TABLE OF CONTENTS

Section 10: Claims Submission 10-1

Claims Management 10-1
Requirements for a Complete Claim 10-1
Complete Claim Submission Options 10-2
Claim Submission Timelines 10-3
Claims Determination Notification 10-3
Claim Reimbursement 10-4
Claim Overpayment 10-5
Personal Care Services (PCS) and Home Health Care Services (HHCS) 10-6
Ancillary Claims 10-7
Required Fields; CMS1500 10-11
Required Fields; UB04 10-16
Important Billing Tips 10-22
Claims Status and Questions 10-23
Member Billing 10-23

SECTION 10: CLAIMS SUBMISSION

CLAIMS MANAGEMENT

A key component of quality health care is accurate, timely and efficient claims processing. Health Plan utilizes industry standard billing codes and guidelines in the processing of paper and electronic claims set forth by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).

REQUIREMENTS FOR A COMPLETE CLAIM

A **Complete Claim**, as defined in the *California Knox-Keene Act*, is a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information and "information necessary to determine payer liability" as defined.

****Reasonably relevant information and/or Information necessary to determine payer liability**: *the minimum amount of itemized, accurate and material information generated by or in the possession of the Provider related to the billed services that enables a claims adjudicator to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with any governmental information requirements in a timely and accurate manner.*

For Emergency Services and Care Provider Claim as Defined By Section 1371.35©

- The information specified in section 1371.35© of the Health and Safety Code; and
- Any state-designated data requirements included in statues or regulations

For Institutional Providers:

- The completed **UB04** 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 statute and regulations; and
- Any state-designated data requirements included in statutes or regulations.

For 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-10 or its successors) codes.
- Entries stated as mandatory by NUCC and required by federal statute and regulations; and
- Any state-designated data requirements included in statutes or regulations.

SECTION 10: CLAIMS SUBMISSION

For <u>Providers Not Otherwise Specified</u> in These Regulations:

- A properly completed paper or electronic billing instrument submitted in accordance with the plan's reasonable specifications; and
- Any state-designated data requirements included in statutes or regulations

COMPLETE CLAIM SUBMISSION OPTIONS

Claims can be submitted either paper form or electronically.

Note: *Before submitting a claim, verify the Member's eligibility (See Eligibility Verification, Enrollment, and Customer Service section).*

Paper claim submission are mailed to address below:

Health Plan of San Joaquin/Mountain Valley Health Plan
Paper Processing Facility
P.O. Box 211395
Eagan, MN 55121

To submit claims electronically, Providers must establish an account with a clearing house of choice.

Examples of clearing houses are Change Healthcare (Payer ID 68035), Office Ally (Payer ID HPSJ1) and ClaimsRemedi (68035). Please contact the clearinghouse vendor of choice to set up electronic claim submission. If Health Plan does not already have the clearing house set up as a trading partner, it will be set up once Health Plan is contacted by the clearing house. For any questions or assistance, contact the Provider Services Department at (209) 942-6340.

Health Plan 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.

Note: *<u>Working Days</u> are defined as Monday through Friday, excluding recognized federal holidays.*

Advantages of Electronic Claims Submission

- **Expedited claims processing:** Electronic submission allows Health Plan 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.

SECTION 10: CLAIMS SUBMISSION

CLAIM SUBMISSION TIMELINES

Health Plan's timely filing guideline for claims submission is three hundred and sixty-five (365) days from the date of service. If a claim is received 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 as defined can be presented.
Note: *Date of Service is the date upon which the Provider delivered separately billable health care services to the Member.*

Note: *Date of Receipt is the working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor.*

- ❖ *In the event where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.*

A "good cause", as defined in the *California Knox-Keene Act, is as follows:*

- A catastrophic event that substantially interferes with normal business operations of the Provider
- Administrative delays or errors by Health Plan or the California Department of Health Care Services (DHCS) and/or Department of Managed Health Care (DMHC)
- Other special circumstances reviewed and approved by Health Plan

**The submission of complete documentation to establish "good cause" is required for such consideration and approval.*

The requests for a claim adjustment, corrections, or reconsideration of an adjudicated claim must be received no later than three hundred sixty-five (365) days following the date of payment or denial of the original claim.

CLAIMS DETERMINATION NOTIFICATION

Upon submission of a **Complete Claim**, payment or denial will be made within forty-five (45) working days. Health Plan shall notify Providers in writing no later than forty-five (45) working days after receipt of a claim by Health Plan. If a portion and/or whole claim has been contested (denied), the notice will identify the portion of the claim that is contested (denied) and the specific reason Health Plan is contesting the claim. If the claim is contested (denied) because Health Plan has not received the information necessary to determine Health Plan liability for the claim, then the Provider will have forty-five (45) working days from the date of the notice to provide the information requested. Heath Plan will then complete its consideration of the claim within forty-five (45) working days after receiving the requested information.

Note: *Date of contest, Date of denial or Date of notice: the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid.*

Claims Pend/Review

Claims that cannot be auto adjudicated, fail an edit, and/or audit check, may "pend" for review either by rule-based algorithms or by a claims analyst who has identified potential additional review is needed. All paper claim submissions are scanned, and images reviewed for completeness along with any attachments submitted with the claim.

