

Claims Procedures



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At a Glance

UPMC Health Plan pledges to provide accurate and efficient claims processing. To make this possible, the Health Plan requests that providers submit claims promptly and include all necessary data elements.

A key to controlling administrative costs is reducing excess paperwork, particularly paperwork generated by improperly completed claims.

Key Points



Type claims or submit them electronically. Handwritten claims may be returned.

▶ See *Filing Methods*, chapter H.



Claims with eraser marks or white-out corrections may be returned.



If a mistake is made on a claim, the provider must submit a new claim. Claims must be submitted by established filing deadlines or they will be denied.

▶ See *Deadlines*, chapter H.



Services for the same patient with the same date of service may not be unbundled. For example, an office visit, a lab work-up, and a venipuncture by the same provider on the same day must be billed on the same claim.

▶ See *Coding Practices Subject to Review*, chapter H.



Only clean claims containing the required information will be processed within the required time limits. Rejected claims—those with missing or incorrect information—may not be resubmitted. A new claim form must be generated for resubmission.

▶ See *Clean vs. Unclean Claims*, chapter H.



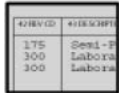
Bill physician extenders (e.g., physician assistants, CRNPs) under the supervising physician.

- ▶ See *Billing for Physician Extenders*, chapter H.



Resubmit claims only if the Health Plan has not paid within 45 days of the initial submission.

- ▶ See *Claims Resubmission*, chapter H.



Use proper place-of-service codes for all commercial, UPMC *for Life*, and UPMC *for You* claims.

- ▶ See *Place-of-Service Code Table*, chapter H.



Use modifier code “25” when a provider performs a significant, separately identifiable evaluation and management of a member on the same date of service as the original visit.

- ▶ See *Modifiers*, chapter H.



Bill anesthesia claims with the correct codes from the American Society of Anesthesiologists with appropriate anesthesia modifiers and time units if applicable.

- ▶ See *Anesthesia Modifiers*, chapter H.



Submit only one payee address per tax identification number.

- ▶ See *Multiple Payee Addresses*, chapter H.
- ▶ See *Claim Denials and Appeals*, chapter H.



Submit all appeals in writing within 30 business days of receipt of the notice indicating the claim was denied.

Submission Guidelines

Filing Methods Electronic

UPMC Health Plan's claims processing system allows providers access to submitted claims information, including the ability to view claim details such as claim status (i.e. Was there an error on submission?) and the UPMC claim number to be used as a reference indicator.

Electronically filed claims may be submitted in the following ways:

Individual Claim Entry

Individual claim entry, known as Prelog, is available to network providers with established Provider OnLine accounts. This feature allows direct submission of both professional (CMS-1500) and institutional (UB-04) claims via a user-friendly interface, using the Internet's highest level of security to make the process safe and easy. In order to use Prelog, providers must complete a brief e-learning course and a short post-course assessment. Upon successful course completion, the provider's office can enter claims and verify acceptance.

▶ See *Welcome and Key Contacts* chapter, *Provider OnLine*, chapter A

Electronic Data Interchange (EDI)

UPMC Health Plan also accepts electronic claims in data file transmissions. Electronic claim files sent directly to the Health Plan are permitted only in the HIPAA standard formats.

Providers who have existing relationships with clearinghouses such as *WebMD* (UPMC Health Plan Payer ID: 23281), NDC, and HDS can continue to transmit claims in the format produced by their billing software. These clearinghouses are then responsible for reformatting these claims to meet HIPAA standards and passing the claims on to the Health Plan.

For all EDI submissions, the NPI (National Provider Identifier) number is required. In addition, the member's 11-digit identification number or the Medical Assistance Recipient Identification number is necessary. When care is coordinated, the referring provider's name and NPI or UPIN also are required.



Closer Look at Direct EDI Submissions

Providers are able to submit claims directly without incurring clearinghouse expenses. These claims are loaded into batches and immediately posted in preparation for adjudication. Via the Provider OnLine EDI tools, these batches can be viewed in several standard report formats.

