



Corporate Policies and Procedures

Physician Bulletin

20000825

Subject: Claims Payment Practices Excluding Green Bay Claims	Bulletin Date: 8-25-2000
	Effective Date: 10-25-2000
Plan(s) Affected: PPO and Commercial HMO	Market: Texas

Please insert this bulletin into your Physician's Administration Manual. The policies and procedures in this bulletin supersede any related policies and procedures within the aforementioned manual.

The purpose of this bulletin is to explain the required data elements and necessary attachments for clean claims as required by House Bill (HB) 610, Texas Administrative Code 21.2801 - 21.2816. HB 610 may be accessed through the Internet at www.house.state.tx.us. This bulletin also sets out the additional information that Humana requires its physicians and providers to submit with claims.

Overview

In 1999, the Texas legislature passed HB 610 concerning prompt claims payment for services provided to enrollees of health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The Texas Department of Insurance (TDI) adopted rules to implement HB 610 effective August 1, 2000 for outpatient dates of service and inpatient confinements beginning on or after August 1, 2000.

The regulation requires HMOs and PPOs to process "clean claims" within 45 days of receipt. If the carrier is not able to pay or deny in whole or part, within 45 days of receipt, 85% of the contracted rate is paid by the carrier and the carrier may audit the physician or provider claim. The carrier must notify the provider or physician of such an audit. Upon completion of the audit, if additional payment is due a physician or provider, payment is made within 30 calendar days after the audit. If the carrier is due a refund, the provider or physician refunds the amount no later than the 30th day after the later of the date that the physician or provider receives notice of the audit results, or any appeal rights of the enrollee have been exhausted. Refunds are made according to the terms in the physician/provider agreement, which may include chargebacks against the physician or provider.

If a physician or provider submits a deficient claim, written notice must be sent to the provider or physician within 45 calendar days of receipt of the claim.

Definitions Established by the TDI

The following definitions have been established by the TDI for use in prompt payment of physician and provider claims:

- **Clean Claim** - a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured under a health insurance policy with documentation reasonably necessary for the HMO or PPO carrier to process the claim, which contains:

(A) the required data elements set forth in rule 21.2803(b) relating to Elements of a Clean Claim;

(B) the attachments of which the physician or provider has been properly notified as necessary for processing pursuant to rule 21.2803(c) relating to Elements of a Clean Claim and rule 21.2804 relating to Disclosure of Necessary Attachments;

(C) any additional elements of which the physician or provider has been properly notified pursuant to rule 21.2803(d) relating to Elements of a Clean Claim and rule 21.2805 relating to Disclosure of Additional Clean Claim Elements;

(D) the amount paid by the primary plan or other valid coverage pursuant to rule 21.2803(e) relating to Elements of a Clean Claim, if applicable; and

(E) any revised data elements, attachments, and additional clean claim elements of which the physician or provider has been properly notified pursuant to rule 21.2806 relating to Disclosure of Revision of Data Elements, Attachments, or Additional Clean Claim Elements.

- **Billed Charges** - the charges made by a physician or provider who renders or furnishes services, treatments, or supplies provided the charge is not in excess of the general level of charges made by other physicians or providers who render or furnish the same or similar services, treatments, or supplies to persons in the same geographical area and whose illness or injury is comparable in nature or severity. In the event of a case rate agreed to between the physician or provider and the HMO or PPO carrier, billed charges shall be considered the higher of the case rate or billed charges.
- **Case Rate** - a method of compensation in which a physician or provider receives one negotiated payment for all care rendered for a particular procedure or a specific diagnosis.

Required Data Elements

The TDI has defined specific data elements of the Health Care Financing Administration (HCFA) 1500 and Uniform Billing (UB-92) claim forms and necessary attachments needed to process a claim. The rules allow for an HMO or PPO to define additional data elements and necessary attachments to process a claim. The carrier is required to give the provider or physician a 60-day advance notice before implementing such requirements.

