# 9 Health Partners Provider Manual
## Provider Billing & Reimbursement

**Purpose:** This chapter provides an overview of provider billing requirement and reimbursement considerations.

**Topics:**

- Provider Reimbursement
- Claim Billing Instructions

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# Overview

At Health Partners, we provide services to individuals who are eligible for benefits through our participation in the HealthChoices (Medical Assistance) program, or through our participation in the Children's Health Insurance Program (KidzPartners). We issue payments because the service or related service was approved and was medically necessary.

For Health Partners members, these payments are made at the lesser of billed charges or Medical Assistance rates unless otherwise contracted. For KidzPartners (CHIP) members, payments are made at the lesser of billed charges or Health Partners fee schedules. In either case, we consider such remittance to be payment in full.


Do not bill Health Partners Medicaid members for services.

Health Partners members are never responsible to pay participating providers any amount for covered medical services, other than approved coinsurance or copayment amounts as part of the member's benefit package.

If you are participating in the Medical Assistance Program you may NOT seek reimbursement from the member for a balance due unless it is for a non-compensable service or one beyond his/her covered limits and the recipient is told by the provider, in writing, BEFORE the service is rendered.

If the member is dually eligible (Medicare/Medicaid) or has other insurance coverage, and the claim is for a coinsurance or deductible amount, please be aware that Health Partners reimburses these amounts up to the applicable contracted or statutory limits.

# Provider Reimbursement

The following sections provide an overview and guidelines for the reimbursement methods and requirements utilized at Health Partners.

## Primary Care Physician (PCP) Capitated Services

The following primary care services are covered under capitation:

- Office Visits
- Routine EKG and interpretation
- Venipuncture
- Vision screening for children
- Fitting and prescribing of family planning methods
- Local treatment of burns
- 24-hour per day, 7-day per week telephone coverage
- Telephone Consultations
- Coordination of access to secondary, tertiary and specialty services

**Note:** *All capitated services must be reported to Health Partners on a CMS-1500 form or via electronic submission.*

## PCP Fee-for-Service Reimbursement (Billaboves)

PCPs are also eligible for compensation above capitation for certain services, as listed below:

- Suturing of minor wounds
- Removal of benign lesions
- Nail trimming and debridement, avulsion of nail plate
- Nebulizer Treatment
- Audiometry/Tympanometry
- Administrations of immunizations (must bill related immunization code to receive payment)
- Inpatient visits to a hospital, skilled nursing facility, or rehabilitation facility
- Home visits
- Childhood (ages 0-20) weight management services (CPT codes 96150-96154, S9470, and T1015) and nutritional counseling (S9470)
- EPSDT visits (use appropriate preventive E&M code with EP modifier)
- Normal newborn care (Circumcision, inpatient newborn care, attendance at delivery)
- Lead screening
- Diabetes self-management training (G0108 & G0109)

**Note:** *Reimbursement for all non-capitated services requires completion of either the CMS-1500 form or electronic submission.*

## Additional Compensation for PCPs (Medicaid Only)

For Health Partners' Medicaid program, certain immunizations, pediatric preventive services and hospital visits to newborns are eligible for additional compensation to primary care physicians without further authorization from Health Partners. Reimbursement for these immunizations and hospital visits is based on the completion and submission of the following form(s):

- EPSDT Encounter

  Providers should report the appropriate level Evaluation and Management CPT code, plus CPT code EP Modifier and all immunization CPT codes to properly report an EPSDT claim. Without this required coding, Encounters (claim services) will not be able to be reported to the Department of Public Welfare (DPW). If the Encounter is unable to be reported, the provider may be subjected to retraction of payments made for these services.

- Administration of immunizations when participating in the Vaccines for Children Program

## Fee for Service Providers (Medicaid Only)

All specialists and PCPs on a fee-for-service agreement are compensated based on the then prevailing or contracted rates. Examples of fee schedules are available on request through the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-14). ALL services must be reported to Health Partners on a CMS-1500 form or via electronic submission in an ASC X12N-837 P format, using current HIPAA-standard coding. All facility services must be reported to Health Partners on a UB-04 form.

## Missed Appointments (Medicaid Only)

According to Pennsylvania Department of Public Welfare Medical Assistance Bulletin 99-10-14 a provider is not permitted to bill a member for amissed appointment. According to The Centers for Medicare and Medicaid Services (CMS) a missed appointment is not a distinct reimbursable Medicaid service, but a part of the provider's overall cost of doing business. As such, it is included in the MA rate and providers may not impose separate charges on Medicaid recipients. State Medicaid programs, including Pennsylvania's MA Program, must cimply with the CMS policey on this subject; therefore MA enrolled providers who render services to MA recipients may not bill recipients for missed appointments.

## Provider Compensation (KidzPartners)

All provider reimbursement is fee-for-service. Compensation is based on the then prevailing or contracted rates, including reimbursement for childhood immunizations Examples of fee schedules are available on request through the Provider Services Helpline at **215-991-4350** or **888-991-9023**. ALL professional services must be reported to Health Partners on a CMS-1500 form or via electronic submission in an ASC X12N-837 P format, using current HIPAA-standard coding. All facility services must be reported to Health Partners on a UB-04 form.

# Referrals, Authorizations & Encounters Data

The following sections provide guidelines for referring members to specialist services, obtaining authorization for those services when necessary and accurately recording member encounters.

## Referrals

When it is determined by the PCP that a Health Partners or KidzPartners member needs specialist services, the PCP must issue a referral to a specialist or facility within the Health Partners or KidzPartners network. The referral may be given to the member to take to the participating specialist or facility, or may be faxed to the provider prior to the member's appointment. The referral is to be issued on the individual PCPs script. Health Partners no longer provides or utilizes a referral form and the referral does not need to be submitted with the claim. The member's PCP must follow the steps below before directing a member to another participating provider:

- Verify member eligibility via HP Connect, the password-protected site within *http://www.healthpartners.com*.

  Providers can get the current day status regarding member eligibility (as well as status information on submitted claims) by clicking Providers, and then keying your password. HP Connect allows providers to quickly and easily verify eligibility 24 hours a day, seven days a week.

  To gain access to HP Connect, providers will need to register on line for a secured log-on ID and password. Please visit our website at *http://www.healthpart.com*. Click Providers and complete the online registration form. When doing so, make sure to designate a Super User. This person will be authorized to make changes to your account (for example, reset password and add additional users). Please allow three business days for processing your registration. Health Partners will contact you by E-mail or phone to confirm that you have access to HP Connect.

**Note:** *Providers without office Internet access or those with questions can call the Provider Services Helpline for current information on member eligibility see Table 1: Service Department Contact Information on page 1-13.*

- Assure that the procedure does not require prior authorization from Health Partners.
- Select a participating Health Partners specialist appropriate for the member's medical needs.

When making a referral, the PCP should complete a script. Both the referring PCP and the specialist must keep a copy of the referral in the member's medical record. The referral does not need to be sent to Health Partners. Health Partners realizes that PCPs may occasionally need to refer members to a non-participating provider for some need or service not available through a participating provider. However, we require prior authorization before making referrals to non-participating physicians. If the PCP does not obtain prior authorization, reimbursement will be denied to the specialist.

The referral is valid for 60 days only. A PCP is not restricted regarding the specialist referral criteria (i.e. length of time the member sees the specialist or the number of visits that are ordered). If the specialist does not participate with Health Partners, prior authorization must be obtained and these claims are adjudicated accordingly. PCP's are expected to keep all referrals on file in the patient's record. Members are given a copy of the referral to bring to the specialist office to confirm that the PCP made the referral.

Possession of a referral from a participating PCP does not guarantee payment. If a member is not eligible with Health Partners/KidzPartners on the date of service, the physician will not be paid. To be sure, log on to HP

Connect (http://www.healthpart.com) or call the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-13) before the service is rendered.

The specialist may only treat a Health Partners/KidzPartners member for the specific condition that has been noted on the referral. The referral should be noted as consult and treat. The specialist is able to provide consultation and any additional services required to treat the condition for which the member was referred. If the additional services being ordered require prior authorization it is the specialist's responsibility to obtain the prior authorization.

