n05659

Claim Submission Policy

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This policy outlines Network Health's process, for all lines of business, for clean claim submissions, clinical documentation, as well as timely filing and corrected claim submissions.

Policy Detail:

Network Health's goal is to process all claims at initial submission. Before Network Health can process a claim, it must be a "clean" or complete claim submission, which includes the following claim elements when applicable:

A. Patients' Network Health member identification number
B. Patients' first and last name
C. Patients' date of birth (month, day, and year)
D. Subscribers' full name and address
E. Patients' signature or indication of signature on file
F. Standard International Classification of Diseases (ICD) codes
G. Dates of service
H. Place of service (HCFA claim); Bill Type (Facility claim)
I. Standard Current Procedural Terminology (CPT) code sets
J. Standard Healthcare Common Procedure Coding System (HCPCS) code sets
K. Revenue codes (Facility)
L. Modifiers
M. Diagnosis-related group code (DRG)
N. Resource Utilization Groups (RUG) code (when applicable)
O. Individual charges for each billed service
P. Units of services
Q. Providers' National Provider Identifier (NPI) number
R. Individual Physician NPI required in box 24j and box 33a.
S. Service Facility NPI required in box 32a if the place of service line equals 21, 22, 23, 31, 32, 51 or 54.
T. Billing Provider (Pay-To) NPI required in box 33a
U. Provider Tax Identification number (TIN)
V. Taxonomy code (required for **Medicare claims only**)
   - Box 24j & box 33b for Physician/HCFA claims
   - Box 81cc for Facility/UB04 claims
W. Facility/provider name, address, and telephone number
X. Billing provider name, address, and telephone number
Y. Accident state
Z. Providers' signature
AA. Primary carrier Explanation of Benefits (EOB) when Network Health is the secondary payer

BB. Miscellaneous circumstances (such as Corrected claim, Covering MD, and/or unlisted CPT/HCPCS) require an explanation
CC. Miscellaneous drug codes require the National Drug Code (NDC) on the corresponding claim line.
DD. Clinical Trial Number
    a. UB04/Institutional claims - The 8-digit numeric clinical trial number should be placed in the value amount with value code D4
    b. HCFA/Professional Paper claims – The clinical trial registry number should be preceded with the two alpha characters CT and placed in Field 19 of the HCFA-1500 claim form
    c. HCFA/Professional EDI/electronic claims – The clinical trial registry number should be entered WITHOUT the CT prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4)

If any of the above information is missing from the claim, Network Health will not be able to process your claim. If you have questions regarding the required fields on a claim, please contact Network Health's Member Experience Department.

Clean Claim Form Criteria:

I. Claims need to be submitted on a UB04-1450 (Institutional) or HCFA-1500 (Professional) claim form.

II. Services provided in different calendar years cannot be processed as a single claim. A separate claim is required for the services provided in each calendar year.

III. Date spanned claims cannot be processed if the patient's coverage terminates during the date span. A separate claim is required for the services provided before and after termination.

IV. Professional claims submitted with multiple places of service cannot be processed as a single claim. A separate claim is required for each place of service.

V. **Incomplete or Missing Information:**
If a claim does not include all the information set forth under the minimum claim elements listed above, the claim will be considered unclean and will be denied with the appropriate National Claims Adjustment Reason code (CARC) indicating additional information is required. Until Network Health receives a clean claim, the **provider** is liable for charges and cannot bill the patient.

VI. **Claims Requiring Additional Information:** If a claim contains all the required billing information required for claim submissions, however, requires additional information necessary for Network Health to make a benefit decision on the claim, Network Health will notify both the patient (via Explanation of Benefits) and the provider (via Remittance Advice), that additional information is necessary to make a benefit determination.

VII. Patients cannot be billed when the provider does not bill appropriately, or when information is needed from the provider to accurately process a claim.

VIII. If required billing information is needed from the patient, the patient may be billed by the provider until the patient supplies Network Health the appropriate information.
   a. An example would be other insurance information from the patient. Network Health cannot determine benefits until we have verified Network Health is the patients' primary carrier.