In order to submit EDI files directly to the Health Plan, providers must:

- Have an existing Provider OnLine account or register for a new provider or submitter account by filling out the application form at <https://mcnet.upmchp.com/hponline> and selecting the “sign up” menu link
- Use billing software that allows the generation of a HIPAA-compliant 837 professional or institutional file
- Have a sample 837 file exported from their billing system containing only UPMC Health Plan claims
- Have a computer with Internet access
- Have the ability to download and install a free Active-X secure FTP add-on
- Complete testing with UPMC Health Plan

For questions about this process, contact UPMC Health Plan Web Services at 1-800-937-0438 from 8 a.m. to 4:30 p.m., Monday through Friday.

Medicare Crossover

UPMC Health Plan Medicare Select currently receives crossover files from HGSA and Veritus.

UPMC *for You* accepts crossover claims from HGSA and Veritus for members with both Medicare and Medical Assistance coverage. The Medicare eligibility record must indicate that the beneficiary is enrolled in UPMC *for You*. Providers should review the Explanation of Medicare Benefits (EOMB) to determine whether the claim crossed over.

Paper Claim Forms

CMS-1500 forms

These forms are for professional services performed in a provider’s office, hospital, or ancillary facility. (Provider-specific billing forms are not accepted.)

- ▶ [See Required Fields on a CMS-1500 Claim Form, chapter H.](#)

UB-04 forms

These forms are for inpatient hospital services or ancillary services performed in the hospital. (Hospital-specific billing forms are not accepted.)

- ▶ [See Required Fields on a UB-04 Claim Form, chapter H.](#)
-

Deadlines

The Health Plan accepts new claims for services up to 365 days after the date of service for commercial and UPMC *for Life* members. The Health Plan accepts claims up to 180 days after the date of service for UPMC *for You* members.

When UPMC Health Plan is the secondary payer, claims are accepted with the explanation of benefit (EOB) from the primary carrier. This claim must be received within 90 days of the primary EOB remittance date or up to the new claim timely filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing.

Members cannot be billed for the Health Plan's portion of the claims submitted after these deadlines; however, they may be billed for copayments, coinsurance, and/or deductibles.

Claims Addresses

Claim forms should be submitted to the appropriate address below:

For commercial claims:

UPMC Health Plan
P.O. Box 2999
Pittsburgh, PA 15230-2999

For UPMC *for Kids* claims:

UPMC *for Kids*
P.O. Box 2999
Pittsburgh, PA 15230-2999

For UPMC *for You* claims:

UPMC *for You*
P.O. Box 2995
Pittsburgh, PA 15230-2995

For UPMC *for Life*/UPMC *for Life* Specialty Plan claims:

UPMC *for Life*
P.O. Box 2997
Pittsburgh, PA 15230-2997

Diagnosis Codes

Claims must be submitted with a diagnosis code, indicating the member's medical condition or circumstances necessitating evaluation or treatment. The diagnosis codes submitted on claim forms must correlate to the documentation contained within the member's medical record and reflect or support the reason services have been provided.



Key Points

Follow these guidelines to avoid the most common claims coding problems:

- New POA (Present on Admission Indicator)
- Diagnosis should be coded using ICD-9-CM. Make sure the diagnosis code is valid and complete (i.e., includes all digits).
- The primary diagnosis should describe the chief reason for the member's visit to the provider.
- When a specific condition or multiple conditions are identified, these conditions should be coded and reported as specifically as possible.
- For coding of services provided on an outpatient basis, do not code the diagnosis as "rule out" "suspect," or "probable" until such time as the condition is confirmed. Code the condition to the highest degree of certainty, such as symptoms, signs, or abnormal test results.
- When addressing both acute and chronic conditions, assign codes to all conditions for which the member is seeking medical care.
- When coding ongoing or chronic conditions, do not assume the code used at a previous visit is appropriate for a current visit.
- In coding diabetes, be certain to identify the current status of the member's condition as Type I or Type II, controlled or uncontrolled, referring to the direction of ICD-9-CM.
- Use caution in coding injuries, identifying each as specifically as possible.
- Refer to guidelines throughout ICD-9-CM for "late effect" coding and sequencing.
- "Well" vs. "sick" visits—If a preventive visit was scheduled, but symptoms of illness or injury exist at the time of the visit, code the primary diagnosis as "preventive." The condition(s) for which the member is being treated should be coded as a secondary diagnosis.
- V-codes are used for circumstances affecting a member's health status or involving contact with health services that are not classified under ICD-9 codes 001–999. In general, they do not represent primary disease or injury conditions and should not be used routinely. V-codes used to describe personal and/or family history of medical conditions are covered when used for a screening procedure; however, V-codes that pertain to mental health, learning disorders, or social conditions are not covered.

Billing for Provider Extenders

Physician assistants (PAs) and certified registered nurse practitioners (CRNPs) may not submit claims on their own behalf. However, if the PA or CRNP is employed and supervised by a provider who participates in UPMC Health Plan, their services may be billed under the supervising provider.



Alert—Exception

The only exception to the “billing for provider extenders” policy is for UPMC *for You*, and only under very specific conditions. The Commonwealth of Pennsylvania allows CRNPs to act as PCPs in certain circumstances:

- The CRNP’s credentials must be verified and certified by the Pennsylvania Department of Health’s Bureau of Managed Care.
- The CRNP must receive an assigned PROMISe number from the Pennsylvania Department of Public Welfare.
- The CRNP must be credentialed by UPMC Health Plan.
- The CRNP can bill individually for service when credentialed as a social worker by Community Care Behavioral Health.

If all four of these requirements are met, and the state has allowed the CRNP to act as a PCP, then the CRNP may submit a claim to UPMC *for You* on the member’s behalf.

Claims Resubmission

Claims may be resubmitted if the Health Plan has not paid within 45 days of the initial submission. These claims can be a photocopy or a reprinted claim.

Late Charges On CMS-1500 forms

When submitting late charges on a CMS-1500 form, please write “late charges” on the claim. This allows the Health Plan to route the claims to the appropriate processing area. Late charges are subject to the timely filing limit.

On UB-04 forms

When submitting late charges on a UB-04 form, please submit the appropriate bill type in box 4.

- ▶ [See Explanation of Required Fields on a UB-04 Claim Form, chapter H.](#)

Claims Documentation

Clean vs. Unclean Claims

Pennsylvania Act 68 guidelines and UPMC Health Plan define a “clean” claim as a claim with no defects or improprieties. A defect or impropriety may include, but is not limited to, the following:

- Lack of required substantiating documentation
- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim
- Any required fields where information is missing or incomplete
- Invalid, incorrect, or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes)
- A missing explanation of benefits (EOB) for a member with other coverage
- Claims requiring medical review before payment
- ▶ *See Medical Management chapter, Procedures Requiring Predetermination, chapter G.*
- Claims requiring authorization that was not obtained
- Newborn claims, which must be routed to the Enrollment department for addition of the newborn and the newborn’s PCP, if applicable

Only clean claims containing the required information will be processed in a timely manner. Claims that are submitted on behalf of providers who are under investigation for fraud and abuse are not considered clean claims.



Alert—Rejected Claims

Rejected claims—those with missing or incorrect information—cannot be resubmitted. A new claim form must be generated for resubmission.

