Claims Procedures

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

- 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 *Deadlines*, 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.
  - See *Coding Practices Subject to Review*, Claims Procedures, Chapter H.

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

  ▶ See *Clean vs. Unclean Claims,* 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 Health Plan (Commercial), UPMC *for Life* (Medicare), UPMC *for You* (*Medical Assistance*) and UPMC Community HealthChoices claims.

  ▶ See *Place-of-Service Code Table (H-3),* Claims Procedures, Chapter H.

- Use modifier code "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 *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 *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 30 business days of receipt of the notice indicating the claim was denied.

Submission Guidelines

Filing Methods

Electronic

UPMC Health Plan's claims processing system allows providers access to submitted claims information, including the ability to view claim details such as claim status (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.

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 NPI (National Provider Identifier) number is required, and the member's 11-digit identification number or the Medical Assistance Recipient Identification number is necessary. (Note: The Medical Assistance Recipient Identification number is utilized for UPMC *for You* and UPMC Community HealthChoices). When care is coordinated, the referring provider's name and NPI or UPIN are also required.

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 https://mcnet.upmchp.com//hponline and selecting the "sign up" menu link.
- Use billing software that allows the generation of a HIPAA-compliant 837 professional or institutional file.
- Have a sample 837 file exported from their billing system containing only UPMC Health Plan claims.
- Have a computer with Internet access
- 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 currently receives crossover files from COBA.

UPMC *for You* accepts crossover claims for members younger than 21 years old, with both Medicare and Medical Assistance coverage (dual eligibles). The Medicare eligibility record must indicate that the beneficiary is enrolled in UPMC *for You.* Providers should review the Explanation of Medicare Benefits (EOMB) to determine whether the claim crossed over.

Paper Claim Forms

CMS-1500 forms
These forms are for professional services performed in a provider's office, hospital, or ancillary facility. (Provider-specific billing forms are not accepted.)

▶ See *Required Fields on a CMS-1500 Claim Form*, 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 *Required Fields on a UB-04 Claim Form*, Claims Procedures, Chapter H.

Claim Submission for UPMC Community HealthChoices Home and Community Based Providers

HHAeXchange (HHA) is a proprietary platform for LTSS/HCBS Payers and Providers that streamlines authorization, case placement and acceptance, case management and communication, and billing and remittance processing. UPMC CHC has chosen HHA as the authorization/claims solution for LTSS/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 CHC 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) members.

The following are things 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 the 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 if a direct care worker goes to the home of the participant and the participant was not there to receive the service or cancelled 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).
- 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 PERS, Home Adaptations, Specialized Medical Equipment and Supplies, Assistive Technology
- Provider cannot bill for services that were not approved in service plan. (per 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 (1) staff 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.

Deadlines

UPMC Health Plan accepts new claims for services up to 365 days after the date of service for UPMC Health Plan (Commercial), UPMC *for Kids* (CHIP), UPMC Medicare Special Needs Plan (SNP), and UPMC *for Life* (Medicare) members.

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

UPMC *for You* EPSDT claims must be submitted within 90 days after the date of service.

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

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

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

Addresses

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

Table H1: Claim Addresses

Claim Type	Address
UPMC Health Plan (Commercial)	UPMC Health Plan PO Box 2999 Pittsburgh, PA 15230-2999
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 Medicare Special Needs Plans (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 Community HealthChoices (Medical Assistance)	UPMC Community HealthChoices PO Box 106042 Pittsburgh, PA 15230

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:

- 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.

- When coding ongoing or chronic conditions, do not assume the code used at a previous visit is appropriate for a current visit.

- In coding diabetes, be certain to identify the status of the member's condition as Type I r 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 (2) codes are required, one for the diabetes and the second for the manifestation.

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

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

- V-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. V-codes used to describe personal and/or family history of medical conditions are covered when used for a screening procedure; however, V-codes that pertain to mental health, learning disorders, or social conditions are not covered.

- "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 V-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

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**.

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 Assessment Bulletin, MA 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 and Medicaid Services (CMS). A list of HACs can be found at **www.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 web page at **www.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.

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

Table H2: OPPC

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 *Explanation of Required Fields on a UB-04 Claim Form,* 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 with no defects or improprieties. A defect or impropriety may include, but is not limited to, the following:

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

For UPMC Community HealthChoices, a clean claim is defined as one that can be processed without obtaining additional information from the Provider or from a third party, including a Claim with errors originating in UPMC Community HealthChoices Claims system. Claims under investigation for Fraud or Abuse or under review to determine if they are Medically Necessary are not Clean Claims.

