Claims Procedures

H.1 Table of Contents

H.2 At a Glance

H.4 Submission Guidelines

H.6 Provider OnLine

H.10 Timely Filing Requirements
Table H1 - Claim Addresses
Table H2 - New Claim Submission Time Frames
Table H3 - Secondary Claims Submission Time Frames
Table H4 - Corrected Claims Submission Times Frames
Table H5 - Clean Claims Payment Time Frames
Table H6 - Claims Appeal Time Frames

H.14 Diagnosis Codes
Table H7 - Other Preventable Conditions (OPPC – Medical Assistance Modifiers)

H.18 Claims Documentation
Figure H1 - CMS1500 Claim Form
Figure H2 - CMS1500 Claim Form Required Fields
Figure H3 - UB04 Claim Form
Figure H4 - UB04 Claim Form Required Elements

H.30 Table H8 - Commonly Used Place-of-Service Codes

H.31 Modifiers
Table H9 - Physician Modifiers
Table H10 - Assistant Surgeon Modifiers
Table H11 - Therapy Modifiers
Table H12 - Modifiers (Medical Assistance only)
Table H13 - EPSDT Modifiers (UPMC *for You* only)
Table H14 - Anesthesia Modifiers
Table H15 - Anesthesia Modifiers (CRNA)
Table H16 - Home Medical Equipment Modifiers

H.40 Reimbursement

H.45 Denials and Appeals

H.46 False Claims

At a Glance

UPMC Health Plan pledges to provide accurate and efficient claims processing. To make this possible, UPMC 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

- It is the treating provider's responsibility for the appropriate billing of services in addition to maintaining accurate documentation that supports and justifies the services.
- Type claims or submit them electronically. Handwritten claims may be returned.
    - ➢ See ***Filing Methods***, Claims Procedures, 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 ***Timely Filing Requirements***, Claims Procedures, 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.
- 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***, Claims Procedures, Chapter H.
- Resubmit claims only if UPMC Health Plan has not paid **within 45 days** of the initial submission.
    - ➢ See ***Claims Resubmission***, Claims Procedures, Chapter H.

- Use proper place-of-service codes for all UPMC Community HealthChoices (Medical Assistance), UPMC *for Kids* (CHIP), UPMC *for Life* (Medicare), UPMC *for You* (Medical Assistance), and UPMC Health Plan (Commercial) claims.

  - See ***Table H8: Commonly Used Place-of-Service Codes***, Claims Procedures, Chapter H.

- Use **modifier 25** when it is necessary to indicate that the Member's condition required a significant, separately identifiable evaluation and management service above and beyond the other procedure or service performed on the same date by the same provider.

  - See ***Table H9: Physician Modifiers***, Claims Procedures, 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 ***Tables H14 & H15: Anesthesia Modifiers***, Claims Procedures, Chapter H.

- Submit only one payee address per tax identification number.

  - See ***Multiple Payee Addresses***, Claims Procedures, Chapter H.
  - See ***Claim Denials and Appeals***, Claims Procedures, Chapter H.

- Submit all appeals in writing **within the required number of business days** of receipt of the notification indicating that 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 (e.g., whether there was an error on the submission) and the UPMC Health Plan 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. 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 ***Provider OnLine***, Welcome and Key Contacts, Chapter A.
- See ***Provider OnLine***, Claims Procedures, Chapter H.

Electronic Data Interchange (EDI)

UPMC Health Plan also accepts electronic claims in data file transmissions. Electronic claim files sent directly to UPMC 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), RelayHealth,** or **ALLScripts (among others)** 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 UPMC Health Plan.

The National Provider Identifier number (NPI) is required, and 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 are also required.

- **Note:** The Medical Assistance Recipient Identification number is utilized for UPMC Community HealthChoices and UPMC *for You*.

Closer Look at Direct EDI Submissions

Providers can 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.

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 **upmchealthplan.com/providers** and selecting the "**Register for Provider OnLine Here.**"
  - ➢ See ***Provider OnLine,*** Welcome and Key Contacts, Chapter A.
  - ➢ See ***Provider OnLine***, Claims Procedures, Chapter H.
- 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.
- Can 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, Medicare Supplemental, Medicare Complementary, and UPMC Community HealthChoices currently receive crossover files from the Coordination of Benefits Agreement (COBA).

UPMC *for You* accepts crossover claims for Members **younger than 21 years old** with both Medicare and Medical Assistance coverage (dual eligibility). 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.

Provider OnLine

Provider OnLine (POL) is a self-serve website that is available **24 hours a day, 7 days a week** and can significantly reduce the number of telephone calls a network provider needs to make to UPMC Health Plan, thereby reducing the time it takes to perform daily tasks.

This secure online service, available from any computer with internet access allows providers to perform a wide variety of administrative functions, including submitting a prior authorization request, checking on the status of an authorization request, checking Member eligibility and covered benefits, submitting claims for reimbursement, checking on the status of a claim, viewing an Explanation of Payment (EOP), sending and receiving messages or chatting with a Provider Services representative in real time.

POL is utilized to relay general communications to Providers; Providers should frequently check POL for updates.

In addition, POL allows the Provider to complete an authorization to receive electronic payments from Electronic Funds Transfer (EFT). EFT Transfer will allow the Provider's office or practice to receive reimbursement from UPMC Health Plan sooner than paper checks.

- **Note:** All contracted Providers are required to complete the Authorization for Electronic Reimbursement form by going to **upmchealthplan.com/providers/online** and selecting EFT Transfer Form.

Providers can also request Electronic Remittance Advice (ERA) through Provider OnLine.

- **Note:** Per HIPAA, the only permissible format for an electronic remittance advice, in a data file, is the ANSI ASC X12.835, Health Care Claim Payment/Advice. This is commonly referred to as an 835. It requires the recipient's Practice or Billing System to have the ability to automate loading of a file in the mandated format.

- **Note:** All contracted providers should utilize POL to review their current and historical EOPs and print a paper copy of the EOP. Providers with POL access and those who elect to utilize ERA will not receive a paper EOP. Paper EOPs will only be sent upon request. POL is available **24 hours a day, 7 days a week.**

The eligibility section of POL shows the Member's specific schedule of benefits, including riders (additional benefits beyond basic coverage), and the date such benefits became effective. This section also shows up to date coordination of benefit (COB) information and current out-of-pocket costs (copays, deductible, etc.) that have been incurred. To view information about an eligible Member, the Provider needs one of the following:

- Member's first and last name
- Member's identification number

Provider OnLine can be accessed from **upmchealthplan.com/providers.** Enter the provider's user ID in the **provider login** box. If the provider does not have a POL account, the practice's online account administrator will help the provider gain this access.

➢ **Note:** The **online account administrator (OAA)** is the individual within a practice who manages all Provider OnLine security and access.

If the provider does not have an OAA, complete the first-time user registration at **upmchealthplan.upmc.com/WebPortals/Requests/SecurityRequest.aspx.**

To submit a prior authorization request, log into **Provider OnLine** at **upmchealthplan.com/providers.** Select the **Auth Entry/Inquiry** option from the main menu and follow the prompts.

If the provider forgot his or her **UPMC Health Plan Provider OnLine user ID** or needs assistance registering as a first-time user, call the **Help Desk** at **1-800-937-0438.** If the provider has any questions, he or she should contact their physician account executive or call **Provider Services** at **1-866-918-1595.**

Providers who need to request authorization to prescribe a medication that may have a quantity limit, require prior authorization or for a non-formulary medication should submit the request online at **upmc.promptpa.com** or visit **upmchealthplan.com** to obtain a prior authorization form and submit it by fax to **412-454-7722.**

➢ See ***Obtaining Prior Authorization***, Pharmacy Services, Chapter J.

