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SECTION 10: CLAIMS SUBMISSION

CLAIMS MANAGEMENT

A key component of quality health care is accurate, timely and efficient claims processing. HPSJ utilizes recognized industry standard billing codes and guidelines in the processing of paper and electronic claims.

MEMBER BILLING

As a Medi-Cal plan, many of the same rules that apply to Medi-Cal fee-for-service apply to HPSJ. If the services provided are Covered Services, then HPSJ's reimbursement to Provider constitutes full payment and the Member cannot be balance billed for these services. In addition, neither co-pays nor deductibles are permitted in Medi-Cal.

If a Member is willing to compensate a Provider for a non-covered service and the Provider is willing to accept a negotiated payment between the parties, that agreement is considered outside of Medi-Cal and thus outside the supervision of HPSJ. However, the service must clearly not be for a Covered Service or covered benefit under Medi-Cal.

Violation of the Medi-Cal or HPSJ payment rules could result in the immediate termination of the Provider's Agreement.

REQUIREMENTS FOR A COMPLETE CLAIM

A Complete Claim is a complete and accurate claim form that includes all Provider and Member information, as well as Members records, information, or documents needed to enable HPSJ to process the claim. The Complete Claim date is the date on which all such required information has been received.

CLAIMS AND PAYMENT TIMELINES

The timely filing guideline for HPSJ claims is three hundred and sixty-five (365) days from the date of service. If a claim is not submitted within the appropriate time frame, the claim will be denied unless disputed pursuant to C.C.R. Section 1300.71.38 and a good cause for delay can be presented. Requests for a claims adjustment, corrections, or reconsideration of an adjudicated claim must also be received no later than three hundred sixty-five (365) days following the date of payment or denial of the claim.

Extenuating circumstances causing delay would include but not be limited to:

- A catastrophic event that substantially interferes with normal business operations of the Provider
- Administrative delays or errors by HPSJ or the California Department of Health Care

Services (DHCS) and/or the California Department of Managed Care (DMHC)

- Other special circumstances reviewed and approved by HPSJ

Consideration will be given for extenuating circumstances provided that complete documentation is submitted to HPSJ justifying the delay.

ADVANTAGES OF ELECTRONIC CLAIMS SUBMISSION

To submit claims electronically Providers must establish an account with *Office Ally* or *Emdeon*. Please contact one of these vendors to set up electronic claims submission, using the contact numbers listed in the table. For assistance in setting up the account with either vendor, contact the Provider Services Department at (209) 942-6340.

Submitting claims electronically has substantial benefits including:

- **Expedited claims processing:** Electronic submission allows HPSJ to begin adjudicating claims faster than if the claim is submitted by paper.
- **Cost effectiveness:** Electronic submission eliminates the cost of purchasing billing forms, envelopes and postage.
- **Claims Submission Confirmation:** Electronic submission provides fast electronic confirmation of a claim submission from the clearinghouse.

CLAIM FORMS AND CLAIM SUBMISSIONS

Claims can be submitted in either paper form or electronically. The standard forms accepted are Form 1500 (formerly CMS 1500), UB04, and any successors to these forms. HPSJ will acknowledge the receipt of electronic claims within two (2) Working Days of receipt and acknowledge receipt of paper claims within fifteen (15) Working Days.

Before filing a claim, be sure to verify the Member's eligibility (see Eligibility Verification, Enrollment, and Customer Service section). Our clearinghouse vendors for electronic claims submission are *Emdeon* and *Office Ally*. Information on where to file claims is indicated below:

Paper Claims for HPSJ	Electronic Claims	Claims Disputes
HPSJ PO BOX 839 El Cerrito, CA 94530	**Office Ally** (866) 575-4120 info@officeally.com Payer ID: HPSJ1 **Emdeon** (877) 469-3263 Payer ID: 68035	HPSJ PO BOX 30490 Stockton, CA 95213- 0490