If the specialist identifies the need to refer the member to another specialist, the PCP must issue that additional referral.

In accordance with Pennsylvania Law and Department of Public welfare requirements, Health Partners will maintain procedures by which a member, with a life-threatening degenerative or disabiling disease or condition, shall, upon request, receive an evaluation to determine if the member qualifies to select a specialist to act as his/her Primary Care Physician. This evaluation will include a written letter of medical necessity from the specialist and a determination by the Medical Director. If the member qualifies, he/she be permitted to receive a standing referral to a specialist with clinical expertise in treating the disease or condition; or the designation of a specialist to provide and coordinate the enrollee's primary and specialty care. If the specialist is designated as the primary care provider, he/she must be credentialed as a PCP.

# Prior Authorization

Referrals to non-participating providers require prior authorization by calling Health Partners Inpatient Services or Outpatient Services (see Table 1: Service Department Contact Information on page 1-14).

Services requiring Prior Authorization include:

- All elective inpatient admissions
- Inpatient Acute Rehabilitation stays
- Inpatient Skilled Nursing Facility stays
- Transplants
- Cosmetic surgery
- Outpatient rehab services (PT/OT/ST)
- Home care
- CT, MRI and PET scans
- Covered durable medical equipment exceeding $500 per line item
- Durable medical equipment rentals
- Non-emergent transportation
- All non-participating provider services
- Home infusion therapy and injectables
- For CHIP members, prior authorization is also needed for SPU services, MRI's, and CT Scans

Prior authorization is never required to provide emergency services. If an inpatient admission results following the provision of emergency/triage care, clinical review policies and procedures apply. For a more detailed description of prior authorization requirements and guidelines, see Prior Authorizations on page 6-6.

All inpatient admissions require a clinical review. For DRG contracted hospitals, reviews are required once the DRG trim point has been reached, and thereafter daily reviews are required through discharge. For per diem contracted hospitals, daily reviews are required from admission through discharge. If clinical reviews are not provided as required from admission through discharge, authorization and claim payment may be denied.

Providers must communicate all required information to Inpatient Services at Health Partners. Unless complete prior authorization information is provided, unless appropriate concurrent review and discharge planning is performed, and unless a final determination of approved services rendered, an "authorization" will not transfer to the claim processing system. Incoming claims will edit for a "no match on authorization" error due to the authorization data remaining in an incomplete thus un-transferred status and the claim will likely be denied. The elements required to accurately complete an authorization and successfully match and pay claims are:

- Member ID

  This is particularly important for newborns. Until the newborn is assigned a permanent Medicaid recipient number by DPW, authorizations will be set-up under a temporary ID. The temporary ID is usually the baby's mother's ID ending with Z and a sequential number at the end.

  A permanent ID can be assigned as early as ten days after the date of birth. The newborn's ID, whether temporary or permanent, can be confirmed through Provider Services at **215-991-4350** or **888-991-9023**.

- Dates of service

  It is extremely important that discharge or service end date be provided so that authorizations can be closed. Often authorizations are left open ended because the discharge dates or disposition is not known during preliminary discussions. Providers are responsible to follow-up on open/incomplete authorization and to ensure accurate dates of services or admission and discharge dates are communicated to Health Partners Inpatient Services at the time of discharge along with disposition information. If the dates of service change after the authorization number was given, it is the provider's responsibility to contact Health Partners with the new dates of service. Without exact dates, the claims submitted may deny or will only be paid for those dates matched between the claim and the authorization on file

- Provider ID

  Unless a valid and accurate provider ID is incorporated in the authorization, the claim may not be matched and will subsequently be denied. It is important that providers ensure the correct provider ID is associated with any authorizations.

# Member Encounters

Health Partners PCPs, specialists, Ambulatory Surgical Centers, ancillary and allied health providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter with a Health Partners/KidzPartners member. All providers must submit this form within 180 days following the encounter date or payment will be denied. PCPs must report encounter data associated with EPSDT screens of Medicaid members within 180 days from the date of service.

# Claim Billing Instructions

Health Partners is required by State and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure that required data is captured, and that claims are processed in an accurate, timely manner.

## Important Note for Medicaid Claims

Health Partners is required to submit to the Department of Public Welfare (DPW), the Commonwealth of Pennsylvania department responsible for administering Medicaid, all necessary data that characterizes the context and purpose of each encounter between a Medicaid enrollee and a physician/practitioner, supplier, or other provider. State regulation requires services to Medical Assistance recipients be rendered by providers participating in Medicaid, except in emergent or urgent situations. DPW now uses encounter data to develop risk-adjusted ratings that tie to reimbursement for Managed Care Organizations (MCO). A provider's failure to submit complete, accurate and timely encounter data to Health Partners as required may result in actions by Health Partners including, but not limited to, payment delay or no payment at all, as well as possible exclusion from the network.

## Billing Requirements and Guidelines

A mission of Health Partners is to ensure timely and accurate claims processing. To that end, this section is intended to provide guidance to Provider Billing Offices so that complete and precise medical claim filing for payment consideration can be accomplished. These guidelines do not, however, supersede any regulatory or contractual requirements published in legally binding documents or notices.

Capitated, as well as fee-for-service claim (encounter) data, specifically the diagnosis and treatment codes, is used by DPW to develop a risk-adjusted reimbursement rate. DPW will reimburse Medicaid Managed Care Organizations according to the level of illness experienced by and service rendered to their members. As an extension, reimbursements to providers from Medicaid Managed Care Organizations will become dependent upon the quality of the data used in this reimbursement methodology. A provider's failure to submit to Health Partners complete and timely encounter data, coded to the highest level of specificity, will have costly long term effects. It is important that providers file all claims and encounters, as required. Failure to do so could result in possible exclusion from the network.

### Preventable Serious Adverse Events

Health Partners will not cover services that are harmful to members, are of inferior quality or are medically unnecessary as may be the case with a serious and clearly preventable adverse event. In addition, financial compensation for any and all services rendered as a result of or increased by a preventable serious adverse event will be withheld or recovered.

## Initial Claim Submission Procedures

Health Partners has specific, established requirements for filing a notice of claim. These requirements include that the notice of a claim be valid and complete, furnished within a prescribed time, and be delivered to the correct business address. Failure to comply with any of these requirements shall constitute a bar to filing a claim and shall preclude payment. To be accepted as a valid claim, the submission must meet the following criteria:

- Must be submitted on a standard current version of a CMS-1500, CMS-1450/UB-04 or in the ANSI X12-837 electronic format (current version)
- Must contain appropriate, current information in all required fields
- Must be a claim for a Plan member eligible at the time of service
- Must be a claim for a Provider properly established on Health Partners' processing system for the time period and location (site) billed
- Must be an original bill
- Must contain correct current coding, including but not limited to CPT, HCPCS, DRG, Revenue and ICD-9 codes
- Must not be altered by handwritten additions or corrections to procedure/service codes and/or charges
- Must be printed with dark enough ink to be electronically imaged if submitted as a paper claim
- Must be received within 180 days from the date of service as measured by the date stamp applied by a Health Partners representative who has agreed to and has the authority to accept claims at a Health Partners' business address by the system receipt date if filed as a paper claim through the correct claim post office box; or, by system receipt date after passing via an electronic data interchange gateway and through Health Partners' claim validation front-end editing.

# Provider Numbers and Set-Up

All providers billing for services, whether participating or non-participating, must be established on the Health Partners' processing system with effective dates coinciding with the dates of services billed.

## Non-Par Providers

Non-participating providers, whether rendering emergency services or prior authorized and approved treatment, must provide the following information to be established on the Health Partners system:

- W-9 tax form
- Pennsylvania Medicaid Provider Identification Number (in-state, Health Partners Medicaid providers only)
- State Medical License Number and Expiration Date
- Social Security Number
- DEA (Drug Enforcement Administration) Number
- NPI (National Provider Identification) Number
- Provider Specialty
  - Specialist should declare their specialty
  - Facility
  - Allied Health Provider
  - Ancillary Health Care Provider (Home Health, DME, Transportation)

**Note:** *Non-participating provider services, (except for emergency services), require prior certification by calling Health Partners Inpatient Services or Outpatient Services (see Table 1: Service Department Contact Information on page 1-14).*

Information required in order to be established as a non-participating provider on the Health Partners' system can be sent to:

Health Partners

Attn: Provider Reimbursement and Administration

901 Market Street

Suite 500

Philadelphia, PA 19107

Or

FAX to:**215-967-4486**
Attn: Provider Reimbursement and Administration

## Participating Providers

Participating providers must be contracted and credentialed by Health Partners. For electronic claim submission Providers must bill with their individual and billing NPI numbers or their claims will be denied.