For **physicians or noninstitutional providers** using the HCFA 1500 claim form, rule 21.2803 states:

(1) Unless otherwise agreed by contract, the data elements described below are necessary for claims to be filed:

(A) subscriber's/patient's member identification (ID) number (HCFA 1500, field 1a);

(B) patient's name (HCFA 1500, field 2);

(C) patient's date of birth and gender (HCFA 1500, field 3);

(D) subscriber's name (HCFA 1500, field 4);

(E) patient's address (street or P.O. Box, City, ZIP) (HCFA 1500, field 5);

(F) patient's relationship to subscriber (HCFA 1500, field 6);

(G) subscriber's address (street or P.O. Box, City, ZIP) (HCFA 1500, field 7);

(G) subscriber's address (street or P.O. Box, City, ZIP) (HCFA 1500, field 7);

(H) whether patient's condition is related to employment, auto accident, or other accident (HCFA 1500, field 10);

(I) subscriber's policy number (HCFA 1500, field 11);

(J) subscriber's birth date and gender (HCFA 1500, field 11a);

(K) HMO or PPO carrier name (HCFA 1500, field 11c);

(L) disclosure of any other health benefit plans (HCFA 1500, field 11d);

(i) if response is "yes" that the enrollee or insured has other health benefit plans, then

(I) data elements specified in (3)(A)-(E) of this bulletin are essential unless the physician or provider submits with the claim documented proof to the HMO or PPO carrier that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured, any of the information needed to complete the data elements in (3)(A)-(E) of this bulletin.

(II) the data element specified in (3)(I) of this bulletin is essential when submitting claims to secondary payor HMOs or PPO carriers;

(ii) if response is "no" that the enrollee or insured does not have other health benefit plans, the data elements are not considered essential if the claim is accompanied by a copy of a document signed by the enrollee or insured that there is no other health care coverage.

(M) patient's or authorized person's signature or notation that the signature is on file with the physician or provider (HCFA 1500, field 12);

(N) subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (HCFA 1500, field 13);

(O) date of current illness, injury, or pregnancy (HCFA 1500, field 14);

(P) first date of previous same or similar illness (HCFA 1500, field 15);

(Q) diagnosis codes or nature of illness or injury (HCFA 1500, field 21);

(R) date(s) of service (HCFA 1500, field 24A);

(S) place of service code (HCFA 1500, field 24B);

(T) type of service code (HCFA 1500, field 24C);

(U) procedure/modifier code (HCFA 1500, field 24D);

(V) diagnosis code by specific service (HCFA 1500, field 24E);

(W) charge for each listed service (HCFA 1500, field 24F);

(X) number of days or units (HCFA 1500, field 24G);

(Y) physician's or provider's federal tax identification (ID) number (HCFA 1500, field 25);

25);

(Z) total charge (HCFA 1500, field 28);

(AA) signature of physician or provider or notation that the signature is on file with the HMO or PPO carrier (HCFA 1500, field 31);

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(BB) name and address of facility where services were rendered (if other than home or office) (HCFA 1500, field 32); and

(CC) physician's or provider's billing name and address (HCFA 1500, field 33).

For **institutional providers** using the UB-92 claim form, rule 21.2803 states:

(2) Unless otherwise agreed by contract, the data elements described below are necessary for claims to be filed:

- (A) provider's name, address, and telephone number (UB-92, field 1);
- (B) patient control number (UB-92, field 3);
- (C) type of bill code (UB-92, field 4);
- (D) provider's federal tax ID number (UB-92, field 5);
- (E) statement period (beginning and ending date of claim period) (UB-92, field 6);
- (F) patient's name (UB-92, field 12);
- (G) patient's address (UB-92, field 13);
- (H) patient's date of birth (UB-92, field 14);
- (I) patient's gender (UB-92, field 15);
- (J) patient's marital status (UB-92, field 16);
- (K) date of admission (UB-92, field 17);
- (L) admission hour (UB-92, field 18);
- (M) type of admission (e.g. emergency, urgent, elective, newborn) (UB-92, field 19);
- (N) source of admission code (UB-92, field 20);
- (O) patient-status-at-discharge code (UB-92, field 22);
- (P) value code and amounts (UB-92, fields 39-41);
- (Q) revenue code (UB-92, field 42);
- (R) revenue description (UB-92, field 43);
- (S) units of service (UB-92, field 46);
- (T) total charge (UB-92, field 47);
- (U) HMO or PPO carrier name (UB-92, field 50);

(U) HMO or PPO carrier name (UB-92, field 50);

(V) subscriber's name (UB-92, field 58);

(W) patient's relationship to subscriber (UB-92, field 59);

(X) patient's/subscriber's certificate number, health claim number, ID number (UB-92, field 60);

(Y) principal diagnosis code (UB-92, field 67);

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(Z) attending physician ID (UB-92, field 82);

(AA) signature of provider representative or notation that the signature is on file with the HMO or PPO carrier (UB-92, field 85); and

(BB) date bill submitted (UB-92, field 86).

(3) Unless otherwise agreed by contract, the data elements listed below are necessary for claims filed by physicians or providers, if circumstances exist which render the data elements applicable to the specific claim being filed. The applicability of any given data element contained below is determined by the situation from which the claim arose.