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

Alert—Rejected Claims

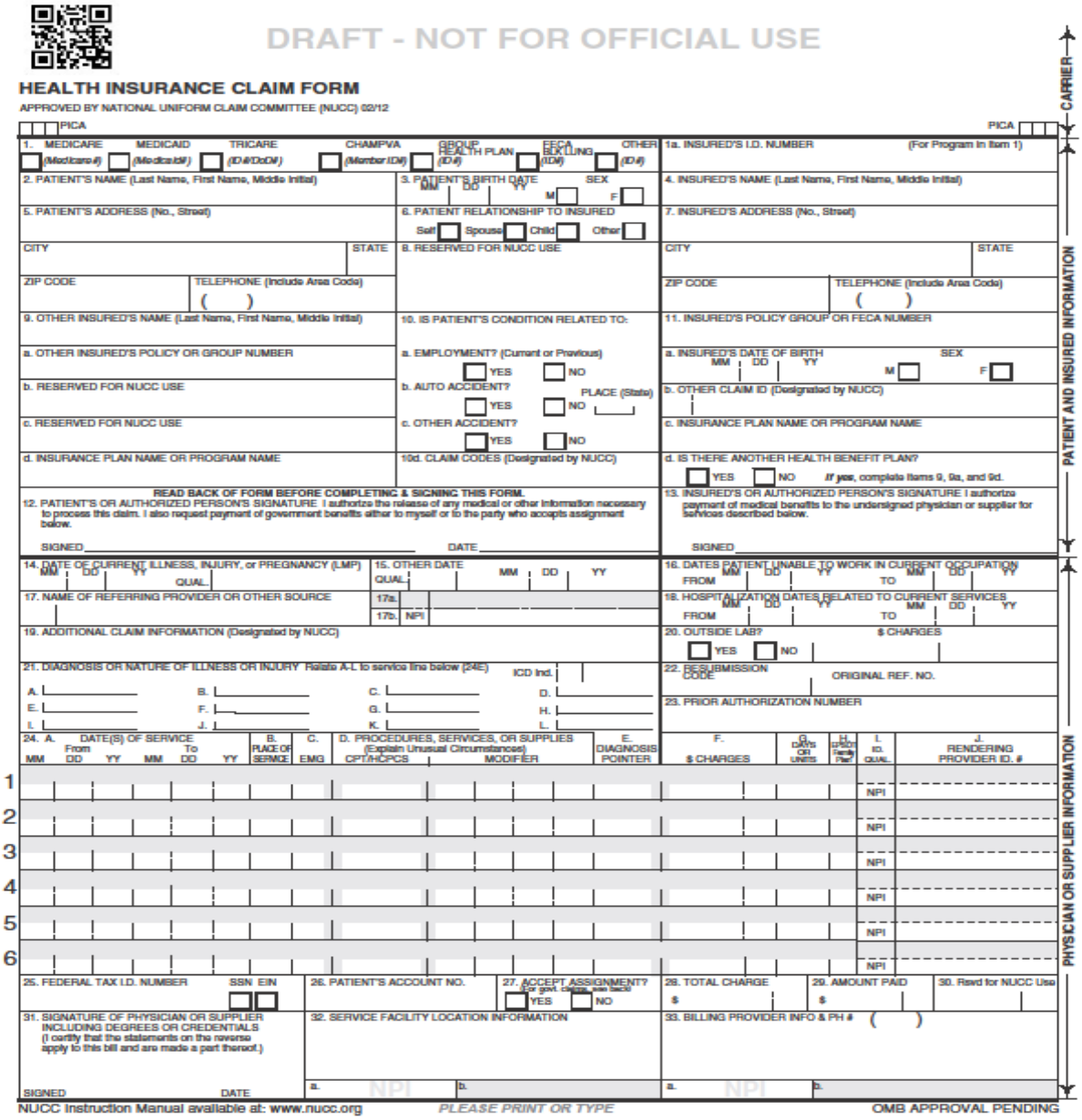
Rejected claims — those with missing or incorrect information — cannot be resubmitted. A new claim form must be generated for resubmission.

Required Fields on a CMS-1500 Claim Form

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

▶ See *Explanation of Required Fields in CMS-1500 Claim Form*, Claims Procedures, Chapter H.

