Health Plan of San Joaquin

Volume 1

Provider Billing and Resource Guide

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Introduction

Health Plan of San Joaquin (HPSJ) is pleased to have you as part of our Provider network. We recognize that the strength of our health care programs depends upon strong collaboration and communication with our Providers and their staff.

HPSJ, a not-for-profit health plan initiative for San Joaquin County, has been serving Members and the community since 1996. HPSJ is the leading Medi-Cal Managed Care Plan in San Joaquin and Stanislaus counties. While our service areas currently cover only San Joaquin and Stanislaus counties, our extensive referral network extends well beyond this local area and includes facilities and Providers in other parts of the Central Valley, the Bay Area, and the Greater Sacramento Area.

We currently have two conveniently located offices to serve Members and Providers. For more information, visit our website at www.hpsj.com. Our friendly staff looks forward to serving you!
The objective of this resource guide is to provide Health Plan of San Joaquin providers with an understanding of our policies and procedures regarding claims and billing for professional and facility services. This resource guide includes detailed information about billing & coding methodologies per Medi-Cal, DHCS, DMHC and CMS reimbursement policies.

In our continuing effort to provide our providers with adequate resources, HPSJ strongly encourages providers to engage in Medi-Cal Provider Training which can be found at https://learn.medi-cal.ca.gov/.

This guide will be revised periodically as needed. Providers will be notified when an updated version becomes effective, and the online version is available on the HPSJ provider website. Additionally, providers may be notified via Provider Alerts and notices posted on the website and potentially on Remittance Advice (RA) notices. Provider Alerts can supersede information within the resource guide.

Policies and Procedures

This section of the guide details HPSJ's policies and procedures

Disclaimer

This manual is also intended to help Providers more effectively do business with HPSJ, so please make time to review it carefully. To the extent there is any inconsistency between the terms of this manual and your network participation agreement, the terms of your network participation agreement will control. Please contact Provider Services by telephone at **209.942.6340** or e-mail at ProviderServices@hpsj.com with questions.

Authorization Requirements

Provider should note that any service or benefit detailed within this guide are subject to prior authorization requirements. HPSJ follows Medi-Cal benefit guidelines; however, the prior authorization requirements may not match the treatment authorization request (TAR) requirementslisted on the state Medi-Cal website. For the most up-to-date list of prior authorization requirements, contracted Providers can access our Provider Portal (DRE), or contact us at **1.888.936.PLAN (7526) or** contact the UM department.

Member/Balance 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

California Children Services (CCS) Eligible Services

Providers should follow the following process for CCS claim submission:

- Any CCS eligible service should be billed to CCS before the Managed Care Plan (MCP).
- As we continue to streamline our claims process to align with MCAL, you may see an increase in the denials you receive regarding possible CCS conditions.
    - If you receive denials, you will need to bill CCS with a Service Authorization Request (SAR).
    - If the SAR is denied, or if you have a Notice of Action (NOA) on file, please resubmit to HPSJ as a corrected claim with a copy of the denied SAR or NOA.
    - For billing criteria pertaining to corrected claims, please refer to the previous Provider Alert dated April 20, 2016 (attached).
    - Please ***DO NOT*** submit a dispute with the SAR denial or NOA as this will delay processing of the claim.
- For tips on billing CCS, please refer to the MCAL website http://www.medi-cal.ca.gov under one of these sections:
- California Children's Services (CCS) Program Eligibility
- California Children's Services (CCS) Program Service Code Groupings
- CCS

Claim Form Use

Claim Form	Provider Type	Billables Services on Form
CMS-1500	PCP	Professional Services
CMS-1500	Specialists	Professional Services
CMS-1500	Clinic	Professional Services
CMS-1500	Imaging Centers	Professional X-ray and related services
?????	Long-Term Care (LTC)	All LTC services
CMS-1500	Pharmacy	
CMS-1500	Laboratory	
UB-04	Hospitals / Clinics / FQHCs / SNFs / ASCs	All professional or facility services

Claims Submission and Processing

This section explains claims submission requirements and general claims processing information.

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.

Claims Submission Process

HPSJ accepts and strongly encourages our providers to submit claims electronically through Electronic Data Interchange (EDI). The advantages of submitting an electronic claim versus a paper claim include:

- Faster, more expedient payment of your claims
- An electronic receipt acknowledging your claim (EDI vendor)
- Improved claims tracking
- Improved claims status reporting
- Improved turnaround time for timely reimbursement
- Elimination of paper and waste
- Improved cost effectiveness

Electronic claims submission (EDI)
To initiate the electronic claims submission process or to get more information, contact the following:

Office Ally
(866) 575-4120
info@officeally.com Payer ID: HPSJ1

Change Health Care
(877) 469-3263
Payer ID: 68035

Paper claims submission
Paper claims should be submitted to HPSJ at the following address:

Health Plan of San Joaquin (HPSJ)
Paper Processing Facility
P.O. Box 211395
Eagan, MN 55121

Corrected Claim Submission

HPSJ will treat corrected claims as replacement claims. When you submit a corrected claim, it is important that you clearly identify that the claim is a correction rather than an original claim. Refer to the guidance below for information on submitting CMS-1500 and UB-04 claims forms – for any of the reasons listed below.

When submitting a revised claim, HPSJ no longer asks providers to stamp or write the word "corrected" on the CMS-1500 paper or electronic form. ***However,*** claims do need to have the right billing code to help us identify when a claim is being submitted to correct a claim that we have processed.

Correcting electronic CMS-1500 claims –

- Enter this Claim Frequency Type (billing) code in the 2300 loop in the CLM*05 03:
- Claim Frequency Type (billing) code 7, for a replacement/correction
- Enter the original claim number in the 2300 loop in the REF*F8*

Correcting paper CMS-1500 claims –

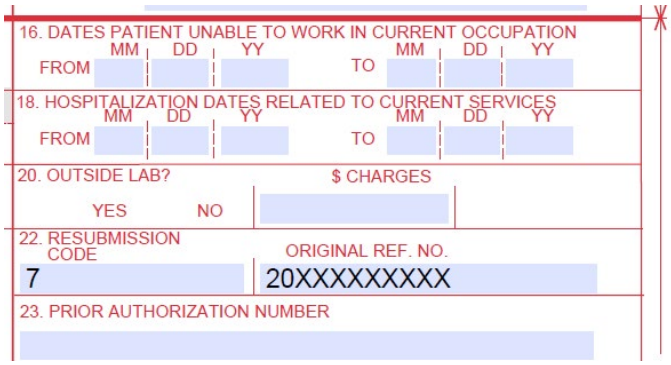
- Fill out box 22 (resubmission code) to include this code:

  - Code 7 (the "replace" billing code), to let us know this is a corrected or replacement claim
- For the **Original Ref. No.** – if available – enter the HPSJ "original" claim number.
- **NOTE:** Corrected claims should be sent with ALL line items filled out for that claim, and they should never be filed with just the line items that need to be corrected.

If your claim denies as a duplicate, when NOT to submit a dispute –

- If your claim denies as a duplicate and it was not sent with the right indicator for "corrected claim" submission, do **not** submit a dispute.
- Resubmit the claim with the indicator for processing.
- If a dispute is received, it will be returned to you to resubmit using the corrected
- claim steps listed above.

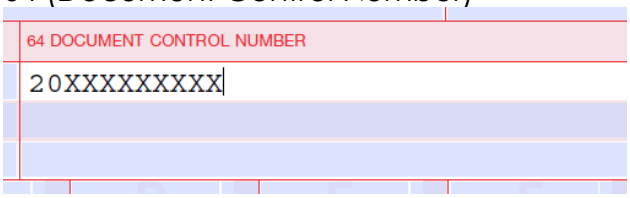
Example (CMS-1500):



Correcting paper UB04 claims –

- The fourth digit of the **"Type of Bill"** (field 4) should be "7"

- Include the original claim number in box 64 (Document Control Number)

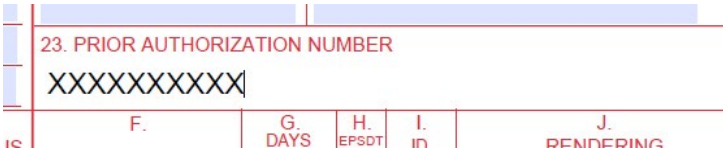


Authorizations

All claims must include the Prior Authorization number to be processed timely. Please ensure all claim submissions include the Prior Authorization number prior to submitting the claim.

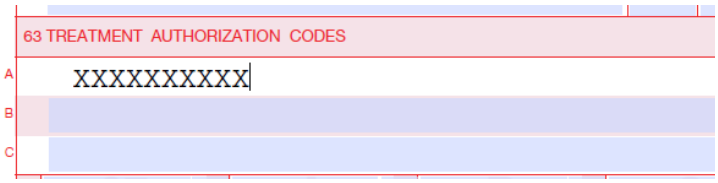
Include Prior Authorization Numbers in the following field(s):

- **Paper - Professional claims** (CMS-1500) - Box 23



- **Electronic – Professional claims (837P)** – REF02 when REF01='G1' in Header Loop 2300 or Line Loop 2400

- **Paper - Institutional claims – (UB-04)** - Box 63



- **Electronic – Institutional claims (837I)** – REF02 when REF01='G1' in Header Loop 2300

DO NOT submit a claim with a hardcopy of an authorization attached to the claim form (CMS-1500 or UB-04).

Please log into our Provider Portal (DRE). If you are not currently a provider portal (DRE) user, please click here and select Sign Up for more information.

Please refer to the HPSJ Provider Manual for complete instructions on how to obtain prior-authorizations and communicate with Utilization Management.

Claim Reimbursement

DHCS Encounter Requirements

HPSJ must conform to California's Department of Health Care Services (DHCS) Quality Measures for Encounter Data and ensure that complete, accurate, reasonable, and timely submission of encounter date for all items and services furnished to our Members.