IX. Written claims will only be accepted if they are submitted in the English language.

Clinical Documentation

I. Network Health will routinely request clinical documentation for a submitted claim to be considered in the following categories:

   A. an "unlisted code" as defined in the CPT/HCPCS code book for unlisted services and procedures
   B. a code that is not elsewhere classified (NEC)
   C. a code that is not otherwise specified (NOS)
   D. a code that is not otherwise classified (NOC)
   E. procedures that are potentially cosmetic
   F. procedures that may be experimental/investigational/unproven
   G. procedures that are medically necessary for some indications and not for others
   H. services performed in an unexpected place of service, such as office services performed in an outpatient surgery center
   I. codes appended with a modifier indicating additional or unusual services
   J. codes to which an assistant or co-surgeon modifier is attached that do not normally require assistant or co-surgeons

II. Types of clinical documentations that may be requested include:

   A. Ambulance transport notes
   B. Anesthesia records
   C. Emergency Room records
   D. Facility notes
   E. MD notes
   F. Laboratory results
   G. Operative notes
   H. Physician office notes
   I. Radiology interpretation and report

Beyond the above categories, Network Health may require submission of clinical records before or after payment of claims for the purpose of identifying improper billings and detecting suspicious claims.

This guideline is not designed to limit Network Health's right to require submission of medical records for precertification purposes.

Timely Filing & EDI Claim Rejection Report – All Products

I. When Network Health is the secondary payer, claims must be submitted to Network Health within 90 days of payment date listed on the primary payer's Remittance Advice, or as specified in your Provider Contract.

II. The EDI Claim Rejection report is located on the provider portal and will indicate if the claim has been rejected due to a provider or member submission error.

III. The clearinghouse may indicate the claim was accepted, however the claim may not be sent back as rejected. It is the providers responsibility to review the EDI Claim Rejection Report if they have not received a payment or denial from Network Health within 30 days of claim submission.

IV. If a claim is rejected for improper EDI submission(s), resubmission must be completed by the Provider within the timely filing limits outlined below.

V. Please be aware that when a provider fails to submit a claim timely, rights to payment from Network Health are forfeited and the provider may not seek payment from the member as compensation for these covered services. Claim(s) will deny with CARC Code "29"/*The time limit for filing has expired*."

Timely Filing – Commercial/All Providers

I. Outpatient claims must be submitted within 90 days of the date of service unless otherwise specified in your provider contract with Network Health.

II. Inpatient claims must be submitted within 90 days from discharge date. This provision applies to all providers unless otherwise specified in your provider contract with Network Health.

Timely Filing – Medicare/Participating Providers

I. Outpatient claims must be submitted within 90 days of the date of service unless otherwise specified in your provider contract with Network Health.

III. Inpatient claims must be submitted within 90 days from discharge date unless otherwise specified in your provider contract with Network Health.

Timely Filing – Medicare/Non-Participating Providers

I. Outpatient claims must be submitted within 365 days of the date of service.

II. Inpatient claims must be submitted within 365 days from discharge date.

Corrected Claims

I. A corrected claim is any claim that has a change to the original claim submission (for example, changes or corrections to charges, procedure or diagnosis codes, dates of service, etc.). Providers who may need to submit a corrected claim must do so within 120 days of the original claim remittance advice.

II. The following guidelines have been established for submitting corrected claims to Network Health:

III. Network Health requires that the provider submit the entire original claim Electronically/EDI when submitting a corrected claim. Network Health will not accept a corrected claim listing only the corrected line/lines.

IV. The provider must indicate what is being corrected. (Providers have a "Remark or Notes" field when submitting EDI claims. This information should be indicated in the appropriate field of the corrected claim, or the claim will be denied as a duplicate claim to the original claim.

V. HCFA claims require a resubmission code of "7" in box 22 along with the original claim number. If the resubmission code is not submitted, the claim may deny for timely filing or as a duplicate submission.

VI. UB04 claims require a bill type of XX5, XX7, XX8 or appropriate bill type indicating a corrected claim; if the correct bill type is not used the claim may deny for timely filing or as a duplicate submission.

   A. UB04 claims submitted with bill type XX7 must include condition code(s) D0-D4, D7-D9 or E0.

   B. If one of these condition code(s) are not listed, the claim will be denied with Claim Adjustment Reason Code (CARC) 5 "*The procedure code/type of bill is inconsistent with the place of service.*"

   C. UB04 claims submitted with bill type XX8 must include condition code(s) D5 or D6.

   D. If one of these the condition code(s) are not listed, the claim will be denied with CARC Code 5 "*The procedure code/type of bill is inconsistent with the place of service*."

VII. If a diagnosis code, procedure code, and/or a modifier is being changed or added, Network Health may request the clinical documentation to review for coverage.

When submitting a corrected claim to Network Health, if any of the above guidelines are not followed, the claim will be denied until such time that a corrected claim has been received meeting all the requirements.

Please be aware that when a provider fails to submit a claim timely, rights to payment from Network Health are forfeited and the provider may not seek payment from the member as compensation for these covered services.

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