized. It is the Provider’s responsibility to monitor all reports of electronic submissions to assure that claims are accepted. Please contact your billing software vendor for additional information regarding all available reports.

To take advantage of EDI, providers should contact their billing software vendor and request that Health Partners Plans claims be submitted directly through the Emdeon claims clearinghouse. Or, billing software vendors may be able to submit claims through their current clearinghouse and request forwarding to Emdeon. (Providers who are already Emdeon submitters, but who do not receive Emdeon claim status reports, should contact their software vendor.) If you require assistance with electronic filing contact Health Partners Plans at EDI@hpplans.com.

**EDI Claim Filing Requirements**

Health Partners Plans Payer ID Number is 80142 for all lines of business.

Claims transmitted electronically must contain all of the required data elements identified within the 837(Professional and Institutional) Claim Filing Companion Guide found at www.HealthPartnersPlans.com and click Info for Providers >HIPAA Connect >HIPAA Companion Guides. Emdeon or any other EDI clearinghouse or vendor may enforce additional, allowable data record requirements.

In order to send claims electronically to Health Partners Plans, all EDI claims must be forwarded through Emdeon. This can be completed through any EDI clearinghouse or vendor.

Emdeon validates against HIPAA-required Transaction Code Set edits, allowable Emdeon proprietary specifications, and allowable Health Partners Plans specific requirements. Claims not meeting the required HIPAA or Emdeon edits are immediately rejected and sent back to the sender via the RPT 05 Provider Daily Statistics report. This report details the rejected claims and the error explanation. Claim records that do not pass these required edits are considered invalid and will be rejected as never received at the plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

Emdeon accepted claims are tracked on the RPT04 Daily Acceptance Report by the provider. This is a list of claims passed to Health Partners Plans, but not necessarily accepted by Health Partners Plans. If there are providers or members not found, or other allowable edits due to invalid claim data, these claims may be rejected by Health Partners Plans.

Providers should pay close attention to the RPT11 Unprocessed Claims Report because it is the notification report that identifies claims that are not accepted in the Health Partners Plans system. This report is a critical part of the workflow in that it contains the reason these claims were not accepted. Claim records that do not pass Health Partners Plans required edits are considered invalid and will be rejected as never received at the plan. In these cases the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

Providers are responsible for verification that EDI claims are accepted by Emdeon and by Health Partners Plans. Acknowledgement reports, claim acceptance reports, error reports for rejected claims, and unprocessed claim reports that are received from Emdeon directly or other contracted billing or gateway vendors must be reviewed and validated against transmittal records daily.
If a provider is submitting claims through a billing company or single source (such as a hospital EDI Unit handling all specialty department billing), and that billing company or single source is combining all records into one daily file when sending electronic submissions to Emdeon, any acknowledgement or rejection reports may also be combined. It is the responsibility of the billing company or single source to separate those errors and work them with each respective provider or medical department. Health Partners Plans' EDI team can see all errors that are reported on the RO59 Unprocessed Claim Report and that the rejection occurred, but can do no more to help with the flow of information at the provider's end.

**EDI Exclusions**
Certain claims may not be submitted through electronic billing. The exclusions fall into two categories:

- **Excluded Providers**
  Providers or vendors who are not contracted with Emdeon, thus whose claims are not transmitted through Emdeon.

- **Excluded Claims**
  Until further notice, the following claims must be submitted on paper
  Claims requiring supportive documentation or attachments such as secondary claims with primary insurer's Explanation of Payment.

**Early Periodic Screening, Diagnosis & Treatment Reporting (Medicaid)**

Early Periodic Screening, Diagnosis and Treatment (EPSDT) reports are filed for all members from the time of birth until 21 years of age. Completion of a claim form documenting any encounter, whether the service is prepaid (capitated) or fee-for-service, is a mandatory requirement, not an option.