CLAIMS FORMS AND REQUIRED FIELDS FOR FORM 1500

Form 1500 Formerly CMS 1500			
Applicable Field	Claim Information		Required (Y, N)
1a	TYPE OF HEALTH INSURANCE		Y
2	PATIENT'S NAME		Y
3	PATIENT'S BIRTH DATE (MM/DD/CCYY) and SEX		Y
4	INSURED'S NAME	If different from patient's	Y
5	PATIENT'S ADDRESS	Complete mailing address (Street/PO Box, City, State, Zip)	Y
6	PATIENT'S RELATIONSHIP TO INSURED		Y
9	OTHER INSURED'S NAME	Complete if applicable	Y
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Complete if applicable	Y
9c	OTHER INSURED'S PLAN NAME OR PROGRAM NAME	Complete if applicable	Y
10	PATIENT'S CONDITION RELATED TO (a) EMPLOYMENT (b) AUTO ACCIDENT (c) OTHER ACCIDENT	Yes or No response required	Y
11	INSURED'S POLICY GROUP OR FECA NUMBER		N
11a	INSURED'S DATE OF BIRTH		Y
11c	INSURANCE PLAN NAME OR PROGRAM NAME		N
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		Y
13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE		Y
14	DATE OF CURRENT ILLNESS (FIRST DATE OF ONSET), INJURY (ACTUAL DATE OF INJURY), OR PREGNANCY (LMP)		Y
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	First name, middle initial, last name, with no credentials	Y
17b	REFERRING PHYSICIAN'S NATIONAL PRACTITIONER IDENTIFIER (NPI)		Y
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		Y
19	SUPERVISING PHYSICIAN'S NAME	When services are rendered by a Physician Assistant of Nurse Practitioner	Y
20	OUTSIDE LAB CHARGES	When services have been rendered by an independent provider as indicated in Item Number 32 and the related costs	Y
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis code(s) to highest level of specificity	Y
22	RESUBMISSION CODE	Indicates the resubmission code and the original claim number	Y

Form 1500 Formerly CMS 1500			
Applicable Field	Claim Information		Required (Y, N)
23	PRIOR AUTHORIZATION NUMBER		Y
24a	DATES OF SERVICE		Y
24b	PLACE OF SERVICE		Y
24d	PROCEDURES, SERVICES, OR SUPPLIES	CPT or HCPCS codes and modifiers; if billing a physician-administered drug charge include NDC number on claim; Ambulatory Surgical Centers (ASC) must bill with modifier SG when billing the facility charge.	Y
24e	DIAGNOSIS POINTER	Use the diagnosis designations (A-L) listed in field 21, as the reference pointers in this field. The primary reason (primary diagnosis) for the service must be the first diagnosis pointer listed in the field. Use multiple pointers for secondary diagnoses related to the service line, if appropriate.	Y
24f	$ CHARGES		Y
24g	DAYS OR UNITS	Days, units or number of minutes for anesthesia if applicable	Y
24j	RENDERING PROVIDER ID#	Rendering provider’s NPI number	Y
25	FEDERAL TAX I.D. NUMBER	Federal Tax ID or Social Security Number of provider	Y
26	PATIENT’S ACCOUNT NUMBER		N
27	ACCEPT ASSIGNMENT?	Yes or No entry is required.	Y
28	TOTAL CHARGE		Y
29	DOLLAR AMOUNT	Total amount the patient/or other payers paid on the Covered Services only must contain a dollar amount or zero	Y
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	Attending/supervising provider name, with credentials	Y
32	SERVICE FACILITY LOCATION INFORMATION	Service site name and address where Covered Services are rendered, if different from billing address. Required for Medicare.	Y
32a	SERVICE FACILITY NPI	If applicable	Y
33	BILLING PROVIDER NAME, ADDRESS, AND PHONE NUMBER		Y
33a	BILLING PROVIDER NPI		Y

SECTION 10: CLAIMS SUBMISSION

CLAIMS SUBMISSION NOTIFICATION

Upon submission of a Complete Claim, payment or denial will be made within forty-five (45) Working Days. HPSJ shall notify Providers in writing no later than forty-five (45) Working Days after receipt of a claim by HPSJ if HPSJ intends to contest or deny the claim. The notice will identify the portion of the claim that is contested and the specific reason HPSJ is contesting the claim. If the claim is contested because HPSJ has not received the information necessary to determine HPSJ liability for the claim, then Providers will have forty-five (45) Working Days from the date of the notice to provide the information requested. HPSJ will then complete its consideration of the claim within forty-five (45) Working Days after receiving the requested information.