UPMC Community HealthChoices Home and Community Based Services providers can access Provider OnLine to check Member eligibility and benefits but claims submission will occur in HHAeXchange.

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 ***Figure H2, CMS-1500 Claim Form***, Claims Procedures, 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 ***Figure H4, UB-04 Claim Form Required Elements***, Claims Procedures, Chapter H.

Claim Submission for UPMC Community HealthChoices Home and Community Based Providers

UPMC Community HealthChoices Home and Community Based providers can access Provider OnLine to check Member eligibility and benefits but claim submission occurs in HHAeXchange.

HHAeXchange (HHA) is a proprietary platform for Home and Community Based Services (HCBS) Payers and Providers that streamlines authorization, case placement and acceptance, case management and communication, and billing and remittance processing. UPMC Community HealthChoices has chosen HHA as the authorization/claims solution for HCBS services.

All HCBS authorization/case placement and Claim Submission must be performed through HHA unless otherwise indicated. HHA platform is used by HCBS providers to integrate visit/claims data to enable HHA to submit claims from HCBS providers directly to UPMC Health Plan. Payment of claims will be from UPMC Community HealthChoices directly to the HCBS provider.

Additional information on HHA, including HHA Login link and HHA Companion Guide, can be obtained through the HCBS Secure Provider Portal.

UPMC Health Plan accepts claims up to **180 days** after the date of service for UPMC Community HealthChoices (Medical Assistance) Participants.

➢ See additional ***UPMC Community HealthChoices billing guidance, nursing home facility billing, and corrected claims information*** on Provider OnLine at **upmchealthplan.com/providers.**

The following are items that home and community based direct care providers cannot bill related to UPMC Community HealthChoices:

- Provider cannot bill while Participant is in a nursing facility, hospitalized, incarcerated, out of state (unless services continue with prior authorization), or while the direct care worker is being paid to work another job.
- It is not permissible to submit timesheets for hours of work performed by someone else.
- It is not permissible to bill for time during which the direct care worker was sleeping.
- Provider cannot bill if the Participant cancels the service. This includes instances when a direct care worker goes to the home of the Participant and the Participant was not there to receive the service or canceled the service once the worker arrived.
- The hours billed must be the exact hours worked by the direct care worker.
- Pay may not be split between the Participant and direct care worker.
- Provider cannot submit any false data on claims, such as the date of service, units of service, or the provider of service.
- Provider cannot bill for services that are outside of the type, scope, amount, duration, and frequency as specified on the Participant's approved service plan (except in emergency situations as authorized by UPMC Community HealthChoices).
- Provider cannot bill when services are rendered to a Participant who does not have an approved service plan for the date when the service was rendered.
- Provider cannot bill separately for administrative costs associated with services such as Personal Emergency Response System (PERS), Home Adaptations, Specialized Medical Equipment and Supplies, Assistive Technology.
- Provider cannot bill for services that were not approved in the service plan.
    - See ***55 Pa. Code §1101.75*** *and* ***OLTL bulletin* #05-11-04, 51-11-04, 52-11-04, 54-11-04, 55-11-04, 59-11-04.**
- Provider cannot bill for **a 15-minute unit** if the billable activity occurs for **less than 7 1/2 minutes.**
- Provider cannot bill for more than **one staff member** at a time. Services are to be **delivered 1:1** unless otherwise noted by service definition or prior authorization.
- Provider cannot bill for staff travel time.
- Provider cannot bill for staff training.

Timely Filing Requirements

Providers are required to submit or resubmit claims within time frames from the date of service, date of denial, or date of another insurance payment. The filing time frames vary based on state or federal timely filing guidelines.

- See ***Tables H2, H3, and H4*** for filing time frames.

- **Note:** Rejected claims are not entered into UPMC Health Plan's system and therefore can be resubmitted as a **new claim** within the timely filing time frames.

- **Note:** Claims denied, for not meeting payment criteria, are entered into UPMC Health Plan's system and can be resubmitted as a **corrected claim** within timely filing time frames.

- **Note:** When UPMC Health Plan is the **secondary payer,** claims are accepted with the explanation of payment (EOP) from the primary carrier. The claim must be received with the primary EOP remittance and within the timely filing time frames.

Claims submitted after these deadlines will be denied for untimely filing.

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

- **Note:** **Exceptions** are Medical Assistance, Medicare Special Needs Plan (HMO SNP), and other Qualified Medicare Beneficiary (QMB) Members **cannot be billed** for copayments, coinsurance, and deductibles.

Addresses for Claims Submissions

Claim forms should be submitted to the appropriate address listed below.

Table H1: Claim Addresses

Claim Type	Address
UPMC Community HealthChoices (Medical Assistance)	UPMC Community HealthChoices PO Box 106042 Pittsburgh, PA 15230-106042
UPMC *for Kids* (CHIP)	UPMC *for Kids* PO Box 2999 Pittsburgh, PA 15230-2999
UPMC *for Life* (Medicare)	UPMC *for Life* PO Box 2997 Pittsburgh, PA 15230-2997
UPMC *for Life* Complete Care (HMO SNP)	UPMC *for Life* PO Box 2997 Pittsburgh, PA 15230-2997
UPMC *for You* (Medical Assistance)	UPMC *for You* PO Box 2995 Pittsburgh, PA 15230-2995
UPMC Health Plan (Commercial - including FEHB)	UPMC Health Plan PO Box 2999 Pittsburgh, PA 15230-2999

Table H2: New Claims Submission Time Frames

UPMC Health Plan will accept new claims for services up to the following number of calendar days after the date of service:	
UPMC Community HealthChoices (Medical Assistance)	**180**
UPMC *for Kids* (CHIP)	**180**
UPMC *for Life* (Medicare)	**365**
UPMC *for Life* (Medicare—University of Pittsburgh retirees only)	**365**
UPMC *for Life* Complete Care (HMO SNP)	**365**
UPMC *for You* (Medical Assistance)	**180**
UPMC *for You* (Medical Assistance—EPSDT claims)	**90**
UPMC Health Plan (Commercial—including FEHB claims)	**365**

Table H3: Secondary Claims Submission Time Frames

When UPMC Health Plan is the secondary payer, claims are accepted within the following number of calendar days of the EOP date or the new claim filing date (whichever is greater).		
	EOP date	**New claim filing**
UPMC Community HealthChoices (Medical Assistance)	**90**	**180**
UPMC *for Kids* (CHIP)*	**90***	**180***
UPMC *for Life* (Medicare)	**90**	**365**
UPMC *for Life* Complete Care (HMO SNP)	**90**	**365**
UPMC *for You* (Medical Assistance)	**90**	**180**
UPMC *for You* (Medical Assistance—EPSDT claims)	**90**	**90**
UPMC Health Plan (Commercial—including FEHB claims)	**90**	**365**

- **Note*:** UPMC *for Kids* (CHIP) Members **cannot** be enrolled in any other insurance coverage, therefore, UPMC *for Kids* **would not pay as a secondary payer.**

Table H4: Corrected Claims Submission Time Frames

UPMC Health Plan will accept corrected claims within the following number of calendar days from the date of the EOP or the date of service (whichever is greater).		
	EOP date	**Corrected claim filing**
UPMC Community HealthChoices (Medical Assistance)	**90**	**365**
UPMC *for Kids* (CHIP)	**90**	**365**
UPMC *for Life* (Medicare)	**90**	**365**
UPMC *for Life* Complete Care (HMO SNP)	**90**	**365**
UPMC *for You* (Medical Assistance)	**90**	**365**
UPMC *for You* (Medical Assistance—EPSDT claims)	**90**	**90**
UPMC Health Plan (Commercial—including FHEB claims)	**90**	**365**