The Primary Care Physician of a member under the age of 21 years should perform and report EPSDT screens and appropriate immunizations, or make arrangements for EPSDT screens to be performed elsewhere. These screens must be in accordance with the schedule developed by DHS and recommended by the American Academy of Pediatrics. As per the EPSDT guidelines, providers must advise members to obtain the appropriate dental services, contact Health Partners Plans EPSDT unit (1-800-500-4571) to coordinate dental appointments and document the referral on the claim.

Health Partners Plans providers may use the CMS-1500 form or file an electronic claim to report EPSDT activity. Dental referrals (YD) should be keyed in the IOD field of the claim. Health Partners Plans relies on receipt of thoroughly completed CMS-1500 forms to obtain useful aggregate information about overall delivery of preventive care.

To properly report an EPSDT claim, Primary Care Physicians should report:

- The appropriate level Evaluation and Management CPT code with the modifier EP, plus CPT code EP Modifier.
- Age Appropriate Evaluation and Management Codes (as listed on the current EPSDT Periodicity Schedule and Coding Matrix). These are:
Table 1: EPSDT Periodicity Schedule and Coding Matrix

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 Age less than 1 year</td>
<td>99391 Age less than 1 year</td>
</tr>
<tr>
<td>99382 Age 1-4 years</td>
<td>99392 Age 1-4 years</td>
</tr>
<tr>
<td>99383 Age 5-11 years</td>
<td>99393 Age 5-11 years</td>
</tr>
<tr>
<td>99384 Age 12-17 years</td>
<td>99394 Age 12-17 years</td>
</tr>
<tr>
<td>99385 Age 18-20 years</td>
<td>99395 Age 18-20 years</td>
</tr>
</tbody>
</table>

**Note:** If both the Evaluation and Management and EP Modifier are not submitted, the claim will not generate any additional above-capitation payment and may reject for incomplete coding.

- All immunization CPT codes,
- Developmental Screening code 96110 - (ages 9-11 months, 18 months, and 30 months)
- Lab Codes 85013 (Blood Count-hematocrit), 85018 (Blood Count-hemoglobin) - ages 9 through 12 months
- Lab Code 83655 (Lead Screening) - ages 9 months through 6 years
- Lab Code 80061 (Lipid Panel) - ages 18, 19, and 20
- Visual Acuity Screening Code 99173 - ages 3 through 20
- Hearing Codes 92551 (audio screen) and 92552 (pure tone) - ages 3 through 20

Without this required coding, the encounter will not be able to be reported to DHS. If an encounter is unable to be reported, the provider may be subject to retraction of payments made for these services.

When making a dental referral a provider must submit a remark code of YD on the claims. If submitting a CMS1500 form the YD should be places in field 10D. If submitting electronically the YD code is placed in 2300NET01.

All EPSDT documentation is required as a permanent part of the member's medical record.

**Benefits for Pregnant Women (Medicaid Only)**

Certain limitations on the number of services or applicability of copayments do not affect pregnant women. Women who are confirmed to be pregnant are eligible for comprehensive medical, dental, vision, and pharmacy coverage with no copayments or visit limits during the term of their pregnancy, and until 60 days postpartum. These services include expanded nutritional counseling and smoking cessation services. However, services which are not covered under a pregnant woman's HealthChoices Benefit Package (HCBP) are also NOT covered, even while pregnant. For a fuller description of the benefits for pregnant women, please see HP Benefits During and After Pregnancy on page 4-12.

To ensure that a claim be processed without a service limitation, providers must bill with a pregnancy indicator on the claim.
Notes on Copayments

Copayments for services are summarized in the benefits section. Services may not be denied to any Medical Assistance recipient on the basis of inability to collect a copay at the time of service.