Claim Mailing Instructions

For Health Partners (Medical Assistance), claims should be mailed to:

Health Partners
P.O. Box 1220
Philadelphia, PA 19105-1220
For electronic claims use ID #80142.

For KidzPartners (CHIP), claims should be mailed to:

KidzPartners
P.O. Box 1230
Philadelphia, PA 19105-1220
For electronic claims use Emdeon payer ID #80142.

For claims reconsiderations:

Claims Reconsiderations (Health Partners and KidzPartners)
Health Partners
901 Market Street, Suite 500
Philadelphia, PA 19107

## Claim Filing Deadlines

Health Partners allows 180 calendar days from the date of service or discharge date to submit and have accepted a valid, initial claim.

A claim must be accepted as valid (as proven by entry into the Health Partners claims processing system and assignment of a claim control number) to be considered filed. Paper claim submissions that cannot be entered

into the claim processing system because of invalid member, provider or coding information are returned to the provider with a rejection notice (form letter or insert) explaining the reason for rejection.

Electronic claim submissions are rejected on electronic submission/error reports. The submission/error report(s) a provider's office receives depends on the billing service and/or electronic interchange vendor used. Because Health Partners uses Emdeon as the gateway for all electronic submissions from other billing services and/or electronic interchange vendors, an acknowledgement of all claims accepted through Emdeon and submitted to Health Partners is generated, as well as a first level rejection report of those claims not passing Emdeon edits. Once the Emdeon edits are passed, Health Partners' system edits for member, provider and coding information, and these edits generate a second level of acceptance and/or error reports. Providers should check with their billing service and/or electronic interchange vendor to fully understand how the Health Partners specific information is being provided.

During the 180 calendar day initial filing period, a provider may re-submit a non-accepted (invalid or EDI rejected) claim as often as is necessary to have it accepted. It is the provider's responsibility to ensure their claims are accepted. Once an initial claim is accepted, any subsequent (repeat) filing, regardless if it is paper or electronic, will deny as a duplicate filing. The initial claim, however, will be processed.

If the claim does not appear on an Explanation of Payment within 45 calendar days of submission as paid, denied, or as a duplicate of a claim already under review, and no rejection notice has been received, the provider must pursue the claim status to ensure it was accepted.

Claim status can be confirmed by calling the Provider Services Helpline at 215-991-4350 or 888-991-9023 or by accessing HP Connect on our website, www.healthpart.com.

An inquiry does not extend or suspend the timely filing requirement.

If, after resubmission, another 45 calendar days pass without the claim appearing on the Explanation of Payment, (even as a duplicate denial), the provider should contact the Provider Services HelpLine to discuss what could be preventing the claim from being accepted.

Claims that have been adjudicated (paid or denied) cannot currently be re-filed as though they were initial, unprocessed claims. Re-filing a previously adjudicated claim will cause automatic denial as a duplicate submission. To contest an incorrectly processed claim, see the Claims Inquiry and Reconsideration Section.

Any further questions regarding electronic transactions, please contact the EDI Support Line at **1-888-991-9023**.

## Filing Period Exceptions

The only exceptions to the 180-calendar day filing period are:

- If the delay was caused by a third party resource filing. Third party resource claims must be submitted within 60 calendar days of the initial determination notification from the primary carrier.
- If Health Partners' Enrollment Department verifies a problem determining a member's eligibility.

## Claim Form Filing Requirements

Claim form completion requirements for both CMS-1500 and UB-04 forms are outlined on the charts in Appendix 1. These charts list each field by number and include a description of the data needed along with an "R", "A" or "O" field code. If the field is coded "R" (required), the data must be completed on every form submitted. If the field is not complete or contains invalid data, the claim will not be considered for payment.

If a field is coded "A" (when Applicable), the data is required only for claims submissions where the field is directly related to the billed services for that record type. However, if the information is not included but is applicable to the billed services, the claim will not be considered for payment. Only claims completed as outlined will be eligible for payment consideration.

A field coded "O" is optional.

Common Reasons for Claim Rejections or Denials

Some of the more common reasons for claim denials and rejections include the following:

- Incorrect Member Identification number.

  Do not use the Medicaid Access card number when submitting claims. Use of this number will cause a claim rejection. Until DPW has assigned a permanent Medical Assistance number, newborn claims may be billed using their temporary Health Partners identification number, which is usually Mother's identification plus a 'Z' and a number at the end. This identification number will be provided by Health Partners when the provider obtains the authorization. Providers must validate that the newborn's permanent identification number has not been assigned before billing. Once the permanent number is assigned, claims will reject if submitted under the temporary number.

- Incorrect Provider Identification number.

  For electronic claims a provider must use both the individual and the billing NPI number. For paper claims providers can bill with either their individual NPI or the Health Partners legacy number. If these numbers have not been established on the Health Partners processing system it may cause a provider to appear as non participating, thus requiring authorization for services. Without an authorization, or a valid legacy provider number all claims will be denied.

- Authorization and claim service dates do not match.

  Providers are responsible for communicating all service dates, beginning/admission through ending/discharge. If the scheduled service date is cancelled or rescheduled, providers must call Inpatient Services or Outpatient Services to update the authorization to reflect the change. Any service dates not included in the authorization will be denied.

- Invalid procedure and /or diagnosis codes.

  Claims must be coded with the most current procedure codes and diagnosis codes at the highest level of specificity. Unless claims are properly and completely coded, they will be rejected if invalid or denied if obsolete.

- Referrals to non-participating providers.

  Except for emergency services, all non-participating providers require prior authorization. (Please call Health Partners Inpatient Services or Outpatient Services.) Without proper authorization non-participating provider claims will be denied.

- Health Partners billed as primary when other insurance exists.

  Providers must verify coverage every time a member is seen for services. Health Partners can be contacted to review other insurance information on file. If Health Partners is billed before the primary carrier has made a determination, the claim will be denied.

- Explanation of Payments/Benefits (EOP/EOBs) from primary insurers not submitted for secondary payment.

  Health Partners will only pay up to our allowable fee schedule or contracted rate, minus what the primary payer did or would have paid as demonstrated on the EOP attachment. The claim will be denied until the required EOP information is submitted.

- Member benefit limitation has been exceeded.

  Certain benefit packages have limitation to the number of services allowed. Health Partners will only pay for those services covered under their respective benefit package and will only reimburse the allowable portion of the claim, i.e. coinsurance and deductible.

# Electronic Data Interchange (EDI)

Health Partners offers providers the speed, convenience and lower administrative costs of electronic claims filing or Electronic Data Interchange (EDI). EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative cost. The Plan uses Emdeon Transaction Services (also may be known as NEIC, ENVOY or WebMD ENVOY) as our claims clearinghouse.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs.

  EDI eliminates the need for most paper claim submissions.

- Faster transaction time for claims submitted electronically.

  An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received by Health Partners. Many electronically submitted claims, because of the "clean data" embedded within the claim, can be auto-adjudicated.

- Validation of data elements on the claim form.

  By the time a claim is successfully received electronically, information needed for processing has been prescreened for required elements and, if passed, will be accepted as submitted. This reduces the chance of data entry errors that occur when completing paper claim forms.

For all claims (837Institutional and 837Professional) submitted electronically through the Emdeon clearinghouse, Health Partners can electronically return detailed status information through Emdeon.

The status message will show which claims were accepted, rejected and/or pending, and provide the amount paid on the submitted claim once it has been finalized. It is the Provider's responsibility to monitor all reports of electronic submissions to assure that claims are accepted. Please contact your billing software vendor for additional information regarding all available reports.

