Chapter 7: General Billing Rules

General Information

This chapter contains general information related to Health Choice Insurance Co. billing rules and requirements.

Health Choice follows the coding standards described in the *Uniform Billing Manual; Classification of Disease, (current ICD-10) Manual;* current editions of the *Physicians' Current Procedural Terminology (CPT) Manual and HCF Common Procedure Coding System (HCPCS) Manual;* the *First Data Bank Blue Book* for pharmacy information and the *Current Dental Terminology (CDT) Manual.*

National Practitioner Identification (NPI)

Effective January 23. 2004. The final rule regarding the National Provider Identifier (NPI) was published. Health Choice Insurance Co. requires NPI to be used as the healthcare provider identifier for all claim submissions starting in May 2007.

Contracted providers can submit their NPI number to the Health Choice Provider Service Representative.

To submit the NPI number, providers can mail or fax a copy of their NPI notification to:

Health Choice
Attention: Network Services
410 N. 44th St. Ste 900
Phoenix, AZ 85009
Fax: 480-303-4433

The documentation must include the provider's name and provider's signature. NPI numbers will also be accepted via written notification mailed or faxed to the address or fax number listed above.

All claims must be submitted with the NPI as applicable.

Claim Submission Requirements

Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or not submitted on the correct form will be returned to the provider without processing. If you receive a returned claim, the provider must re-file a legible copy of the claim on the correct claim form type and it must be refiled within the appropriate time frame.

Mailing Address for Paper Claims & Encounters

Mail new claims to:

Attn: Claims Department
Health Choice Insurance Co.
410 N. 44th Street, Suite 927
Phoenix, AZ 85008

Please note: Faxed claims are not accepted for processing.

Electronic Billing

Health Choice offers the ability to submit claims electronically. There are three methods by which this can be accomplished.

- Send claims directly to Health Choice via FTP or (No CD's) or secured e-mail.
- Send claims directly from your office to our clearinghouse Emdeon (formerly known as WebMD). Send claims from your clearinghouse to our clearinghouse Change Health (formerly known as Emdeon).

The Health Choice Insurance Co. payer ID number for clearing house submissions is 46221.

Claim Submission Time Frames

Health Choice adjudicates claims that include all information necessary for processing (i.e., a "clean claim") within thirty (30) days of receipt. A clean claim is defined as one that may be processed without obtaining additional information from the provider of service or from a third party. Claims that require review for medical necessity or claims that are under investigation for fraud and abuse, are not considered clean claims.

- Initial claims must be submitted within 180 days (6 months) of the last date of service (or date of discharge in the case of an inpatient stay). Initial claim submissions received outside these time limits will be denied **as exceeding timely filing limits.**
- Resubmission of a claim denied for any reason other than timeliness of submission must be received within twelve (12) months from the last date of service with the appropriate corrections or documentation. Claims that do not achieve a clean claim status within 12 months from the date of service will be denied.

General Billing Rules

Billing must follow completion of service delivery

- A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

Referring/Ordering provider information

- Providers submitting CMS Form 1500 claims; referring/ordering physician information is required in box 17a/17b when an ordering/referring provider is requesting any of the following services:
    - Laboratory
    - Radiology
    - Medical and Surgical Supplies
    - Respiratory DME
    - Enteral and Parenteral Therapy
    - Durable medical Equipment
    - Drugs (J-Codes)
    - Temporary K codes
    - Orthotics
    - Prosthetics
    - Temporary Q Codes
    - Vision Codes (V-Codes)
    - 97001-97546

An ordering/referring provider specialty that is subject to submitting this information is one of the following:

- M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

PLEASE NOTE: Claims submitted for the above mentioned services will be denied if the ordering provider is not submitted.

NDC Requirements

Providers of "Physician-Administered" Drugs:

Providers of "physician-administered" drugs include those registered providers whose license and scope of practice permits the administration of drugs, such as a medical doctor (MD), doctor of osteopathic medicine (DO), nurse practitioner (NP), physician assistant (PA), ambulatory surgery centers (ASCs), hospital outpatient clinic/services and skilled nursing facilities (SNFs).