Table H5: Clean Claims Payment Processing Time Frames

Time frame for the processing of clean claims is for the following number of calendar days from the date received:	
UPMC *for Life* (Medicare)	Contracted provider's clean claims are processed based on the timeliness **standards stated in their provider agreement**
UPMC *for Life* Complete Care (HMO SNP)	
Medical Assistance: • UPMC Community HealthChoices • UPMC *for You*	**100%** of clean claims are processed within **45 calendar days**
UPMC *for Kids* (CHIP)	
UPMC Health Plan (Commercial—including FEHB)	

Table H6: Claims Appeal Time Frames

Providers have a certain number of business days to appeal a claim	
UPMC Community HealthChoices (Medical Assistance)	Claim must be appealed within the number of business days as stated on the Explanation of Payment or other denial notification
UPMC *for Kids* (CHIP)	
UPMC *for Life* (Medicare)	
UPMC *for Life* Complete Care (HMO SNP)	
UPMC *for You* (Medical Assistance)	
UPMC *for You* (Medical Assistance—EPSDT claims)	
UPMC Health Plan (Commercial—including FEHB claims)	

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:

- **Chronic conditions** should be documented if they affect treatment, management or medical decision making. All chronic conditions should be documented at least annually, and the documentation should show evidence of management, evaluation, assessment, or treatment.

- Diagnosis should be coded using **ICD 10-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 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, or which affect medical decision making.

- When **coding ongoing or chronic conditions,** do not assume the code used at a previous visit is appropriate for a current visit. All submitted codes must be supported in the documentation for the office visit for that date of service.

- In **coding diabetes,** be certain to identify the status of the Member's condition as Type I or Type II, controlled or uncontrolled, referring to the direction of ICD-10-CM. For Members with diabetes with complications (i.e., renal) please note that **two codes** are required, one for the diabetes and the second for the manifestation for some, but not all, complications. Code as many diabetic complications that exist for the Member.

- Use caution in **coding injuries,** identifying each as specifically as possible.

- Refer to guidelines throughout ICD-10-CM for **"late effect"** coding and sequencing.

- **Z-codes** are used for circumstances affecting a Member's health status or involving contact with health services that are not classified under ICD-10. In general, they do not represent primary disease or injury conditions and should not be used routinely. Z-codes used to describe personal and/or family history of medical conditions are covered when used for a screening procedure; however, Z-codes that pertain to mental health, learning disorders, or social conditions are not covered.

- **Do not code** past conditions as active. For example, Members who have completed treatment for cancer should have a diagnosis of "history of," not an active cancer diagnosis. Members who have had a CVA and have residual effects should not be coded with an active CVA code. Rather, the diagnosis codes for the residual or late effects should be submitted on the claim.

- **"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.

  - **Note:** For well visits, a Z-code must be used for the primary diagnosis. Other conditions may be submitted on the claim for the encounter.

Alert—EPSDT "Well" vs. "Sick" visit (UPMC *for You* Members only)

Providers may not submit claims to UPMC *for You* (Medical Assistance) for a sick visit and an EPSDT visit on the same day. The provider may bill **either a** sick visit **or** the EPSDT visit, but **not both on the same day.**

- **Note:** **Exception,** a provider may bill an EPSDT visit and a Childhood Nutrition and Weight Management Services (initial assessment or re-assessment) visit rendered to the child on the same day.

  - See ***Medical Assistance bulletin, #99-07-19***, for additional information about Childhood Nutrition and Weight Management Services.

  - See ***EPSDT Services***, UPMC *for You* (Medical Assistance), Chapter E.

- **Health Care Acquired Conditions (HCAC)**: As part of the Patient Protection and Affordable Care Act, acute care hospitals will not receive additional reimbursement if a HCAC is identified on a claim. HCACs are the same as the Hospital Acquired Conditions (HACs) identified by the Centers for Medicare & Medicaid Services (CMS). A list of HACs can be found at **cms.gov/HospitalAcqCond.** When one of the conditions is identified on a claim and no other co-morbidities (CC) or major complications/co-morbidities (MCC) are on the claim, the claim will be adjusted retrospectively to recover payment.

- **The Present on Admission Indicator (POA)** must be included on acute care hospital claims or the claim will be denied. Hospitals must submit the POA indicator along with the corresponding diagnosis code in the HI segments of the 2300 loop (9) for the Principal Diagnosis (BK/ABK), External Cause of Injury (BN/ABN), and Other Diagnosis Information (BF/BF). The valid values are: N=No, U= Unknown, W=Not Applicable, Y=Yes. Visit the HAC and POA webpage at **cms.gov/HospitalAcqCond** for additional information.

- **Other Provider Preventable Conditions (OPPC):** As part of the Patient Protection and Affordable Care Act, Other Provider Preventable Conditions (OPPC) must be reported on professional claims at **$0 charge** using informational modifiers.

  - **Note:** This applies to UPMC Community HealthChoices and UPMC *for You* claims only.

Table H7: OPPC (Medical Assistance Modifiers)

Other Provider Preventable Conditions	Informational Modifier
Surgical or other invasive procedures performed on the **wrong body part**	PA
Surgical or other invasive procedure performed on the **wrong patient**	PB
The **wrong surgical or other invasive procedure** performed on a patient	PC

Alert—OPPC or HCAC reduced payments

Providers and hospitals **may not bill** Members for any amounts decreased due to a HCAC or OPPC.

Claims Resubmission

Claims may be resubmitted if UPMC 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 UPMC 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 ***Figure H4: UB-04 Claim Form Required Elements***, Claims Procedures, Chapter H.

Claims Documentation

Clean vs. Unclean Claims

Pennsylvania Act 68 guidelines and UPMC Health Plan define a "clean claim" as a claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include:

- Lack of required substantiating documentation, or
- A particular circumstance requiring special treatment which prevents timely payment from being made on the claim

This term shall not include a claim from a health care provider is under investigation for fraud or abuse regarding that claim.

Only clean claims containing the required information will be processed in a timely manner.

➢ **Note:** For Medical Assistance (UPMC Community HealthChoices and UPMC *for You*), a clean claim is defined as a claim that can be processed without obtaining additional information from the provider of service or from a third party. Claims under investigation for Fraud or Abuse, or under review to determine if they are Medically Necessary, **are not** clean claims.