To take advantage of EDI, providers should contact their billing software vendor and request that Health Partners' claims be submitted directly through the Emdeon claims clearinghouse. Or, billing software vendors may be able to submit claims through current clearinghouse and request forwarding to Emdeon. (Providers who are already Emdeon submitters, but who do not receive Emdeon claim status reports, should contact their software vendor.)

If you require assistance with electronic filing contact the Provider Services Help Line at **215-991-4350** or **888-991-9023**, option 4.

## EDI Claim Filing Requirements

Health Partners Payer ID Number is **80142**.

KidzPartners Payer ID Number is **80142**.

Claims transmitted electronically must contain all of the required data elements identified within the 837 (Professional and Institutional) Claim Filing Companion Guide found at *http://www.healthpart.com* and click **Info for Providers** > **HIPAA Connect** > **HIPAA Companion Guides**. Emdeon or any other EDI clearinghouse or vendor may enforce additional, allowable data record requirements.

In order to send claims electronically to Health Partners, all EDI claims must be forwarded through Emdeon. This can be completed through any EDI clearinghouse or vendor.

Emdeon validates against HIPAA required Transaction Code Set edits, allowable Emdeon proprietary specifications, and allowable Health Partners' specific requirements. Claims not meeting the required HIPAA or Emdeon edits are immediately rejected and sent back to the sender via the RPT 05 Provider Daily Statistics report. This report details the rejected claims and the error explanation. Claim records that do not pass these required edits are considered invalid and will be rejected as never received at the Plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

Emdeon accepted claims are tracked on the RPT04 Daily Acceptance Report by Provider. This is a list of claims passed to Health Partners, but not necessarily accepted by Health Partners. If there are providers or members not found, or other allowable edits due to invalid claim data, these claims may be rejected by Health Partners.

Provider should pay close attention to the RPT11 Unprocessed Claims Report because it is the notification report that identifies claims that are not accepted in the Health Partners system. This report is a critical part of the workflow in that it contains the reason these claims were not accepted. Claim records that do not pass Health Partners required edits are considered invalid and will be rejected as never received at the Plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service.

Providers are responsible for verification that EDI claims are accepted by Emdeon and by Health Partners. Acknowledgement reports, claim acceptance reports, error reports for rejected claims, and unprocessed claim reports that are received from Emdeon directly or other contracted billing or gateway vendors must be reviewed and validated against transmittal records daily.

If a provider is submitting claims through a billing company or single source (such as a hospital EDI Unit handling all specialty department billing), and that billing company or single source is combining all records into one daily file when sending electronic submissions to Emdeon, any acknowledgement or rejection reports may also be combined. It is the responsibility of the billing company or single source to separate those errors and work them with each respective provider or medical department. Health Partners' EDI team can see all errors that are reported on the RO59 Unprocessed Claim Report and that the rejection occurred, but can do no more to help with the flow of information at the provider's end.

## EDI Exclusions

Certain claims may not be submitted through electronic billing. The exclusions fall into two categories:

- Excluded Providers

  Providers or vendors who are not contracted with Emdeon, thus whose claims are not transmitted through Emdeon.

- Excluded Claims

  Until further notice, the following claims must be submitted on paper:

  Claims requiring supportive documentation or attachments such as secondary claims with primary insurer's Explanation of Payment.

### EDI Common Rejections

Some of the common claim rejections from Emdeon include:

- Claims with missing or invalid required fields.
- Claims with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-9).
- Claims without a valid NPI number. Refer to the Health Partners' 837I or 837P Companion Guide for the most current information on required fields and their positions. Failure to include this information will result in a rejection of the claim.
- Claims without a valid member number. Do not use the Medicaid Access card number when submitting an electronic claim. Use of this number will cause a claim rejection.

## Early Periodic Screening, Diagnosis & Treatment Reporting (Medicaid)

Early Periodic Screening, Diagnosis and Treatment (EPSDT) reports are filed for all members from the time of birth until 21 years of age. Completion of a claim form documenting any encounter, whether the service is pre-paid (capitated) or fee for service, is a mandatory requirement, not an option.

The Primary Care Physician of a member under the age of 21 years should perform and report EPSDT screens and appropriate immunizations, or make arrangements for EPSDT screens to be performed elsewhere. These screens must be in accordance with the schedule developed by DPW and recommended by The American Academy of Pediatrics. As per the EPSDT guidelines, providers must advise members to obtain the appropriate dental services, contact Health Partners' EPSDT unit (1-800-500-4571) to coordinate dental appointments and document the referral on the claim.

Health Partners' providers may use the CMS-1500 form or file an electronic claim to report EPSDT activity. Dental referrals (YD) should be keyed in the IOD field of the claim. Health Partners relies on receipt of thoroughly completed CMS-1500 forms to obtain useful aggregate information about overall delivery of preventive care.

To properly report an EPSDT claim, Primary Care Physicians should report:

- The appropriate level Evaluation and Management CPT code with the modifier EP, plus CPT code EP Modifier.

- Age Appropriate Evaluation and Management Codes (as listed on the current EPSDT Periodicity Schedule and Coding Matrix). These are:

**Table 1: EPSDT Periodicity Schedule and Coding Matrix**

| New Patient | Established |
|---|---|
| 99381 Age less than 1 year | 99391 Age less than 1 year |
| 99382 Age 1-4 years | 99392 Age 1-4 years |
| 99383 Age 5-11 years | 99393 Age 5-11 years |
| 99384 Age 12-17 years | 99394 Age 12-17 years |
| 99385 Age 18-20 years | 99395 Age 18-20 years |

**Note:** *If both the Evaluation and Management and EP Modifier are not submitted, the claim will not generate any additional above capitation payment and may reject for incomplete coding.*

- All immunization CPT codes,
- Developmental Screening code 96110 - (ages 9-11 months, 18 months, and 30 months)
- Lab Codes 85013 (Blood Count-hematocrit), 85018 (Blood Count-hemoglobin) - ages 9 through 12 months
- Lab Code 83655 (Lead Screening) - ages 9 months through 6 years
- Lab Code 80061 (Lipid Panel) - ages 18, 19, and 20
- Visual Acuity Screening Code 99173 - ages 3 through 20
- Hearing Codes 92551 (audio screen) and 92552 (pure tone) - ages 3 through 20

Without this required coding, the encounter will not be able to be reported to DPW. If an Encounter is unable to be reported, the provider may be subjected to retraction of payments made for these services.

When making a Dental referral a provider must submit a remark code of YD on the claims. If submitting a CMS 1500 form the YD should be places in field 10D. If submitting electronically the YD code is places in 2300 NET01.

All EPSDT documentation is required as a permanent part of the member's medical record.

## Benefits for Pregnant Women (Medicaid Only)

Certain limitations on the number of services or applicability of copayments on General and Medical Assistance do not affect pregnant women. Women who are confirmed to be pregnant are eligible for comprehensive medical, dental, vision, and pharmacy coverage with no copayments or visit limits during the term of their pregnancy, and until 60 days post-partum. These services include expanded nutritional counseling and smoking cessation services. However, services which are not covered under a pregnant woman's Health Choices Benefit Package (HCBP) are also NOT covered, even while pregnant. For a fuller description of the benefits for pregnant women, please see HP Benefits During and After Pregnancy on page 4-9.

To ensure that a claim be processed without a service limitation, providers must bill with a pregnancy indicator on the claim.

### *Notes on Copayments*

Copayments for services are summarized in the benefits section. Services may not be denied to any Medical Assistance recipient on the basis of inability to collect a copay at the time of service.

