
SECTION 10: CLAIMS AND BILLING GUIDELINES

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CLAIMS MANAGEMENT

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

REQUIREMENTS FOR A COMPLETE CLAIM

A **Clean Claim**, as defined by CMS, 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”.

An **Unclean Claim**, or “other than clean” claim, as defined by CMS, is a claim requiring additional information to make a payment determination. Unclean claims are suspended and a written request identifying necessary information is sent to Provider. (See Claim Development in this section).

***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.

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 statutes or regulations

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.

Physicians and Other Professional Providers:

- The **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.

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Providers Not Otherwise Specified above:

- A properly completed paper or electronic billing instrument submitted in accordance with the plan's reasonable specifications
- Any state-designated data requirements included in statutes or regulations; and
- Referring physician national provider identifier (NPI) for claims for durable medical equipment (DME)

COMPLETE CLAIM SUBMISSION OPTIONS

Claims can be submitted on a paper form or electronically.

Note: Before submitting a claim, verify Enrollee eligibility (See Section 6 Eligibility).

Paper claim submissions are mailed to address below:

Health Plan Advantage D-SNP
Paper Processing Facility
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 Advantage D-SNP does not already have the clearing house set up as a trading partner, it will be set up once Health Plan Advantage D-SNP is contacted by the clearing house. For any questions or assistance, contact the Provider Services Department at 1-888-361-7526 (TTY:711).

Health Plan Advantage D-SNP will acknowledge the receipt of electronic claims within two working days of receipt and acknowledge receipt of paper claims within 15 working days.

Note: Working Days are defined as Monday through Friday, excluding recognized federal holidays.

Advantages of Electronic Claims Submission

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

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CLAIM SUBMISSION TIMELINES

Health Plan Advantage D-SNP's timely filing guideline for claims submission is 365 calendar days from the date of service or date of discharge for acute inpatient claims. If a claim is not received within the appropriate time frame, the claim will be denied as untimely unless evidence of an exception (described below) accompanies claim submission. The determination of good cause is made by Health Plan Advantage D-SNP.

Note: Date of Service is the date which the Provider delivered separately billable health care services to the Enrollee.

Note: Date of Receipt is the calendar day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, designated claims processor, or Health Plan Advantage D-SNP delegate.

Medicare regulations allow for the following exceptions to the 1 calendar year time limit for filing a claim:

- Administrative errors by Medicare contractor or Health Plan Advantage D-SNP
- Retroactive Medicare or Medi-Cal entitlement to or before the date the service was furnished.
- Retroactive disenrollment from a Medicare Advantage or PACE plan

See Section 12: Disputes for instructions on requesting adjustments, corrections, or reconsiderations of an adjudicated claim.

CLAIMS DETERMINATION NOTIFICATION

Upon submission of a Clean Claim, payment or denial will be made within 30 calendar days. Health Plan Advantage D-SNP shall notify Providers in writing no later than 30 calendar days after receipt of a clean claim by Health Plan Advantage D-SNP. If a portion or whole claim is determined as unclean, one written attempt to obtain the necessary information is sent to Provider and the claim will remain suspended for no more than 60 calendar days to allow for the submission of requested information. Provider remittance advice notice will identify the specific reason Health Plan Advantage D-SNP is denying the claim. If the claim is denied because Health Plan Advantage D-SNP has not received the information necessary to determine Health Plan Advantage D-SNP liability for the claim, Provider will have 120 calendar days from the date of the notice to provide the information requested. Health Plan Advantage D-SNP will make a determination within 30 calendar days after receiving the requested information.

Note: Date of denial or Date of notice: the date the notice is deposited with the United States Postal Service (USPS) or electronically sent to clearinghouses.

Claims Pend/Review

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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 Development

Health Plan Advantage D-SNP will reject a claim billed with invalid and/or missing required data elements including but not limited to industry-standard diagnosis and procedure codes. Health Plan Advantage D-SNP will develop a claim with incomplete information and/or additional information is needed to make a determination. Provider will receive written notice requesting a resubmission of a complete claim or the specific information needed to make a determination. The claim will be identified as an unclean claim and will remain open for not more than 60 calendar days from the date of receipt to allow for receipt and review of requested information. If the information is not received before the 60th day, the claim will be denied, in whole or in part, indicating requested records were not received. Provider is encouraged to submit the records as expeditiously as possible to the address indicated in the written request. *Reference Important Billing Tips and Claim Form Requirements* to avoid denials and ensure prompt payment.

CLAIM REIMBURSEMENT

The reimbursement of a submitted claim is the payment for services rendered based upon either a contract term, letter of agreement (LOA) and/or in accordance with the Medicare fee schedules and guidelines. All Providers will receive remittance advice, indicating payment and/or the denied reason (*see Claims Determination Notification*).