Alert—Rejected Claims

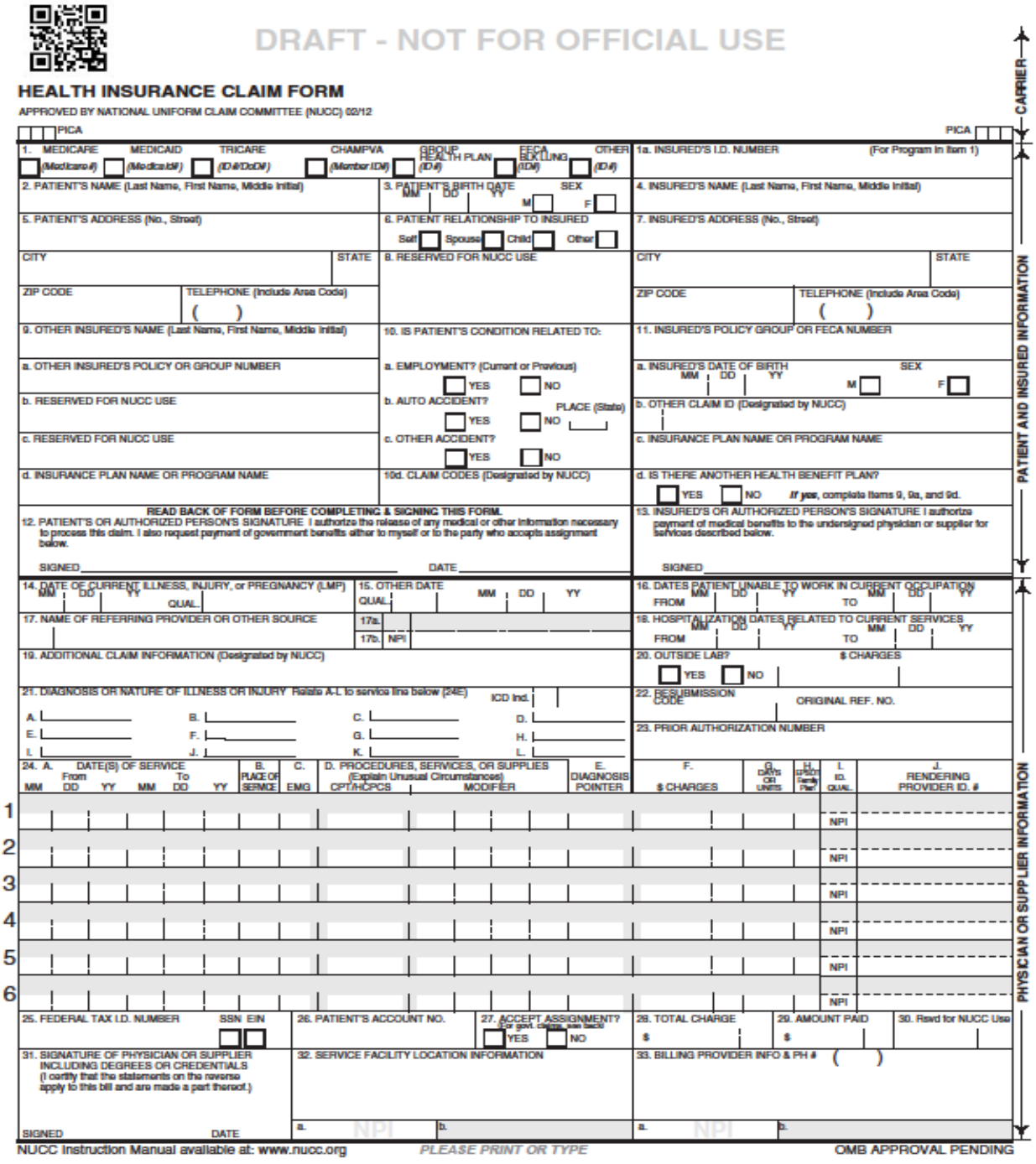
Rejected claims—those with missing or incorrect information—cannot be resubmitted. A new claim form must be generated for resubmission.

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 complete only those fields noted in the figure on the following page. Each field is explained in the numbered key that follows this illustration.

➢ See ***Figure H2: CMS-1500 Claim Form Required Fields***, Claims Procedures, Chapter H.

Figure H1: CMS-1500 Claim Form



DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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 MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS 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

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

Explanation of Required Fields in CMS-1500 Claim Form

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

Figure H2: CMS-1500 Claim Form Required Fields

Field #	Required Field Explanation
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 policyholder
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	Reserved for NUCC use
9	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
10	Patient's condition related to — check boxes if condition is related to employment, auto accident, or other accident
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"

Figure H2: CMS-1500 Claim Form Required Fields (cont'd)

Field #	Required Fields Explanation
17a	Referring physician's ID number—Universal Physician Identification Number (UPIN)
17b	Referring Provider's NPI ➢ **Note:** Referring Provider Name and NPI are required for UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for You* for the following DME, Home Nursing, Hospice, Laboratory, Nutritionist, Renal Dialysis, and X-ray.
21	Diagnosis or nature of illness or injury — submit all diagnoses, assessed, managed, or treated at the time of the encounter. (ICD-10 coding)
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)
24E	Diagnosis Pointer — 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
24J	Rendering Provider ID# ➢ **Note:** Rendering (Servicing) provider name and NPI required for UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for You* unless the provider is the same as the billing provider. If the provider is an atypical provider type, then the DHS MPI is required.
25	Federal tax ID number — tax ID number of the 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	Service Facility Location Information Name and address of facility — name of facility where services were rendered ➢ **Note:** Facility Name and NPI as required for UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for You* for POS 19, 21, 22, 23, 24, 31, or 32.
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. Each field is explained in the numbered key that follows this illustration.

➢ See ***Figure H4, UB-04 Claim Form Required Elements***, Claims Procedures, Chapter H.

Figure H3: UB-04 Claim Form

Figure H4: UB-04 Claim Form Required Elements

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
1	Required by Medicare	Billing Provider Name	1	AN	25
	Required by Medicare	Billing Provider Street Address	2	AN	25
	Required by Medicare	Billing Provider City, State, ZIP	3	AN	25
	Required by Medicare	Billing Provider Telephone, Fax, Country Code	4	AN	25
2	May be required by another payer when applicable/not required by Medicare	Billing Provider's Designated Pay-to Name	1	AN	25
	May be required by another payer when applicable/not required by Medicare	Billing Provider's Designated Pay-to Address	2	AN	25
	May be required by another payer when applicable/not required by Medicare	Billing provider's Designated Pay-to City, State	3	AN	25
	May be required by another payer when applicable/not required by Medicare	Billing provider's Designated Pay-to ID	4	AN	25
3a	Required by Medicare	Patient Control Number	1	AN	24
3b	May be required by another payer when applicable/not required by Medicare	Medical/Health Record Number	2	AN	24
4	Required by Medicare	Type of Bill (TOB)	1	AN	4
5	Required by Medicare	Federal Tax Number	1	AN	4
	Required by Medicare	Federal Tax Number	2	AN	10
6	Required by Medicare	Statement Covers Period – From/Through	1	N/N	6/6
7	Field not used	Unlabeled	1	AN	7
	Field not used	Unlabeled	2	AN	8
8a	Required by Medicare	Patient Name/ID	1	AN	19
8b	Required by Medicare	Patient Name	2	AN	29
9a	Required by Medicare	Patient Address – Street	1	AN	40
9b	Required by Medicare	Patient Address – City	2	AN	30
9c	Required by Medicare	Patient Address – State	2	AN	2
9d	Required by Medicare	Patient Address – ZIP	2	AN	9
9e	May be required by another payer when applicable/not required by Medicare	Patient Address – Country Code	2	AN	3
10	Required by Medicare	Patient Birth Date	1	N	8
11	Required by Medicare	Patient Sex	1	AN	1
12	Required for Types of Bill 011X, 012X, 018X, 021X, 022X, 026X, 032X, 033X, 041X, 081X, or 082X	Admission/Start of Care Date	1	N	6