Copayments that are due, but not paid should be indicated on the claims as follows:

| | |
|---|---|
| CMS-1500 | Box 24H code **11** |
| UB92/UB04 | Condition code/indicator, **Y3** |
| 837-I | 2300 Loop, HI, 01, qualifier **BG**, data element **Y3**. The condition code/ indicator is **Y3**. |
| 837-P | 2300 Loop, NTE 01= **ADD** and NTE 02 = **VC11** to indicate copay not collected. |
| NCPDP | N/A |

# Coordination of Benefits

Health Partners' Medical Assistance plan is payer of last resort, thus is secondary payer to all other forms of health insurance, Medicare, or other types of coverage. With the exception of pre-natal (excluding hospital delivery claims) and preventive pediatric care, if other coverage is available, the primary plan must be billed before Health Partners will consider any charges. Pre-natal (excluding hospital delivery claims) and preventive pediatric care is paid, regardless of other insurance. After all other primary and/or secondary coverage has been exhausted; providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payer to Health Partners. Secondary claims may also be filed electronically following the HIPAA compliant transaction guidelines.

DPW provides Health Partners with Third Party Liability Resource information files on all Medical Assistance recipients. Health Partners uses DPW's Resource information as a base for other insurance coverage. If, however, evidence of other insurance is discovered and validated by Health Partners, this information will be added to the Health Partner's system and relayed to DPW. All information on the Health Partners' file is available to the providers by calling Health Partners' Provider Services HelpLine. If, while providing medical services, the provider learns about third party resources that do not appear on the member's information file or that resources on the file are not longer effective, he/she is required to report the information to Health Partners.

Health Partners will coordinate benefits to pay up to Health Partners' Medicaid fee schedule allowable or otherwise contracted rate. If a primary insurer pays more than Health Partners would have paid as primary, no additional reimbursement will be made.

Providers who receive payment from both a carrier who was primary to Health Partners and Health Partners, and find they are in an overpayment situation, should return Health Partners' payment, per Medicaid regulatory requirement. If Health Partners discovers overpayment to a provider, the provider must comply with Health Partners' recovery efforts.

Third Party Liability also relates to automobile insurance and personal injury insurance coverage (homeowners, business liability insurance, etc.). Should a provider render services for injuries resulting from an accident, the

automobile or other liability carrier(s) should be billed as primary. If Health Partners is billed and pays inappropriately as primary, the rights of recovery fall to DPW. The provider is required by regulation to return these incorrect payments to DPW.

Third Party Liability also relates to personal injury legal actions brought by a member against a liable party to recover losses. Providers should bill medical insurers for all services even if the member intends to bring a lawsuit. Providers should not hold bills expecting to file against any legal settlement or with insurers after judgment. If Health Partners is billed and pays as primary, and the member succeeds in their legal action, the right of subrogation to recover for medical losses falls to DPW. DPW may place a lien against any judgment handed down compensating the member, thus shifting the cost of the member's medical losses to the liable party.

Claims that could have been paid by a primary carrier, but were denied because the provider failed to adhere to that carrier's claim filing or utilization management requirements, will not be considered by Health Partners. Unless an allowed amount from the primary carrier is present on the Explanation of Benefits and payment was not issued because of reasons other than the provider's error, Health Partners will not assume the primary insurer responsibility.

**Note:** *Members enrolled in KidzPartners may not be enrolled in any other health insurance program.*

# Copayment, Coinsurance and Deductibles

Providers are advised NOT to collect any copayments, coinsurance or deductibles at the time of service for a Health Partners Medicaid member who has other coverage (making Health Partners the secondary payer). Providers must consider payment from all sources in accordance with their payer contracts before determining if there is ever any member liability. If Health Partners is the secondary payer, the member, as a Medicaid recipient, never has payment liability unless the service is a non-covered service and the member has been notified in writing and in advance of the service of their liability for payment.

**Note:** *Services may not be denied to any Medical Assistance recipient on the basis of inability to collect a copay at the time of service.*

After the primary payer has made a claim determination, a secondary claim and the primary carriers Explanation of Payment should be submitted to Health Partners for consideration. Please use the post office box established for claims with attachments. HIPAA required Transaction Code Standards apply to electronic secondary claims.

If the primary payer pays less than the Health Partners' allowed amount, additional payment will be issued to make the provider whole up to the Health Partners' allowed amount, not to exceed the member's liability, assuming all filing criteria and medical appropriateness criteria are met. If the primary insurer has paid up to or more than the Health Partners' allowed amount, no additional payment will be made. Once the Health Partners' allowed amount is reached by payment from either/or both payers, the provider is considered "paid in full" under the Health Partners' contract or negotiated fee arrangements. No additional money (copayment, coinsurance or deductible) can be collected from the member. Any money collected from the member that exceeds the Health Partners' allowable must be immediately returned to the member. To collect money from a member exceeding what is owed under a Medicaid contract or fee arrangement violates Medicaid regulations and Pennsylvania statutes.

If a primary payer denies payment due to the provider's failure to follow that Plan's utilization management processes or claim filing procedures, Health Partners will also deny that claim unless payment is required by regulation, statute or contract. If Health Partners is required to issue payment even though the primary payer denies the claim, the most Health Partners is obligated to pay is the amount that would have been paid as

secondary payer. If the claim is denied by both the primary payer and Health Partners, the member has no liability to pay copayment, coinsurance or deductible.

Members enrolled in KidzPartners may not be enrolled in any other health insurance program. If a KidzPartners member presents with other active insurance a Provider should verify eligibility with the other payer, collect applicable copays and submit the claim to the other insurer. The Provider should notify Health Partners of the insurance by calling the provider help line at **215-991-4350** or **800-991-9023** or sending in the Explanation of Payment (EOP) from the other insurer. Health Partners Enrollment Department will determine the effective dates of the other insurance and contact the member if there is termination in coverage.

## Overpayments

Providers who participate with Health Partners' Medicaid program must participate in the Medical Assistance (MA) Program. Providers who participate in Medical Assistance enter into a written provider agreement with the State of Pennsylvania and must adhere to the MA Regulations. Under MA Regulation, (55 Pa. Code § 1101.69), a provider who is overpaid on a claim is obligated to reimburse the excess payment. This Regulation applies to money paid by the State or by Health Partners, as one of the State contracted Managed Care Organizations (MCO). Providers who participate Health Partners Chip program must adhere to federal regulations relating to overpayments. Under Federal Regulations (42CFR489.21, 42CFR489.40 and 42CFR489.41), a provider who is overpaid is obligated to reimburse the excess payment. Any overpayment received by the provider on one claim may not be applied to the outstanding balance of any other claim. Claims are individual financial transactions and must be accounted for in that manner by all parties.

There is no time limitation for requesting reimbursement of overpayments from providers receiving State or Federal Funds. Health Partners (Medicaid and CHIP Programs), however, follows the same recovery time period guidelines for non-fraud related claims as are adopted by the Department of Public Welfare: two years from the date of payment notice.

Provider known overpayments should be returned to:

Attn: Recovery Unit
Health Partners
901 Market Street
Philadelphia, PA 19107

If Health Partners discovers an overpayment, recovery will be initiated and will be reflected on the provider's current Explanation of Payment. If the amount owed Health Partners by a provider exceeds the amount of money to be paid within a payment cycle(s), an Explanation of Payment(s) will not generate until the credit balance is cleared. Once the amount owed is offset by current payments, the retractions and the offsetting payments will generate on the most current Explanation of Payment.

## Retroactive Disenrollments and Recovery

Medicaid and CHIP recipients are occasionally retroactively disenrolled from Health Partners and KidzPartners, respectively. When this occurs, any premiums paid to Health Partners are retracted by DPW or the Department of Insurance. Therefore, since Health Partners received no revenue to offset the member's medical expenses, Health Partners is under no obligation to pay for such services.

When this happens, claim payments to providers will be retracted for services occurring within the retro-disenrollment period.

## Correct Coding Intervention

Health Partners applies correct coding standards that integrate nationally accepted guidelines including Current Procedural Terminology (CPT) logic as documented by the American Medical Association, and Correct Coding Initiatives (CCI) and post-operative guidelines as outlined by the Center for Medicare and Medicaid Services to review claim submissions.

Codes determined to be included in or incidental to another procedure will be replaced with the more comprehensive code. Invalid codes that have been superseded with a current code may be replaced. If, however, there is any doubt about how to correct the coding, the claim will be denied for invalid coding, allowing the provider to take corrective action and re-file the claim. Pertinent modifiers must be used to communicate bilateral and repeated procedures performed on the same day.