Required Fields on a CMS-1500 Claim Form

The following CMS-1500 claim form is standard in the insurance industry; however, UPMC Health Plan requires providers to fill out only those fields noted in the figure below. Each field is explained in the numbered key that follows this illustration.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PAC#

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE DD | YY M | F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED Spouse Child Other 7. INSURED'S ADDRESS (No. Street)

CITY STATE CITY STATE

8. PATIENT STATUS Employed Married Other 8a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO 8b. AUTO ACCIDENT? PLACE (State) YES NO 8c. OTHER ACCIDENT? YES NO 10. RESERVED FOR LOCAL USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME c. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM | DD | YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. ID. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES NO 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS PERIOD OR Family Plan	EMG	COB	RESERVED FOR LOCAL USE
24A	24B	24C	24D	24E	24F	24G			

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE #88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PHYSICIAN OR SUPPLIER INFORMATION

► See Explanation of Required Fields in CMS-1500 Claim Form, chapter H.

Explanation of Required Fields in CMS-1500 Claim Form

If a numbered field is not included, it is not required by UPMC Health Plan in order to process a claim.

- 1A Insured's ID number— 11-digit member ID number (combination of the 9-digit member number and the 2-digit relationship code on the front of the member ID card)
- 2 Patient's name—patient's last name, first name, and middle initial
- 3 Patient's birth date—patient's date of birth in month/day/year format; also, patient's gender
- 4 Insured's name—last name, first name, and middle initial of policy holder
- 5 Patient's address—patient's current address, including city, state, and zip code; also, patient's telephone number
- 6 Patient's relationship to the insured—applicable relationship box marked
- 7 Insured's address—insured's current address, including city/state/zip code; also, insured's telephone number
- 8 Patient's status—applicable box(es) marked Other insured's name—if the patient is covered by another health insurance plan, please list the insured's last name, first name, and middle initial here; also, list the insured's policy or group number, date of birth, gender, employer's name or school name, and insurance plan name or program name
- 9
- 10 Patient's condition related to— check boxes if condition is related to work, auto, or other
- 12 Patient's release—indicates if patient has signed release of information from provider
- 13 Authorized signature—indicates if patient's signature authorizing payment to provider is on file
- 17 Referring physician's name—first and last name of referring physician; if patient self-directed, please print "NONE"
- 17A Referring physician's ID number— Universal Physician Identification Number (UPIN) Diagnosis or nature of illness or injury—minimum of one diagnosis code (ICD-9 coding)
- 21
- 24A Date(s) of service (from/to) in month/day/year format
- 24B Place of service—2-digit CMS standard code indicating where services were rendered
- 24D Procedures, services, and modifier—CPT or HCPCS code and modifier (if applicable)

▶ *continued*

Explanation of Required Fields in CMS-1500 Claim Form, continued

- 24E Diagnosis code—indicates diagnosis code or diagnoses that apply to service on a given line
- 24F Charges—amount charged for service
- 24G Days or units—number of times service was rendered
- 25 Federal tax ID number— tax ID number of provider rendering service
- 26 Patient's account number—provider-specific ID number for patient (up to 12 digits)
- 28 Total charge—total of all charges on bill
- 29 Amount paid—amount paid by patient and third-party payers
- 30 Balance due—current balance due from insured
- 31 Signature of provider/supplier— should include degree or credentials (please make sure the signature is legible.)
- 32 Name and address of facility—name of facility where services were rendered (if other than home or provider's office)
- 33 Physician's billing information—billing physician's name, address, and telephone number; also, list the PIN number (6-digit ID number assigned to the physician by UPMC Health Plan)

Required Fields on a UB-04 Claim Form

The following UB-04 claim form is standard in the insurance industry; however, UPMC Health Plan requires providers to fill out only those fields noted in the figure below. Each field is explained in the numbered key that follows this illustration.

The form is a UB-04 claim form with various fields numbered 1 through 86. A large number '1' is placed in the top left corner. The form includes sections for patient information, admission details, procedure codes, charges, and provider information. A 'DUE FROM PATIENT' arrow points to the right in section 57.

► See Explanation of Required Fields in UB-04 Claim Form, chapter H..

Explanation of Required Fields in UB-04 Claim Form

If a numbered field is not included, it is not required by UPMC Health Plan in order to process a claim.