Figure H4: UB-04 Claim Form Required Elements (cont'd)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
13	May be required by another payer when applicable/not required by Medicare	Admission Hour	1	AN	2
14	Required for Types of Bill 011X, 012X, 018X, 021X, and 041X	Priority (Type) of Admission or Visit	1	AN	1
15	Required by Medicare	Point of Origin for Admission or Visit	1	AN	1
16	May be required by another payer when applicable/not required by Medicare	Discharge Hour	1	AN	2
17	Required for Types of Bill 011X, 012X, 013X, 014X, 018X, 021X, 022X, 023X, 026X, 032X, 033X, 034X, 041X, 071X, 073X, 074X, 075X, 076X, 081X, 082X, 085X	Patient Discharge Status	1	AN	2
18-28	Required if applicable	Condition Codes		AN	2
29	May be required by another payer when applicable/not required by Medicare	Accident State		AN	2
30	Field not used	Unlabeled	1	AN	12
	Field not used	Unlabeled	2	AN	13
31-34	Required if applicable	Occurrence Code/Date	a	AN/N	2/6
	Required if applicable	Occurrence Code/Date	b	AN/N	2/6
35-36	Required if applicable	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6
	Required if applicable	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6
37	Field not used	Unlabeled	a	AN	8
	Field not used	Unlabeled	b	AN	8
38	May be required by another payer when applicable/not required by Medicare	Responsible Party Name/Address	1	AN	40
	May be required by another payer when applicable/not required by Medicare	Responsible Party Name/Address	2	AN	40
	May be required by another payer when applicable/not required by Medicare	Responsible Party Name/Address	3	AN	40
	May be required by another payer when applicable/not required by Medicare	Responsible Party Name/Address	4	AN	40
	May be required by another payer when applicable/not required by Medicare	Responsible Party Name/Address	5	AN	40
39-41	Required if applicable	Value Code	a-d	AN	2
	Required if applicable	Value Code Amount	a-d	N	9

Figure H4: UB-04 Claim Form Required Elements (cont'd)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
42	Required by Medicare	Revenue Codes	1-23	N	4
43	May be required by another payer when applicable/not required by Medicare	Revenue Code Description/Investigational Device Exemption (IDE) Number/Medicaid Drug Rebate	1-23	AN	24
44	Required if applicable	Healthcare Common Procedure Coding System (HCPCS)/Accommodation Rates/Health Insurance Prospective Payment System (HIPPS) Rate Codes	1-23	AN	14
45	Required if applicable	Service Dates	1-23	N	6
46	Required if applicable	Service Units	1-23	N	7
47	Required by Medicare	Total Charges	1-23	N	9
48	Required if applicable	Non-Covered Charges	1-23	N	9
49	Field not used	Unlabeled	1-23	AN	2
		Page _ of Creation Date _	23	N/N	3/3
50	Required by Medicare	Payer Identification – Primary	A	AN	23
	Required by Medicare	Payer Identification – Secondary	B	AN	23
	Required by Medicare	Payer Identification – Tertiary	C	AN	23
51	Required by Medicare	Health Plan ID	A	AN	15
	Required if applicable	Health Plan ID	B	AN	15
	Required if applicable	Health Plan ID	C	AN	15
52	Required by Medicare	Release of Information	A	AN	1
	Required by Medicare	Release of Information – Secondary	B	AN	1
	Required by Medicare	Release of Information – Tertiary	C	AN	1
53	May be required by another payer when applicable/not required by Medicare	Assignment of Benefits – Primary	A	AN	1
	May be required by another payer when applicable/not required by Medicare	Assignment of Benefits – Secondary	B	AN	1
	May be required by another payer when applicable/not required by Medicare	Assignment of Benefits – Tertiary	C	AN	1
54	Required if applicable	Prior Payments – Primary	A	N	10
	Required if applicable	Prior Payments – Secondary	B	N	10
	Required if applicable	Prior Payments – Tertiary	C	N	10

Figure H4: UB-04 Claim Form Required Elements (cont'd)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
55	May be required by another payer when applicable/not required by Medicare	Estimated Amount Due – Primary	A	N	10
	May be required by another payer when applicable/not required by Medicare	Estimated Amount Due – Secondary	B	N	10
	May be required by another payer when applicable/not required by Medicare	Estimated Amount Due – Tertiary	C	N	10
56	Required by Medicare	Billing provider – National Provider Identifier (NPI)	1	AN	15
56	Required by CHIP and Medical Assistance**.**	Billing provider – National Provider Identifier (NPI) **and** Name	1	AN	15
57	Required if applicable	Other Provider ID	A	AN	15
	Required if applicable	Other Provider ID	B	AN	15
	Required if applicable	Other Provider ID	C	AN	15
	➢ **Note:** The Ordering Provider Name and NPI are required if different from the attending provider for UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for You.*				
58	Required by Medicare	Insured's Name – Primary	A	AN	25
	Required by Medicare	Insured's Name – Secondary	B	AN	25
	Required by Medicare	Insured's Name – Tertiary	C	AN	25
59	Required if applicable	Patient's Relationship – Primary	A	AN	2
	Required if applicable	Patient's Relationship – Secondary	B	AN	2
	Required if applicable	Patient's Relationship – Tertiary	C	AN	2
60	Required by Medicare	Insured's Unique ID – Primary	A	AN	20
	Required by Medicare	Insured's Unique ID – Secondary	B	AN	20
	Required by Medicare	Insured's Unique ID – Tertiary	C	AN	20
61	Required if applicable	Insurance Group Name – Primary	A	AN	14
	Required if applicable	Insurance Group Name – Secondary	B	AN	14
	Required if applicable	Insurance Group Name – Tertiary	C	AN	14
62	Required if applicable	Insurance Group No. – Primary	A	AN	17
	Required if applicable	Insurance Group No. – Secondary	B	AN	17
	Required if applicable	Insurance Group No. – Tertiary	C	AN	17
63	Required if applicable	Treatment Authorization – Primary	A	AN	30
	Required if applicable	Treatment Authorization – Secondary	B	AN	30
	Required if applicable	Treatment Authorization – Tertiary	C	AN	30
64	Required if applicable	Document Control Number (DCN)	A	AN	26
	Required if applicable	Document Control Number (DCN)	B	AN	26
	Required if applicable	Document Control Number (DCN)	C	AN	26

Figure H4: UB-04 Claim Form Required Elements (cont'd)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
65	Required if applicable	Employer Name (of the insured) – Primary	A	AN	25
	Required if applicable	Employer Name (of the insured) – Secondary	B	AN	25
	Required if applicable	Employer Name (of the insured) – Tertiary	C	AN	25
66	Required by Medicare	Diagnosis and Procedure Code Qualifier (International Classification of Diseases [ICD] Version Indicator)	1	AN	1
67	Required for Types of Bill 011X. 012X, 013X, 014X, 021X, and 026X	Principal Diagnosis Code and Present on Admission (POA) Indicator	1	AN	8
67 A-Q	Required if applicable	Other Diagnosis and POA Indicator	A-O	AN	8
68	Field not used	Unlabeled	1	AN	8
	Field not used	Unlabeled	2	AN	9
69	Required for Types of Bill 011X, 012X, 021X, and 022X	Admitting Diagnosis Code	1	AN	7
70a	Required if applicable	Patient Reason for Visit Code	1	AN	7
70b	Required if applicable	Patient Reason for Visit Code	1	AN	7
70c	Required if applicable	Patient Reason for Visit Code	1	AN	7
71	May be required by another payer when applicable/not required by Medicare	Prospective Payment System (PPS) Code	1	AN	3
72a	May be required by another payer when applicable/not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
72b	May be required by another payer when applicable/not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
72c	May be required by another payer when applicable/not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
73	Field not used	Unlabeled	1	AN	9
74	Required if applicable	Principal Procedure Code/Date	1	N/N	7/6
74a	Required if applicable	Other Procedure Code/Date	1	N/N	7/6
74b	Required if applicable	Other Procedure Code/Date	1	N/N	7/6
74c	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
74d	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
74e	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
75	Field not used	Unlabeled	1	AN	3
	Field not used	Unlabeled	2	AN	4
	Field not used	Unlabeled	3	AN	4
	Field not used	Unlabeled	4	AN	4