Both the originally submitted code and the more accurate code will appear on the processed claim. The originally submitted code will have no payment. The new code will have payment, if appropriate. An explanation of the coding modifications will be clearly documented on the Explanation of Payment.

## Interest Payment

Under Pennsylvania law, (Act 68), Health Partners is required to pay 10% per annum interest on clean claims and uncontested portions of a contested claim that are not paid within forty-five (45) days of receipt. A clean claim is defined as a health care service claim for payment that has no defect or impropriety. A defect or impropriety includes, but is not limited to, the lack of required substantiating information or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. Claims from a health care provider who is under investigation for fraud or abuse regarding those claims are outside the definition of clean claims.

Forty-five (45) days is measured on an initial submission from the date of receipt by the Health Plan to the date of the check issuing payment or the date of electronic fund transfer. If a paid claim is re-adjudicated, a new 45-day period begins on the date additional information prompting the re-adjudication is received by Health Partners. Only additional monies paid are subject to interest calculation. If a claim or portion of a claim is contested (not paid) by Health Partners, then overturned and paid, interest will be calculated on the amount subsequently paid, beginning from the date additional information prompting the re-adjudication was received by Health Partners.

Under Act 68, interest may be calculated and paid as a separate check issued outside the claim payment and remit process, or may be included as part of the claim payment. Interest owed of less than $2.00 on a single claim does not have to be paid. If more than $2.00 interest payment is owed, but not received via the claim payment and remit or via a separate check within 30 days after claim payment, providers should contact the Provider Services HelpLine (see Table 1: Service Department Contact Information on page 1-14).

# Claim Inquiries and Reconsiderations

The procedures for inquiring about the status of claims or to request reconsideration of a payment decision are provided in the section below.

## Claim Inquiries

All telephonic claim inquiries are directed through Provider Services HelpLine at **215-991-4350**, option #2 or **1-800-991-9023**, option #2. Providers may verify the following over the telephone:

- claim status
- payment amount
- check date and number;
- denial and denial reason

The Provider HelpLine assists providers in determining why claims were not accepted.

Providers can also check claim status via Health Partners' HP Connect at www.healthpart.com. The on-line registration for access to HP Connect is under the Info for Providers tab.

## Claim Reconsiderations

A provider can request a reconsideration determination for a claim that a provider believes was paid incorrectly or denied inappropriately, whether the result of a provider billing error or a Health Partners processing error. Providers have three options to request a reconsideration of a claim:

1. For your convenience, our Rapid Reconsideration program provides an easy way to request claim reconsideration. Call to speak "live" with a claim reconsideration specialist who can reprocess a claim (or confirm a denial) while you're on the line. If the claim is approved for payment a check will be processed and mailed during the next scheduled check run - in a maximum of eight days. This service is available Monday to Friday, 8:00 am to 5:00 pm, by calling **888-991-9023** or **215-991-4350**, and choosing option #7. Please be sure to have the claim number or EOP ready when you contact the call center.
2. Written requests for claim reconsiderations. Whichever method is used, aclaim reconsideration request must be received within 180 calendar days from the date of the Explanation of Payment (EOP) advising of the adjudication decision.

   Claim reconsideration requests should include a copy of the Health Partners EOP and documentation supporting the assertion that the claim was paid incorrectly or why the denial should be overturned.

   Other important points to remember:

   - If the claim involves other insurance, information regarding the member's primary insurance coverage, including a copy of the primary EOP/EOB must be provided.
   - If the claim was denied for lack of an authorization or services not matching the authorization, the provider must contact the appropriate utilization management area to address the authorization problem and, only when resolved, submit a claim reconsideration request.
   - If the claim was denied because the provider is non-participating and lacked authorization, but the provider believes he or she is participating, there may be a problem with credentialing. Provider Helpline must be contacted and this issue resolved before the claim can be reconsidered. Please

contact the Provider Helpline for assistance at (215) 991-4350 or 1-800-991-9023 to verify provider identification numbers.

Claims denied because the requested authorization or level of care was not approved constitute a medical necessity disagreement. Claim reconsiderations due to denial of an authorization or level of care disputes should be mailed to:

Attn: Utilization Management/Appeals
Health Partners
901 Market Street
Philadelphia, PA 19107

All other written requests for reconsiderations are directed through the Claim Services department.

For prompt handling, reconsiderations should be sent to:

Attn: Claim Reconsideration
Health Partners
901 Market Street
Philadelphia, PA 19107

The provider will be advised of the claim reconsideration outcome generally within 30 calendar days of the date the written request was received by Claim Services. Claims that are overturned and have payment issued will appear on the provider's EOP and no other notice will be provided. If the original denial is upheld, the provider will be sent a form letter such advising of the right to dispute and appeal the outcome.

3. Providers may also submit requests through the new provider portal, HP Connect. to request assistance with access to HP Connect, providers may call the Provider Services HelpLine at **888-991-9023** or **215-991-4350**.

# Sample CMS-1500 Form (Version 8-05 New Form)

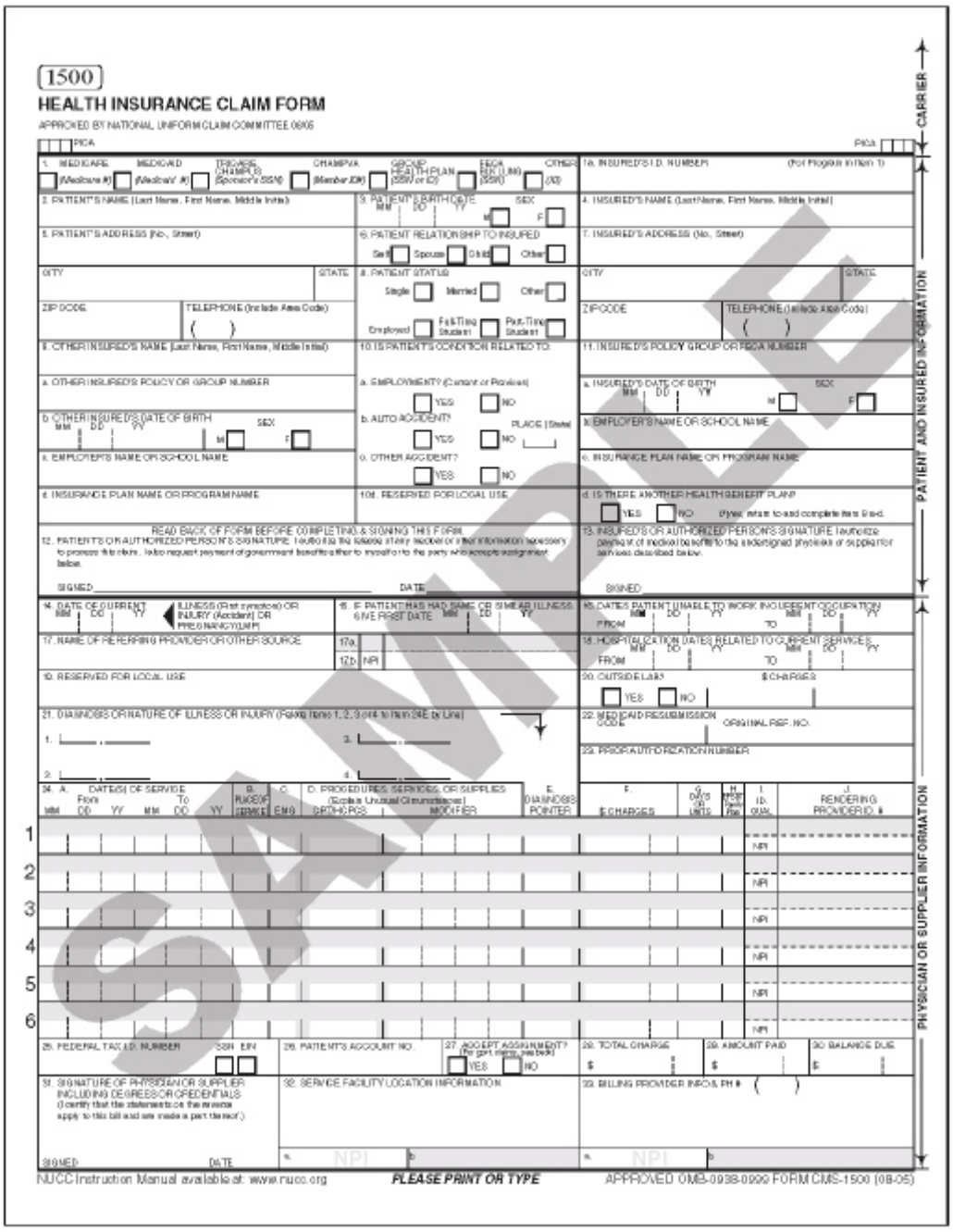


***Figure 9.1:*** *CMS-1500 Form*

Billing Requirements for CMS-1500 Form (Version 8-05 New Form)