Interest on Claims

Health Plan Advantage D-SNP will pay interest on clean claims paid after the 30th day from the date of receipt. Health Plan Advantage D-SNP will also pay interest on payment adjustments made if Health Plan Advantage D-SNP is responsible for the error resulting in an underpayment. Interest payments will apply to both contracted and non- contracted Providers.

The interest rate is updated bi-annually on first of January and July by the Bureau of the Fiscal Service. The applicable interest rate is selected based on the effective rate on the date the claim enters the mail stream or funds are released to Provider. Interest rates are available at [Prompt Payment: Interest Rates](#).

The number of days for which interest is due is calculated as the date the payment is deposited with the USPS or funds released by the bank to Provider.

Interest is calculated as reimbursement amount multiplied by the interest rate divided by 365 and multiplied by the number of days interest is due.

Example:

Reimbursement amount: \$100

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Date received: March 1

Date payment deposited with USPS or funds released to Provider electronically: May 15

Number of days interest is due: 45 days (May 15 less March 1 less 30 days)

Applicable interest rate on May 15: 4.65%

Interest payable: $\$100 \times (4.65\%/365) \times 45 \text{ days} = \0.57

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 (contracted Provider) or request reconsideration (non-contract Provider) of the denial. If Provider is requesting reimbursement for ED room charges only, please bill those services on a separate claim following the outpatient billing guidelines.

RISK ADJUSTMENT

Risk adjustment is the process of considering Enrollees' health status and associated risk factors when determining Medicare payments to Health Plan Advantage D-SNP and/or Provider. This approach aims to provide compensation based on the diversity of Enrollee illness and complexity. Risk adjustment relies on patient diagnoses, mainly recorded via ICD-10 codes, to estimate anticipated healthcare expenses. Enrollees with more complex or severe conditions receive higher risk scores. Key Elements of Risk Adjustment include:

- Hierarchical Condition Categories (HCCs): HCCs group-related diagnoses that predict similar costs. Each diagnosis has a weight, and all weights contribute to the Enrollee's total risk score.
- Demographic Factors: Age, gender and Medicaid level are incorporated into risk adjustment calculations.
- Annual Reset: Risk scores generally reset each calendar year, underscoring the importance of documenting all relevant diagnoses annually.

Provider Engagement

For Providers, risk adjustment affects patient care approaches and the management of medical practices. Reasons include:

- Reimbursement Accuracy: Allows practices to receive compensation aligned with the complexity and needs of their patient population.
- Quality Reporting: Quality metrics and star ratings are based on risk-adjusted data; insufficient or inaccurate coding may affect these scores.
- Population Health Management: Evaluating patients' risk profiles supports targeted interventions, care coordination, and resource allocation.
- Regulatory Compliance: Proper documentation and coding meet requirements set by CMS.
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Patient Engagement

Engaged patients are more likely to share complete information and participate in recommended care, leading to more accurate risk adjustment and better outcomes.

- Build trust to encourage open communication about symptoms and social challenges.
- Educate patients about the importance of chronic disease management and routine follow-up visits.
- Discuss the impact of accurate health information on care planning and resources.

Accurate Coding and Documentation

Accurate coding and documentation are essential for risk adjustment. Diagnoses need to be supported in the medical record and coded with the highest, detailed specificity.

- Document all chronic conditions, even if stable.
- Use precise ICD-10 codes—avoid generic or unspecified codes when possible.
- Ensure each diagnosis is assessed, monitored, or treated during the encounter
- Update diagnoses annually to maintain accurate risk scores.

Best Practices

Accurate risk adjustment depends on thorough clinical documentation and coding practices. Primary care providers may implement several steps:

- Annual Wellness Visits: Use these opportunities to review and document all existing conditions and screen for undiagnosed issues.
- Team-Based Care: Engage nurses, medical assistants, coders, and care managers to help capture and document patient complexity.
- Stay Up to Date on Coding Guidelines: Regularly review ICD-10 updates and payer guidance.
- Utilize Technology: Electronic health records (EHRs) often have tools and prompts to assist with documentation and coding; ensure your practice makes full use of these resources.
- Provide Ongoing Training: Offer staff and provider education on documentation, HCCs, and risk adjustment concepts.

Risk adjustment is an integral component of primary care, affecting payment structures, care quality and resource allocation. When primary care Providers apply risk adjustment principles, they contribute to the delivery of appropriate care and help maintain the financial stability of their practice.

By providing thorough documentation, accurate coding, and patient-focused care, primary care providers facilitate effective risk adjustment for both patient health outcomes and healthcare system sustainability.