Copayments that are due but not paid should be indicated on the claims as follows:

<table>
<thead>
<tr>
<th>CMS-1500</th>
<th>Box 24H code 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>UB92/UB04</td>
<td>Condition code/indicator, Y3</td>
</tr>
<tr>
<td>837-I</td>
<td>2300 Loop, HI, 01, qualifier BG, data element Y3. The condition code/indicator is Y3.</td>
</tr>
<tr>
<td>837-P</td>
<td>2300 Loop, NTE 01= ADD and NTE 02 = VC11 to indicate copay not collected.</td>
</tr>
<tr>
<td>NCPDP</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Physician Administered Drugs (Medicaid Only)

In accordance with the Department of Human Services Operations Memorandum (#10/2013-012), if a claim type is an 837P or 837 I Outpatient, and the payment is based upon a HCPCS code such as a J-code or Q-code, the drug must be submitted with the NDC code along with the units dispensed.

Coordination of Benefits

Health Partners Plans’ Medical Assistance plan is payer of last resort, thus is secondary payer to all other forms of health insurance, Medicare, or other types of coverage. With the exception of prenatal (excluding hospital delivery claims) and preventive pediatric care, if other coverage is available, the primary plan must be billed before Health Partners Plans will consider any charges. Prenatal (excluding hospital delivery claims) and preventive pediatric care is paid regardless of other insurance. After all other primary and/or secondary coverage has been exhausted, providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payer to Health Partners Plans. Secondary claims may also be filed electronically following the HIPAA compliant transaction guidelines.

DHS provides Health Partners Plans with Third Party Liability Resource information files on all Medical Assistance recipients. Health Partners Plans uses DHS's resource information as a base for other insurance coverage. If, however, evidence of other insurance is discovered and validated by Health Partners Plans, this information will be added to the Health Partners Plans system and relayed to DHS. All information on the Health Partners Plans file is available to the providers by calling Health Partner Plans’ Provider Services Helpline. If, while providing medical services, the provider learns about third-party resources that do not appear on the member's information file or that resources on the file are no longer effective, he/she is required to report the information to Health Partners Plans.

Health Partners Plans will coordinate benefits to pay up to Health Partners Plans’ Medicaid fee schedule allowable or otherwise contracted rate. If a primary insurer pays more than Health Partners Plans would have paid as primary, no additional reimbursement will be made.
Providers who receive payment from both Health Partners Plans and a carrier who was primary to Health Partners, and find they are in an overpayment situation, should return Health Partners Plans' payment per Medicaid regulatory requirement. If Health Partners Plans discovers overpayment to a provider, the provider must comply with Health Partners Plans' recovery efforts.

Third Party Liability also relates to automobile insurance and personal injury insurance coverage (homeowners, business liability insurance, etc.). Should a provider render services for injuries resulting from an accident, the automobile or other liability carrier(s) should be billed as primary. If Health Partners Plans is billed and pays inappropriately as primary, the rights of recovery fall to DHS. The provider is required by regulation to return these incorrect payments to DHS.

Third Party Liability also relates to personal injury legal actions brought by a member against a liable party to recover losses. Providers should bill medical insurers for all services even if the member intends to bring a lawsuit. Providers should not hold bills expecting to file against any legal settlement or with insurers after judgment. If Health Partners Plans is billed and pays as primary, and the member succeeds in their legal action, the right of subrogation to recover for medical losses falls to DHS. DHS may place a lien against any judgment handed down compensating the member, thus shifting the cost of the member's medical losses to the liable party.

Claims that could have been paid by a primary carrier, but were denied because the provider failed to adhere to that carrier's claim filing or utilization management requirements, will not be considered by Health Partners Plans. Unless an allowed amount from the primary carrier is present on the Explanation of Benefits and payment was not issued because of reasons other than the provider's error, Health Partners Plans will not assume the primary insurer responsibility.

Note: Members enrolled in KidzPartners may not be enrolled in any other health insurance program.

Copayment, Coinsurance and Deductibles
Providers are advised NOT to collect any copayments, coinsurance or deductibles at the time of service for a Health Partners (Medicaid) member who has other coverage (making Health Partners Plans the secondary payer). Providers must consider payment from all sources in accordance with their payer contracts before determining if there is ever any member liability. If Health Partners Plans is the secondary payer, the member, as a Medicaid recipient, never has payment liability unless the service is a non-covered service and the member has been notified in writing and in advance of the service of their liability for payment.