Claims Denial and Rejections

Health Plan will contest (deny) or reject a claim when the claim has been billed with invalid and/or incomplete information and/or does not meet Health Plan guidelines. *Reference Important Billing Tips and Claim Form Requirements* to avoid denials and ensure prompt payment.

CLAIM REIMBURSEMENT

The reimbursement of a submitted complete claim is the payment for services rendered based upon either a contract term, letter of agreement (LOA) and/or in accordance with the Medi-Cal fee schedule and guidelines. All Providers will receive a Remittance Advice (RA), indicating payment and/or the denied/contested reason *(see Claims Determination Notification)*.

Interest on Claims

Health Plan will pay interest on each uncontested claim not paid timely, frivolous contested claims, and claims where Health Plan supplies late notice, or no notice of the claim being contested or denied *(see Claims Determination Notification)*. Health Plan will also pay interest on payment adjustments made if a Provider Dispute Resolution (PDR) 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 Health Plan fails to pay the interest due on the late claim payment within 5 business days, Health Plan will pay a ten-dollar ($10.00) penalty for that late claim in addition to any amounts due. In determining the timelines, Health Plan 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.

California Children's Services (CCS)

Health Plan is not financially responsible to reimburse Providers for unauthorized services to patients (Members) who qualify under California Children's Services (CCS). The Provider must submit a Service Authorization Request (SAR) to a CCS county or state office and bill CCS for eligible services, except in an emergency. The Provider and facility must be CCS paneled and/or certified to receive reimbursement for such services. For more information about the CCS program, please visit the CCS website at www.dhcs.ca.gov/services.

For information on the authorization process for CCS qualifying conditions, please refer to Section 8 – Utilization Management.

Emergency Department (ED)/Trauma Admissions

If an inpatient stay that was the result of an Emergency or Trauma is denied, Providers have the right to dispute the denial. If the Provider is requesting reimbursement for ED room charges only, please bill those services on a separate claim following the outpatient billing guidelines.

CLAIM OVERPAYMENT

If a Provider identifies an overpayment, the Provider is required to inform Health Plan and return the overpayment to Health Plan within thirty (30) working days from the date the Provider identifies the overpayment.

In accordance with California Knox-Keene Health Care Service Plan Act and Regulations 2019 edition §1300.71 and DHCS, All Plan Letter (APL) 17-003, if Health Plan determines that it has overpaid a claim(s) to a Provider, Health Plan will notify the Provider in writing within 365 days of claim paid date and pursue collections of overpayments. * *The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the Provider.*

Additionally, in accordance with DHCS, APL 20-010, all post-payment recoveries and identified overpayments related to Member(s) having Other Healthcare Coverage (OHC) at the time services are rendered will be reported no later than the 15th of each month to DHCS. All unrecovered monies after the 13th month of the date of payment will be reported and pursued by DHCS and/or assigned contractor. Any monies received by Health Plan after the 13th month of the date of payment from the Provider will be paid to DHCS.

Health Plan will notify the Provider in writing, to the Provider's address of record with Health Plan, which clearly identifies the claim, the name of the patient (Member), the date of service and explanation of the basis upon which Health Plan believes the amount paid on the claim was more

than the amount due, including interest and penalties.

Non-Contested Overpayment

If the Provider does not contest the notice of reimbursement of overpayment, the Provider must reimburse Health Plan within 30 working days of receipt of Health Plan's notice of reimbursement of overpayment [Knox-Keen Act §1300.71(5)].

Offsetting Against Future Claims

Health Plan may offset an uncontested notice of reimbursement of overpayment against a Provider's current claim submissions plus interest at ten percent (10%) per annum [Knox-Keen Act §1300.71(6)] when:

- The Provider fails to reimburse Health Plan within 30 working days of the notice, and
- The Provider's contract specifically authorizes Health Plan to offset an uncontested notice of overpayment from the Provider's current claim submission.
- OR Provider submits Offset Request Form allowing Health Plan to offset overpayment and/or future identified overpayments.

If the overpayment is offset against the Provider's current claim submission, Health Plan will provide a detailed written explanation identifying the specific payments that have been offset against that specific current claim(s).

Contested Overpayment

If the Provider wishes to contest the notice of reimbursement of overpayment, the Provider must state in writing the basis upon which the Provider believes the claim was not overpaid within 30 working days of the date of notice [Knox-Keen Act §1300.71(4)].

Note*: The written notice is considered a Provider Dispute Resolution and is tracked and acknowledge as such (See Provider Dispute Resolution)*

PERSONAL CARE SERVICES (PCS) AND HOME HEALTH CARE SERVICES (HHCS)

All claims for personal care services (PCS) and home health care services (HHCS) for in-home visits by a Provider must be submitted with:

- Allowable current procedural terminology and healthcare common procedure codes as outlined in the DHCS Medi-Cal Provider Manual.

- Proper Place of Service Code or Revenue Code and Bill Type to indicate the rendering of PCS or HHCS in a Member's home

Refer to the following link for EVV Provider Type, Procedure, and Place of Service Code: https://www.dhcs.ca.gov/Documents/EVV-Provider-Types-and-Codes.pdf.