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CLAIM OVERPAYMENT

If a Provider identifies an overpayment, the Provider is required to inform Health Plan Advantage D-SNP and return the overpayment to Health Plan within 60 days from the date the Provider identifies the overpayment as specified in the Social Security Act section 1128J(d).

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 Advantage D-SNP determines that it has overpaid a claim(s) to a Provider, Health Plan Advantage D-SNP 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 Enrollee 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 Advantage D-SNP after the 13th month of the date of payment from the Provider will be paid to DHCS.

Health Plan Advantage D-SNP will notify Provider in writing, to the Provider's address of record with Health Plan Advantage D-SNP, which clearly identifies the claim, the name of the patient (Enrollee), the date of service and explanation of the basis upon which Health Plan Advantage D-SNP 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 Advantage D-SNP within 30 days of receipt of Health Plan Advantage D-SNP's notice of overpayment. Interest accrues on any uncontested overpayment amounts after the 30th day as described in the Medicare Financial Management Manual, Chapters 3 and 4.

Offsetting Against Future Claims

Health Plan Advantage D-SNP may offset an uncontested notice of reimbursement of overpayment against a Provider's current claim submissions when:

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

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

Offsets against current or future claims are available to Provider expected to have future claim submissions under the tax identification number associated with the overpayment.

Contested Overpayment

If Provider contests the notice of reimbursement of overpayment, it 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 acknowledged as such (See Section 12 - Disputes)

ANCILLARY CLAIMS

Billing for ancillary covered services should be in accordance with D-SNP guidelines.

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

PROVIDER TYPE	BILLING FORMS
Diagnostic Services	CMS-1500 Form
Skilled Nursing Facilities	UB04 Form
Ambulatory Surgery Center	UB04 Form, include correct type of bill
Ambulance Services	CMS-1500 Form
Durable Medical Equipment	CMS-1500 Form
Home Health	UB04 Form; use bill type 32X

Observation Stay Claims Submission and Payment Rules

Provider service agreements which contain a provision for reimbursement of an observation stay are reimbursed under the Outpatient Prospective Payment System (OPPS). No Authorization is required for an observation stay lasting 0-72 hours.

If the Enrollee is admitted to the hospital following or on the same day as an observation stay, charges from the observation stay will be included in the calculation of the inpatient stay. No separate reimbursement will be paid for the observation stay.

Submit observation stay (or portion of the stay if admitted) using revenue code 0762 with the corresponding CPT/HCPCS code. The unit(s) billed for the observation should reflect the number of observation hours beginning with the hour the admission order is written.

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Applicable Trauma Level of Care (Level 1-4)

When the Enrollee is downgraded to med/surg during the hospital stay the hospital will be paid the hospital's contracted rate for med/surg inpatient days.

1. 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

Provider agreements which contain a provision for the reimbursement of implants and prosthetic devices may receive reimbursement for high-cost implants and prosthetic devices provided to an Enrollee or only receive reimbursement for high-cost implants and prosthetic devices when the unit cost exceeds a defined dollar amount threshold. Health Plan Advantage D-SNP will only reimburse Providers for covered services identified in Medicare fee schedules as "pass-through" items. When Provider identifies an implant or prosthetic device has been provided to an Enrollee 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 manufacturer's invoice cost plus an additional percentage, Provider must submit a manufacturer'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 0274, 0275, 0276 or 0278 and manufacturer's invoice (if applicable) will be denied for lack of information.

Health Plan Advantage D-SNP 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 Advantage D-SNP 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. Claims 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 percentage, the Provider must submit a manufacturer'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 Provider agreement.

Claims missing the required revenue code 0636, HCPCS, NDC code and manufacturer's invoice (if applicable) will be developed (See Claim Development).

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

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REQUIRED FIELDS FOR CMS-1500 FORM (PROFESSIONAL)

BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
1	MEDICAID/ MEDICARE/ OTHER ID	For D-SNP Enrollee, enter an "X" in the Medicare box.	Y
1a	INSURED'S ID NUMBER	Enter the recipient's ID number from Health Plan Advantage D-SNP Identification Card.	Y
2	PATIENT'S NAME	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).	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.	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	Enter when the policy holder's name differs from the patient's name and Enrollee has healthcare coverage other than Medicare and Medi-Cal	Y
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Enter other policy or group number when Enrollee has healthcare coverage other than Medicare and Medi-Cal .	Y
9d	INSURED PLAN NAME OR PROGRAM NAME	Complete this field if patient has other healthcare coverage (OHC). Billing Tip: Do not populate with "Medicare" or "Medi-Cal". Health Plan Advantage D-SNP will determine financial liability.	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