Please review the following:

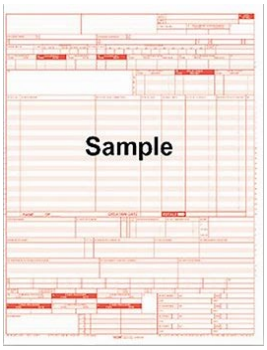
1. **From Service/Statement Date** must be less than or equal to **Received Date** *(Claim Submission Date)*
2. **COB Paid Date** must be greater than or equal to **TO Service/Statement Date**
3. **COB Paid Date** must be less than or equal to **Received Date** *(Claim Submission Date,*
4. **Admission Date** is **required** for **inpatient encounters** *(both institutional and professional claims)*
5. **Admission Date** must be less than or equal to **From Statement Date***
6. **Admission Date** must be less than or equal to **To Statement Date**
7. **Death Date** must be greater than or equal to **To Service Date**
8. **Discharge Date** must be greater than or equal to **To Service Date**
9. **Procedure Date** must be greater than or equal to **From Statement Date*** *(institutio claims)*
10. **Procedure Date** must be less than or equal to **To Statement Date** *(institutional clai*
11. **From Service/Statement Date** must be less than or equal to **To Service/Statemen Date**
12. **To Statement Date** must be less than or equal to **Received Date** *(Claim Submission Date) (institutional claims)*
13. **To Service Date** must be less than or equal to **Adjudication Date** *(Claim processing date)*
14. **Date of Service** must be greater than or equal to **From Service Date** *(Professional claims)*
15. **Date of Service** must be less than or equal to **To Service Date** *(Professional claims)*
16. **Date of Service** must be less than or equal to **Adjudication Date** *(Claim processing date) (Professional claims)*
17. **Date Prescription Written** must be less than or equal to **Date of Service** *(Professio claims)*

Health Insurance Claim (CMS 1500) Form Instructions

The most current and standard Center of Medicaid and Medicare Services (CMS) 1500 form must be used to bill HPSJ for medical services. The form isused by Physicians and Allied Health Professionals to submit claims for medical services. All items must be completed unless otherwise noted in the appendix forCMS1500 paper or electronic claim forms.

Health Insurance Claim Form(UB 04) Instructions

The UB 04 claim form is used to submit claims for inpatient and outpatient services by institutionalfacilities (for example, outpatient departments, Rural Health Clinics,chronic dialysis, and Community-Based Adult Services). All fieldsmust be completed unless otherwise noted in the appendix for UB paper or electronic claim forms.



For more detailed information regarding required fields for each form, please refer to the HPSJ Provider Manual.

NOTE: *IN ORDER TO MAINTAIN THE HIGHEST LEVEL OF DATA INTEGRITY, HPSJ WILL NOT ADD OR CHANGE ANY INFORMATIONON A SUBMITTED CLAIM (ELECTRONIC OR PAPER), THEREFORE, THE ENTIRE CLAIM MAY BE REJECTED IF ANY OF THE REQUIRED DATA ELEMENTS ARE MISSING OR INVALID.*

Other Insurance / Coordination of Benefits

State law requires Medi-Cal to be the payer of last resort for services in which there is a responsible third party.

HPSJ gives as much information as mandated per DHCS. The Local Health Plans of California are working with DHCS to ensure Automated Eligibility Verification System (AVES) is updated in a timely manner. However, it is ultimately the providers responsibility to search for and verify OHC (***Medicare and/or Commercial***) and bill the other carrier(s) before submitting to HPSJ for processing.

Prior to delivering services providers are required to review the Medi-Cal Eligibility Record for the presence of OHC. If the member has active OHC, HPSJ or any subcontractor of HPSJ must ensure providers compare the OHC code (Appendix A) to the requested service. If the requested service is covered by the OHC, HPSJ or any subcontractor of HPSJ must ensure providers are identifying and billing the OHC carrier as primary.

Medi-Cal Members with Other Health Coverage (OHC) must utilize their OHC for covered services prior to accessing their Medi-Cal benefits.

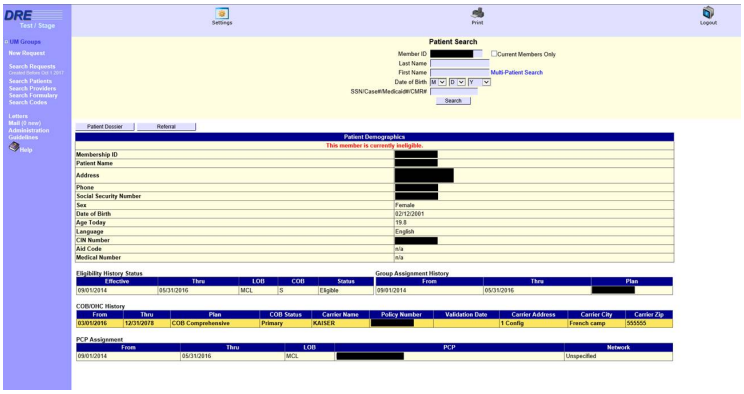
- Providers verify other insurance coverage
  - Report other insurance coverage discrepancies
- Providers bill the other insurance carrier
  - Exhaust other commercial health insurance sources
- Review outputs of other insurance processing:
  - Explanation of Benefits (EOB)
  - Remittance Advice (RA)
- Providers submit claims to HPSJ using the following:
  - Electronic submission
  - Paper claims and the Explanation of Benefits (EOB) form

Verifying Other Insurance Coverage

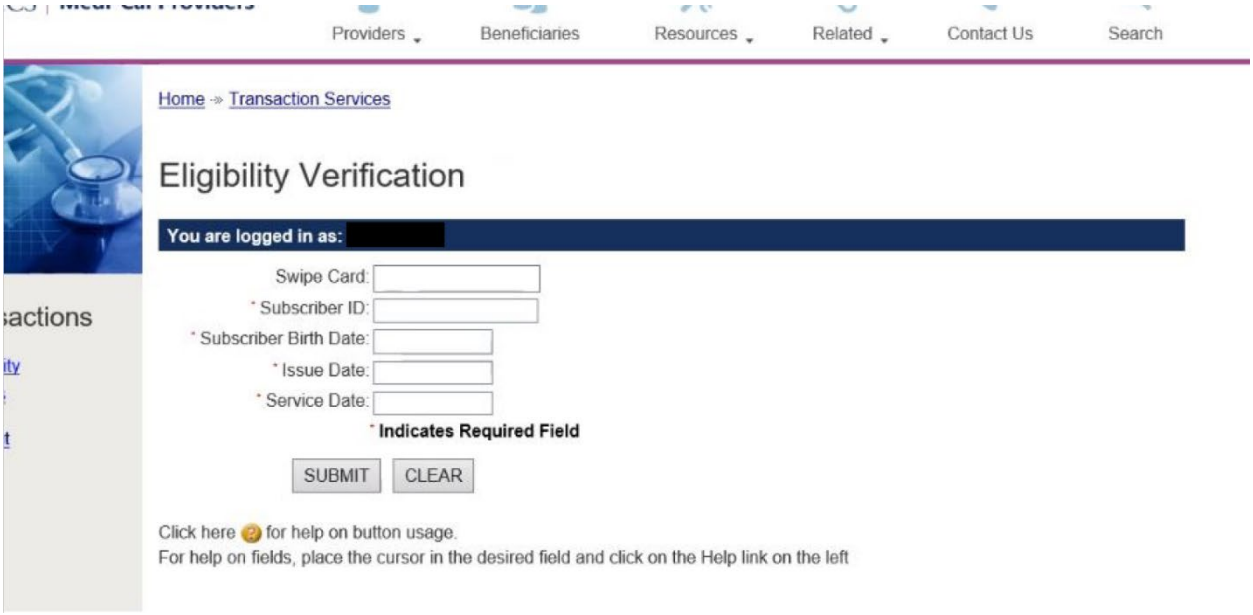
- Contracted providers can access HPSJ's DRE to determine if a member has other health insurance coverage
- Non-Contracted providers can access DHCS' Enrollment Verification System (EVS) to determine if a member has other health insurance coverage.

DRE

When verifying a Member's eligibility, an indicator will be visible in the HPSJ's secure Provider portal Doctor's Referral Express (DRE) by viewing "COB/OHC History." It is the Providers' responsibility to review the information available through the Other Health Coverage indicator to determine the responsible payer.



AVES



Denied Claim Due to OHC

When a claim is denied due to OHC, requiring Providers to first bill the primary health coverage and then HPSJ as the secondary payer:

Providers will be directed to our secured webpage via the remittance advice or 835 files. HPSJ should be billed as the secondary carrier once the primary payer has made a payment or denial determination.

Contracted Providers may access DRE for robust eligibility verification record of OHC.

HPSJ's OHC Look-up Tool can be accessed by ***non-contracted*** providers (https://www.hpsj.com/non-contracted/) for robust eligibility verification record of OHC.

Submitting Claims to HPSJ for Secondary Payment

- The provider is required to demonstrate that a correct and complete claim was submitted to the commercial insurer before submitting a claim to HPSJ.
- When submitting a claim to HPSJ for secondary payment, the claim must:
    - be identical to the claim submitted to the primary payer (e.g., codes, modifiers, and units billed)
    - include the primary payer's processing information from the RA OR EOB (payments, reason/remark codes)

Note: Medicare claims are sent to HPSJ directly, therefore you are not required to send a claim and COMB to the plan for review and processing

Fraud, Waste, and Abuse

HPSJ cooperates with the California Department of Health Care Services (DHCS) in working to identify Medi-Cal fraud, waste, and abuse. Fraud and abuse prevention are monitored and managed by the HPSJ Quality Improvement Department.
HPSJ works with analysts, investigators, and clinicians to perform audits to monitor compliance with standard billing requirements. These audits can be used to identify the following activity (not an inclusive list):

- Inappropriate "unbundling" of codes
- Claims for services not provided
- Up-Coding/Incorrect coding
- Potential overutilization
- Coding (diagnostic or procedural) not consistent with the Member's age/gender
- Improper use of benefits
- Use of exclusion codes
- High number of units billed