Health Partners Essential – Providers will be required to collect copayments from members in accordance with PCO OPS Memos and/or compliance with approved 1115 Demonstration waiver.

Health Partners Essential is prohibited from holding a Member liable for the following:

- Debts of Health Partners Essential in the event of insolvency.
- Services provided to the Member in the event of Health Partners Essential failing to receive payment from DHS for such services.
- Services provided to the Member in the event of a healthcare provider with a contractual, referral or other arrangement with Health Partners Essential failing to receive payment from DHS or Health Partners Essential for such services.
• Payments to a provider that furnishes compensable services under a contractual, referral or other arrangement with Health Partners Essential in excess of the amount that would be owed by the Member if Health Partners Essential had directly provided the services.

Note: Services may not be denied to any Medical Assistance or Private Coverage Option recipient on the basis of inability to collect a copay at the time of service.

After the primary payer has made a claim determination, a secondary claim and the primary carrier’s Explanation of Payment should be submitted to Health Partners Plans for consideration. Please use the post office box established for claims with attachments. HIPAA required Transaction Code Standards apply to electronic secondary claims.

If the primary payer pays less than the Health Partners Plans allowed amount, additional payment will be issued to make the provider whole up to the Health Partners Plans allowed amount, not to exceed the member’s liability, assuming all filing criteria and medical appropriateness criteria are met. If the primary insurer has paid up to or more than the Health Partners Plans allowed amount, no additional payment will be made. Once the Health Partners Plans allowed amount is reached by payment from either/or both payers, the provider is considered “paid in full” under the Health Partners Plans contract or negotiated fee arrangements. No additional money (copayment, coinsurance or deductible) can be collected from the member. Any money collected from the member that exceeds Health Partners Plans’ allowable amount must be immediately returned to the member. To collect money from a member exceeding what is owed under a Medicaid contract or fee arrangement violates Medicaid regulations and Pennsylvania statutes.

If a primary payer denies payment due to the provider's failure to follow that Plan's utilization management processes or claim filing procedures, Health Partners Plans will also deny that claim unless payment is required by regulation, statute or contract. If Health Partners Plans is required to issue payment even though the primary payer denies the claim, the most Health Partners Plans is obligated to pay is the amount that would have been paid as secondary payer. If the claim is denied by both the primary payer and Health Partners Plans, the member has no liability to pay copayment, coinsurance or deductible.

Members enrolled in KidzPartners may not be enrolled in any other health insurance program. If a KidzPartners member presents with other active insurance a Provider should verify eligibility with the other payer, collect applicable copays and submit the claim to the other insurer. The Provider should notify Health Partners Plans of the insurance by calling the Provider Helpline at 215-991-4350 or 800-991-9023 or sending in the Explanation of Payment (EOP) from the other insurer. Health Partners Plans’ Enrollment department will determine the effective dates of the other insurance and contact the member if there is termination in coverage.

Overpayments
Providers who participate with Health Partners and Health Partners Essential must participate in the Medical Assistance (MA) Program. Providers who participate in Medical Assistance enter into a written provider agreement with the State of Pennsylvania and must adhere to the MA Regulations. Under MA Regulation, (55 Pa. Code § 1101.69), a provider who is overpaid on a claim is obligated to reimburse the excess payment. This Regulation applies to money paid by the State or by Health Partners Plans, as one of the state contracted Managed Care Organizations (MCO). Providers who participate in Health Partners Plans’ CHIP program must adhere to federal regulations relating to
overpayments. Under Federal Regulations (42CFR489.21, 42CFR489.40 and 42CFR489.41), a provider who is overpaid is obligated to reimburse the excess payment. Any overpayment received by the provider on one claim may not be applied to the outstanding balance of any other claim. Claims are individual financial transactions and must be accounted for in that manner by all parties.