Figure H4: UB-04 Claim Form Required Elements (cont'd)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
76	Required if applicable	Attending Provider – NPI/QUAL/ID	1	AN	11/2/9
	Required if applicable	Attending Provider – Last/First	2	AN	16/12
	➢ **Note:** The Attending Provider's name and NPI are required for UPMC Community HealthChoices, UPMC *for Kids*, and UPMC *for You*.				
77	Required if applicable	Operating Physician – NPI/QUAL/ID	1	AN	11/2/9
	Required if applicable	Operating Physician – Last/First	2	AN	16/12
78	Required if applicable	Other Provider – QUAL/NPI/QUAL/ID	1	AN	2/11/2/9
	Required if applicable	Other Provider – Last/First	2	AN	16/12
79	Required if applicable	Other Provider – QUAL/NPI/QUAL/ID	1	AN	2/11/2/9
	Required if applicable	Other Provider – Last/First	2	AN	16/12
80	Required if applicable	Remarks	1	AN	21
	Required if applicable	Remarks	2	AN	26
	Required if applicable	Remarks	3	AN	26
	Required if applicable	Remarks	4	AN	26
81	Required if applicable	Code-Code – QUAL/CODE/VALUE	a	AN/AN/AN	2/10/12
	Required if applicable	Code-Code – QUAL/CODE/VALUE	b	AN/AN/AN	2/10/12
	Required if applicable	Code-Code – QUAL/CODE/VALUE	c	AN/AN/AN	2/10/12
	Required if applicable	Code-Code – QUAL/CODE/VALUE	d	AN/AN/AN	2/10/12

Closer Look at claim requirements (CMS 1500 and UB-04)

Per DHS policy, UPMC Health Plan will require the following information to be included on claims for Children's Health Insurance Program (UPMC *for Kids*), Medical Assistance (UPMC Community HealthChoices and UPMC *for You),* and Medicare Special Needs Plans (UPMC *for Life* Complete Care). Claims that fail to meet the requirements will be denied.

- Facility name and facility NPI of the Medical Assistance-enrolled facility where professional services were rendered for professional claims performed in the following places of service:
  - 21 Inpatient Hospital
  - 22 Outpatient Hospital
  - 23 Emergency Room
  - 24 Ambulatory Surgical Center
  - 31 Skilled Nursing Facility
  - 32 Nursing Facility

- Provider name and provider NPI of a Medical Assistance-enrolled referring provider on claims for DME, home health, hospice, laboratory, nutritionist, and x-ray services.

- Provider name and provider NPI of a Medical Assistance-enrolled attending provider on all institutional claims.

  - ***Inpatient facility services:*** Claims for inpatient facility services are to include the name and NPI of the attending provider, or the provider who ordered the admission, or the provider who was responsible for determining the diagnosis or treatment of the patient.

  - ***Extended care facility services:*** Claims for nursing facility services are to include the NPI number of the attending physician or the medical director as defined in **28 Pa Code § 211.2** or the provider who initially certifies or recertifies the recipient's need for a nursing facility.

➢ See ***Medical Assistance bulletin #99-17-02*** Submission of Claims that Require the National Provider Identifier (NPI) of a Medical Assistance enrolled Ordering, Referring or Prescribing Provider at **dhs.pa.gov/docs/Publications/Documents/FORMS_AND_PUB_OMAP/c_257246.pdf.**

➢ See ***Medical Assistance bulletin #99-18-11*** Service Location Enrollment Deadline at **dhs.pa.gov/docs/Publications/Documents/FORMS_AND_PUBS_OMAP/c_284208.pdf.**

Place-of-Service Codes

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 UPMC Health Plan products.

Table H8: Commonly Used Place-of-Service Codes

Code	Description
02	Telehealth
11	Office
12	Home
15	Mobile
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

Modifiers

To align with the industry standard coding guidelines and modifier descriptions, UPMC Health Plan utilizes nationally sourced guidelines to look for justification of the use of frequently misused modifiers.

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

Table H9: Physician Modifiers

Modifier	Description
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
33	Preventive services
50	Bilateral procedure
57	Decision for surgery
59	Distinct procedural service
62	Two surgeons
76	Repeat procedure by same physician or another qualified health care professional
77	Repeat procedure by another physician or another health care professional
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period

Closer Look at Physician Modifier 33 – Preventive Services

Modifier 33 should be appended to codes representing preventive services under applicable laws, and the Member cost sharing does not apply.

Modifier 33 is used when the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory). The service may be identified by adding **modifier 33** to the procedure. For separately reported services specifically identified as preventive, such as immunizations, annual pelvic exams, PAP smears, and screening mammography, the modifier should not be used.

Closer Look at Physician Modifier 50 – Bilateral Procedure

Bilateral procedures are procedures that can be performed on identical anatomic sites, aspects, or organs (e.g., arms, legs, kidneys) during the same operative session or on the same day.

These should be identified by appending **modifier 50 – *Bilateral Procedure*** to the procedure code. Report such procedures as a single line item with a **unit count of one.** Procedures with a code descriptor that specifically states that the ***procedure is bilateral,*** or the procedure may be performed unilaterally or bilaterally, cannot be reported with **modifier 50.** These codes, by their terminology description, already identify the services as bilateral.

Closer Look at Physician Modifier 59 – Distinct Procedural Services

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.

Closer Look at Physician Modifiers 76 and 77 – Repeat Procedure

This is regarding assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). It is an industry standard to process a separate claim for the services from each physician/supplier. Where the assigned claim is from a person or organization to which the physicians performing the services have reassigned their benefits, process all the services as a single claim.

Modifier 76 is added to the repeat service to indicate that a procedure or service was redone subsequent to the initial service.

Modifier 77 is added to the service that was performed to indicate that a basic procedure conducted by another provider needed to be redone by a different provider.

Table H9: Physician Modifiers (cont'd)

Modifier	Description
91	Repeat Clinical Diagnostic Laboratory Test
LT	Left Side
RT	Right Side
PT	Colorectal cancer screening test, converted to diagnostic test or other procedure
XE	Separate encounter
XP	Separate practitioner
XS	Separate Structure
XU	Unusual non-overlapping service

Closer Look at Physician Modifiers 25, 50, 59, XE, XP, XS, XU

Modifier 25 should be used to indicate separately identifiable E/M services.

Modifiers 59, XE, XS, XP and XU should be used when the physician needs to indicate that a procedure of services was distinct or independent from other services performed on the same day. These modifiers have a high error rate and have been used incorrectly to override certain unbundling edits.

Regarding bilateral procedure and Medicare, the Medicare Physician Fee Schedule (MPFS) includes a bilateral payment policy indicator for each HCPCS code. When the bilateral indicator is ”3,” the standard bilateral reduction does not apply, and Medicare allows the procedure to be reported with **modifier 50 (1 unit) or with RT and LT modifiers (1 unit each).** Services in this category are generally radiology procedures or other diagnostic tests.

Although UPMC Health Plan follows Medicare sourced bilateral payment policies for all products, the **bilateral “3” procedures** are configured to reimburse with the **RT and LT modifiers** only. If **modifier 50** is used for one of these codes, the claim is held for manual pricing causing potential delays or manual errors.