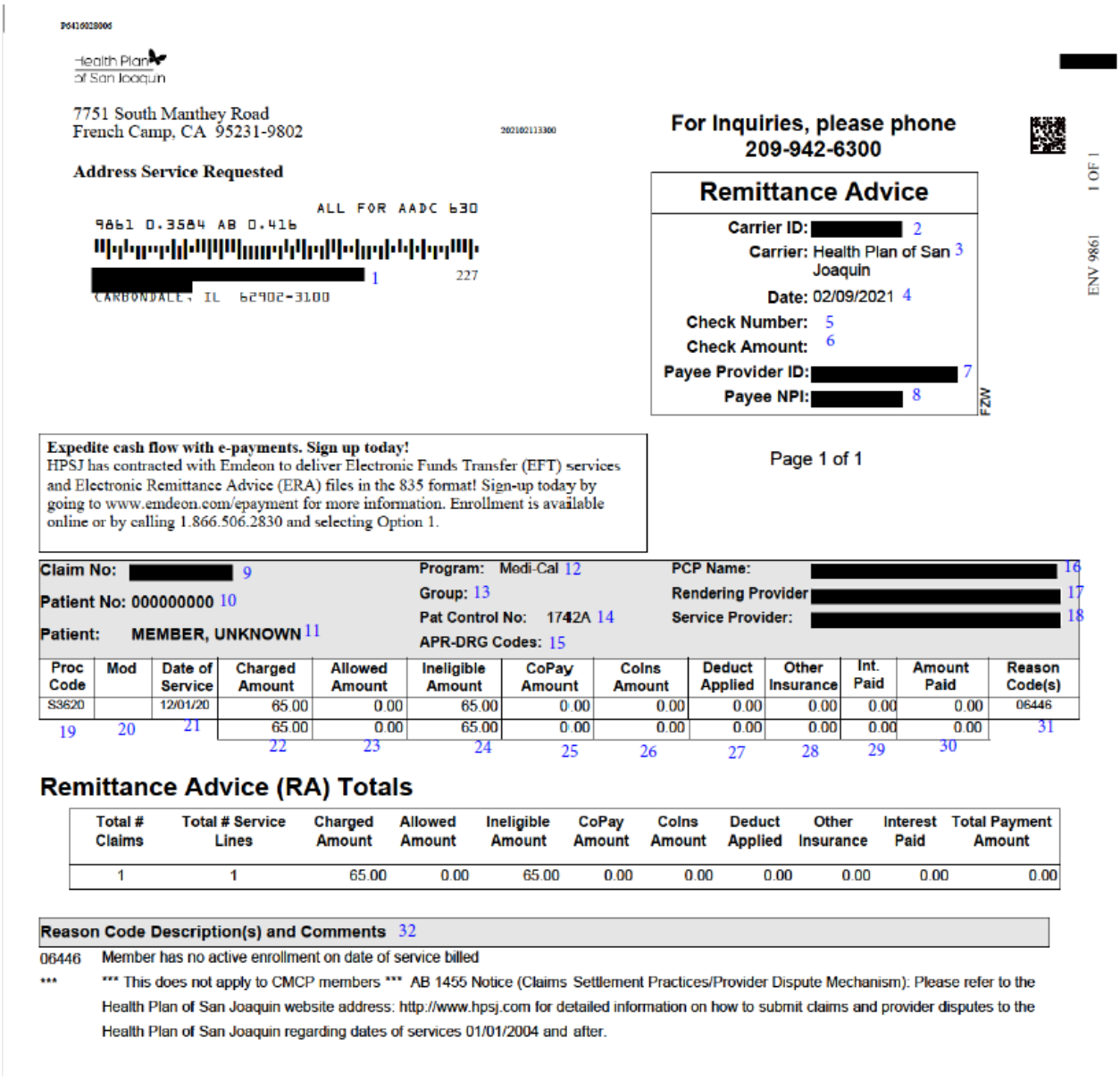
When required, HPSJ will report suspected fraud and/or abuse to the DHCS and Department of Justice (DOJ) Bureau of Medi-Cal Fraud. Providers must cooperate in potential investigations by making office staff and subcontracted personnel available for interviews, consultation, conferences, hearings, and in any other activities required in an investigation.

For information regarding potential fraud, waste, and abuse or to report potential occurrences, Providers should contact the UM Department at 209.942.6320.

How to read your Remittance Advice

This guide provides an overview and detailed information for the RA for professional providers. It includes the definitions for headers, numbers, and remarks used in the new Provider EOB.

Use this guide as a reference tool for office staff to understand and interpret HPSJ remittances.



Health Plan of San Joaquin

7751 South Manthey Road
French Camp, CA 95231-9802

Address Service Requested

ALL FOR AADC 630
9861 0.3584 AB 0.416
[redacted] 1 227
CARBONDALE, IL 62902-3100

For Inquiries, please phone 209-942-6300

ENV 9861 1 OF 1

Remittance Advice

Carrier ID: [redacted] 2
Carrier: Health Plan of San Joaquin 3
Date: 02/09/2021 4
Check Number: 5
Check Amount: 6
Payee Provider ID: [redacted] 7
Payee NPI: [redacted] 8

FZW

Expedite cash flow with e-payments. Sign up today!
HPSJ has contracted with Emdeon to deliver Electronic Funds Transfer (EFT) services and Electronic Remittance Advice (ERA) files in the 835 format! Sign-up today by going to www.emdeon.com/epayment for more information. Enrollment is available online or by calling 1.866.506.2830 and selecting Option 1.

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Claim No: [redacted] 9
Patient No: 000000000 10
Patient: MEMBER, UNKNOWN 11
Program: Medi-Cal 12
Group: 13
Pat Control No: 1742A 14
APR-DRG Codes: 15
PCP Name: [redacted] 16
Rendering Provider [redacted] 17
Service Provider: [redacted] 18

Proc Code	Mod	Date of Service	Charged Amount	Allowed Amount	Ineligible Amount	CoPay Amount	Coins Amount	Deduct Applied	Other Insurance	Int. Paid	Amount Paid	Reason Code(s)
S3620		12/01/20	65.00	0.00	65.00	0.00	0.00	0.00	0.00	0.00	0.00	06446
19	20	21	65.00 22	0.00 23	65.00 24	0.00 25	0.00 26	0.00 27	0.00 28	0.00 29	0.00 30	31

Remittance Advice (RA) Totals

Total # Claims	Total # Service Lines	Charged Amount	Allowed Amount	Ineligible Amount	CoPay Amount	Coins Amount	Deduct Applied	Other Insurance	Interest Paid	Total Payment Amount
1	1	65.00	0.00	65.00	0.00	0.00	0.00	0.00	0.00	0.00

Reason Code Description(s) and Comments 32

06446 Member has no active enrollment on date of service billed

*** *** This does not apply to CMCP members *** AB 1455 Notice (Claims Settlement Practices/Provider Dispute Mechanism): Please refer to the Health Plan of San Joaquin website address: http://www.hpsj.com for detailed information on how to submit claims and provider disputes to the Health Plan of San Joaquin regarding dates of services 01/01/2004 and after.

Provider Summary

The first page of each Remittance Advice (RA) is a Provider Summary. This page displays addresses, financial totals, and payment information for a paper check or Electronic Funds Transfer (EFT).

1. Provider Number: The Billing Provider's Name and address
2. Carrier ID: HPSJ's carrier identification number.
3. Carrier Name: Health Plan of San Joaquin
4. Date: Date of payment
5. Provider Check Number: Identifies the check number of the payment.
6. Provider Check Amount: Identifies the check amount.
7. Provider Number: The Billing Provider's National Provider Identifier (NPI).
8. Payee Provider ID Number: A identification number assigned to each payee, for whom payments may be issued.
9. Claim Number: The number that identifies or refers to the claim that the provider submitted to HPSJ.
10. Patient Number: Payments made to the member by the Plan.
11. Patient: If you receive an EFT payment, this field displays the amount deposited.
12. Program: The incentive pool accrued for provider performance programs.
13. Group: The Billing Provider's National Provider Identifier (NPI).
14. Patient Control Number: This is your provider-assigned patient ID number
15. APR-DRG Codes: All Payer Refined - Diagnosis Related Groups
16. PCP: Primary Care Physician
17. Rendering Provider: Individual, facility, institution, corporate entity, or other organization that supplies health services or items.
18. Service Provider: An individual or entity that provides services to the member
19. Procedure Code: The procedure or revenue code for each service.
20. Modifier: The procedure code modifier.
21. Date(s) of Svc: The date(s) that the member received health care services.
22. Charged Amount: The dollar amount charged by the provider for the services rendered.
23. Our Allowance: The amount allowed (i.e., contract rate) for each covered service.
24. Ineligible Amount: Lists the codes that describe the type of pricing on the claim.
25. Co-Pay Amount: The co-payment amount owed by the member to the provider.
26. Co-Ins Amount: The co-insurance amount owed by the member to the provider.
27. Deductible Amount: The deductible amount owed by the member to the provider.
28. Other Insurance: The other payment amount (e.g., other insurance payments).
29. Interest Paid: Total interest amount, if due.
30. Amount Paid: The amount paid to the provider
31. Reason Code(s): Codes that correspond to the messages at the bottom of the Detail pages.
32. Reason Code Description(s) and Comments: A note or notes that explain(s) more about the costs, charges, and paid amounts for the billed claim.

Provider Dispute Resolutions (PDR) Submission

When submitting a PDR, Provider must be sure to completely and accurately fill out all the requested information listed on the PDR form. To process your PDR timely and effectively HPSJ needs a clear description of the basis for the appeal. HPSJ will resolve disputes and issue a written determination within forty-five (45) Working Days of receipt of the Provider dispute or amended Provider dispute. In no case will HPSJ discriminate or retaliate against a Provider because the Provider filed a dispute.

- **Contracted Providers** must submit a provider dispute online through the Provider Portal/ Doctors Referral Express (DRE) https://provider.hpsj.com/dre/default.aspx.
- **Non-Contracted Providers** must mail in provider disputes with the appropriate HPSJ Provider Dispute Resolution (PDR) form (https://www.hpsj.com/provider-dispute-resolution/) to the attention of the Claims Department at:

Health Plan of San Joaquin
P.O. Box 30490
Stockton, CA 95213-30490

Note*: Failure to submit the provider dispute through DRE or on the HPSJ PDR form will be returned for completion and may result in a delay of processing and potentially could fall outside of the dispute processing guidelines set by DMHC.*

PDR Reasons:

- **Contract Dispute:** Original claim did not pay per contracted or MCL rate
- **Appeal of Medical Necessity/Utilization Management Decision:** Original claim denied because of a denied authorization or partial authorization
- **Seeking Resolution of a Billing Determination:** Do not agree with claim or claim line denial
- **Recovery Dispute:** A letter was received regarding an identified overpayment and you do not agree with the determination
  - If the provider wishes to contest (Recovery Request Dispute) the notice of reimbursement of overpayment request it must be within thirty (30) working days.
- **Seeking Resolution of a Supplemental Payment:** Do not agree with the amount supplemental and/or denial of supplemental payment

Enhancements to the PDR process

- Revisions have been made to the PDR form to make it easier for providers to use.
- All provider appeals must be submitted with a completed PDR Form.
- Providers should not submit a PDR for claims that have been rejected due to billing errors. Providers should submit a corrected claim for these circumstances. Click here for corrected claim submission.
- Using the PDR form enables us to properly route your request, along with all supporting documentation, to the appropriate area for review.
- Submissions must include the most appropriate supporting documentation. - Examples include surgical/operative/office notes, pathology reports, medical invoices(e.g., DME or pharmaceuticals), medical record entries, etc.
- A PDR form that is not completed correctly will be returned as incomplete.
- Provider/Facility may only submit a total of 3 PDRs per claim ***number***.