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
Ambulance Services	1500 Form
Durable Medical Equipment	1500 Form
Home Health/Hospice	UB Form; use bill type 32X

Administrative Day Claims Submission and Payment Rules

Certain Health Plan contracted hospital service agreements contain a provision for the reimbursement of an administrative day. When a hospital identifies that a Member requires an administrative day, the hospital must obtain Authorization from Health Plan's Utilization Management (UM) Department. See Chapter 8-Utilization Management- Facility/Ancillary Referrals and Authorizations for authorization requirements for an administrative day.

When the Member is released from the hospital, the hospital must submit separate claims for the inpatient stay and administrative day. An administrative day must be billed with Rev Code 0169. The hospital will be reimbursed at the hospital's contracted reimbursement rates for the inpatient stay and administrative day.

Observation Stay Claims Submission and Payment Rules

Certain Health Plan contracted hospital service agreements contain a provision for reimbursement of an observation stay. No Authorization is required for an observation stay lasting 0-24 hours. The following claims payment rules for an observation stay will apply if a Member is admitted to the hospital:

- When the inpatient admission and observation stay occur on the same day the observation stay will be included in the hospital's contracted inpatient reimbursement rate. The hospital will only submit a claim for the inpatient admission and be reimbursed for the inpatient admission. No separate reimbursement will be paid for the observation stay.
- When the inpatient admission occurs on the day following the observation stay the hospital will be reimbursed for the inpatient stay and the observation stay at the hospital's contracted reimbursement rates. Separate claims for the inpatient admission and the observation stay must be submitted. Rev code 0762 with the corresponding CPT/HCPCS code must be submitted on the claim for the observation stay. The unit(s) billed for the observation stay should be based on the hospital's contracted reimbursement rate:

  For an observation stay per diem rate up to 24 hours, 1 day =1 unit
  For an observation stay hourly rate up to 24 hours, 1 hour =1 unit

When the Member is not admitted to the hospital after an observation stay a claim should be submitted for the observation stay with Rev code 0762 and the corresponding CPT/HCPCS. The unit(s) billed should be based on the hospital's contracted reimbursement rate:

For an observation stay per diem rate up to 24 hours, 1 day= 1 unit
For an observation stay hourly rate up to 24 hours, 1 hour = 1 unit

An observation stay prior to or post of an outpatient surgery will be included in the hospital's contracted outpatient surgery reimbursement rate. No separate payment will be made for the observation stay.

Trauma Care Claims Submission and Payment Rules

Certain Health Plan contracted hospital service agreements contain a provision for the reimbursement of trauma care. When a hospital identifies a Member as a trauma case the hospital must obtain Authorization from Health Plan's Utilization Management (UM) Department. See Chapter 8- Utilization Management -Facility/Ancillary Referrals and Authorizations for authorization requirements for trauma care. The hospital must be a designated trauma facility to receive trauma care reimbursement rates.

When the Member is discharged from the hospital, the hospital will submit a claim for payment of the trauma admission. If the hospital's service agreement contains a provision for the reimbursement of a trauma activation fee, the trauma activation fee must be billed with Rev code 681-684 and admit type 5 indicating a trauma admission. The trauma activation fee (if applicable) will only be paid once per trauma admission. The following payment rules apply to the reimbursement of trauma care:

1. The hospital's contracted trauma reimbursement rate will not be paid if the initial evaluation of the Member does not take place within 30 minutes of the Member arriving in the emergency department or within 8 hours of the traumatic event if the Member is transferred to another facility.
2. The activation of the trauma team must be in response to the notification of key hospital personnel by pre-hospital caregivers.
3. A Member who dies prior to arriving at the hospital cannot be charged the trauma team activation rate regardless of whether the pre-hospital caregiver notification was provided to the receiving hospital.
4. A Member who dies within 24 hours of arriving in the Emergency Department can be charged the outpatient trauma rate.
5. Authorized trauma admissions will be paid at the hospital's contracted rate for the applicable trauma level of care (Level 1-4). When the Member is downgraded to med/surg during the hospital stay the hospital will be paid the hospital's contracted rate for med/surg inpatient days.
6. Hospital admissions not authorized as trauma will be reimbursed at the hospital's contracted rate for inpatient med/surg admission.

Inpatient and Outpatient Implant and Prosthetic Device Claims Submission and Payment Rules

Certain Health Plan contracted Provider agreements contain a provision for the reimbursement of implants and prosthetic devices. Based on the terms of the Provider's agreement, Providers may receive reimbursement for high-cost implants and prosthetic devices provided to a Member or only receive reimbursement for high-cost implants and prosthetic devices when the unit cost exceeds a defined dollar amount threshold. Health Plan follows the Medi-Cal covered benefit guidelines for implants and prosthetic devices and will only reimburse Providers for such covered services. When a Provider identifies an implant or prosthetic device has been provided to a Member and (if applicable) exceeds the unit cost dollar threshold as defined in their Provider agreement, the Provider may submit a claim for the implant or prosthetic device. The claim must be billed with revenue code 274, 275, 276 or 278.