Figure H1: CMS-1500 Claim Form



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 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 fields (continued)

Field #	Required Fields Explanation
17A	Referring physician's ID number—Universal Physician Identification Number (UPIN)
17B	Provider's NPI
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
25	Federal tax ID number — tax ID number of provider rendering service
26	Patient's account number — provider-specific ID number for patient (up to 12 digits)
28	Total charge — total of all charges on bill
29	Amount paid — amount paid by patient and third-party payers
30	Balance due — current balance due from insured
31	Signature of provider/supplier — should include degree or credentials (Please make sure the signature is legible.)
32	Name and address of facility — name of facility where services were rendered (if other than home or provider's office)
33	Physician's billing information — billing physician's name, address, and telephone number; also, list the PIN number (6-digit ID number assigned to the physician by UPMC Health Plan)

Required Fields on a UB-04 Claim Form

The following UB-04 claim form is standard in the insurance industry. Each field is explained in the numbered key that follows this illustration.

▶ See *Explanation of Required Fields in UB-04 Claim Form*, Claims Procedures, Chapter H

Figure H3: UB-04 Claim Form

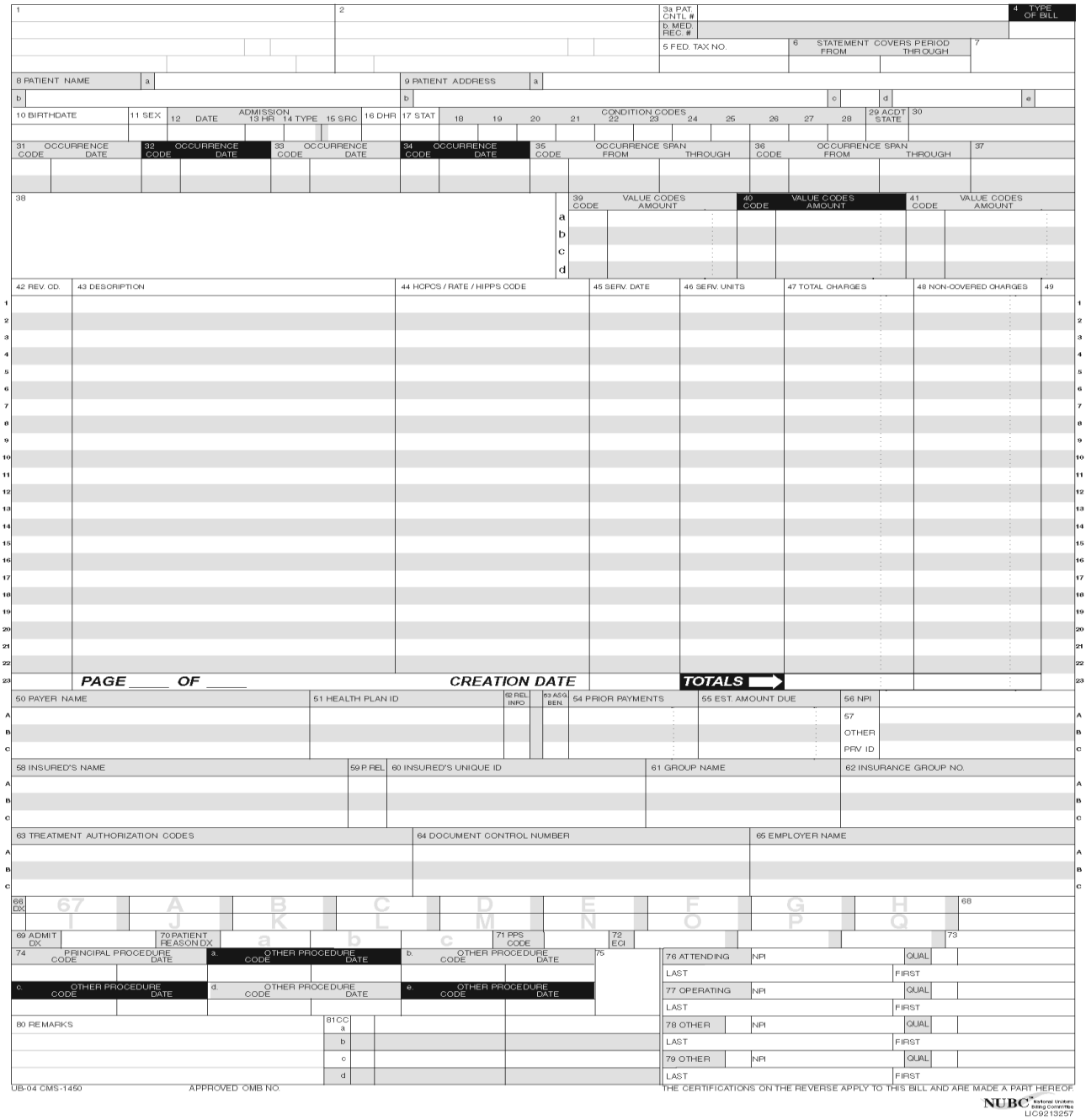


Figure H3: UB-04 Claim Form (continued)