Billing and Coding Methodologies

This section of the guide provides coding requirements to assist you in billing correctly for services rendered to HPSJ members. Providers are responsible for submission of accurate claims. The guidance below is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. HPSJ reimbursement policies use Medi-Cal coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

Diagnosis

As of October 1, 2015 HPSJ, implemented ICD-10 (International Classification of Diseases, 10th Edition) as adopted by Medi-Cal.

It would be inappropriate to report a diagnosis just because it is on an approved list of diagnosis codes that meet medical necessity by a payer. Reporting a diagnosis that the patient does not have solely for the purpose of obtaining reimbursement for a service is construed as fraud.

Emergency Room Services

Emergency services do not require prior authorization. HPSJ does not deny claims for Emergency Services including screening (triage) even when the condition does NOT meet the medical definition of "Emergency Services". Hospitals, urgent care centers, and professional services (including labs, ancillary services, etc.) cannot bill, charge, or collect money from any Member for any Emergency or Urgent Care Services. PCPs should council Members if they are using hospital Emergency Services for routine, non-Emergency medical conditions.

Facility Billing

This segment will familiarize providers with an overview of the most common components when billing for outpatient services on the UB-04 claim form.

Description

HPSJ require outpatient facility providers and hospitals to indicate the most appropriate Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) code(s) in addition to the revenue code for all electronic outpatient facility claims.

Billing

The following information must be included on every inpatient UB-04 claim:

- **Institutional Providers:**
  - The completed UB 04 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC. Entries stated as mandatory by NUBC and required by federal statue and regulations and any state designated data requirements included in statues or regulation

- **Physicians and Other Professional Providers:**
  - The Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format. Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD) codes. Entries states as mandatory by NUCC and required by federal statute and regulation and any state designated data requirements included in statutes or regulations.

Type of Bill Code Structure: UB-04

This four-digit alphanumeric code provides three specific pieces of information after a leading zero. CMS ignores the leading zero. This three-digit alphanumeric code gives three specific pieces of information.

First Digit = Leading zero (Ignored by CMS)
Second Digit = Type of facility
Third Digit = Type of care
Fourth Digit = Sequence of this bill in this episode of care. Referred to as a "frequency" code

Bill Type

The type of bill code includes the two-digit facility type code and one-character claim frequency code. This is a required field when billing Medi-Cal. The following facility type codes are a subset of the National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual facility type codes commonly used by Medi-Cal. Use one of the following codes as the first two digits of the three-character type of bill code:

Code	Table of Facility Type Codes Institutional Type (UB04)
11	Hospital – Inpatient (Including Medicare Part A)
12	Hospital – Inpatient (Medicare Part B only)
13	Hospital – Outpatient
14	Hospital – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment). Use admit type "1" when billing for emergency services.
18	Hospital – Swing Beds
21	Skilled Nursing – Inpatient (Includes Medicare Part A)
22	Skilled Nursing – Inpatient (Includes Medicare Part B)
23	Skilled Nursing – Outpatient
24	Skilled Nursing – Clinic (For hospital referenced diagnostic services, or home health not under a plan of treatment)
25	Skilled Nursing – Intermediate Care Level II (Level A)
26	Skilled Nursing – Intermediate Care Level II (Level B)
28	Skilled Nursing – Swing Beds
32	Home Health – Inpatient (Plan of treatment under Part B only)
33	Home Health – Outpatient (Plan of treatment under Part A only, including Durable Medical Equipment (DME) under Part A
34	Home Health – Other (For medical and surgical services not under a plan of treatment)
41	Religious Non-Medical Health Care Institutions – Hospital Inpatient
43	Religious Non-Medical Health Care Institutions – Outpatient Services
44	Religious Non-Medical Health Care Institutions, Hospital Inpatient – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)

54	Religious Non-Medical Health Care Institutions, Post Hospital Extended Care Services – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)
64	Intermediate Care – Other (For hospital referenced diagnostic services or home health not under a plan of treatment)
65	Intermediate Care – Intermediate Care Level I
66	Intermediate Care – Level II
71	Clinic – Rural Health
72	Clinic – Hospital Based or Independent Renal Dialysis Center
73	Clinic – Free Standing
74	Clinic – Outpatient Rehabilitation Facility (ORF)

Reimbursement Information

A four-digit revenue code must be included on outpatient claims billed on paper UB-04 claim forms (Box 42) or ANSI 837I transactions for electronic billing (FL42; reference ASC X12N 837 v.5010 Loop 2400 Segment SV201).

A revenue code identifies specific accommodations, ancillary services, or unique billing calculations or arrangements. As defined by the National Uniform Billing Committee (NUBC) and required by the HIPAA, services covered in an outpatient setting require a valid four-digit revenue code to accompany the CPT and HCPCS national procedure code(s).

Outpatient claims that are submitted on paper UB-04 claim forms or ANSI 837I transactions with missing, incomplete, or invalid revenue codes will be denied. Inpatient hospitals must use national revenue codes to summarize the charges for each Cost Center.

Revenue Code Rates

Prior to implementation of the DRG model, reimbursement was established as follows:

- Based on information supplied by the Department of Health Care Services (DHCS), the Fiscal Intermediary (FI) uses a file of every facility's established rates to calculate reimbursement for revenue codes.

The preceding is true for non-DRG reimbursed hospitals also.

All claims submitted by an outpatient facility provider or hospital must include a supporting HCPCS or CPT code with a revenue code. Revenue codes and procedure code

combinations that are submitted on electronic outpatient claims should reflect the services that were provided to the patient on that date of service. These codes should be submitted on the same line for accurate claims processing. If more than one HCPCS or CPT code is needed for a revenue code, you should repeat the revenue code on a separate line.

Rev Code	Revenue Codes for Inpatient Services Description
111	Room and Board – Private, Medical/Surgical/Gynecological
112	Room and Board – Private, OB
113	Room and Board – Private, Pediatric
114	Room and Board – Private, Psychiatric
117	Room and Board – Private, Oncology
118	Room and Board – Private, Rehabilitation
119	Room and Board – Private, Other
121	Room and Board – Semiprivate 2 Bed, Medical/Surgical/Gynecological
122	Room and Board – Semiprivate 2 Bed, Obstetric
123	Room and Board – Semiprivate 2 Bed, Pediatric
124	Room and Board – Semiprivate 2 Bed, Psychiatric
127	Room and Board – Semiprivate 2 Bed, Oncology
128	Room and Board – Semiprivate 2 Bed, Rehabilitation
129	Room and Board – Semiprivate, 2 Beds, Other
131	Room and Board – Semiprivate 3 or 4 Bed, Medical/Surgical/Gynecological
132	Room and Board – Semiprivate 3 or 4 Bed, Obstetric
133	Room and Board – Semiprivate 3 or 4 Bed, Pediatric
134	Room and Board – Semiprivate 3 or 4 Bed, Psychiatric
137	Room and Board – Semiprivate 3 or 4 Bed, Oncology
138	Room and Board – Semiprivate 3 or 4 Bed, Rehabilitation
139	Room and Board – Semiprivate, 3 and 4 Beds, Other
151	Room and Board – Ward (Medical or General), Medical/Surgical/Gynecological

152	Room and Board – Ward (Medical or General), Obstetric
153	Room and Board – Ward (Medical or General), Pediatric
154	Room and Board – Ward (Medical or General), Psychiatric
157	Room and Board – Ward (Medical or General), Oncology
158	Room and Board – Ward (Medical or General), Rehabilitation
159	Room and Board – Ward, Other
169	Room and Board, Other
170	Nursery, General Classification
171	Nursery, Newborn, Level I
172	Nursery, Newborn, Level II
173	Nursery, Newborn, Level III
174	Nursery, Newborn, Level IV
190	Room and Board, Subacute Pediatric (Private Hospital)
199	Room and Board, Subacute Adult (Private Hospital)
200	Intensive Care, General Classification
201	Intensive Care, Surgical
202	Intensive Care, Medical
203	Intensive Care, Pediatric
204	Intensive Care, Psychiatric
206	Intensive Care, Intermediate ICU
207	Intensive Care, Burn Care
208	Intensive Care, Trauma
209	Intensive Care, Other
210	Coronary Care, General Classification
211	Coronary Care, Myocardial Infarction
212	Coronary Care, Pulmonary Care

214	Coronary Care, Intermediate CCU
219	Coronary Care, Other
790	Lithotripsy, General Classification

Trauma Services

Federally Qualified Health Centers (FQHCs)

Federally Qualified Health Centers (FQHCs) were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989.

Enrollment

Providers should enroll in the FQHC program through the Department of Health Care Services (DHCS) Audits and Investigations. As facilities enroll in the FQHC program, they will receive a new National Provider Identifier (NPI) and their current provider numbers will be inactivated.

Covered Services

FQHCs may bill for the following:

- Physician services
- Physician assistant services
    - Incident-to billing
    - Modifier
- Nurse practitioner services
    - Incident-to billing
    - Modifier
- Certified nurse midwife services
- Visiting nurse services (as defined in Code of Federal Regulations [CFR], Title 42,
- Section 405.2416)
- Comprehensive Perinatal Services Program (CPSP) practitioner services, if the clinic has an approved application on file with the California Department of Public Health, Maternal, Child and Adolescent Health Division
- Licensed clinical social worker services
- Clinical psychologist services
- Optometry services
- Acupuncture services

Inpatient and Outpatient High Cost Drug Claim Submission and Payment Rules

HPSJ has established a list of drugs, medications and biologics that are defined as high cost drugs. (See High Cost Drug List Below) Periodic updates will be made to this list as new drugs, medications and biologics are approved by the FDA.

Certain HPSJ provider agreements contain a provision for the reimbursement of high cost drugs. Depending upon the terms of the provider's agreement providers may receive reimbursement for

all high cost drugs provided to a Member or will only receive reimbursement for high cost drugs when the unit cost exceeds a defined threshold dollar amount.

When a provider identifies a high cost drug on HPSJ's approved list has been provided to a Member and (if applicable) exceeds the unit cost threshold as defined in their provider agreement, the provider may submit a claim for the high cost drug.

The claim must be billed with revenue code 0636, HCPCS code and NDC code. If the provider's agreement reimburses high cost drugs at manufacturer's invoice cost or manufacture's invoice cost plus an additional %, the provider must submit a manufacture's invoice with the claim.