CLAIMS PEND/REVIEW

Claims that cannot be auto adjudicated, or that fail an edit, or audit check, may be "pended" for review by a claims analyst who will identify the reason for the pended status. For paper claims, the claims analyst will examine the scanned image of the claim and attachments.

CLAIMS REIMBURSEMENT

Claims for Providers will be reimbursed according to the terms specified in the Provider's Agreement. Claims for non-contracted providers will be adjudicated primarily in accordance with Medi-Cal guidelines for Medi-Cal patients. All providers will receive a Remittance Advice (RA), indicating payment or the denied reason if the claim is denied.

CLAIMS OVERPAYMENT

Providers should inform HPSJ of any claims overpayment and return the overpayment to HPSJ within thirty (30) business days from the date the Provider identifies the overpayment. This is particularly true for overpayments resulting from subsequent payments made by California Children's Services (CCS).

If HPSJ determines that it has overpaid a claim, either in connection with an audit or otherwise, HPSJ will notify the Provider in writing through a separate overpayment notice clearly identifying:

- Claim
- Member
- Date of service
- Explanation of overpayment
- Interest and penalties that may be due on the claim

The overpayment notice will be issued within:

- Three hundred sixty-five (365) days of the date of payment on the overpaid amount for claims arising from Benefit Plans regulated by the DMHC; or
- At any time, in the event of fraud and/or misrepresentation

Overpayment notices will be sent to the Provider's address of record with HPSJ for the receipt of claim related correspondence and payments unless the Provider informs HPSJ in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.

Non-Contested Overpayment

If the Provider does not contest HPSJ's overpayment notice, the Provider must reimburse HPSJ within thirty (30) business days from the date of receipt of the overpayment notice. If the Provider fails to reimburse HPSJ within those thirty (30) business days, then, beginning on the first calendar day after the expiration of this thirty (30) business day time period, HPSJ will offset the amounts due against future payments and including interest at the rate of ten percent (10%) per annum.

Contested Overpayment

If the Provider wishes to contest the overpayment notice, it must be done within thirty (30) business days from the date of receipt of the overpayment notice, by sending to HPSJ a written appeal clearly stating the basis upon which he/she believes that the claim was not overpaid. HPSJ will review and make a decision with respect to this appeal, and notify the Provider of its decision in writing within forty-five (45) business days from the date HPSJ receives the written appeal.

Offsetting Against Future Claims

If HPSJ denies the Provider's appeal, the Provider must reimburse HPSJ for the overpayment within thirty (30) business days from the date it receives the written notice of HPSJ's denial of the written appeal. If the Provider fails to reimburse HPSJ within those thirty (30) business days, then beginning on the first calendar day after the expiration of this thirty (30) business day time period, HPSJ may offset this amount, plus interest at ten percent (10%) per annum, against future claims. HPSJ will provide written notice and details identifying the specific overpayments that have been offset against the specific current claims.

INTEREST ON UNPAID CLAIMS

HPSJ will pay interest on each uncontested claims not paid timely, frivolous contested claims, and claims where HPSJ supplies late notice or no notice of the claim being contested or denied. HPSJ will also pay interest on payment adjustments made if a Provider dispute involves a claim and the dispute is determined in whole or in part in favor of the Provider.

Interest payments will apply to both contracted and non-contracted providers. The interest rate is fixed at a fifteen percent (15%) annual rate. For claims from an emergency services facility, the minimum amount of interest is the greater of fifteen dollars ($15) or the fifteen percent (15%) per annum. Interest will be paid for each day beginning with the first day after the deadline through the date payment is mailed.