NDC codes are required on the following code sets upon submission of the claim:

- A, C, J, Q and S codes as applicable**.**
  (Some Axxxx codes (Supplies) do not need to be submitted with NDC nor do Bxxxx, Exxxx codes as well as contrast and radiopharmaceuticals.)
- "Not otherwise classified" (NOC) and "Not otherwise specified" (NOS) drug codes (e.g., J3490, J9999, and C9399).
- CPT codes, 90281-90399 for immune globulins
- CPT Codes 90476-90749 for vaccines and toxoids

Revenue Center Codes affected:

To support the NDC claims submission requirements, the following Revenue Center Codes may require a CPT or HCPCS code for administration of the drug and reporting of the specific NDC and quantity:

- 0250-259
- 0262
- 0263
- 0331
- 0332
- 0335
- 0634-0637

In addition, providers **must** adhere to the following guidelines when submitting NDC numbers:

Required NDC elements:

- Providers **must** submit a valid 11-digit NDC **without dashes or spaces** between the numbers when billing a HCPCS drug or CPT procedure code. Claims submitted with NDCs in any other configuration may fail resulting in claim denial.
- The qualifier "N4" must be entered in front of the 11-digit NDC. The NDC will be submitted on the same detail line as the CPT/HCPCS drug procedure code in the pink shaded area.

NDC quantity to be billed and claim elements required:

NDC units are based on the numeric quantity administered to the patient and the unit of measurement. **The 11 digit NDC number, actual metric decimal quantity administered and the unit of measurement are required for billing.**

If reporting a fraction, use a decimal point. The units of measurement codes are as follows:

1. NDC of the drug administered as described above
2. NDC Unit of Measure
    - **F2** = International Unit
    - **GR** = Gram - usually for products such as ointments, creams, inhalers, or bulk (This unit of measure is typically used in the retail pharmacy setting.)
    - **ML** = Milliliter - for drugs that come in vials which are in liquid form
    - **UN** = Unit (each) - for unit of use preparations, generally those that must be reconstituted prior to administration.
3. Quantity administered equals number of NDC units
4. NDC unit price equals detail charge divided by the quantity administered

Note: Providers must also continue to submit Revenue Codes, HCPCS codes and related service units in addition to the required NDC information.

HCPCS to NDC quantity conversion examples:

Note: Payment is based on the quantity of J code units administered.

HCPCS	NDC	Quantity Conversion
J9305	00002762301	HCPCS code is per 10mg and the product comes as a dry powder injection 500mg. NDC units are “each vial” Dose was 100 mg, for example HCPCS quantity = 10 and the NDC quantity = 100/500 = 0.2 3. Enter: N400002762301 UN0.2 on the CMS-1500.
J3110	00002897101	HCPCS code is for 10mcg and the product comes as 250mcg/ml NDC units are ml Dose was 750mcg HCPCS quantity = 75 and the NDC quantity = 3 4. Enter:
J1745	57894003001	HCPCS code is for 10mg and product comes as 100mg powder for injection. NDC units are "each vial" Dose was 200mg HCPCS quantity = 20 (20 x 10mg) = 200mg and the NDC quantity is 2. This is true even if the dry powder was reconstituted to 20ml.

Paper Billing Instructions

All institutional (UB04/837I) and professional (CMS-1500/837P) claims must include the following information:

- NDC and unit of measurement for the drug billed
- HCPCS/CPT code and units of service for the drug billed
- The actual metric decimal quantity administered

UB04 Claim Form

Providers must report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field
- The NDC 11-digit numeric code, without hyphens

- The NDC Unit of Measurement Qualifier (as listed above)
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank
- The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens
- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC
- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered

UB-04 Claim Example

42. REV. CD.		43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00

CMS-1500 Claim Form

Providers must report the NDC on the CMS-1500 claim form by entering the following information:

- N Field 24A of the CMS-1500 Form in the shaded area, enter the **NDC Qualifier** of N4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column **G** (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

CMS 1500 claim example:

24. A		B	C	D		
DATE(S) OF SERVICE From To		Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		
N400074115278 ML10						
070112	070112	11		J1642		