Revenue code 0636 should only be used when the high cost drug qualifies as separately payable as defined by their provider agreement.

Claims for high cost drugs will be paid according to their provider's agreement.

Claims missing the required revenue code 0636, HCPCS, NDC code and manufacturer's invoice (if applicable) will be denied for lack of information.

HPSJ may perform periodic audits of the provider's high cost drug billing practices to ensure compliance with their provider agreement and these rules.

Health Plan of San Joaquin HIGH COST DRUG LIST
Effective 12/01/2020

Generic Name	Trade Name	HCPCS	HCPCS Description
ANDEXANET ALFA	ANDEXXA	C9041	Injection,coagulation Factor Xa (recombinant), inactivated (Andexxa), 10 mg
ARGATROBAN	ARGATROBAN	C9121	Injection, argatroban, per 5 mg
PROTHROMBIN COM.CONC	KCENTRA (SOOIU) IU INJ	C9132	IX activity
ANTIVENIN CROTALIDAE POLYVLNT	CROFAB	C9274	Crotalidae polyvalent immune fati (ovine), vial
ABATACEPT	ORENCIA	J0129	Injection, abatacept,10 mg
AMPHOTERJCI N B	ABELCET	J0287	Injection, amphotericin b lipid

LIPID COMPLEX			complex, 10mg
CI ESTERASE INHIBITOR	BERJNERT	J0597	Injection, c-1 esterase Inhibitor (human)berinert, 10 units
CALCITONI N	MIACALCIN	J0630	Injection,calcitonin salmon,up to 400 units
CEFTAZIDIME-A VIBACTAM	AVYCAZ	J0714	Injection, ceftazidime and avibactam, O.Sg/0.125g
CIDOFOVIR	VISTIDE	J0740	Injection, cidofovir, 375 mg
ANTIVENIN CROTALIDAE POLYVLNT	N/A	J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1g
DALBAVANCIN	DALVANCE	J0875	Injection, dalbavancin, 5mg
DAPTOMYCIN	CUBICIN DSHP	J0878	Injection,daptomycin, 1 mg
DARBEPOETIN ALFA/ POLYSORBATE	ARAN ESP	J0881	Injection, darbepoetin alfa, Imicrogram (non-esrd use)
ARGATROBAN Inject ion	Argatroban	J0883	Injection, argatroban, 1mg (for non-ESRD use)
EPOETIN	EPOETIN	J0885	Injection,epoetin alfa, (for non-ESRD use), 1000 units
DECITABINE	DACOGEN	J0894	Injection, decitabine, Img
DENOSUMAB	PROLIA	J0897	Injection, denosumab, Img
DIGOXINIMMUNEFAB	DIGIFAB	J1162	Injection, digoxin immune fab (ovine), per vial
ECULIZUMAB 10MG INJ	SOURIS	J1300	Injection, ecullzumab, 10 mg
EPTIFIBATIDE	INTEGRILIN	J1327	Injection, eptifibatide, 5 mg
FILGRAS G-CSF 1MCG	GRANIX, NEUPOGEN	J1442	Injection, filgrastim (G- CSF),

INJ PN			excludes biosimilars, 1 mcg
GALSULFASE	NAGLAZYME DSHP	J1458	Injection, galsulfase, Img
IMMUNE GLOBULIN	PRIVIGEN	J1459	Injection, immune globulin (privigen), intravenous, non- lyophilized (e.g. liquid},500 me
IMMUNE GLOBULIN INTRAVENOUS	BIVIGAM	J1556	Inject ion,immune globulin (Bivigam}, 500 mg
IMMUNE GLOBILING INTRAVENOUS	GAMMAPLEX	J1557	Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid}, 500 mg
IMMUNE GLOBULIN	GAMUNEX-C	J1561	Injection, immune globulin, (gamunex-c/gammaked}, non- lyophilized (e.g.liquid), 500mg
IMMUNE GLOBULIN	CARIMUNENF	J1566	Injection, immune globulin, intravenous, lyophilized (e.g. powder}, not otherwise specified, 500 mg
IMMUNE GLOBULIN	OCTAGAM5%	J1568	Injection, immune globulin, (octagam}, intravenous, non- lyophiiized (e.g. liquid}, 500mg
IMMUNE GLOBULIN	GAMMAGARD LIQUID	J1569	Injection, immune globulin, (gammagard liquid), non lyophilized, (e.g. liquid), 500mg
IMMUNEGLOBULIN	FLEBOGAMMA/FLEBOGAMMA dif	J1572	Injection, immune globulin, (Flebogamma/Flebogamma Dif}, intravenous, nonlyophilized (e.g.,liquid), 500 mg
immune globulin	N/A	J1599	Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid}, not otherwise specified, 500 mg
IDURSULFASE ALTEPLASE	ELAPRASE DSHP	J1743	Injection, idursulfase, I mg
ALTEPLASE	ACTIVASE	J2997	injection, alteplase recombinant, 1

			mg
TRIPTOR PAM 3.75MGINJPN	TRELSTAR	J3315	Injection, triptorelin pamoate, 3.75 mg
COPPER IUD	PARAGARD	J7300	Intrauterin copper contraceptive
DOXORUBICIN HCL LIPOSOMAL	DOXIL	J9000	Injection, d_oxorubicin hydrochloride, 10 mg
ATEZOLIZUMAB	TECENTRJQ	J9022	Injection, atezolizumab, 10mg
BENDAMUSTINE HCL	TREANDA	J9033	Injection, bendamustine hcl,1 mg
BEVACIZUMAB	AVASTIN	J9035	Injection, bevacizumab, 10mg
BORTEZOMIB	VELCADE DSHP	J9041	Injection, bortezomib, 0.1mg
BRENTUXIMAB VEDOTIN	ADCETRJS DSHP	J9042	Injection, brentuximad vedotin, 1mg
CARFILZOMJB	KYPROLIS	J9047	Injection, carfilzomib, 1mg
CETUXI MAB	ERBITUX	J9055	Injection, cetuximab,10 mg
CYCLOPHOSPHAMIDE	CYCLOPHOSPHAMI DE	J9070	Cyclophosphamide,100 mg
CYTARABI NE UPOSOME	DEPOCYT	J9098	Injection, cytarabine, liposome, 10 mg
DACTINOMYCIN	COSMEGEN DSHP	J9120	Injection, dactinomycin, 0.5 mg
DARATUMUMAB	DARZALEX	J9145	Injection, daratumumab, l0 mg
DOCETAXEL	DOCETAXEL	J9171	Injection, docetaxel,1mg
ERIBULIN MESYLATE	HALAVEN	J9179	Injection, eribulin mesylate,0.1mg
GOSERELIN ACETATE	ZOLADEX IMPLANT	J9202	Goserelin acetate implant, per 3.6 mg
PEMBROLIZUMAB	KEYTRUDA	J9271	Injection, pembrolizumab, 1mg
ADO-TRASTUZUMAB EMTANSINE	KADCYLA	J9354	Injection, ado-trastuzumabemtansine, lmg
FULVESTRANT	FASLODEX	J9395	Injection, fulvestrant,25mg
EPOETIN 1OOOOU ESRD SDV	EPOGEN	Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)

NIVOLUMAB	OPDIVO	J9299	NIVOLUMAB 1MG INJ
TRASTUZUMAB	HERCEPTIN	J9355	TRASTUZUMAB 10MG INJ
PEMTREXED	ALIMTA	J9305	PEMTREXED 10MG INJ PN
PANITUMUMAB	VECTI BIX	J9303	PANITUMUMAB 10MG INJJG
RITUXIMAB	RITUXAN	J9312	RITUXIMAB 10MG INJJG
PERTUZUMAB	PERJETA	J9306	PERTUZUMAB 1MG INJ
FERRIC CARBOXYMALTOSE	INJECTAFER	J1439	FERRIC CARBOXYMAL 1MG INJ
INFLIXIMAB	REMICADE	J1745	INFLIXIMAB 100MG INJ
ROMIPLOSTIM	NPLATE	J2796	ROMIPLOSTIM PER 10MCG INJJG
PEGFILGRASTIM	NEULASTA	J2505	PEGFILGRASTI M 6MG INJ
PALONOSETRON	ALOXI	J2469	PALONOSETRON 2SMCG INJ PN
PEGFILGRASTI M-CBQV	UDENYCA	Q5111	PEGFILGRAS-CBQV 0.5MG INJ
OXALIPLATIN	ELOXATIN	J9263	OXALIPLATI N 0.5MG INJ PN
FILGRASTIM	NEUPOGEN	Q5101	FILGRASTIM G-CSF BIO 1MCGPN
GEMCITABI NE	GEMZAR	J9201	GEMCITABINE HCL 200MG PN
FOSAPREPITANT	EMEND	J1453	FOSAPREPITANT 1MG INJ PN
DEGARELIX ACETATE	FIRMAGON	J9155	DEGARELIX 1MG INJ PN
CISPLATIN	PLATINOL	J9060	CISPLATIN PER 10MG INJ
IRINOTECAN	CAMPTOSAR	J9206	IRINOTECAN 20MG/1ML SDV
APREPITANT	EMEND	J0185	APREPITANT 1MG INJ
ETOPOSIDE	ETOPOPHOS	J9181	ETOPOSIDE 10MG (500MG)MDV
RABIES IMMUN GLOBULIN	N/A	90375	RABIES IMMUN GLOB 150U 2M
LEUPROLIDE	ELIGARD	J9217	LEUPROLIDE 7.5MG DEPO KIT

GRANISETRON	KYTRIL	J1627	GRANISETRON ER O.1MG INJ
EPOETIN ALPHA NON- ESRD	EPOGEN, PROCRIT	Q5106	EPOETIN A NONESRD 1KU INJ
ISOSULFAN BLUE	LMYPHAZURI N	Q9968	ISOSULFAN BLUE 50MG/5MG INJ
CARBOPLATIN	PARAPLATIN	J9045	CARBOPLATIN /50MG 50MG MDV
ZOLEDRONIC ACID	NOVARTIS	J3489	ZOLEDRONIC ACID PER 1MG
ONABOTU LINUMTOXINA	BOTOX	J0585	ONABOTULINUMTOXI NA 100UVL

Billing surgical procedures with Medi-Cal modifiers

The use of modifiers is an integral part of billing for health care services. Modifiers give additional information for claims processing.

CPT modifiers are used to supplement information or adjust care descriptions to provide extra details concerning a procedure or service provided by a physician. Code modifiers help further describe a procedure code without changing its definition. CPT modifiers are also referred to as Level I modifiers.