If the Provider's agreement reimburses implants and prosthetic devices at the manufacture's invoice cost plus an additional %, the Provider must submit a manufacture's invoice with the claim. Claims for implants and prosthetic devices will be paid according to their Provider agreement. Claims missing the required revenue code 274, 275, 276 or 278 and manufacturer's invoice (if applicable) will be denied for lack of information.

Health Plan may perform periodic audits of the Provider's implant and prosthetics billing practices to ensure compliance with their Provider agreement and these rules.

Inpatient and Outpatient High-Cost Drug Claim Submission and Payment Rules

Health Plan 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 Health Plan 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 Health Plan'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.

Health Plan may perform periodic audits of the Provider's high- cost drug billing practices to ensure compliance with their Provider agreement and these rules.

REQUIRED FIELDS FOR CMS 1500 FORM (Professional)

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
1	MEDICAID/ MEDICARE/ OTHER ID	For Medi-Cal, enter an "X" in the Medicaid box. Billing Tip: If billing Medicare crossover, there is no need to submit a paper/electronic claim. Health Plan receives crossover claims from CMS.	Y
1a	INSURED'S ID NUMBER	Enter the recipient's ID number from the HPSJ Identification Card. **NOTE:** When submitting a claim for a newborn infant under the mother's eligibility, use the newborn infants Health Plan ID number. This number is available 24-48 hours after receipt of the newborn face sheet. **Billing Tip:** Use the Health Plan Portal to verify that the recipient is eligible for the services rendered.	Y
2	PATIENT'SNAME	Enter the recipient's last name, first name and middle initial (if known). A comma is required between recipient's last name, first name and middle initial (if known). **Billing Tip: Newborn Infant:** When submitting a claim for a newborn infant under the mother's eligibility, use the mother's last name followed by BABY BOY or BABY GIRL. Avoid nicknames or aliases.	Y
3	PATIENT'S BIRTH DATE (MM/DD/CCYY) and SEX	Enter the recipient's date of birth in six-digit MMDDYY format (month, day, year). If the recipient is 100 years or older, enter the recipient's age and the full four-digit year of birth in Box 19. Enter an "X" in the M or F box. **Billing Tip**: **Newborn Infant:** Enter the infant's sex and date of birth in Box 3.	Y
4	INSURED'S NAME	Not Required.	N
5	PATIENT'S ADDRESS	Enter the recipient's complete address and telephone number.	Y
6	PATIENT'S RELATIONSHIP TO INSURED	Not Required.	N
9	OTHER INSURED'S NAME	This field should only be used when the primary insurance is Medicare or Other Healthcare Coverage (OHC) and the policy holder's name differs from the patient's name.	Y
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	This field should only be used when the primary insurance is Medicare or Other Healthcare Coverage (OHC).	Y
9d	INSURED PLAN NAME OR PROGRAM NAME	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
10a, b or c	PATIENT'S CONDITION	Complete this field if services were related to an accident or injury. Enter an "X" in the Yes box if accident/injury is employment related. Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the Date of Current Illness, Injury or Pregnancy field (Box 14).	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
11	INSURED'S POLICY GROUP OR FECA NUMBER	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
11a	INSURED'S DATE OF BIRTH	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	N
11d	ANOTHER HEALTH PLAN BENEFIT	Enter an "X" in the Yes box if the recipient has Other Health Coverage (OHC). Enter the amount paid (without the dollar or decimal point) by the other health insurance in the right side of Box 11d. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, Providers must bill the recipient's other health coverage prior to billing Medi-Cal. Eligibility under Medicare is not considered OHC.	N
14	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP)	Enter the date of the onset of the recipient's illness, the date of accident/injury or the date of the Last Menstrual Period (LMP).	Y
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name of the referring Provider in this box. When the referring Provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the NMP must be entered. However, the NPI of the supervising physician needs to be entered in box 17b, below.	Y
17b	NPI (OF REFERRING PHYSICIAN)	Enter the 10-digit NPI. The following Providers must complete Box 17 and Box 17b: Audiologist, Clinical laboratory (services billed by laboratory), Durable Medical Equipment (DME) and medical supply, Hearing aid dispenser, Nurse anesthetist, Occupational therapist, Orthotist, Pharmacy, Physical therapist, Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B, Portable imaging services, Prosthetist, Radiologist, Speech pathologist.	Y
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.	Y