- 1 Facility name, address, and telephone number
- 3 Patient control number— patient account number
- 4 Type of bill: First digit—type of facility code Second digit—bill classification code Third digit—frequency of billing
- 5 Federal tax ID number of the provider or facility
- 6 Statement covers period—span of admit and discharge dates; if outpatient, both fields should be the same date
- 12 Patient name
- 13 Patient address
- 14 Birth date—patient date of birth
- 15 Sex—patient gender
- 16 Marital status S—Single M—Married X—Legally separated D—Divorced W—Widowed U—Unknown Date of admission—date patient was admitted
- 17
- 18 Hour of admission—hour patient was admitted (use 24-hour clock— e.g., 10:10 p.m. is 22:10)
- 19 Type of admission— admission priority 1—Emergency 2—Urgent 3—Elective 4—Newborn 9—Information not available
- 22 Discharge status
- 23 Medical record number—number assigned by the provider to the patient medical record
- 38 Responsible party name and address
- 39 through Value code and amount—codes that identify deductibles and other financial information
- 41
- 42 Revenue codes
- 43 Revenue code description
- 44 CPT or HCPCS code, if applicable
- 45 Service date—date of service Units of service Total charges—total
- 46
- 47 charges for that line of service Payer—name of insurance company
- 50
- 51 Provider number assigned by UPMC Health Plan Release information—indicates if patient's signature is on file to authorize payment to facility
- 52
- 53 Assignment of benefits—indicates if patient's signature is on file to authorize payment to facility
- 55 Estimated amount due from insurer Insured's name Patient's relationship to insured
- 58
- 59

▶ *continued*

Explanation of Required Fields in UB-04 Claim Form, continued

- 60 Subscriber's certificate number—11-digit member ID number (combination of the 9-digit member number and the 2-digit relationship code on the front of the member's ID card)
- 62 Insurance group number
- 63 Treatment authorization code— enter the 12-digit UPMC Health Plan authorization number, if applicable
- 65 Employer name
- 66 Employer location
- 67 Principal diagnosis code
- 68 through Other diagnosis codes
- 75
- 76 Admitting diagnosis code
- 80 Principal procedure codes and dates
- 82 Attending physician ID—Universal Physician Identification Number (UPIN) Other physician ID—
- 83A UPIN for surgeon or other physician who also rendered services
- 83B Other physician ID— effective April 1, 2002, enter referring/admitting physician UPIN if care is coordinated
- 85 Provider representative— name of person submitting the UB-04 form
- 86 Date—date bill was submitted

Place-of-Service Code Table

All providers are required to submit CMS-1500 claim forms with CMS standard two-digit place-of-service codes entered in Box 24B. Forms submitted without these codes will be rejected with no adjudication and returned to the provider for resubmission. This policy applies to all lines of business.

Table H3: **Commonly Used Place-of-Service Codes**

Code	
11	Office
12	Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Chemical Dependency Treatment Facility
56	Psychiatric Residential Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory

Codes and Modifiers

Claims Coding

For provider and ancillary services, the Health Plan reimburses on a fee-for-service basis. Network providers agree to accept the network reimbursement, less deductibles and coinsurance, as payment in full for covered services provided to Health Plan members.



Alert—Balance Billing

Providers are not permitted to balance-bill members for the difference between the provider's charge and the reimbursement. The Health Plan annually updates all fee schedules with CPT-4 and HCPCS code additions and deletions. Coverage policy follows Centers for Medicare & Medicaid Services (CMS) guidelines whenever appropriate.

All provider claims are subject to coding review edits based on CMS National Correct Coding Initiative (NCCI) guidelines or Health Plan payment policies. Providers may view NCCI edits at www.cms.hhs.gov/NationalCorrectCodInitEd/.

The practices listed on the next page are considered improper and inappropriate and will be subject to Health Plan system edits.