Providers should refer to the "Modifiers: Approved List section" in the Part 2 provider manual for a complete list of approved modifier codes for billing Medi-Cal. Modifiers not listed in the "Modifiers: Approved List section" are unacceptable for billing Medi-Cal and HPSJ.

All procedure codes and the appended modifier(s) must be appropriate for the diagnosis code(s) listed. A claim will result in a delay in payment or denial for the use of an inappropriate modifier, or for using a modifier when it is not necessary to do so. For your reference and convenience, the information below has been excerpted from the 2020 Medi-Cal Provider Training manual.

Primary Surgeon (Modifier AG): The primary surgeon or podiatrist is required to use modifier AG on the only, or the highest valued, procedure code being billed for the date of service.

Multiple Primary Surgeons (Modifier AG): Two or more surgeons may use modifier AG for the same patient on the same date of service, if the procedures are performed independently and in a different anatomical area or compartment. All claims must include:

- Medical justification

- Operative reports by all surgeons involved
- Clearly indicated start and stop times for each procedure

Bilateral Procedures (Modifier 50): Modifier 50 is used when bilateral procedures performed add significant time or complexity to patient care at a single operative session.
Multiple Bilateral Procedures: When billing for multiple bilateral procedures performed by the same physician at the same operative session, providers must use modifiers AG, 50, 51 and 99.
Multiple Procedures (Modifier 51): The multiple procedures modifier identifies the secondary, additional or lesser procedures for multiple procedures performed on the same day or at the same operative session.

Modifier	Description
AG	Primary Surgeon; Multiple Primary Surgeons
50	Bilateral Procedure
51	Multiple Procedures
99	Multiple Modifiers

Billing Tip: For bilateral procedures - Reimbursement is the total of:

- 150% of the fee schedule or contracted/negotiated rate for the highest valued procedure.
- 50% for the secondary through fifth procedures.
- 50% for the sixth and additional procedures.

Reimbursement Rule:

CPT Code/Modifier	Reimbursement Formula
64490-AG	100% of full-fee rate
64490-50	50% of full-fee rate
64491-51	50% of full-fee rate
64491-50,51	25% of full-fee rate
64492-51	50% of full-fee rate
64492-50,51	25% of full-fee rate

Assistant Surgeon (Modifier 80): Assistant surgeons must use modifier 80 as a part of each procedure billed. The major surgical procedure is identified by the use of modifier 80 (assistant surgeon) and multiple surgical procedures must be identified by the use of modifier 99 (multiple modifiers).

NOTE: Not all surgical procedures are reimbursable to an assistant surgeon. To determine if there are any policy restrictions, refer to the Treatment Authorization Request and Non-Benefit List: Codes (tar and non cd) section in the appropriate Part 2 provider manual.

Modifier	Description
80	Assistant Surgeon

99	Multiple Modifiers

Refer to the *Modifiers: Approved List section (modif app)* in the Part 2 provider manual for a complete list of approved modifier codes for billing for Medi-Cal patients. Modifiers not listed in the *Modifiers: Approved List section* are not acceptable for billing Medi-Cal. The inappropriate use of a modifier, or using a modifier when it is not necessary, will result in a denial or delay of payment. All modifiers (and procedure codes) must be appropriate for the diagnosis code listed.

For more information, please visit the DHCS Medi-Cal Program and Eligibility provider manual, and review the section titled *Surgery: Billing with Modifiers ("surg bil mod")* or the 2020 Medi-Cal Provider Training manual, which may be accessed online at:

https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/ah_2020.pdf.

Billing Tip: Certain procedures billed by the primary surgeon with modifier 51 are exempt from the multiple procedure reduction rule and are paid at 100 percent of the Medi-Cal maximum allowable. For a list of exempt procedures, refer to the *Surgery: Billing with Modifiers* (surg bil mod) section in the Part 2 provider manual.

National Correct Coding Initiative Edits

The Center for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. These mandatory national edits have been incorporated into the Medi-Cal claims processing system and are effective for dates of service as specified by CMS.

Please note that CMS updates NCCI payment policies quarterly.

The following website is aimed at providing information to Providers on Medicare's National CCI edits, but will not address specific CCI edits:

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index

NDC EDI billing requirements

The National Drug Code (NDC) is required to be billed on claim forms for drugs administered by physicians, clinics and hospitals. NDC codes must be reported when HPSJ is the secondary or tertiary payer as well. The State of California requires appropriate NDC numbers to be utilized for ***ALL*** claims to MCPs, including Medicare Crossover (COBA) claims. Therefore, any claim submitted via COBA from Medicare, direct to HPSJ, will be denied for corrected billing to include required NDC code(s). When submitting the corrected

claim(s) with NDC codes to HPSJ, please include the resubmission code of 7 and the HPSJ claim number of the denied claim.

NDC BILLING REQUIREMENTS

When submitting a claim for a physician-administered drug in both professional and institutional clinical settings, you must bill with the appropriate 11-digit National Drug Code (NDC) number in both the CMS-1500/UB04 claim forms and/or EDI 837 transaction. In addition, you will need to provide the HCPCS code, the appropriate NDC unit measure and the units administered. Failure to submit the accurate information in the appropriate fields may result in delayed claim reimbursement or the denial of your claim.

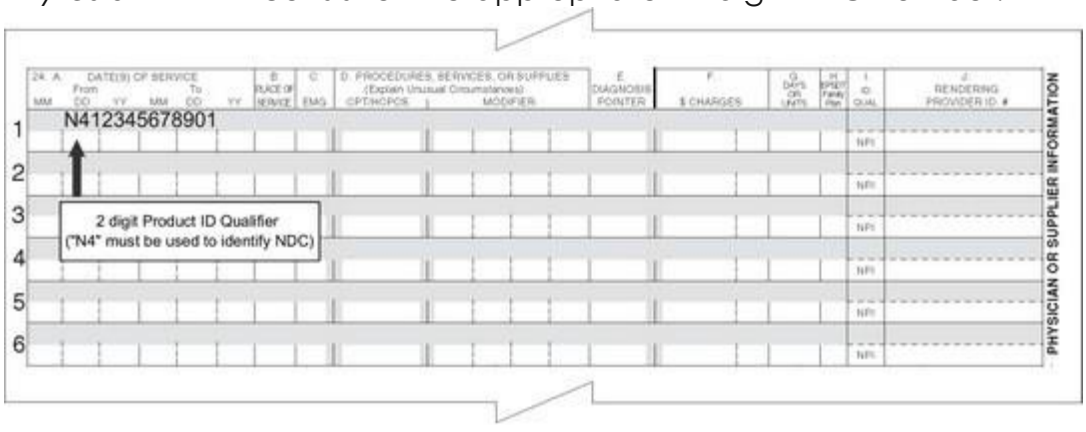
NDC CMS-1500 PAPER CLAIM BILLING REQUIREMENTS

When billing a claim that requires an NDC Code on the CMS-1500 claim form, please use the following guidelines to submit your information. It is important to use the correct billing qualifiers and bill each requirement in the appropriate fields:

Box 24A (Shaded Area) – *"N4" Qualifier and 11-digit National Drug Code (NDC)*

This area will have a combination of two values entered:

- *Bytes 1 and 2* will include the Product ID Qualifier. The code 'N4' is used to identify an NDC number.
- *Bytes 3 – 21* will consist of the appropriate 11-digit NDC number.



Example: *In this example, N4 is used as the Product ID Qualifier, followed by the 11-digit NDC –* ***N412345678901***

Box 24D (White Area) – *HCPCS*

Code **Box 24F (White Area)** – *Billed*

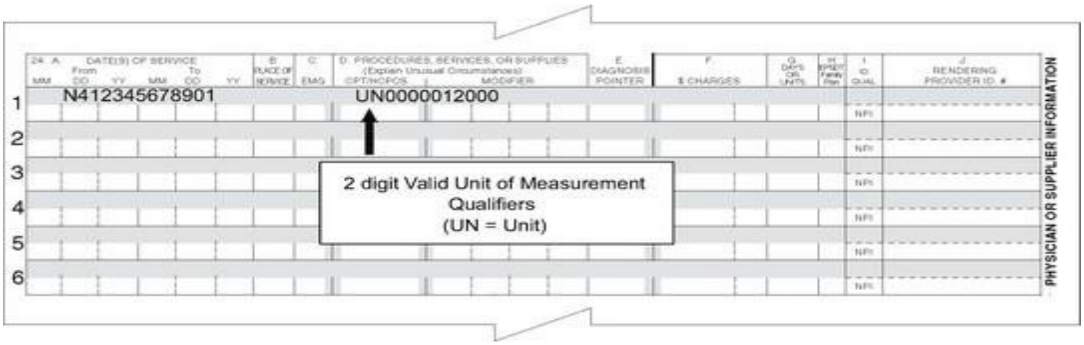
Charges **Box 24G (White Area)** –

Units of Service

Box 24D (shaded area) – *NDC unit of measure (two positions)*

In this area, enter the NDC unit of measure (two positions) immediately followed by the numeric quantity administered to the patient, which is a full 10-digit number. The 10 digits consist of seven digits for the whole number, followed by the three-digit decimal portion of the number.

Note: *The quantity field should be entered from left to right; do not enter a decimal. Valid Unit of Measurement Qualifiers are the following:*



NDC UB-04 PAPER CLAIM BILLING REQUIREMENTS

For paper claims submitted on the institutional *UB-04* claim form, the NDC is reported in the following:

Box 43 (Description Field) – *"N4" Qualifier and 11-digit National Drug Code (NDC)*

- First two positions include the Product ID Qualifier of 'N4' followed by the 11-digit NDC (no hyphens).
- Directly following the last digit of the NDC (no delimiter), enter the two-digit Unit of Measurement Qualifier as noted below followed by the nine-digit quantity. The nine digits consist of six digits for the whole number, followed by the three-digit decimal portion of the number.

Example: *In this example, the 'N4' is used as the Product ID Qualifier with an NDC code of '12345678901'. Code 'UN' is used to identify the unit quantity of 30 reported as '000030000' (Nine-digit quantity).*

Box 44 – Using the *HCPCS/RATE/HIPPS Code* field, enter the five-character HCPCS code.