(A) other insured's or enrollee's name (HCFA 1500, field 9) is applicable if patient is covered by more than one health benefit plan, generally in situations described in (3)(E) of this bulletin. If the essential data element specified in (1)(L) of this bulletin is answered yes, this is applicable unless the physician or provider submits with the claim documented proof to the HMO or PPO carrier that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(B) other insured's or enrollee's policy/group number (HCFA 1500, field 9a) is applicable if patient is covered by more than one health benefit plan, generally in situations described in (3)(E) of this bulletin. If the essential data element specified in (1)(L) of this bulletin is answered yes, this is applicable unless the physician or provider submits with the claim documented proof to the HMO or PPO carrier that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(C) other insured's or enrollee's date of birth (HCFA 1500, field 9b) is applicable if patient is covered by more than one health benefit plan, generally in situations described in (3)(E) of this bulletin. If the essential data element specified in (1)(L) of this bulletin is answered yes, this is applicable unless the physician or provider submits with the claim documented proof to the HMO or PPO carrier that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(D) other insured's or enrollee's plan name (employer, school, etc.) (HCFA 1500, field 9c) is applicable if patient is covered by more than one health benefit plan, generally in situations described in (3)(E) of this bulletin. If the essential data element specified in (1)(L) of this bulletin is answered yes, this is applicable unless the physician or provider submits with the claim documented proof to the HMO or PPO carrier that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

complete this data element;

(E) other insured's or enrollee's HMO or insurer name (HCFA 1500, field 9d) is applicable if patient is covered by more than one health benefit plan, generally in situations described in (3)(E) of this bulletin. If the essential data element specified in (1)(L) of this bulletin is answered yes, this is applicable unless the physician or provider submits with the claim documented proof to the HMO or PPO carrier that the physician or provider has made a good faith but unsuccessful attempt to obtain from the enrollee or insured any of the information needed to complete this data element;

(F) subscriber's plan name (employer, school, etc.) (HCFA 1500, field 11b) is applicable if the health benefit plan is a group plan;

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(G) prior authorization number (HCFA 1500, field 23) is applicable when prior authorization is required;

(H) whether assignment was accepted (HCFA 1500, field 27) is applicable when assignment under Medicare has been accepted;

(I) amount paid (HCFA 1500, field 29) is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan in accordance with (1)(L) of this bulletin and as required by (3)(E) of this bulletin;

(J) balance due (HCFA 1500, field 30) is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber;

(K) covered days (UB-92, field 7) is applicable if Medicare is a primary or secondary payor;

(L) noncovered days (UB-92, field 8) is applicable if Medicare is a primary or secondary payor;

(M) coinsurance days (UB-92, field 9) is applicable if Medicare is a primary or secondary payor;

(N) lifetime reserve days (UB-92, field 10) is applicable if Medicare is a primary or secondary payor, and the patient was an inpatient;

(O) discharge hour (UB-92, field 21) is applicable if the patient was an inpatient, or was admitted for outpatient observation;

(P) condition codes (UB-92, fields 24-30) is applicable if the HCFA UB-92 manual contains a condition code appropriate to the patient's condition;

(Q) occurrence codes and dates (UB-92, fields 31-36) is applicable if the HCFA UB-92 manual contains an occurrence code appropriate to the patient's condition;

(R) occurrence span code, from and through dates (UB-92, field 36) is applicable if the HCFA UB-92 manual contains an occurrence span code appropriate to the patient's condition;

(S) HCPCS/Rates (UB-92, field 44) is applicable if Medicare is a primary or secondary payor;

(T) prior payments - payer and patient (UB-92, field 54) is applicable if payments

(T) prior payments - payor and patient (UB-92, field 54) is applicable if payments have been made to the physician or provider by the patient or another payor or subscriber, on behalf of the patient or subscriber, or by a primary plan as required by (3)(E) of this bulletin;

(U) diagnoses codes other than principle diagnosis code (UB-92, fields 68-75) is applicable if there are diagnoses other than the principle diagnosis;

(V) procedure coding methods used (UB-92, field 79) is applicable if the HCFA UB-92 manual indicates a procedural coding method appropriate to the patient's condition;

(W) principal procedure code (UB-92, field 80) is applicable if the patient has undergone an inpatient or outpatient surgical procedure; and

(X) other procedure codes (UB-92, field 81) is applicable as an extension of (3)(W) of this bulletin, if additional surgical procedures were performed.

Note: The required elements of a clean claim must be complete, legible, and accurate.