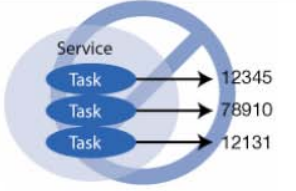
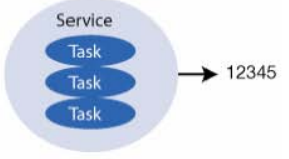
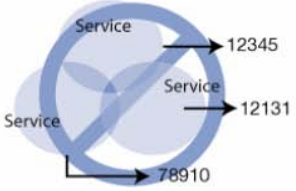
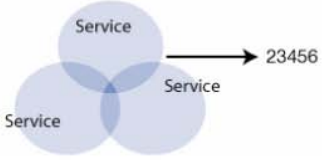
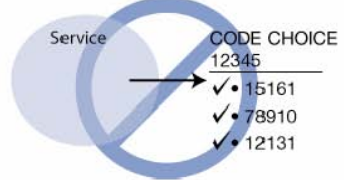
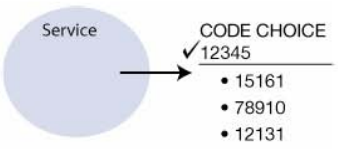
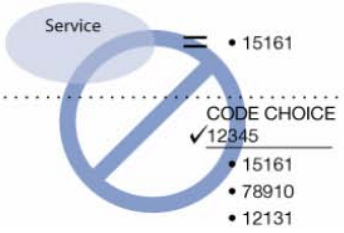
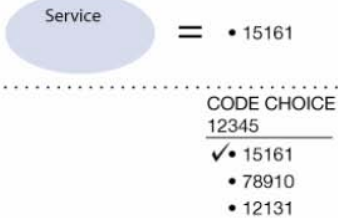


► See *Table H4: Coding Practices Subject to Review*, chapter H.



Alert—Type of Service Codes for Medical Assistance Claims

UPMC Health Plan no longer requires type of service (TOS) codes for UPMC *for You* members. All UPMC *for You* claims must contain standard codes with place of service and modifiers when appropriate.

Table H4: Coding Practices Subject to Review

Practice	Improper Coding	Proper Coding
<p>Fragmenting</p> <p>Breaking down a multitask service and coding each task of the service or procedure separately.</p>		
<p>Unbundling</p> <p>Reporting separate codes for related services when a single code exists to identify all of the services.</p>		
<p>Downcoding</p> <p>Selecting two or more lower-level codes to identify a service that could have been identified with a single higher-level code.</p>		
<p>Upcoding</p> <p>Selecting a code at a higher level than was actually provided for the sake of higher reimbursement.</p>		
<p>Surgical Field Separation</p> <p>Separately identifying the surgical approach from the major surgical service when the major surgical service code includes the approach or exploration of the surgical field.</p>		

Unlisted Codes

Procedures

When necessary and appropriate, a provider may bill for a procedure that does not have an existing CPT/ HCPCS code. The provider should use the “miscellaneous” or “not otherwise classified” code that most closely relates to the service provided.

When using “unlisted” or “not otherwise classified” codes for billing, providers may be asked to supply supporting documentation.

Medications

“Unlisted” or “not otherwise classified” drugs must be submitted with applicable HCPCS codes. The claim must include a description of the item/drug supplied, the correct dosage, and the National Drug Classification Code number (NDC#).

Modifiers Physician Modifiers

Frequently used modifiers are listed in the following table. For a complete list of modifiers, refer to the CPT manual and the HCPCS Level II manual.

Table H5: **Physician Modifiers**

Modifier	Description
22	Unusual procedural services
24	Unrelated evaluation and management service by the same physician during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
50	Bilateral procedure
51	Multiple procedures
52	Reduced services
59	Distinct procedural service
62	Two surgeons
76	Repeat procedure by same physician
77	Repeat procedure by another physician
80	Assistant surgeon
82	Assistant surgeon (when qualified resident surgeon not available)



Alert—A Closer Look at Modifiers 50 and 59

Providers should use modifier 50 only when the same service/code is reported for each bilateral anatomical site. Bilateral procedures that are not identified as bilateral in the description must be reported with modifier 50. Providers should report such procedures as one line item with a unit number of one.