Box 46 – Using the '*Serv Units*' field, enter the corresponding service units for the HCPCS reported

HIPPA-COMPLIANT 837 EDI NDC CLAIM BILLING REQUIREMENTS

837 NDC BILLING REQUIREMENTS			
LOOP	**SEGMENT**	**FIELD NAME**	**REQUIREMENT**
2400	SV101-1	Product/Service ID Qualifier	A value of 'HC' is expected for HCPCS code
2400	SV101-2	Product/Service ID	Enter appropriate HCPCS code
2410	LIN02	Product/Service ID Qualifier	A value of 'N4' is expected to identify the National Drug Code (NDC)
2410	LIN03	Product/Service ID	Enter the 11-digit NDC number
2410	CTP04	Quantity (National Drug Unit Count)	Enter the national drug unit count for the NDC billed in LIN03.
2410	CTP05	Unit or Basis for Measurement Code	Enter one of the following qualifiers to identify the unit or basis for measurement code for the NDC billed: F2 = International Unit GR = Gram ME = Milligram ML = Milliliter UN = Unit

Example of the NDC requirements billed on an EDI 837 transmission:

LIN**N4*12345678901~

CTP****2*UN~

Additional information and billing guidelines can be found in the following resource:

https://files.medi-cal.ca.gov/pubsdoco/ndc/ndc_faqs.aspx

Medi-Cal Newborns

For mothers who have Medi-Cal coverage at the time of delivery should be advised to call their county Medi-Cal office or fill out and send in the Newborn Referral Form. The newborn will be eligible for Medi-Cal until at least age one if living in California.

Providers should ***always*** note:

1. Newborns are covered at the time of birth, and are paid under the mother's Medi-Cal eligibility for the month of birth and the following month, regardless of the eligibility status on the State Automated Eligibility and Verification System (AEVS). Once newborn has their own active number they are no longer cover under the mother.

2. HPSJ strongly encourages physicians to assist parents in applying for Medi-Cal benefits for the newborn by initiating the enrollment process.

The following link will guide provider's with assisting mothers and newborns:

https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/Medi-CalAccessProgram.aspx

Please note that Hospitals must notify HPSJ of member newborns within twenty-four (24) hours of birth. Under HPSJ rules, newborns are covered under the mother's coverage one (1) month after birth or until the newborn has been their own approved eligibility.

- Newborn will be issued own HPSJ ID number under the mother's coverage.
- Claims should be submitted using newborn baby's HPSJ id number
- Do not submit charges for the newborn on the same claim form as the mother
- Do not submit charges for the newborn with the mother's HPSJ ID number
- Submit the newborn claim after the mother's claim has been submitted.
- A healthy newborn is submitted with the newborn baby's id number, newborn information
- If the newborn requires a longer stay, an authorization is required under the newborn ID number
- 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 submitted on each claim.

Proposition 56 Supplemental Payments

California Proposition 56 increased the excise tax rate on cigarettes, electronic cigarettes, and other tobacco products in phases beginning April 1, 2017. The Department of Health Care Services (DHCS) is responsible for structuring the supplemental payments from Proposition 56 funds. DHCS has provided guidance and requirements to Medi-Cal managed care plans on how funds are to be distributed to Medi-Cal providers through policy guidance called All-Plan Letters (APL).

Please visit the DHCS Proposition 56 Program website at

https://www.dhcs.ca.gov/provgovpart/Pages/Proposition-56.aspx

HPSJ's supplemental payments go through our payment processing vendor in separate checks rather than the regular FFS payments. The supplemental payment will NOT be reflected in your normal check run cycles. Each month HPSJ will capture qualified claims in finalized PAID status (regardless of an actual dollar amount paid on the claim) from the month prior and process for supplemental

payment. These payments will come monthly and the Remittance Advice (RA) will identify the supplemental payment with SUPP indicated on the claim line level.

Supplemental Payment Programs Through Proposition 56

Adverse Childhood Experiences (ACEs) Screening Services— DHCS APL 19-018 Prop 56

Effective for dates of service beginning January 01, 2020. Network Providers must meet the criteria documented in the APL to be eligible for the payment.

Beginning July 1, 2020, Medi-Cal providers must attest to completing a certified core ACE training on the DHCS website to continue receiving payment for ACE screenings:

- The Becoming ACEs Aware in California Training is a free, two-hour training to learn about Adverse Childhood Experiences (ACEs), toxic stress, screening, risk assessment, and evidence-based care to effectively intervene on toxic stress.
- Providers may receive 2.0 Continuing Medical Education (CME) and 2.0 Maintenance of Certification (MOC) credits upon completion.
- The training is available to any provider, but it is particularly geared towards primary care clinicians who serve Medi-Cal (California's Medicaid program) beneficiaries.
- Be sure to check out the ACEs Aware website to access resources and support around ACEs, toxic stress and trauma-informed care.

Developmental Screening— DHCS APL 19-016 Prop 56

Effective for dates of service beginning January 01, 2020. Proposition 56 supplemental payments must be in addition to whatever other payments the Network Providers would normally receive for developmental screenings.

Family Planning Services— DHCS APL 20-013 Prop 56

Supplemental payment to providers qualified to offer family planning services for specific family planning procedure codes.

Physician Services –DHCS APL 19-015 Prop 56

Supplemental payment for qualified network providers (excluding FQHCs, RHC/IHCs and Cost-Based Reimbursement Clinics and members dually eligible for Medi-Cal and Medicare Part B, regardless of enrollment in Medicare Part A or Part D).

Ground Emergency Medical Transport (GEMT)

The Department of Health Care Services (DHCS) has established a Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) program. In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, Medi-Cal Managed Care Health Plans must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

Additionally, please note that HPSJ does not pay the add-on QAF/GEMT supplemental payment for out of state GEMT. DHCS confirmed that MCP's are not required to pay the add-on for out of state transports.

HPSJ only reimburses the add-on QAF/GEMT supplemental payment to certain emergency transportation services provided by ***NON contracted*** transportation providers.

Value-Based Payment (VBP) Program Directed Payments — DHCS APL 20-014 Prop 56

For dates of service on or after July 1, 2019. This Prop 56 program provides VBP supplemental payments to Network Providers to improve health care in the domains of prenatal and postpartum care, early childhood prevention, chronic disease management, and behavioral health care.

FQHCs, AIHS Programs, and Cost-Based Reimbursement Clinics are not eligible Network Providers for the purposes of the VBP Program. Please see the reference on eligible code sets for 2019 and 2020 below. HPSJ is providing these code sets as guidance to assist provider offices. Code updates for 2020 to be communicated in early 2021.

Telehealth

This section outlines the HPSJ Telehealth Program provisions and benefits. The goal of telehealth with HPSJ is to improve both access and quality health services provided in rural and other medically underserved areas through the use information and telecommunications technologies.

What Is Telemedicine?

Telemedicine generally refers to the provision of clinical services from a distance. The Institute of Medicine of the National Academy of Science defines telemedicine as "the use of electronic information and communication technologies to provide and support health care when distance separates the participants". Telemedicine is a component of telehealth.

What Is Telehealth?

Telehealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies.

As state and federal policymakers, private payors, practitioners, and consumers realize telehealth' s potential benefits, there is a growing need to create a consistent framework for understanding what is meant by "telehealth," and how the term is accurately applied.

First and foremost, telehealth is a collection of means or methods, not a specific clinical service, to enhance care delivery and education. Ideally, there should not be any regulatory distinction between a service delivered via telehealth and a service delivered in person. Both should be held to the same quality and practice standards. The "tele-"descriptor should ultimately fade from use as these technologies seamlessly integrate into health care delivery systems.

While "telemedicine" has been more commonly used in the past, "telehealth" is a more universal term for the current broad array of applications in the field. Its use crosses most health service disciplines, including dentistry, counseling, physical therapy, and home health, and many other domains. Further, telehealth practice has expanded beyond traditional diagnostic and monitoring activities to include consumer and professional education.

While the State of California now uses the term "telehealth", some providers and payor organizations still use the term "telemedicine" when referring to the provision of clinical care over a distance.

Note that while a connection exists between health information technology (HIT), health information exchange (HIE), and telehealth, neither HIE nor HIT are considered to be telehealth.

How Does Telehealth Work?

Today, telehealth encompasses four distinct domains of applications. Note, however, that each state Medicaid program and private insurer varies in its use and reimbursement of these applications. These are commonly known as:

- **Live Videoconferencing** (Synchronous): Live, two-way interaction between a person and a provider using audiovisual telecommunications technology.
- **Store-and-Forward** (Asynchronous): Transmission of images and recorded health history through an electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.

Is Telemedicine A Billable Service?
In many cases telemedicine services are covered benefits and are billable by government programs and private payors. This guide provides information on major telemedicine reimbursement programs in California. As the field is rapidly expanding, it should be noted that more and more public, private, and commercial payors may begin to cover telemedicine. It is important that you check with your major payors on a regular basis to see if additional services have been added for reimbursement.
Billing and Reimbursement

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. The site receives a flat reimbursement rate. The originating site is eligible to receive a facility fee for providing services via telehealth. **Sites fee are limited to once per day, same recipient, same provider.**

- Originating sites are to use HCPCS code Q3014 when submitting facility fee claims.
- The place of service code is 02 - Telehealth

Distant Site Clinical Services Fees

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Distant site claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided. ***As of January 2018, a telehealth modifier is no longer required. Instead, you will submit the appropriate CPT code and use place of service 02 – Telehealth.***

Modifiers

Only services rendered from the distant site are billed with modifiers. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:

- GT or 95 for interactive audio and video telecommunications system (live interactive) or
- GQ for Store and forward applications.

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Type	Description	Billing guidelines for Originating Site Providers	Billing guidelines for Distant Site Providers
Traditional Synchronous Telehealth Services	Connects the patient in a provider office with a distant provider of health services through live video-conferencing, which is a two-way audiovisual link between a patient and a care provider.	**CPT code(s):** Q3014; T1014 **Modifier:** n/a	**CPT code(s):** T1014; 99201 – 99215; 99241-99255; 99221-99233; 99291 or G0508; 99292 or G0509 **Modifier**: 95 (modifier required for all CPT-Codes except Transmission Cost codes)
Asynchronous Telehealth Services (Store and Forward)	The transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.	**CPT code(s)**: Q3014 **Modifier**: n/a	**CPT code(s)**: 99451 **Modifier**: GQ (modifier required for all asynchronous, store-and-forward services billed)
Synchronous: Provider to Patient Telehealth Services	Telehealth services provided between a qualified provider and patient at a distant location through live video-conferencing. The location may be a health facility, residential home, patient's home or other location.	**CPT code(s)**: n/a **Modifier:** n/a	**CPT code(s)**: T1014; E&M codes 99201 – 99215 **Modifier**: 95 (modifier required for all CPT-Codes except Transmission Cost codes)

Please note that a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) and Indian Health Service (HIS) cannot bill for site fee or transmission charges. These charges are included in their FQHC/RHC Prospective Payment System (PPS) rate or the IHS Memorandum of Agreement (MOA) rate.