19	ADDITIONAL CLAIM INFORMATION	Use this area for procedures that require additional information, justification, or an Emergency Certification Statement. **Billing Tip:** "By Report" codes, complicated procedures, modifier breakdown, unlisted services and anesthesia time require attachments. If the rendering Provider is an NP/PA or locum, there last name, first name and NPI should be documented in this field (for informational purposes only). Box 19 may be used if space permits. Please do not staple attachments.	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
20	OUTSIDE LAB	If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X." Outside laboratory refers to a lab not affiliated with the billing Provider. Indicate in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank, if not applicable.	Y
21a-l	DIAGNOSIS OR NATUREOF ILLNESS OR INJURY	Enter all letters and/or numbers of the ICD-10-CM (or latest version) diagnosis code, diagnosis code(s) should be in order of severity/illness presented, include fourth through seventh characters, if present. (Do not enter decimal point.) Relate A-L to service line(s) below (24e).	Y
22	RESUBMISSION CODE	Use to identify a corrected claim and add the original claim number when possible. In all other circumstances, these codes are optional.	Y
23	PRIOR AUTHORIZATION NUMBER	Use for Health Plan authorization number. **Billing tip:** Only one authorization number can cover services billed on any one claim.	Y
24a	DATE(S) OF SERVICE	Enter the date the service was rendered in the From and To boxes in the six-digit, MMDDYY (month, day, year) format in the unshaded area. When billing for a single date of service, enter the date in From box in Field 24A.	Y
24b	PLACE OF SERVICE	Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered. **Billing Tip:** The national Place of Service codes are listed in the CMS-1500 Completion section (CMS COMP) of the Medi-Cal Provider Manual, Part 2.	Y
24c	EMG	Emergency Code: Only one emergency indicator is allowed per claim and must be placed in the bottom-unshaded portion of Box 24C. Leave this box blank unless billing for emergency services.	Y
24d	PROCEDURES, SERVICESOR SUPPLIES/MODIFIER(S)	Enter the appropriate procedure code (CPT-4 or HCPCS) and modifier(s). For additional information on how to bill modifiers, please refer to the Medi-Cal Provider Manual. **Billing Tip:** The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple National Correct Coding Initiative (NCCI)-associated modifiers on the same claim line. If necessary, the procedure description can be entered in the Additional Claim Information field (Box 19). **Billing Tip:** Do not submit a National Correct Coding Initiative (NCCI)-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted.	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	$CHARGES	In the unshaded area of the form, enter the usual and customary fee for service(s) in full dollar amount. Do not enter a decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000."	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
24g	DAYS OR UNITS	Enter the number of medical "visits" (days) or procedures, surgical "lesions," units of anesthesia time, items, or units of service, etc. The field permits entries up to 999 in the unshaded area. **Billing Tip:** Providers billing for units of time should enter the time in 15-min increments. For example, one hour should be entered as "4."	Y
24h	EDSDT FAMILY PLANNING	Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.	Y
24j	RENDERING PROVIDER ID#	Enter the NPI for a rendering Provider (unshaded area) if the Provider is billing under a group NPI. **Billing Tip:** If the rendering Provider is an NP/PA or locum, enter the supervising physicians NPI in this field.	Y
25	FEDERAL TAX ID#	Enter the Rendering/Supervising physicians Federal Tax ID in this field.	Y
26	PATIENT'S ACCOUNT NUMBER	Field use for Provider's unique patient account number.	N
27	ACCEPT ASSIGNMENT	"Yes" or "No" entry is required.	Y
28	TOTAL CHARGE	Enter the full dollar amount for all services without the decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000." **Billing Tip:** If billing more than 1 claim form (or more than 6 lines) only enter total charge on the last claim form.	Y
29	DOLLAR AMOUNT	Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient's Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($). **Billing Tip:** Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare EOMB/MRN/RA when submitted with the claim.	Y
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	The claim must be signed and dated by the Provider, or a representative assigned by the Provider, in black ballpoint pen only. **Billing Tip:** If the rendering physician/Provider is PA/NP or locum, enter the supervising physicians name in this field. Signatures must be written, not printed and should not extend outside the box. Stamps, initials, or facsimiles are not accepted.	Y

32	SERVICE FACILITY LOCATION INFORMATION	Enter the Provider's name. Enter the Provider's address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. **Billing Tip:** Use the name and address of the facility where the services were rendered if other than a home or office.	Y
32a	SERVICE FACILITY NPI	Enter the NPI of the facility where the services were rendered.	Y
33	BILLING PROVIDER INFORMATION AND PHONE NUMBER	Enter the Provider's name. Enter the Provider address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. Enter the telephone number.	Y
33a	BILLING PROVIDER NPI	Enter the billing Provider's NPI.	Y

REQUIRED FIELDS FOR THE UB FORM (Institutional)

The following form outlines only the REQUIRED Field Information:

UBREQUIREDFIELDINFORMATON			
BOX #	**FIELDNAME**	**INSTRUCTIONS**	**REQUIRED (Y, N)**
1	ADDRESS, ZIP CODE	Enter the Provider's name, hospital and clinic address, without a comma between the city and the state, and the nine-digit ZIP code without a hyphen. A telephone number is optional in this field. **NOTE:** The nine-digit ZIP code entered in this box must match the billing Provider's ZIP code on field for claims to be reimbursed correctly.	Y
3a	PATIENT CONTROL NUMBER	Enter the patient's financial record number or account number in this field.	N
3b	MEDICAL RECORD NUMBER	Use Box 3a to enter a patient control number.	N
4	INSURED'S NAME	Not Required.	Y
6	STATEMENT COVERS PERIOD (FROM- THROUGH)	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the dates of service for this claim in six-digit MMDDYY (month, day, year) format. The date of discharge should be entered in the THROUGH box, even though this date is not reimbursable (unless the day of discharge is the date of admission). **NOTE:** For "From- Through" billing instructions, refer to the UB-04 Special Billing Instructions for Inpatient Services section (U B SPEC IP) in the Part 2 portion of the Medi-Cal Provider manual.	Y
8b	PATIENT NAME	Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases. **Newborn infant:** When submitting a claim for a newborn infant using the mother's eligibility, enter the infant's name in Box 8b. if the infant has not yet been named, use the mother's last name followed by "Baby Boy" or "Baby Girl" (for example, JONES, BABY GIRL). **Billing Tip:** If billing for newborn infants from a multiple birth, each newborn must also be designated by a number or a letter (for example, JONES, BABY GIRL TWIN A) on separate claims. Enter infant's date of birth/sex in boxes 10 and 11. **Organ Donors:** When submitting a claim for a patient donating an organ to a HPSJ recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Heath Plan recipient's name in the Insured's Name field (Box 58) and enter "11" (Donor) in the Patient's Relationship to Insured field.	Y
10	BIRTH DATE	Enter the patient's date of birth, using an eight-digit MMDDYYY (month, day, year) format (for example, September 16, 1967 = 09161967). **NOTE:** If the recipient's full date of birth is not available, enter the year preceded on 0101. For newborns and organ donors, see item 8b).	Y
11	SEX	Enter the capital letter "M" for male or "F" for female	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
12 and 13	ADMISSION DATE AND HOUR	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the date of hospital admission, in a six-digit format. Convert the hour of admission to the 24-hour (00-23) format. Do not include the minutes. **Billing Tip:** The admit time of 1:45p.m. will be entered on the claims as 13.	Y
14	ADMISSION TYPE	**Outpatient Claims:** Enter an admit type code of "1" when billing for emergency room-related services (in conjunction with the facility type "14" in Box 4). This field is not required by Health Plan for any other use. **Inpatient Claims:** Enter the numeric code indicating the necessity for admission to the hospital. **NOTE:** If the delivery was outside the hospital, use admit type code "1" (emergency) in the Type of Admission and admission source code "4" (extramural birth) in the Source of Admission field (Box 15).	Y
15	ADMISSION SOURCE	**Outpatient Claims:** Not required. **Inpatient Claims:** If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. Enter code "1" or "3" in Box 14 to indicate whether the transfer was an emergency or elective. When the type of admission code in Box 14 is "4" (newborn; baby born outside of hospital), submit claim with source of admission code "4" in Box 15 and appropriate revenue code in Box 42.	Y
31 through 34a and b	OCCURRENCE CODES AND DATES	Occurrence codes and dates are used to identify significant events related to a claim that may affect payer processing. Occurrence codes and dates should be entered from the left to right, top to bottom in numeric-alpha order starting with the lowest value. Example: If billing for two occurrence codes "24" (accepted by another payer) and "05" (accident/no medical or liability coverage), enter "05" in Box 31a and "24" in Box 32a. Enter the accident/injury date in corresponding box (6-digit format MMDDYY). **NOTE:** Enter code "04" (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related**. Outpatient Claims:** Discharge date in not applicable. **Inpatient Claims**: Discharge Date: Enter occurrence code "42" and the date of hospital discharge (in six-digit format) when the date of discharge is different from the "THROUGH" date in Box 6.	Y
37a	UNLABELED (USE FOR DELAY REASONCODES)	If there is an exception to the billing limit, enter on the delay reason codes in Box 37a and include the required documentation. **NOTE:** Documentation justifying the delay reason must be attached to the claim for review. **For hospitals that are not reimbursed according to the diagnosis related groups (DRG) model:** Providers must use claim frequency code "5" in the Type of Bill field (Box 4) of the claim when adding a new ancillary code to a previous stay, if the original stay was already billed.	N

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
42	REVENUE CODE	**Outpatient Claims:** Revenue codes are required (for instance, for organ procurement). **Inpatient Claims:** Enter the appropriate revenue or ancillary code. Refer to the Revenue Codes for Inpatient Services section (REV CD IP) in the appropriate Part 2 of the Medi-Cal Provider manual. Ancillary codes are listed in the Ancillary Codes section (ANCIL COD) of the Part 2 Medi-Cal Provider manual. **Billing Tip:** For both outpatient and inpatient claims (single-page claims), enter code "001" in Box 42, line 23 to designate the total charge line. Enter the total amount in Box 47, line 23.	Y
43	DESCRIPTION	**Outpatient Claims:** Information entered this field will help separate and identify the descriptions of each service. The description must identify the service code indicated in the HCPCS/Rate/HIPPS Code field (Box 44). This field is optional, except when billing for physician-administered drugs. Refer to the Physician-Administered Drugs-NDC UB-04 Billing Instructions section (physician MDC UB) of the Part 2 Medi-Cal Provider manual for more information. **Inpatient Claims:** Enter the description of the revenue or ancillary code listed in the Revenue Code field (Box 42). **NOTE:** If there are multiple pages of the claims, enter the page numbers on line 23 in this field.	Y
44	HCPCS/RATE	**Outpatient Claims:** Enter the applicable procedure code and modifier. Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Attach reports to the claims for "By Report" codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures. Non-payable CPT codes are listed in the TAR & Non-Benefit List: Codes (10000- 99999) sections in the appropriate Part 2 Medi-Cal Provider manual. All modifiers must be billed immediately following the HCPCS code in the HCPCS/Rate field (Box 44) with no spaces. Up to four modifiers may be entered on the outpatient UB-04 claim form. **Inpatient Claims**: Not required.	Y
45	SERVICE DATES	Outpatient Claims: Enter the date the service was rendered in six- digit format. Inpatient Claims: Not required. Billing Tip: For "From- Through" billing instructions, see the UB-04 Special Billing Instructions for Outpatient Services section (UB SPEC OP).	Y
46	SERVICE UNITS	**Outpatient Claims:** Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units on two or more lines**.** **Inpatient Claims:** Enter the number of days of care by revenue code. Units of service are not required for ancillary services. If billing for more than 99 units, divide the units between two or more lines. **Billing Tip:** Although Service Units is a seven-digit field, only two digits are allowed.	Y