| FIELD# | FIELD DESCRIPTION | R (Required)<br>C (Conditional) |
|---|---|---|
| 1a | Health Partners ID number | R |
| 2 | Patient name (Last name, first name, middle initial) | R |
| 3 | Patient's birth date and Sex | R |
| 4 | N/A (Same as field #2) | R |
| 5 | Patient complete address and telephone number | R |
| 6 | Patient's relationship to insured | R |
| 7 | N/A (Same as field #5) | C |
| 8 | Patient's status | C |
| 9 | Other insured information | C |
| 10 | Is Patient condition related to<br>a. Employment?<br>b. Auto accident?<br>c. Other accident? | <br>R<br>R<br>R |
| 11 | Insured's policy group of FECA number | C |
| 11a | Insured's date of birth | C |
| 11b | Employer's name or school name | C |
| 11c | Insurance plan or program name | C |
| 11d | Is there another health benefit plan? | R |
| 12 | Patient's or authorized person's signature | R |
| 13 | Insured's or authorized person's signature | C |
| 14 | Date of current illness, injury pregnancy (R. CHIRO) | C |
| 15 | Date of same or similar illness | C |
| 16 | Dates patient unable to work in current occupation | C |
| 17 | Name of referring Physician | C |
| 17a | Other Referring ID number (must be reported with one of the NUCC qualifiers) | C |
| 17b | NPI (the referring HIPAA NPI number) | C |
| 18 | Hospitalization dates related to current services | C |
| 19 | Medical License Number | R |
| 20 | Outside lab? | C |
| 21 | Diagnosis code(s) Relate items to 24c by procedure line. | R |
| 22 | Medicaid resubmission code (original DCN for adjustments) | C |

| FIELD# | FIELD DESCRIPTION | R (Required)<br>C (Conditional) |
|---|---|---|
| | | |
| 23 | Prior authorization number or referral number | C |
| 24a | Date(s) of service | R |
| 24b | Place of service | R |
| 24c | EMG | C |
| 24D | Procedures, Services or supplies/Modifiers | R |
| 24e | Diagnosis pointer | R |
| 24f | Charges | R |
| 24g | Days or Units | R |
| 24h | EPSDT (family plan) | C |
| 24I | Rendering provider- Other ID number ( must be reported with one of the NUCC qualifiers) | C |
| 24j | Rendering provider NPI ID number | C |
| 25 | Federal tax ID number | R |
| 26 | Provider's patient account number | C |
| 27 | Accept assignment (assumed yes by Health Partners contract | C |
| 28 | Total Charge | R |
| 29 | Amount paid | C |
| 30 | Balance due | C |
| 31 | Signature of physician or supplier | R |
| 32 | Service Facility location information | C |
| 32a | NPI number of the service facility location | C |
| 32b | Other ID number (must be reported with one of the NUCC qualifiers) | C |
| 33 | Billing provider name, address, zip code and phone number | R |
| 33a | NPI (HIPAA provider number) | R |
| 33b | Non-NPI – Other ID number ( must be reported with one of the NUCC qualifiers) | Optional |