For latest updates and changes to Telehealth Services, please refer to the following DHCS sites:

https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf

https://www.dhcs.ca.gov/provgovpart/Pages/FAQ-Telehealth-Payments.aspx

Transportation

Medical transport is transport that is medically necessary. Benefits include:

- **Emergency transport** – Ambulance transport to the nearest hospital is covered if the member has reason to believe that the medical problem is an emergency, and that the problem calls for emergency transport. This includes ambulance transport services supplied through the "911" emergency response system
- **Non-emergency transport** – May be covered when the member:
    - o Moves to or from a hospital or skilled nursing facility for an authorized admission.
    - o Needs to go to and from the member's home to a scheduled medical appointment.

All requests for non-emergency transportation require prior authorization. The HPSJ uses the Medi-Cal Criteria for Medical Transportation to review requests for nonemergency transportation. The transportation must be arranged by HPSJ Member Services and provided by an approved service provider. Please call at least three business days before your scheduled appointment and as soon as possible in the case of urgent appointments. The HPSJ will approve only the lowest cost type of nonemergency medical transportation that is adequate for your medical need and is available at the service level required.

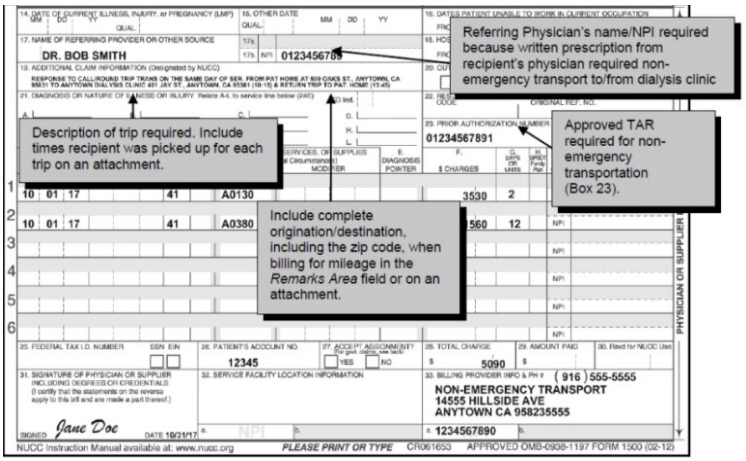
Exclusions:

- Transport to the home unless medically necessary and authorized by the HPSJ.
- This benefit does not cover transportation solely for the member's convenience. An HPSJ doctor must certify that your medical condition meets the HPSJ criteria for coverage of nonemergency transportation.

Non-Emergency Medical Transportation Billing Requirements

In accordance with Medi-Cal and California Department of Health Care Services (DHCS) guidelines, the following information outlines the billing requirements for all Non-Emergency Medical Transportation (NEMT) providers.

1. Name of Referring Provider & NPI (Boxes 17a & 17b)
2. Pick-up & Drop-Off Location with times (Box 19)
3. Prior Authorization Number (Box 23)

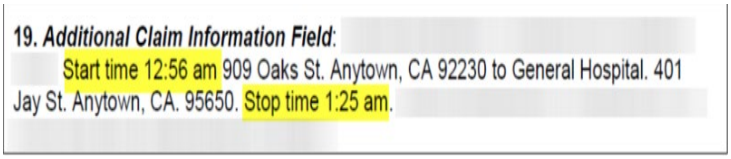


Night Calls (transportation between 7pm and 7am) may be reimbursed in any of the following scenarios:

1. Transport starts during the day and ends at night (after 7pm)
2. Entire transport occurs at night
3. Transport starts at night and ends during the day (after 7am)

Night Call Claim Documentation must include:

- Appropriate HCPCS Code with Modifier UJ
- Indicate start and stop time in Additional Claim Information Field (Box 19)



Air Medical Transportation

An air ambulance is any aircraft specifically constructed, modified or equipped and used primarily for responding to emergency calls and to transport critically ill or injured recipients. Air ambulances must have two medical flight crew members who are certified or licensed in advanced life support.

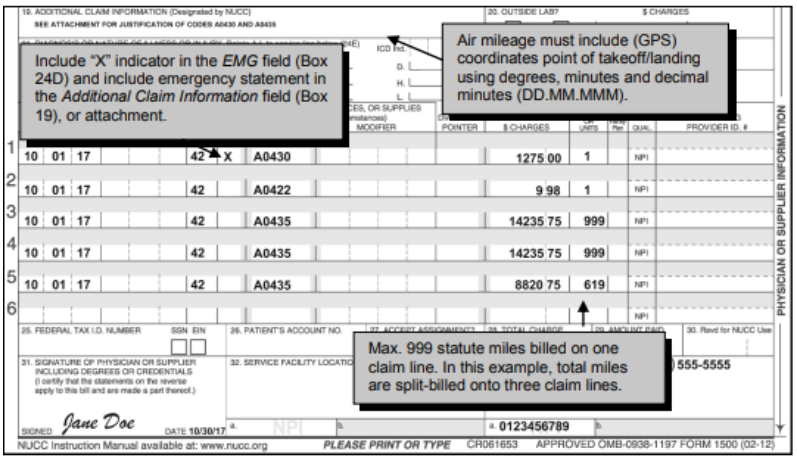
HCPCS codes A0430 (ambulance service, conventional air services, transport, one way [fixed wing]) and A0431 (ambulance service, conventional air services, transport, one way [rotary wing]) do not require a TAR if the closest available provider renders the emergency medical transportation.

Air ambulance one-way recipient miles must be billed in statute miles, and not in nautical miles. Mileage must be calculated with Global Positioning System (GPS) coordinates from point of takeoff to point of landing.

The GPS coordinates of takeoff and landing points must be documented in the Additional Claim Information field (Box 19) on the CMS-1500 claim form or an attachment, using the degrees, minutes and decimal minutes (DD:MM.MMM) format only.

Providers should bill for the actual miles flown, even if this exceeds the straight-line distance between point of takeoff and point of landing

In this billing scenario, an emergency air transport is being billed.



Emergency Air Transport

Note: For electronic claim submission of transportation claims, HPSJ strongly recommends that providers first contact your Clearinghouse to gather information about their transmission and configuration options to ensure proper claim submission.

Glossary

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. See Balance billing.

Balance billing: Balance billing is the practice of a provider billing you for all charges not paid by your insurance plan, even if those charges are above the plan's usual, customary, and reasonable (UCR) charges or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed copayments, coinsurance, and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (for example, because of bankruptcy)

CCS (California Children's Services): The CCS program provides health services to eligible children with certain physical limitations and chronic health conditions or diseases. CCS covers doctor services, hospital care and surgical care, physical and occupational therapy, laboratory tests, X-rays, orthopedic appliances, medical equipment, and medical case management. The program is funded with state, county, and federal tax monies, along with some fees paid by parents.

Clean Claim: A claim received by an insurance payer that is free from errors and processed is a timely manner. Clean claims are a huge boon to providers, as they reduce turnaround time for the reimbursement process and lower the need for time-consuming appeals processes. Many providers send their claims to third parties, like clearinghouses (See "Clearinghouse"), that specialize in creating clean claims.

CMS 1500: A paper form used to submit medical claims to Medicare and Medicaid. Many commercial insurance payers also require providers to submit their claims using a CMS 1500, making this one of the most common and important tools in the medical billing process.

Co-Insurance: A type of insurance arrangement between the payer and the patient that divides the payment for medical services by percentage. While this is sometimes used synonymously with a co-pay, the arrangements are different: While a co-pay is a fixed amount the patient owes, in a co-insurance, the patient owes a fixed percentage of the bill. These percentages are always listed with the payer's percentage first (eg a 70-30 co-insurance).

Coordination of benefits (COB): Coordination of benefits is an agreement between your insurers to prevent double payment for your care when more than one plan provides coverage. The agreement determines which insurer has primary responsibility for payment and which has secondary responsibility.

Electronic Remittance Advice (ERA): A digital version of the EOB, this document describes how much of a claim the insurance company will pay and, in the case of a denied claim, explains why the claim was returned.

Explanation of Benefits (EOB): Is the insurance company's written explanation regarding a claim, showing what they paid and what the patient must pay. The document is sometimes accompanied by a benefits check, but it's

more typical for the insurer to send payment directly to the medical provider.

FFS (Fee-for-Service) - The traditional method of billing for health services under which a health care provider charges separately for each patient encounter or service rendered.

HCPCS (Healthcare Common Procedure Coding System) - HCPCS is a national, uniform coding structure developed by the Centers for Medicare & Medicaid Services (CMS) to standardize the coding systems used to bill for Medicare and Medicaid services on a national basis. All Medi-Cal claims require HCPCS service codes.

Medicare: The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure that requires dialysis or a transplant, sometimes called ESRD).

Member: Any eligible Medi-Cal member enrolled with HPSJ who is entitled to get covered services.

Mental health services provider: Licensed individuals who provide mental health and behavioral health services to patients.

Network: A group of doctors, clinics, hospitals, and other providers contracted with HPSJ to provide care.

Network provider (or in-network provider): Go to "Participating provider."

Non-covered service: A service that HPSJ does not cover.

Non-emergency medical transportation (NEMT): Transportation when you cannot get to a covered medical appointment and/or to pick up prescriptions by car, bus, train or taxi. HPSJ pays for the lowest cost NEMT for your medical needs when you need a ride to your appointment.

Non-formulary drug: A drug not listed in the drug formulary.

Non-medical transportation: Transportation when traveling to and from an appointment for a Medi-Cal covered service authorized by your provider and when picking up prescriptions and medical supplies.

Non-participating provider: A provider not in the HPSJ network.

Other health coverage (OHC): Other health coverage (OHC) refers to private health insurance and service payers other than Medi-Cal. Services may include medical, dental, vision, pharmacy and/or Medicare supplemental plans (Part C & D).

Out-of-area services: Services while a member is anywhere outside of the service area.

Provider Dispute Resolution (PDR): A request for the health plan to review a claim/billing decision or a grievance.

Prior authorization (pre-approval): A formal process requiring a health care provider to get approval to provide specific services or procedures.

Referral: When a PCP request care from another provider. Some covered care services require a referral and pre-approval (prior authorization).

Health Plan of San Joaquin

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