There is no time limitation for requesting reimbursement of overpayments from providers receiving State or Federal Funds. Health Partners Plans (Medicaid, PCO and CHIP programs), however, follow the same recovery time period guidelines for non-fraud related claims as are adopted by the Department of Human Services: two years from the date of payment notice.

Provider known overpayments should be returned to:

Attn: Recovery Unit
Health Partners Plans
901 Market Street
Philadelphia, PA 19107

If Health Partners Plans discovers an overpayment, recovery will be initiated and will be reflected on the provider's current Explanation of Payment. If the amount owed Health Partners Plans by a provider exceeds the amount of money to be paid within a payment cycle(s), an Explanation of Payment(s) will not generate until the credit balance is cleared. Once the amount owed is offset by current payments, the retractions and the offsetting payments will generate on the most current Explanation of Payment.

Retroactive Disenrollments and Recovery
Health Partners, Health Partners Essential and KidzPartners members are occasionally retroactively disenrolled. When this occurs, any premiums paid to Health Partners Plans are retracted by DHS or the Pennsylvania Insurance Department. Therefore, since Health Partners Plans received no revenue to offset the member's medical expenses, Health Partners Plans is under no obligation to pay for such services. When this happens, claim payments to providers will be retracted for services occurring within the retro-disenrollment period.

Correct Coding Intervention
Health Partners Plans applies correct coding standards that integrate nationally accepted guidelines including Current Procedural Terminology (CPT) logic as documented by the American Medical Association, and Correct Coding Initiatives (CCI) and post-operative guidelines as outlined by the Centers for Medicare & Medicaid Services to review claim submissions.

Codes determined to be included in or incidental to another procedure will be replaced with the more comprehensive code. Invalid codes that have been superseded with a current code may be replaced. If, however, there is any doubt about how to correct the coding, the claim will be denied for invalid coding, allowing the provider to take corrective action and re-file the claim. Pertinent modifiers must be used to communicate bilateral and repeated procedures performed on the same day.

Both the originally submitted code and the more accurate code will appear on the processed claim. The originally submitted code will have no payment. The new code will have payment, if
Interest Payment

Under Pennsylvania law (Act 68), Health Partners Plans is required to pay 10% per annum interest on clean claims and uncontested portions of a contested claim that are not paid within forty-five (45) days of receipt. A clean claim is defined as a healthcare service claim for payment that has no defect or impropriety. A defect or impropriety includes, but is not limited to, the lack of required substantiating information or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. Claims from a healthcare provider who is under investigation for fraud or abuse regarding those claims are outside the definition of clean claims.

Forty-five (45) days is measured on an initial submission from the date of receipt by the health plan to the date of the check issuing payment or the date of electronic fund transfer. If a paid claim is re-adjudicated, a new 45-day period begins on the date additional information prompting the re-adjudication is received by HealthPartners Plans. Only additional monies paid are subject to interest calculation. If a claim or portion of a claim is contested (not paid) by Health Partners Plans, then overturned and paid, interest will be calculated on the amount subsequently paid, beginning from the date additional information prompting the re-adjudication was received by Health Partners Plans.

Under Act 68, interest may be calculated and paid as a separate check issued outside the claim payment and remit process, or may be included as part of the claim payment. Interest owed of less than $2.00 on a single claim does not have to be paid. If more than $2.00 interest payment is owed, but not received via the claim payment and remit or via a separate check within 30 days after claim payment, providers should contact the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-13).

False Claims Act and Self Auditing

Identifying and reporting fraud, waste and abuse is everyone’s responsibility. Health Partners Plans takes this very seriously and holds all employees, members and providers accountable for reporting all concerns of fraud, waste and abuse.