Providers should use modifier 59 when billing a combination of codes that would normally not be billed together. The code is appended only to the procedure that is designated as the distinct procedural service. This modifier should be used when there are no other existing modifiers available, and as required for medical record documentation.

Anesthesia Modifiers

Anesthesia claims for all members should be billed with the correct codes from the American Society of Anesthesiologists (ASA)—00100–01999—which are included in the CPT manual.

Services performed for commercial and UPMC *for Life* members by a Certified Registered Nurse Anesthetist (CRNA) are eligible for reimbursement and can be billed in conjunction with the anesthesiologist’s charges, provided the appropriate modifier is used. CRNA charges are reimbursed for UPMC *for You* only when secondary to Medicare Advantage.

Table H6: Anesthesia Modifiers

Appropriate anesthesia modifiers also should be billed, including, but not limited to the following:

Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a provider; more than four concurrent anesthesia procedures
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	Certified Registered Nurse Anesthetist (CRNA) service with medical direction by a provider
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA service without medical direction by a physician

Home Medical Equipment Modifiers

Home medical equipment (HME) modifiers include, but are not limited to, the following:

Table H7: **Home Medical Equipment Modifiers**

Modifier	Description
RR	Rental
NU	New purchase
UE	Used durable medical equipment

Code-Specific Policies Blood

Draw/Venipuncture

The Health Plan does not reimburse for blood draw/venipuncture when that service is provided in conjunction with any other laboratory or evaluation and management service on the same date of service.

Immunizations

The injection is included with the office evaluation and management code (EM) if billed together or on the same date of service.

Surgical Procedures

Providers must note surgical procedures performed during the same operative session by the same provider on a single claim form or electronic equivalent. Billing on separate claim forms may result in delayed payments, incorrect payments, or payment denial.

Claims Procedures

Reimbursement

Reimbursement

The Health Plan processes all clean claims within 45 days from the date they are received. Pennsylvania Insurance Department regulations stipulate that a claim is paid when the Health Plan mails the check or electronically transfers funds.

The Health Plan pays 10 percent interest based on the CMS rates on clean claims processed beyond the 45-day period for Commercial plans and UPMC *for You*, and beyond the 30-day period for UPMC *for Life* and Medicare plans. Interest for clean claims not processed within the specified period will be included with the claims payment and will be noted on the remittance advice accordingly.

For claims requiring reprocessing, Act 68 requires a new 45-day claims processing payment period, which begins the day the Health Plan receives the necessary information.

Multiple Payee Addresses

The Health Plan does not honor multiple payee addresses. Providers are required to submit a single payee address per tax ID number.

Explanation of Payment (Remittance Advice)

The Explanation of Payment (EOP), referred to on the statement as a “remittance advice,” is a summary of claims submitted by a specific provider. It shows the date of service, diagnosis, and procedure performed as well as all payment information (i.e., money applied to the member’s deductible or copayment, and denied services.)

For additional questions pertaining to the EOP, please contact Provider Services at 1-866-918-1595

▶ See [Table G8: Explanation of Payment Statement, chapter H](#).