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
47	TOTAL CHARGES	In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents, even if the amount is even (e.g., if billing for $100, enter "10000" not "100"). Enter the total charge for all services on the last line or on line 23. Enter "001" in Revenue Code field (Box 42, line 23) to indicate this is the total charge line. **Outpatient Claims:** If an item is a taxable medical supply, include the applicable state and county sales tax. To delete a line, mark with a thin line through the entire detail line (Box 42-49), using a black ballpoint pen. **NOTE:** Up to 22 lines of data (fields 42-49) can be entered. It is acceptable to skip lines.	Y
50a through 50c	PAYER NAME	**Outpatient Claims:** Enter insurance plan name to indicate claim payer. **NOTE:** If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Health Plan. **Billing Tip:** When completing Boxes 50-65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: HPSJ). Do not enter information on Lines A and B for other insurance (or Medicare) if payment was denied by these carriers. If Health Plan is the only payer billed, all information in Boxes 50-65 (excluding Box 56) should be entered online A.	Y
51	HEALTH PLAN ID	Enter the 9-digit Health Plan ID number. **NOTE:** If recipient is a newborn infant covered under the mother's eligibility, enter the newborn infant Health Plan ID number. This ID is available 24-48 hours after receipt of the newborn infant face sheet.	Y
54a through 54c	PRIOR PAYMENTS (OTHER COVERAGE)	Leave blank if not applicable. Enter the full dollar amount of the payment received from the OHC, online A or B that corresponds with OHC in the Payer field (Box 50). Do not enter a decimal point (.), dollar sign ($), plus (+) or minus (-) sign. **NOTE:** For instruction about completing this field for Medicare/Medi-Cal recipients, refer to the Medicare/Medi-Cal Crossover Claims: UB-04 section (MEDCR UB) in the Medi-Cal Provider manual.	N
55a through 55c	ESTIMATED AMOUNT DUE (NETAMOUNT BILLED)	In full dollar amount, enter the difference between "Total Charges" (Box 47, line23) and any deductions. Do not enter a decimal point (.) or dollar sign ($). **Example:** Patient's SOC Value Codes Amount and/or OHC Prior Payments.	N
56	NPI	Enter the appropriate 10-digit National Provider Identifier (NPI) number.	Y
57a through 57c	OTHER PROVIDER ID	Not Required	N

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
58a through 58c	INSURED'S NAME	Enter the last name 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 (e.g., Miller Jr. Roger). **NOTE:** If billing for an organ donor, enter the recipient's name and the patient's relationship to the recipient in the Patient's relationship to Insured field.	N
60a through 60c	INSURED's UNIQUE ID	Enter the recipient's Health Plan 9-digit ID number as it appears on the Health Plan Identification Card. **NOTE:** Health Plandoes not accept the 14-digit ID number on the Benefits Identification Card (BIC). **Billing Tips:** When submitting a claim for a newborn infant for the month of birth or the following month, under the mother's eligibility, use the newborn infant Health Plan9-digit ID number. (This ID number is available 24-48 hours after receipt of the newborn infant face sheet.)	Y
63a through 63c	PRIOR AUTHORIZATION	For services requiring a Prior Authorization, enter the alpha-numeric number in this field. It is not necessary to attach a copy of the Prior Authorization. Recipient information on the claim must match the Authorization. Multiple claims must be submitted for services that have more than one Authorization. Only one Authorization can cover services billed on any one claim. **Inpatient Claims:** Inpatient claims must be submitted with an Authorization.	Y
66	DIAGNOSIS CODE HEADER	Claims with a diagnosis code in Box 67 must include the ICD indicator "0" for ICD-10-CM diagnosis codes, effective October 1, 2015.	Y
67	UNLABELED (PRIMARY DIAGNOSISCODE)	Include all letters and numbers of the ICD-10-CM diagnosis code to the highest level of specificity (when possible) including fourth through seventh digits if present for the primary diagnosis code. Do not include decimal point. Present on Admission (POA) indicator. Each diagnosis code may require a POA indicator. Hospitals must enter a POA indicator (unless exempt) in the shaded portion of boxes 67 and 67a, to the right of the diagnosis field, to indicate when the condition occurred, if known. When the condition is present, use "Y" for yes. When the indicator is "N" for no, it means that the condition was acquired while the patient was in the hospital.	Y
67a	UNLABELED (SECONDARY DIAGNOSIS CODE)	If applicable, enter all letters and/or numbers of the secondary ICD- 10-CM diagnosis code to the highest level of specificity (when possible). Do not include a decimal point. **NOTE:** Paper claims accommodate up to 18 diagnosis codes.	N