Providers in our network are responsible for auditing themselves and reporting any findings that would have resulted in an overpayment or underpayment to them. Providers in our network are responsible for auditing themselves and reporting any findings that would have resulted in an overpayment or underpayment to them. You can find self-auditing protocols on the U.S. Department of Health and Human Services (HHS) website at [http://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp](http://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp), or on the Pennsylvania Department of Human Services (DHS) website at [www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/index.htm](http://www.dhs.state.pa.us/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/index.htm).

The False Claims Act is the single most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including Medicare and Medicaid providers, every year. Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government’s damages plus civil penalties of $5,500 to $11,000 per false claim.
If you wish to report Medicare or Medicaid fraud or suspicious activity, please call the Health Partner Plans SIU Hotline at 1-866-HP-SIU4U (1-866-477-4848), the CMS Medicare Hotline Number at 1-800-MEDICARE (1-800-633-4227), or the Department of Human Services Medicaid Hotline at 1-866-379-8477.

Claim Inquiries and Reconsiderations
The procedures for inquiring about the status of claims or to request reconsideration of a payment decision are provided in the section below.

Claim Inquiries
All telephonic claim inquiries are directed through Health Partners Plans at 215-991-4350, option #2 or 800-991-9023, option #2. Providers may verify the following over the telephone:

- claim status
- payment amount
- check date and number
- denial and denial reason

Providers can also check claim status via Health Partners' HP Connect at www.HealthPartnersPlans.com. The on-line registration for access to HP Connect is under the Info for Providers tab.

Claim Reconsiderations
A provider can request a reconsideration determination for a claim that a provider believes was paid incorrectly or denied inappropriately, whether the result of a provider billing error or a Health Partners Plans processing error. Providers have three options to request a reconsideration of a claim. Whichever method is used, a claim reconsideration request must be received within 180 calendar days from the date of the Explanation of Payment (EOP) advising of the adjudication decision:

1. For your convenience, our Rapid Reconsideration program provides an easy way to request claim reconsideration. Call to speak “live” with a claim reconsideration specialist who can reprocess a claim (or confirm a denial) while you're on the line. If the claim is approved for payment a check will be processed and mailed during the next scheduled check run - in a maximum of eight days. This service is available Monday to Friday, 8:00 am to 4:30 pm, by calling 888-991-9023 or 215-991-4350, and choosing option #7. Please be sure to have the claim number or EOP ready when you contact the call center.

2. Written requests for claim reconsiderations.

Claim reconsideration requests should include a copy of the Health Partners Plans EOP and documentation supporting the assertion that the claim was paid incorrectly or why the denial should be overturned. Other important points to remember:

- If the claim involves other insurance, information regarding the member's primary insurance coverage, including a copy of the primary EOP/EOB must be provided.
- If the claim was denied for lack of an authorization or services not matching the authorization, the provider must contact the appropriate utilization management area to
address the authorization problem and, only when resolved, submit a claim reconsideration request.

- If the claim was denied because the provider is non-participating and lacked authorization, but the provider believes he or she is participating, there may be a problem with credentialing. Health Partners Plans must be contacted and this issue resolved before the claim can be reconsidered. Please contact Health Partners Plans for assistance at 215-991-4350 or 800-991-9023 to verify provider identification numbers. Claims denied because the requested authorization or level of care was not approved constitute a medical necessity disagreement. Claim reconsiderations due to denial of an authorization or level of care disputes should be mailed to:

  Attn: Utilization Management/Appeals  
  Health Partners Plans  
  901 Market Street  
  Philadelphia, PA 19107

All other written requests for reconsiderations are directed through the Claim Services department.

For prompt handling, reconsiderations should be sent to:

  Attn: Claim Reconsideration  
  Health Partners Plans  
  901 Market Street  
  Philadelphia, PA 19107

The provider will be advised of the claim reconsideration outcome, generally within 30 calendar days of the date the written request was received by Claim Services. Claims that are overturned and have payment issued will appear on the provider’s EOP and no other notice will be provided. If the original denial is upheld, the provider will be sent a form letter advising of the right to dispute and appeal the outcome.