Note: Submission of multiple NDCs per HCPCS is not allowed

Electronic Billing Instructions

837 Claims Submission for NDC: 837 Drug Identification			
Loop	Segment	Field Name	Requirement
2410	LIN02	Prod/Serv	A value of "N4" is expected.
2410	LIN03	Prod/Service ID	An 11-digit NDC number is expected and will be mapped to the CPDNDC Prod/Service ID.
2410/2400	CTP03/ SV203	Unit Price	The unit price is expected and will be mapped to CPDNDC unit price. If the unit price on segment CTP03 is different than the unit price on the SV102, then map CTP03; otherwise map SV102.
2410/2400	CTP04/ SV104	Quantity	The quantity is expected and will be mapped to CPDNDC quantity. If the unit price on segment CTP03 is different than the unit price on the SV102, then map CTP04; otherwise map SV104.
2410/2400	CTP05/ SV103	Composite Unit of Measure	The composite unit of measure is expected and will be mapped to CPDNDC composite unit of measure. If the unit price on segment CTP03 is different than the unit price on the SV203, then map CTP04; otherwise map SV103.

Note: Submission of multiple NDCs per HCPCS is not allowed.

Billing Multiple Units

- If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form with the appropriate units. The appropriate use of modifiers is strongly encouraged to avoid claim denial.
- The units field is used to specify the number of times the procedure was performed on the date of service.
- The total billed charge is the unit charge multiplied by the number of units.
- Age, gender, and frequency based service limitations.

Recoupment

Under certain circumstances, Health Choice Insurance Co. may find it necessary to *recoup* or take back money previously paid to a provider. Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments. Upon completion of the recoupment, Health Choice will send a remittance advice explaining the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the recoupment.

Resubmissions, Adjustments and Voids

Providers must resubmit requested documentation on all claims submissions. Many claim submissions do not require records.

Resubmitting a denied CMS 1500 claim or requesting adjustment to a previously paid claim:

- Write or stamp the word "resubmission" and enter the CRN (claim reference number which is found on the remittance advice) of the denied claim in the field labeled "Original Ref. No"
- Resubmit the claim in its entirety, including all original lines if the claim contained more than one line. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim

  Example: Provider submits a three-line claim. Lines 1 and 3 are paid, but Line 2 is denied.
  - When resubmitting the claim, the provider should resubmit all three lines. If only Line 2 is resubmitted, it will be determined Lines 1 and 3 were submitted in error and will be recouped.

Resubmitting a denied UB claim or requesting adjustment to a previously paid claim:

- Write the word "Resubmission" and the CRN of the denied claim in the "Remarks" field (Field 84). However, any other hand written information or corrections on the UB form is not accepted and will be denied with remark code, HU – Handwriting not allowed on UB04 and CMS 1500 Claims.
- Use the appropriate bill type to indicate a replacement claim.

Resubmitting a denied dental claim or requesting adjustment to a previously paid claim:

Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization #)

And, write or stamp the word "resubmission" on the claim

After a claim has been paid by Health Choice Insurance Co. errors may be discovered in the amounts or services that were billed. These errors may require submission of an adjustment to the paid claim.

The original CRN must be included on the claim to identify the claim being adjusted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

Overpayments

A provider must notify Health Choice of an overpayment on a claim by submitting an adjustment to the paid claim. Providers can also send a letter, copy of the claim and/or EOB to the plan indicating that an overpayment has occurred. Providers should attach documentation substantiating the overpayment.

Documentation Requirements

Medical and Dental review is performed to determine if services are provided according to the Health Choice policy related to medical necessity and emergency services. Claims may also be sent to Health Choice Medical Review when there are questions on coding, high level of care, risk issues, minimal or no authorization, etc.

In order for Medical/Dental Review to take place, providers may be required to submit specific information at the time of the claim being submitted. This documentation is necessary to allow the Health Choice Medical Review staff to determine whether services provided fall within the stated policy. If no documentation is submitted with the claim, the claim will be denied with a denial reason indicating what documentation is required. The denial codes are communicated to the provider on the remittance advice.

Additional Information

Correct reporting of all encounters and claims will assure both proper payment for services and the correct accrual of services for the computation of subsequent capitation.