Table H10: Assistant Surgeon Modifiers

Modifier	Description
80	Assistant surgeon
81	Minimum assistance surgeon
82	Assistant surgeon (when qualified resident and surgeon not available)
AS	Assistant surgeon (services performed by a PA or NP)

Closer Look at Assistant Surgeon Modifiers, 80, 81, 82, AS

Modifiers 80, 81, 82 and AS represent surgical assistant services when appended to basic service procedure codes. The primary surgeon and the assistant surgeon report the same procedures codes when using these modifiers. The primary surgeon appends other multiple surgery modifiers as appropriate. The assistant surgeon appends **modifier 80** to all services in which he or she assisted the primary surgeon.

Effective January 1, 2020, UPMC Health Plan revised physician assistant guidelines to simplify the billing process when submitting a claim for a physician assistant (PA), certified registered nurse practitioner (CRNP), or clinical nurse specialist (CNS). To align with industry standard coding guidelines and modifier descriptions, **modifier AS** in conjunction **with 80, 81, or 82 is no longer required.** This applies to any claim submitted after January 1, 2020, regardless of whether the service was performed prior to that date. When billing for a PA, CRNP, or CNS assisting at surgery, modifier AS should be the only assistant surgeon modifier.

Modifier coding guidelines will remain the same when a physician provides surgical assistance, this modifier coding change is only applicable when a physician extender performs assistant-at-surgery services.

Physicians should continue to submit assistant surgeon and primary surgery charges on separate claims.

Table H11: Therapy Modifiers

Modifier	Description
GN	Service delivered under an outpatient speech language pathology plan of care
GO	Service delivered under an outpatient occupational therapy plan of care
GP	Service delivered under an outpatient physical therapy plan of care

Closer Look at Therapy Modifiers, GN, GO, GP

Providers report procedures with modifiers to distinguish the type of therapist who performed the outpatient rehabilitation service. If the service was not provided by a therapist, the discipline of the plan of treatment under which the service is provided should be reported. When a Member receives more than one type of therapy on the same date of service, appropriate therapy modifiers must be appended to procedure codes.

However, be advised that if codes create a NCCI defined code pair, an appropriate modifier must be appended to bypass the NCCI related denial. The therapy **modifiers GN, GO, or GP** alone are not enough to bypass the NCCI code pair denial.

Table H12: Modifiers – Medical Assistance Only: (UPMC Community HealthChoices and UPMC *for You*)

Modifier	Description
HD	Pregnant/parenting program (used for UPMC Health Plan Maternity Program)
YD	Member referred to a Dental Home
PA	Wrong Part – Surgical or other invasive procedures performed on the wrong body part
PB	Wrong Patient – Surgical or other invasive procedure performed on the wrong patient
PC	Wrong Surgery – The wrong surgical or other invasive procedure performed on a patient

Table H13: EPSDT Modifiers (UPMC *for You* Only)

Modifier	Description
EP	EPSDT program services

Anesthesia Claims

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 UPMC *for Life* (Medicare) and UPMC Health Plan (Commercial) 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 Medical Assistance (UPMC Community HealthChoices and UPMC *for You*) **only when** secondary to Medicare Advantage.

Anesthesia for Labor and Delivery

UPMC Health Plan follows the American Society of Anesthesiology (ASA) recommendations that it is inappropriate to report unlimited time units from insertion of the epidural through delivery. Therefore, UPMC Health Plan recognizes a **"Face Time" billing method.** This **includes basic units plus patient contact time** (insertion, management of adverse events, delivery, removal) for procedure code 01967 when billed alone or with add-on code 01968 or 01969.

- **Procedure Code 01967** – Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)

- **Procedure Code 01968** – Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)

- **Procedure Code 01969** – Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)

  - **Note:** **Code 01967**, when billed in conjunction with **01968 or 01969**, must be reported on the same claim form. Anesthesia time should be submitted with the primary anesthesia code, with the exception of add-on obstetrical codes. As such, time should be reported with primary code **01967** in addition to add-on **codes 01968 and 01969.**

Anesthesia minutes must be documented whether submitting paper or electronic claims. Minutes may be identified as total minutes (e.g., 50 minutes) or time span, noting both the beginning and end time (e.g., 10:00 to 10:50). Units are not required on the claim, as UPMC Health Plan's claim system is configured to determine the appropriate number of units in accordance with the ASA code and subsequent modifier.

Anesthesia Modifiers

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

Table H14: Anesthesia Modifiers

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

Table H15: Anesthesia Modifiers – CRNA

Modifier	Description
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 H16: Home Medical Equipment Modifiers

Modifier	Description
MS	Six-month maintenance and servicing
RA	Replacement of a DME, orthotic, or prosthetic
RR	DME rental
NU	New equipment
UE	Used durable medical equipment

Code-Specific Policies

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#).

Unlisted Codes

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.

Reimbursement

Providers who are reimbursed for professional and ancillary services on a fee-for-service basis agree to accept the network reimbursement, less deductibles, coinsurance, and copayments as payment in full for covered services provided to UPMC Health Plan Members.

Closer look at Balance Billing Guidelines for UPMC *for Life* Complete Care (HMO SNP) Members

The annual deductible, coinsurance, and copayments may apply to plan services. Providers may submit any unpaid balance remaining, after UPMC Health Plan payments, to the appropriate State source for consideration. However, providers **may not** attempt to collect copayments (other than permitted Medical Assistance copayments), deductibles, or coinsurance from Members enrolled in UPMC *for Life* Complete Care, for any services provided during the Member's enrollment in UPMC *for Life* Complete Care, including the period of time in which a Member has lost full Medical Assistance coverage but is deemed "continued eligible" for the "Grace Period" of up to **180 days.**

- **Note**: This includes services provided during the **"Grace Period."**

Attempting to collect the deductible, coinsurance, or copayments from Members will hereafter be referred to as ***balance billing***. Federal law prohibits Medicare providers from balance billing a Qualified Medicare Beneficiary (QMB) under any circumstances.

- See ***Section 1902(n)(3)(B) of the Social Security Act***, as modified by Section 4714 of the Balanced Budget Act of 1997.

- See ***Closer Look at Restrictions on Member Cost-Sharing and Balance Billing,*** UPMC *for Life* Complete Care (HMO SNP), Chapter M.

Alert—Balance Billing

Providers are not permitted to balance-bill Members for the difference between the provider's charge and the reimbursement. UPMC Health Plan annually updates all fee schedules with CPT-4 and HCPCS code additions and deletions. Coverage policy follows the 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 UPMC Health Plan payment policies. Providers may view NCCI edits at **cms.hhs.gov/NationalCorrectCodInitEd.**

UPMC Health Plan processes clean claims **within timeliness standards in the provider's agreement.** Pennsylvania Insurance Department regulations stipulate that a claim is paid when UPMC Health Plan mails the check or processes the electronic funds transfer (EFT).

To receive EFT payment(s) providers should complete an authorization for electronic reimbursement form. This allows UPMC Health Plan to process payments for service electronically allowing providers quicker access to their payments.

The EFT Transfer Form is located on **Provider OnLine** at **upmchealthplan.com/providers/online.**

- **Note**: All contracted Providers are required to complete the Authorization for Electronic Reimbursement form by going to **upmchealthplan.com/providers/online** and selecting EFT Transfer Form.
  - See ***Provider OnLine***, Key Contacts, Chapter A.
  - See ***Provider OnLine***, Claims Procedures, Chapter H.