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BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
11	INSURED'S POLICY GROUP OR FECA NUMBER	Complete this field if patient has Other Health Coverage (OHC) which is not Medicare or Medi-Cal.	Y
11a	INSURED'S DATE OF BIRTH	Complete this field if patient has Other Health Coverage (OHC) which is not Medicare or Medi-Cal.	Y
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Complete this field if patient has Other Health Coverage (OHC) which is not Medicare or Medi-Cal.	N
11d	ANOTHER HEALTH PLAN ADVANTAGE D-SNP 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.	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, their 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

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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-1	DIAGNOSIS OR NATURE OF 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 Advantage D-SNP 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 Medical 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, SERVICES OR SUPPLIES/MODIFIER(S)	Enter the appropriate procedure code (CPT-4 or HCPCS) and modifier(s). 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

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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

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REQUIRED FIELDS FOR UB-04 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 an HPSJ/MVHP recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Health 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 MMDDYY (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

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BOX #	FIELDNAME	INSTRUCTIONS	REQUIRED (Y, N)
12 and 13	ADMISSION DATE AND HOUR	<p>Outpatient Claims: Not required.</p> <p>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.</p> <p>Billing Tip: The admit time of 1:45p.m. will be entered on the claims as 13.</p>	Y
14	ADMISSION TYPE	<p>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 Advantage D-SNP 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).</p>	Y
15	ADMISSION SOURCE	<p>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.</p>	Y
18-28	CONDITION CODES	<p>Required to indicate End-Stage Renal Disease (ESRD) and Dialysis and Skilled Nursing Facility (SNF) conditions. See Condition Codes - JE Part A - Noridian for a complete list of condition codes.</p>	Y
31 through 34a and b	OCCURRENCE CODES AND DATES	<p>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.</p> <p>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.</p>	Y

SECTION 10: CLAIMS SUBMISSION

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
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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. 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. 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. Up to four modifiers may be entered on the outpatient UB-04 claim form. Inpatient Claims: Not required.	Y

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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 Advantage D-SNP. 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/MVHP). Do not enter information on Lines A and B for other insurance (or Medicare) if payment was denied by these carriers. If Health Plan Advantage D-SNP is the only payer billed, all information in Boxes 50-65 (excluding Box 56) should be entered online A.	Y
51	HEALTH PLAN ADVANTAGE D-SNP ID	Enter the 9-digit Health Plan Advantage D-SNP ID number.	Y

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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.	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 Advantage D-SNP 9-digit ID number as it appears on Health Plan Advantage D-SNP's Identification Card. NOTE: HealthPlan Advantage D-SNP does 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 Plan Advantage D-SNP 9-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 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

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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 DIAGNOSIS CODE)	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. Do not use a group Provider number. Referring or prescribing physician's first and last names are not required. 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 physician NPI.	Y

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77	OPERATING	<p>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. 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.</p> <p>Required for surgical services.</p>	N
78	OTHER	<p>Outpatient Claims: Not required. Inpatient Claims: Enter the admitting physician's NPI in the first box. Do not enter a group Provider number.</p>	N
80	REMARKS	<p>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 8 1/2 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)</p>	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, and Revenue Codes.
- Identify frequency limits for certain procedure codes using the National Correct Coding Initiative listing of medically unlikely services which are unlikely to be performed in quantities greater than one and/or in multiple/same locations.
- 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).
- Invoices are also required for certain HCPCS codes.
- Review National Correct Coding Initiative (NCCI) and bill appropriate modifiers
- Submit claims with all required documentation.
- 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.

SECTION 10: CLAIMS SUBMISSION

CLAIMS STATUS AND QUESTIONS

Claims status is available through the Provider Portal. The Provider Portal is available through Health Plan Advantage D-SNP website, www.hpsj-mvhp.org. If you are unable to obtain satisfactory answers regarding claims status or other claim questions, please contact Health Plan Advantage D-SNP's Member Services Department at 1-888-361-7526 (TTY:711).

ENROLLEE BILLING

Balance billing D-SNP Enrollees is prohibited by federal and state laws. D-SNP Enrollees should not pay for covered services received from any Health Plan Advantage D-SNP Provider. This means Enrollees cannot be charged for co-pays, co-insurance, or deductibles. Health Plan Advantage D-SNP Providers cannot bill an Enrollee.

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

Billing D-SNP enrollees 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 an Enrollee is willing to compensate Provider for a non-covered service and Provider is willing to accept a negotiated payment between the parties, that agreement is considered outside of D-SNP and thus outside the supervision of Health Plan Advantage D-SNP. However, the service must clearly be identified as not a covered benefit (NCB) in advance of providing the service.

Violation of federal, state, or Health INALPlan Advantage D-SNP payment rules could result in the immediate termination of the Provider agreement.