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
74	OTHER PROCEDURE CODES AND DATES	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. In six-digit format, enter the date the surgery or delivery was performed. **Billing Tip:** Inpatient Providers must enter ICD- 10-PCS code in this field (not CPT-4/HCPCS surgical procedure code).	Y
74a through 74e	OTHER PROCEDURE CODES AND DATES	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. **NOTE:** For OB vaginal or cesarean delivery and transplants, enter a suitable ICD-10-PCS code in Box 74 or 74a-e.	Y
76	ATTENDING	**Outpatient Claims:** Enter the referring or prescribing physician's NPI in the first box. This field is mandatory for radiologists. If the physician is not a Medi-Cal Provider, enter the state license number. Do not use a group Provider number. Referring or prescribing physician's first and last names are not required. **Billing Tip:** For atypical referring or prescribing physicians, enter the Medicaid Identifier "1D" in the Qual ID box and enter the Medi-Cal Provider number next to it. **Inpatient Claims:** Enter the attending physician's NPI in the first box. Do not enter a group number. The attending physician's first and last name is not required. **Billing tip:** For inpatient claims, do not enter the operating or admitting physician NPI in this field.	Y
77	OPERATING	**Outpatient Claims:** Enter the NPI of the facility in which the recipient resides or the physician providing services. Only one rendering Provider number may be entered on claim. Do not use a group number or state license number. **Billing Tip:** For atypical rendering physicians, enter the Medicaid Identifier "1D" in the Qual ID box and enter the Medi-Cal Provider number next to it. **Inpatient Claims:** Enter the operating physician's NPI in the first box. Do not enter a group number. The operating physician's first and last name is not required.	N
78	OTHER	Outpatient Claims: Not required. Inpatient Claims: Enter the admitting physician's NPI in the first box. Do not enter a group Provider number. The admitting physician's first and last name is not required by Medi-Cal.	N
80	REMARKS	Use this area for procedures that require additional information, justification, or an Emergency Certification Statement. This statement must be signed and dated by the Provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in this area, attach the statement to the claim. Billing Tip: If additional information cannot be completely entered in this field, attach the additional information to the claim on single- sided 81/2 by 11-inch white paper. "By Report" claim submissions do not always require an attachment. For some procedures, entering information in the Remarks field (Box 80) of the claim may be sufficient. Eligibility Verification Confirmation (EVC) numbers, are not required as attachments unless the claim is over 1 year old.	N

SECTION 10: CLAIMS SUBMISSION

IMPORTANT BILLING TIPS

- Obtain prior authorization for any covered services that require authorizations.
- The Provider Portal has a list of codes that require authorization.
- File complete claims within the required timely filing requirements.
- File complete claims electronically as recommended.
- 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.
- Identify frequency limits for certain procedure codes www.medi-cal.ca.gov
- 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 physician administered drugs (PAD).
- For a list of High-Cost Pharmacy (drugs), see Section 11 – Provider Payment
- Invoices are also required for certain HCPCS codes.
- Review National Correct Coding Initiative (NCCI) and bill appropriate modifiers
- Submit claims with all required documentation
- 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.

Billing Resource and Guidelines

Health Plan's Provider Billing Handbook includes billing procedures and guidelines to be utilized as a tool to prevent delays, rejections or denied claims. To view the handbook, click the following link to access the Provider Billing Handbook: https://www.hpsj.com/Provider-billing-and-resource-guide/

Newborns

Please note that Hospitals must notify Health Plan of Member newborns within twenty-four (24) hours of birth. Under Health Plan 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 Health Plan ID number under the mother's coverage.
- Claims should be submitted using newborn baby's Health Plan 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 Health Plan 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.

CLAIMS STATUS AND QUESTIONS

Claims status is available through the Provider Portal. The Provider Portal is available through Health Plan website, www.hpsj-mvhp.org. 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.

MEMBER BILLING

As a Managed Care (Medi-Cal) Plan (MCP), many of the same rules that apply to Medi-Cal fee-

for- service apply to Health Plan. Balance billing Medi-Cal Members is prohibited by federal and state laws. Medi-Cal Members should not pay for physician visits and other medical care when they receive covered services from any Health Plan Provider. This means Health Plan Members cannot be charged for co-pays, co-insurance, or deductibles. Health Plan Providers cannot bill a Member.

If the services provided are covered services in accordance with Health Plan benefits, then Health Plan's reimbursement to the Provider constitutes full payment and the Member cannot be balance billed for these services. If a Member was invoiced or charged in error, all billing efforts must cease as soon as the error is identified. If the Member paid for covered services, the Provider must refund the Member within fifteen (15) days.

Billing Medi-Cal Members violates Federal and State laws. as outlined in section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997; California Welfare and Institutions Code, section 14019.4; W&I Code section 14019.3; W&I Code section 14019.4; Title 28 CCR 1300.71; Title 22, §51002; Title 42 CFR, section 447.15.

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 Health Plan. However, the service must clearly be identified as not a covered benefit (NCB) in accordance with Health Plan and/or Medi-Cal. The violation of the Medi-Cal or Health Plan payment rules could result in the immediate termination of the *Provider's Agreement*.