# Sample UB-04/CMS 1450 Form

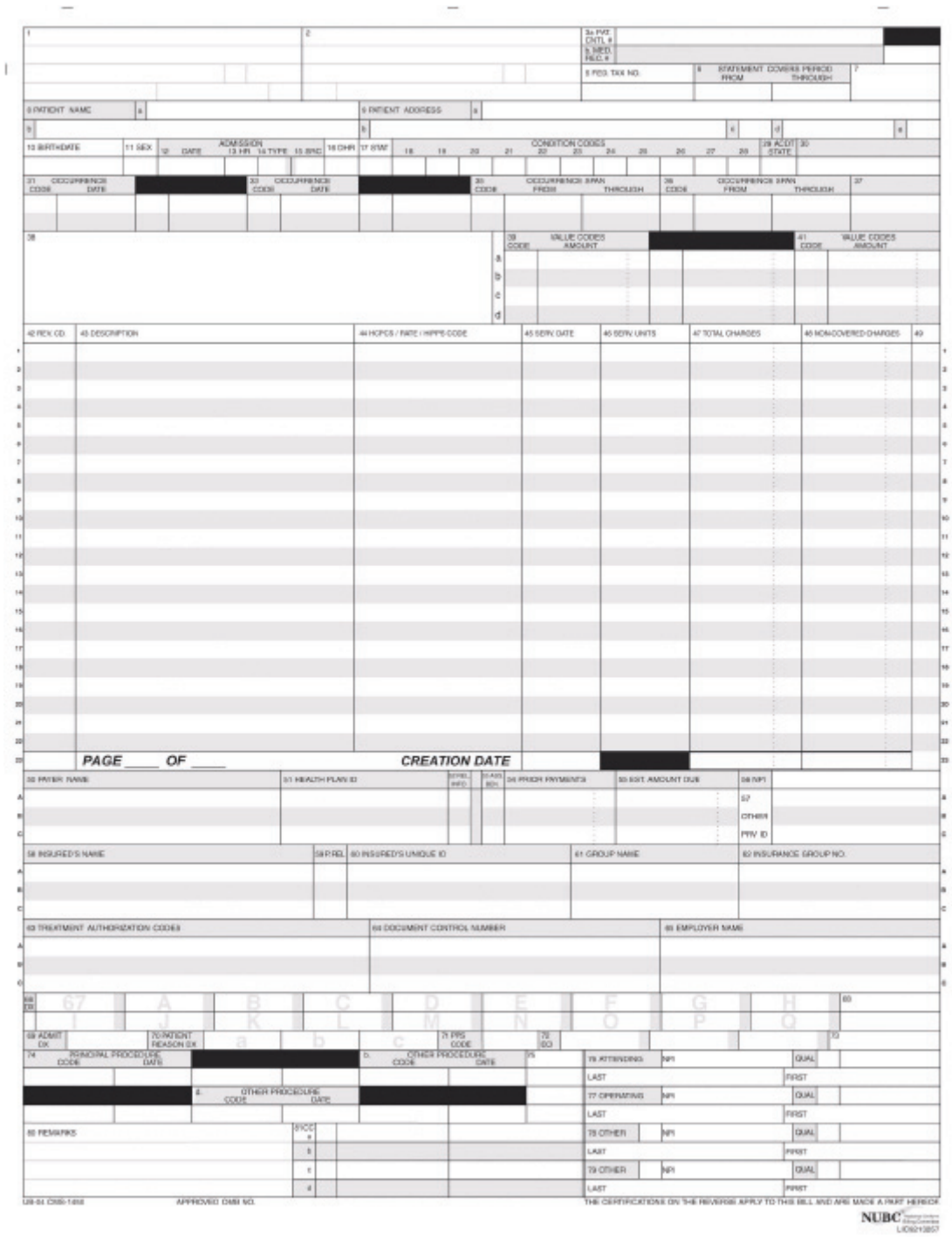


***Figure 9.2:*** *UB-04 Claim Form*

| FIELD# | FIELD DESCRIPTION | Inpatient | Outpatient |
|---|---|---|---|
| 1 | Provider name, address and telephone, county code | R | R |
| 2 | Pay-to-Name, address, pay-to-ID | Optional | Optional |
| 3a | Patient Control Number | R | R |
| 3b | Medical record number | R | R |
| 4 | Type of bill | R | R |
| 5 | Federal Tax number | R | R |
| 6 | Statement coverage period | R | R |
| 7 | Unlabeled | Optional | Optional |
| 8a | Patient ID | Optional | Optional |
| 8b | Patient Name | R | R |
| 9 | Patient address, and county code | R | R |
| 10 | Patient date of birth | R | R |
| 11 | Patient sex | R | R |
| 12 | Admission date of service | R | R |
| 13 | Admission hour | R | C |
| 14 | Type of admission/visit | R | C |
| 15 | Source of admission | R | R |
| 16 | Discharge hour | R | C |
| 17 | Patient discharge status | R | R |
| 18-28 | Condition codes | R | R |
| 29 | Accident state | C | C |
| 30 | Unlabeled | Optional | Optional |
| 31-34 | Occurrence code/date | C | C |
| 35-36 | Occurrence span code and dates | C | C |
| 37 | Unlabeled | Optional | Optional |
| 38 | Responsible party name/address | R | R |
| 39-41 | Value codes and amounts | C | C |
| 42 | Revenue code | R | R |
| 43 | Revenue description | R | R |
| 44 | CPT/HCPCS codes/rates | C | R |
| 45 | Service date | N/A | R |
| 46 | Units of service | R | R |
| 47 | Total charges by revenue code category | R | R |
| 48 | Non-covered charges | Optional | Optional |
| 49 | Unlabeled | Optional | Optional |
| 50a | Payer name - primary | R | R |
| 50b | Payer name – secondary | C | C |
| 50c | Payer name – tertiary | C | C |
| 51 | Health Plan ID (Health Partners Provider ID) | Optional | Optional |

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| FIELD# | FIELD DESCRIPTION | Inpatient | Outpatient |
|---|---|---|---|
| 52 | Release of information certification indicator | R | R |
| 53a | Assignment of benefits – primary | R | R |
| 53b | Assignment of benefits – secondary | R | R |
| 53c | Assignment of benefits – tertiary | R | R |
| 54 | Prior payment – payer and patient (a-c) | C | C |
| 55 | Estimated amount due | R | R |
| 56 | NPI Billing provIDer - (HIPAA provider number) | R | R |
| 57 | Non-NPI – Other ID number Billing Provider ( must be reported with one of the NUCC qualifiers | O | O |
| 58 | Insured's name | R | R |
| 59 | Patient's relationship | R | R |
| 60 | Insured's Unique ID (Health Partners ID number) | R | R |
| 61 | Insured's group name, if applicable | C | C |
| 62 | Insured's group number | C | C |
| 63 | Treatment authorization code | R | R |
| 64 | Document control number | C | C |
| 65 | Employer name | C | C |
| 66 | DX version qualifier (ICDv) | C | C |
| 67 | Principal diagnosis code | R | R |
| 67a-q | Other diagnosis | C | C |
| 68 | Unlabeled | Optional | Optional |
| 69 | Admitting diagnosis code | R | N/A |
| 70 | Patient's reason for visit code | C | C |
| 71 | PPS code – DRG code | R | C |
| 72 | External cause of injury code | C | C |
| 73 | Unlabeled | Optional | Optional |
| 74a-e | Other procedure code/dates | C | C |
| 75 | Unlabeled | Optional | Optional |
| 76 | Attending NPI-qualifier/ID number (first field NPI, second filed qual + ID) | R | R |
| 77 | Operating physician NPI-qualifier/ID number (first field NPI, second field qual + ID) | C | C |
| 78 | Other – qualifier/NPI qualifier/ID | C | C |
| 79 | Other – qualifier/NPI qualifier/ID | C | C |
| 80 | Remarks | Optional | Optional |
| 81 | Code-code-qualifier/code/value | C | C |
| | | | |

R= Required
C= Conditional

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# Explanation of Payment (EOP)

This statement reports fee-for-service payments to providers, including PCPs, specialists, ancillaries and hospitals. (It does not report payments for capitated services.) The EOP reports claim charges that are paid or denied, and the reason for the payment or denial. The EOP also shows any coordination of benefits payments, any adjustments or interest payments, as well as the provider NPI and Health Partners legacy identification

numbers. Additionally, the EOP indicates claims that have been modified to reflect correct coding as determined by Correct Coding Initiative and/or American Medical Association guidelines.

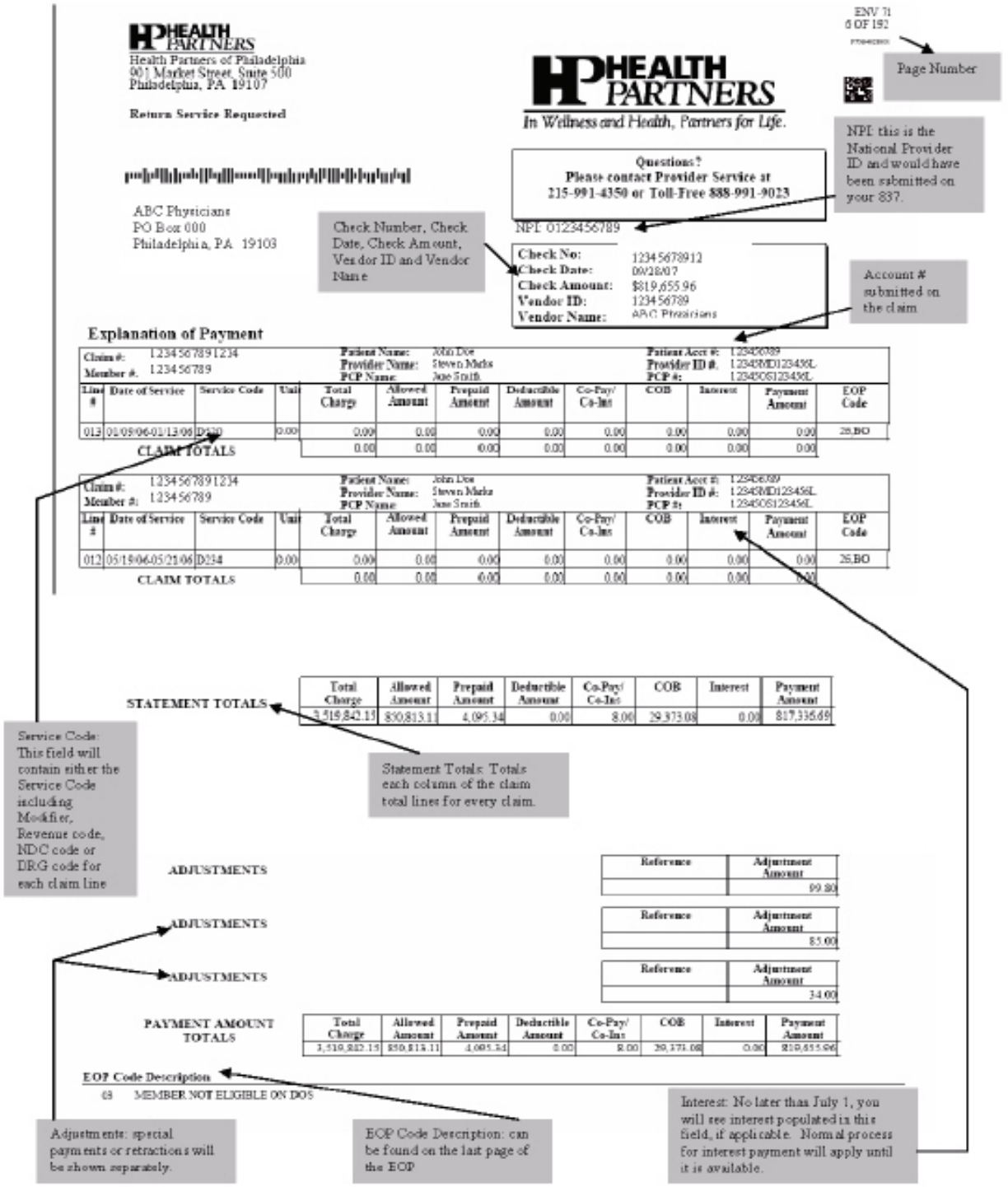


***Figure 9.3:*** *Explanation of Payment form*