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, 032X, 033X, 041X, 081X, or 082X	Admission/Start of Care Date	1	N	6

Figure H3: UB-04 Claim Form (continued)

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, 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 H3: UB-04 Claim Form (continued)

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
55	May be required by another payer when applicable/not required by Medicare	Estimated Amount Due - Primary	A	N	10

Figure H3: UB-04 Claim Form (continued)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
	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	National Provider Identifier (NPI) - Billing Provider	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
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
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

Figure H3: UB-04 Claim Form (continued)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
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, and 021X	Principal Diagnosis Code and Present on Admission (POA) Indicator	1	AN	8
67A-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
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
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

Figure H3: UB-04 Claim Form (continued)

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
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

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 H3: Commonly Used Place-of-Service Codes

Code	Description
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

Codes and Modifiers

Claims Coding

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.

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 and 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 **www.cms.hhs.gov/NationalCorrectCodInitEd/**.

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

▶ See *Figure H4: Coding Practices Subject to Review*, Claims Procedures, Chapter H.

Alert—Type of Service Codes for Medical Assistance Claims

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

Table H4: Coding Practices Subject to Review

	Practice	Improper Coding	Proper Coding
Fragmenting	Breaking down a multitask service and coding each task of the service or procedure separately.	The provider performs an osteotomy (bone cut) of the tibia (27705) and of the fibula (27707). Improper coding would be to report both codes (27705 and 27707).	A properly coded claim would be reported as: Osteotomy; tibia and fibula 27709 (both).
Unbundling	Reporting separate codes for related services when a single code exists to identify all of the services.	The provider reports the following three laboratory codes: 82465, 83718, and 84478.	A properly coded claim would be reported as: Lipid panel, code 80061.
Downcoding	Selecting two or more lower-level codes to identify a service that could have been identified with a single higher-level code.	The provider reports 71550 (MRI of the chest without contrast material) and 71551 (with contrast material).	A properly coded claim would be reported as: 71552 (MRI of the chest without contrast followed by contrast material).
Upcoding	Selecting a code at a higher level than was provided to obtain higher reimbursement.	The provider reports code 73080 (x-ray of elbow complete, minimum of 3 views) when only 2 views were taken.	A properly coded claim would be reported as: 73070 (x-ray of elbow 2 views).

Unlisted Codes

Procedures

When necessary and appropriate, a provider may bill for a procedure that does not have an existing CPT/HCPCS code. The provider should use the "miscellaneous" or "not otherwise classified" code that most closely relates to the service provided. When using "unlisted" or "not otherwise classified" codes for billing, providers may be asked to supply supporting documentation.

Medications

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

Modifiers

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

Table H5: Physician Modifiers

Modifier	Description
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

Table H5: Physician Modifiers (Continued)

Modifier	Description
80	Assistant surgeon
82	Assistant surgeon (when qualified resident and surgeon not available)
91	Repeat Clinical Diagnostic Laboratory Test
LT	Left Side
RT	Right Side

Table H6: Modifiers - UPMC *for You* and UPMC Community HealthChoices (Medical Assistance) only:

Modifier	Description
EP	EPSDT program service (EPSDT does not apply to UPMC Community HealthChoices)
HD	Pregnant/parenting program (used for Healthy Beginnings)
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.

Alert—Closer Look at Modifiers 33, 50, and 59

Modifier 33 - Preventive services

Modifier 33 is a newly developed CPT modifier that became effective January 1, 2011. It should be appended to codes representing preventive services under applicable laws, and the member cost sharing does not apply, unless the service is inherently preventive.

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 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

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.

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

Anesthesia Modifiers

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

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

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

Table H7: 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

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 H8: 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

Blood Draw/Venipuncture

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

Surgical Procedures

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

Reimbursement

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

For non-Medicare Products, if UPMC Health Plan fails to remit payment on a Clean Claim within forty-five (45) days of receipt of that claim, interest at ten per centum (10%) per annum shall be added to the amount owed on the Clean Claim. 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).

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

Process for Refunds or Returned Checks

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

Refunds

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

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

UPMC Health Plan
General Accounting Department
U.S. Steel Tower, 12th Floor
600 Grant Street
Pittsburgh, PA 15219

Overpayment

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

Claim Follow-Up

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

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

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

Denials and Appeals

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

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

Appeals should be submitted to:

UPMC Health Plan
Provider Appeals
P.O. 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 (FEHBP). Any person in violation of this act could be liable to the U.S. government for not less than $5,000 and not more than $10,000 per false claim, plus three times the amount of any other damages the U.S. government sustains because of the fraudulent claims.

- **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 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

Fradulent activity by a UPMC Health Plan provider or member 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.