If HPSJ fails to automatically include the interest due on a late claim payment, HPSJ will pay a ten dollar ($10.00) penalty for that late claim in addition to any amounts due. In determining the timelines, HPSJ will use the receipt date of the original claim, or the receipt date of the dispute, whichever is appropriate.

Capitated Providers are also subject to the payment of interest at the amounts outlined above for any fee-for-service claims that are not covered under the capitation agreement.

CLAIMS DENIAL AND REJECTS

HPSJ requires that all claims be submitted using codes that are current and are accepted by both Medi-Cal and Medicare. Providers should use the most current versions of ICD, ASA, DRG, CPT4, and HCPCS Level II for the date of service rendered. Should either Medi-Cal or Medicare mandate a new set of medical codes for common use, Providers will be required to bill accordingly. For claims for Medi-Cal Members, HPSJ reimburses using the most current Medi-Cal fee contract and processes claims using Medi-Cal billing guidelines.

Below are some common reasons that a claim may be denied or rejected:

- National Correct Coding Initiative (NCCI) edits
- Edits for procedure code frequency
- Missing or invalid codes
- Incorrect modifiers
- Missing or incorrect diagnosis codes
- Procedure codes that indicate a diagnosis inconsistent with what is billed
- Code billed is part of a more comprehensive code billed on the same date of service
- Code is inappropriate for the specialty or location billed
- Code is inappropriate for age or sex of patient
- Claims requiring “consent” submitted without consent forms (i.e., sterilization)

HPSJ issues a denial when the claim has passed initial edits but has been billed with invalid codes or miscellaneous information that causes the system to deny. Elimination of these errors results in prompt payments to Providers.

CLAIMS STATUS AND QUESTIONS

You can view the status of the claims that you have submitted through DRE. To access DRE, please go to the HPSJ website, www.hpsj.com. If you are unable to obtain satisfactory answers regarding claims status or other claim questions, please contact our Customer Service Department at (209) 942-6320 or (888) 936-7526. The Claims Department Fax number is (209) 461-2555.

CALIFORNIA CHILDREN'S SERVICES (CCS)

HPSJ is not financially responsible to reimburse providers for services to patients who qualify for CCS-eligible services. Providers must bill CCS instead of HPSJ for CCS-eligible services by submitting Service Authorization Requests (SARs) to a CCS county or State office, except in an Emergency. To render CCS-eligible services to Medi-Cal patients and to receive reimbursement from CCS, providers must be CCS paneled and the facility must be a CCS certified facility.

For more information about the CCS program, please visit the CCS website at www.dhcs.ca.gov/services.

IMPORTANT BILLING TIPS

- Be sure you obtain prior Authorization for any Covered Services that require prior Authorizations. DRE has a list of codes that require prior Authorization.
- File your claims within the required timely filing requirements.
- File your claims electronically if at all possible.
- Use the standard and most updated Current Procedural Terminology (CPT) codes, International Classification of Diseases (ICD) codes, Health care Procedure Coding System (HCPCS) codes, or Revenue Codes. Please refer to the Medi-Cal manual and website at www.medi-cal.ca.gov for billing guidelines.
- Use the National Provider Identifier Standard (NPI) correctly and appropriately:
- A valid 10-digit NPI must be entered in the billing provider field on the paper claim form or electronic claim submission.
- The NPI must belong to the correct Provider. (A Provider rendering medical care cannot use the Group's NPI and vice versa. Providers who render medical care in a Facility cannot use the Facility's NPI, and vice versa. An individual Provider cannot use another individual Provider's NPI).
- A valid NPI is entered in the attending, admitting, or operating provider ID field.
- A valid NPI is entered in the referring provider field.
- The complete 9-digit ZIP code must be entered in the billing provider address field.