Table H8: **Explanation of Payment Statement**

MC400 AP-PRTCHK Date 7/14/2004 1 Confidential, Contains PHI				UPMC HEALTH PLAN CHECK PROCESSING Remittance Advice CHECK NUMBER: 00000541 CHECK DATE: 7/14/2004				2 Page 4							
3 VENDOR NO.: 0000009999				5 FEDERAL ID NO.: 999999999											
4 VENDOR NAME: JANE SMITH, M.D. VENDOR ADDRESS: 123 MAIN STREET PITTSBURGH, PA 15123															
6 PROVIDER: 999999 JANE SMITH, M.D.				7 PROV ACCT: 646				8 MEMBER: DOE, JOHN				9 000999999-01			
10 CLAIM DATE: 1/23/2004				10 FORM NO.: 01379999				10 ICN: 04030F949001				10 THROUGH DATE: 1/23/04			
11 FROM DATE				12 PROC CODE				13 QUANT				14 BILLED			
11 1/23/04				12 99213				13 1				14 60.00			
15 ALLOWED				16 DISCOUNT				17 CO PAY				18 DEDUCT			
15 3.65				16 6.35				17 .00				18 .00			
19 NOT COV				19 INT/DISC				20 NET EXPLANATION				21 NET EXPLANATION			
19 .00				19 .00				20 .00				21 .00			
22 CLAIM SUBTOTAL				23 MEMBER SUBTOTAL				24 MEMBER SUBTOTAL				24 MEMBER SUBTOTAL			
22 *				23 **				24 *				24 **			
22 60.00				23 60.00				24 3.65				24 6.35			
22 .00				23 .00				24 .00				24 .00			
22 .00				23 .00				24 .00				24 .00			

- 1** Run date — date printed
- 2** Page number
- 3** Provider vendor number
- 4** Provider name and address
- 5** Federal tax ID number—provider tax ID number
- 6** Servicing provider number and name
- 7** Patient account number
- 8** Member name—last name, first name
- 9** Member number
- 10** Form number—claim ID number assigned by the Health Plan

- 11** Date of service
- 12** Procedure code
- 13** Number of units billed
- 14** Billed amount
- 15** The Health Plan's allowed amount
- 16** Discount applied (not member liability)
- 17** Copayment applied (member liability)
- 18** Deductible applied (member liability)
- 19** Amount not covered
- 20** Interest applied

- 21** Net explanation—amount paid
- 22** Claim subtotal line—subtotal for fields 14–21
- 23** Member subtotal line
- 24** Explanation codes

Process for Refunds or Returned Checks

The Health Plan accepts overpayments two ways—providers may refund additional money directly to the Health Plan, or the Health Plan will take deductions from future claims.

Refunds

If the Health Plan has paid in error, providers may return the Health Plan's check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund, and the explanation of benefits (EOB) from other insurance carriers, if applicable.

Refunds should be sent directly to the General Accounting Department at this address:

UPMC Health Plan
General Accounting Department
One Chatham Center
112 Washington Place Pittsburgh, PA 15219

Overpayment

If the Health Plan has paid in error and the provider has not sent a refund or returned the Health Plan's check, money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount.

Claim Follow-Up

To view claim status online, go to www.upmchealthplan.com. Existing users can log in through Provider OnLine. New users will be asked to register. For log-in information, contact the UPMC Health Plan Web Services at 1-800-937-0438 or e-mail HPOnline@upmc.edu.

▶ See *Welcome and Key Contacts* chapter, *Provider OnLine*, chapter A.

To check the status of a claim without going online, call Provider Services at 1-866-918-1595 from 8 a.m. to 5 p.m., Monday through Friday.

Denials and Appeals

All denied claims are reported on the EOP, referred to on the statement as a “remittance advice.” This indicates whether the provider has the right to bill the member for the denied services and/or if the member is financially responsible for payment.

If a provider disagrees with the Health Plan’s decision to deny payment of services, the provider must appeal in writing to the appeals coordinator within 30 business days of receipt of the denial notification. The request must include the reason for the appeal and any relevant documentation, which may include the member’s medical record.

Appeals should be submitted to:

UPMC Health Plan
Provider Appeals
PO Box 2906
Pittsburgh, PA 15230-2906

All appeals undergo the Health Plan’s internal review process, which meets all applicable regulatory agency requirements. The provider will receive written notification in all situations in which the decision to deny payment is upheld.

▶ *See [Provider Standards and Procedures](#) chapter, [Provider Disputes](#), chapter B.*