3. Providers may also submit requests through the provider portal, HP Connect. To request assistance with access to HP Connect, providers may call Health Partners Plans at 888-991-9023 or 215-991-4350.
### Sample CMS-1500 Form (Version 8-05 New Form)

**Figure 9.1: SAMPLE CMS 1500 FORM**

![CMS-1500 Form](image)
## Billing Requirements for CMS-1500 Form (Version 8-05 New Form)

<table>
<thead>
<tr>
<th>FIELD #</th>
<th>FIELD DESCRIPTION</th>
<th>R (Required)</th>
<th>C (Conditional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Health Partners Plans ID number</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Patient name (last name, first name, middle initial)</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Patient's birth date and sex</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>N/A (Same as field #2)</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient complete address and telephone number</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Patient's relationship to insured</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>N/A (Same as field #5)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Patient's status</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other insured information</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is patient condition related to</td>
<td>R</td>
<td>R, R</td>
</tr>
<tr>
<td></td>
<td>a. Employment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Auto accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Other accident?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Insured's policy group of FECA number</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>11a</td>
<td>Insured's date of birth</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>11b</td>
<td>Employer's name or school name</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>Insurance plan or program name</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>11d</td>
<td>Is there another health benefit plan?</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient's or authorized person's signature</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Insured's or authorized person's signature</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Date of current illness, injury, pregnancy</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Date of same of similar illness</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Dates patient unable to work in current occupation</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Name of referring physician</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>Other referring ID number (must be reported with one of the NUCC qualifiers)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>NPI (the referring HIPAA NPI number)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization dates related to current services</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Medical License Number</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Outside lab?</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis code(s) relate items to 24c by procedure line</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Medicaid resubmission code (original DCN adjustments)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>FIELD #</td>
<td>FIELD DESCRIPTION</td>
<td>R (Required)</td>
<td>C (Conditional)</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>23</td>
<td>Prior authorization number</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>24a</td>
<td>Date(s) of service</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>24b</td>
<td>Place of service</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>24c</td>
<td>EMG</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>24d</td>
<td>Procedures, services, or supplies/modifiers</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>24e</td>
<td>Diagnosis pointer</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>24g</td>
<td>Days or units</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>24h</td>
<td>EPSDT (family plan)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>24i</td>
<td>Rendering provider other ID number (must be reported with one of the NUCC qualifiers)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>24j</td>
<td>Rendering provider NPI ID number</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Federal tax ID number</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Provider's patient account number</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Accept assignment (assumed yes by Health Partners Plans contract)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Total charge</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Amount paid</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Balance due</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or supplier</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Service facility location information</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>32a</td>
<td>NPI number of the service facility location</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>32b</td>
<td>Other ID number (must be reported with one of the NUCC qualifiers)</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Billing provider name, address, zip code, and phone number</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>NPI (HIPAA provider number)</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>33b</td>
<td>Non-NPI - Other ID number (must be reported with one of the NUCC qualifiers)</td>
<td>Optional</td>
<td></td>
</tr>
</tbody>
</table>
Sample UB-04

Figure 9.2: UB-04 Claim Form
## Billing Requirements for UB-04 Form

<table>
<thead>
<tr>
<th>FIELD #</th>
<th>FIELD DESCRIPTION</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider name, address and telephone, county code</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>Pay-to name, address, pay-to ID</td>
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**R=Required**  
**C=Conditional**
Explanation of Payment (EOP)
This statement reports fee-for-service payments to providers, including PCPs, specialists, ancillaries and hospitals. (It does not report payments for capitated services.) The EOP reports claim charges that are paid or denied, and the reason for the payment or denial. The EOP also shows any coordination of benefits payments, any adjustments or interest payments, as well as the provider NPI and Health Partners Plans legacy identification numbers. Additionally, the EOP indicates claims that have been modified to reflect correct coding as determined by Correct Coding Initiative and/or American Medical Association guidelines. Please visit www.InstaMed.com for additional information regarding your EOP.