- A valid NPI of the inpatient Facility where medical care is rendered is entered in the service facility NPI field.
- National Drug Code (NDC) numbers are required for certain medical supplies.
- Invoices are also required for certain HCPCS codes.
- Preventative exams for Medi-Cal Members under nineteen (19) years of age must be billed on 1500 claim forms.
- When submitting paper claims:
  - Send the original claim form and retain a copy for your records.
  - Do not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.
  - Carbon copies, photocopies, facsimiles, or forms created on laser printers are not acceptable for claims submission and processing.

FACILITY CLAIMS

Newborns

Please note that Hospitals must notify HPSJ of Member newborns within twenty-four (24) hours of birth. Under HPSJ rules, newborns are covered using the mother's Member number for one (1) month after birth or until the newborn is issued their own number. Also:

- Claims should be filed under the mother's information. Do not file charges for the newborn on the same claim form as the mother.
- Submit the newborn claim after the mother's claim has been submitted. A healthy newborn is submitted with the mother's ID number, newborn information, and the delivery Authorization.
- If the newborn requires a longer stay, submit claim with the same information except with a new Authorization.
- In the case of multiple births, each child's information should be submitted on a separate claim. If the newborns require further hospitalization, each child will have a separate Authorization number which must be used on each claim.

REQUIRED FIELDS FOR THE UB FORM

The following form outlines only the REQUIRED Field Information:

UB Required Field Information			
Applicable Field	**Claim Information**		**Required (Y, N)**
	Service Units	(e.g., the number of days in a particular accommodation) or the time required to provide at least one unit of service for each revenue code billed. For accommodations, the unit of service field must match the total number of days indicated in FL 6. Calculate each 24-hour period as one day. To calculate units, round up to the nearest whole number.	Y
47	Total Charges	Submit a charge for each revenue code billed. Even if there is no charge, you must either enter 0.01 or N/C on the line item.	Y
50	Payer	Enter your local insurance plan name followed by the Plan Code	Y
51	Provider Number	Enter your facility's provider billing number. The provider number you enter must correlate with the Type of Bill (FL 4).	Y
56	NPI	Enter your facility's National Provider Identifier (NPI) number.	Y
58	Insured's Name	Enter the last and first name of the policyholder, using a comma or space to separate the two. Do not leave a space between a prefix (e.g., MacBeth). Submit a space between hyphenated names rather than a hyphen (e.g., Smith Simmons). If the name has a suffix (e.g., Jr., III) enter the last name followed by a space and then the suffix (Miller Jr. Roger).	Y
59	Member Relationship	Enter the code that indicates the relationship of the Member to the Insured.	Y
60	Insured's Unique ID	Enter the identification (ID) number as it appears on the Member's ID Card	Y

UB Required Field Information			
Applicable Field	**Claim Information**		**Required (Y, N)**
67	Principal Diagnosis Code/ Other Diagnoses	Submit a valid principal International Classification of Diseases, ICD diagnosis, including the fourth and fifth digits when appropriate.	Y
69	Admitting Diagnosis Code	Enter the International Classification of Diseases, ICD diagnosis code for the Member at the time of admission.	Y
74	Principal Procedure Code	In-Patient Services: An ICD Volume 3 procedure code and the date the practitioner performed the procedure are required in this field when you bill Revenue Codes 036X, 049X and 075X.	Y
76		Enter the Unique Physician Identification Number (UPIN) and the name	Y
1G	Attending Physician/ ID-Qualifier	of the licensed physician who certifies or recertifies the medical necessity of the services the Member received and/or who has primary responsibility for the Member's medical care and treatment during an inMember stay.	

ANCILLARY CLAIMS

Billing for ancillary Covered Services should be in accordance with Medi-Cal guidelines. Specific information for all ancillary Covered Services can be found in the online Medi-Cal Provider Manual at www.medi-cal.ca.gov under "Publications."

Below are the forms that should be used for billing the following ancillary services:

PROVIDER TYPE	BILLING FORMS
Diagnostic Services	1500 Form
Skilled Nursing Facilities	UB Form
Ambulatory Surgery Center	UB Form, include correct place of service
Ambulance Services	1500 Form
Durable Medical Equipment	1500 Form
Home Health/Hospice	UB Form; use bill type 32X