For non-Medicare Products, if UPMC Health Plan fails to remit payment on a Clean Claim **within 45 days** of receipt of that claim, interest at **10 percent per year** shall be added to the amount owed on the Clean Claim. Interest is calculated beginning the day after the required payment date and ending on the date the claim is paid. UPMC Health Plan shall not be required to pay interest that is calculated to be **less than two dollars ($2.00).** For interest paid under a Medicare Product, the rate of interest shall be that set forth by the United States Secretary of the Treasury, as published in the Federal Register. For claims requiring reprocessing, Act 68 requires a **new 45-day** claims processing payment period, which begins the day UPMC Health Plan receives the necessary information.

Multiple Payee Addresses

UPMC 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 (e.g., money applied to the Member's deductible or copayment, and denied services). The EOP can be viewed by accessing **Provider OnLine** at **upmchealthplan.com/providers.** Providers can also request Electronic Remittance Advice (ERA) through Provider OnLine.

- **Note**: Per HIPAA the only permissible format for an electronic remittance advice, in a data file is the ANSI ASC X12.835, Health Care Claim Payment/Advice. This file is commonly referred to as an 835. It requires the recipient's Practice or Billing System to have the ability to automate loading of a file in the mandated format.

- **Note**: All contracted providers should utilize POL to review their current and historical EOPs and print a paper copy of the EOP. Provider with POL access and those who elect to utilize ERA will not receive a paper EOP. Paper EOPs will only be sent upon specific request.

    - See ***Provider OnLine***, Welcome and Key Contacts, Chapter A.
    - See ***Provider OnLine***, Claims Procedures, Chapter H.

For additional questions pertaining to the EOP, contact **Provider Services** at **1-866-918-1595** from 8 a.m. to 5 p.m., Monday through Friday.

Claim Follow-up

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

- See ***Provider OnLine***, Welcome and Key Contacts, Chapter A.
- See ***Provider OnLine***, Claims Procedures, Chapter H.

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.

Overpayments and Refunds

There may be times when a provider or the provider's practice are overpaid for a service provided to a Member. If UPMC Health Plan has paid in error, providers are given **45 calendar days** to refund the stated overpaid amount to UPMC Health plan. Providers may return the electronic payment or write a separate check for the full amount paid in error. Providers should make the check payable to UPMC Health Plan and 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 to the Claims Payable Department at the following address:

UPMC Health Plan
Claims Payable Department
U.S. Steel Tower, 36th Floor
600 Grant Street
Pittsburgh, PA 15219

If UPMC Health Plan has paid in error and the provider has not sent a refund the overpayments will be deducted from future claim payments. The provider's claims are placed in a negative balance status and future claim payments are applied until the overpayments are satisfied. The related claim information will be shown on the remittance advice as a negative amount.

In the case of a **non-contracted provider** overpaid claims, the overpayments must be refunded to UPMC Health Plan **within 45 days**. If a refund is not received **within 90 days**, the owed amount will be submitted to collections.

If UPMC Health Plan conducts an audit and identifies a claim payment error the provider will be notified by a certified letter. The provider has **30 calendar days** to submit a written appeal. If no appeal is submitted, the provider has **45 calendar days from the receipt of the notice** to return the overpayment. The overpayment amount should be refunded electronically; or by check, or money order made out to UPMC Health Plan. The refund should be accompanied with an explanation noting the reason for the refund, the remittance advice, explanation of payment from other insurance carriers if applicable, or other documentation of the payment.

The refund should be sent to:

UPMC Health Plan Special Investigations Unit
Personal and Confidential (Do Not Open in Mail Room)
PO Box 2968
Pittsburgh, PA 15230

If the provider has not sent a refund or returned the check, money will be deducted from contracted provider's future claims payment. The contracted provider's claims will be placed in a negative balance status and future claim payments are applied until the overpayments are satisfied. Related claim information will be shown on the remittance advice as a negative amount. In the case of non-contracted provider overpaid claims, overpayments must be refunded to the Health Plan **within 45 days**. If a refund is not received **within 90 days,** the owed amount will be submitted to collections.

- **Note:** If the provider conducts an audit following DHS self-audit protocol and identifies Medical Assistance claims that were over paid, they should contact DHS's Department of Program Integrity promptly. When the provider properly identifies and reports to DHS inappropriate payments, that are not fraudulent, DHS will accept repayment without penalty.

- See ***False Claims***, Chapter H.

Denials and Appeals

Denied claims are reported on all forms of the **Explanation of Payment (EOP),** (i.e., paper or electronic), 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 UPMC Health Plan's decision to deny payment of services, the provider must appeal in writing to the appeals coordinator **within a certain number of business days** of receipt of the denial notification. The claims appeal time frames are listed on the EOP or other 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 UPMC 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 Disputes***, Provider Standards and Procedures, Chapter B.

False Claims

The **False Claims Act (31 U.S.C. § 3729)** makes it illegal to present or cause to be presented to the federal or state government a false or fraudulent claim for payment. This would apply to U.S. government programs such as Medicaid, Medicare and Medicare Part D, and the Federal Employees Health Benefit Plan (FEHB). Any person in violation of this act could be liable to the U.S. government for **not less than $11,665 and not more than $23,331 per false claim,** plus **three times** the amount of any other damages the U.S. government sustains because of the fraudulent claims.

> ➢ **Note**: The False Claims Act penalty amounts are subject to change. The amounts may increase each year with inflation.

- **Qui tam** lawsuits can be filed by private citizens referred to as whistleblowers against any health care provider allegedly violating the federal and state False Claims Act.

- **Whistleblowers** are protected if they are discharged because of their involvement with a suit; they are entitled to reinstatement and damages double the amount of their lost wages.

The PA Insurance Fraud Prevention Act (18 Pa. Cons. Stat. § 4117) makes it illegal to knowingly defraud a State or local government agency. In addition, to submit, or cause to be submitted, any false claim to any insurance company.

- It is used to prosecute individuals committing insurance fraud against a nongovernment health care program.

- It allows an insurer to recover compensatory damages related to fraud cases, such as investigative and court costs and attorney fees.

The most common type of fraud involves a false statement, misrepresentation, or deliberate omission that is critical to the determination of benefits payable.

The following examples could also be considered fraudulent activities:

- Knowingly or intentionally presenting for payment a false or fraudulent claim.

- Soliciting, receiving, offering, or paying remuneration, including a kickback, bribe, or rebate, directly or indirectly, in cash or in kind, from or to a person about furnishing services or items, or referral of a patient for services and items.

- Submitting a claim for services or items that were not rendered.

- Submitting a claim for services or items that includes costs or charges that are not related to the cost of the services or items.

- Submitting a claim or referring a patient to another provider by referral, order, or prescription for services, supplies, or equipment that is not medically necessary.

- Submitting a claim that misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the patient or of the attending, prescribing, referring or actual provider.
- Entering an agreement, collaboration, or conspiracy to obtain or aid another in obtaining payment to which the provider or another person is not entitled.

Best Practices

Best practices to help prevent fraud and abuse include:

- Develop and follow the elements of a compliance program.
- Audit claims for accuracy.
- Review medical records for accurate documentation of services rendered.
- Act if you identify a problem [i.e., contact the UPMC Health Plan Special Investigations Unit (SIU)].
- Ask for photo identification when registering patients at the point of service.

Alert—Contacting the Special Investigation Unit

Fraudulent activity by a UPMC Health Plan provider or Member or Participant can be reported by calling the UPMC Health Plan Special Investigation Unit (SIU) at **1-866-FRAUD-01.**

Once issues have been identified, a plan to correct the issue needs to be developed. The SIU can assist with a corrective action plan development. The actual plan will vary depending upon the circumstances of the issue.