Note: HCFA 1500, field 11d - if response is no and UB-92 fields 50 a-c are left blank, Humana requires a copy of a document, every six months, signed by the enrollee or insured to verify that he/she has no other health care insurance. It is not necessary to submit this information with every claim. A *Coordination of Benefits Questionnaire* may be used to help you when obtaining this information. A sample of the questionnaire is shown in this bulletin. You are not required to use this questionnaire.

Additional Data Elements Required by Humana

Additional data elements that are required by Humana are as follows:

(A) Outpatient surgical centers claims filed on a UB-92 - claims must be billed with a CPT procedure code in box 44.

(B) Authorizations - when a claim is filed on a UB-92, field 63 - Treatment Authorization Codes must contain the approved authorization for inpatient or outpatient services, if applicable.

(C) CPT code 99070 - must have a description in field 24 D of a HCFA 1500 form.

(D) Injections - claims submitted with injections must have an NDC # in field 24D of a HCFA 1500 form.

(E) Facility with contractual reimbursement based on DRG codes - the DRG code must be listed in field 78 of a UB-92 form.

(F) Anesthesia claims - total time should be converted to minutes and entered in field 24G on the HCFA 1500 form.

(G) HMO claims - HCFA 1500 field 23 must contain the approved authorization for inpatient or outpatient services, if applicable.

Additional Attachments Required by Humana

Additional attachments that are required by Humana are as follows:

- (A) Dump codes and codes ending in 99 - procedure report or office notes must be submitted.
- (B) Trigger point injections (CPT 20550) - procedure report or office notes must be submitted.
- (C) If your contract contains a provision for calculation of payment based upon a specific dollar threshold, an itemized bill must be submitted.
- (D) Accidental dental claims submitted on a HCFA 1500 must include an ADA form and ADA codes.
- (E) Claims submitted for surgeon and assistant surgeon under the same tax ID number - procedure report or office notes must be submitted.
- (F) Co-surgeon claims - procedure report or office notes must be submitted.
- (G) PPO mental health claims - repricing sheet must be submitted.

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(H) Claims submitted with the following modifiers must include a procedure report or office notes:

-22 Unusual Procedural Services - provider is indicating that although he/she has performed a procedure it was difficult or took longer than usual and he/she wants additional monies. Humana need the procedure report or office notes to verify; i.e., "the patient was extremely obese making the incision and removal difficult and time consuming."

-24 and -79 Unrelated Evaluation and Management or Procedure Service by same Physician during a Postoperative Period - the physician may see the member during a global surgical period; i.e., the member had eye surgery on Friday and is scheduled for a surgical follow-up on the following Friday. On Monday, the member called the surgeon with complaint of vomiting and headaches. The surgeon sees the member that day and determines the member has the flu. These symptoms are not related to the surgery, but the visit was during the global period. Humana needs office/procedure notes for that date of service to determine distinct service that would not fall under global surgical. For modifier 79, maybe a post-op infection occurred and incision and drainage are needed. This is not normally surgical surgical follow-up.

-62 Two Surgeons - two surgeons of different fields work together on one area and bill as co-surgeons; i.e., an orthopedic and neurosurgeon work together on a herniated disk and spinal fusion. The neurosurgeon will cut away the herniated area near the spinal cord and the orthopedic surgeon will graft and fuse the spine together. The operative/procedure notes are needed for the date of service on **both** surgeons to determine exactly who did what and make sure the procedure is eligible for co-surgeon billing.

-59 Distinct Procedural Service - identify distinct service that is unrelated to other services performed by the same physician. For example: the physician was performing a routine appendectomy laporoscopically when he visualized a pair of clamps inside the patient's lower abdomen and removes the clamps. This extra procedure, removal of foreign object from

ne visualized a pair of clamps inside the patient's lower abdomen and removes the clamps. This extra procedure, removal of foreign object from abdomen, is not related to the appendectomy. Humana would need the procedure notes to determine that it is distinct from the primary procedure performed.

-76 Repeat Procedure by Same Physician - The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service.

(I) A copy of the explanation of benefits from the primary carrier if Humana is the secondary carrier.

(J) Algucerase (HCPCS J0205) - medical records must be submitted.

(K) Epoetin (Epogen, Procrit) - (HCPCS Q0136 & Q9920 - Q9940) The initial claim must include the following documentation:

- hematocrit level and date of testing
- patient's weight
- dose given.

Subsequent claims for epoetin must include:

- the most recent hematocrit and date of testing.

Claim Submissions

Claims should be submitted to the address on the member's identification card unless you have been instructed, in writing, by Humana or an independent physician association (IPA) to submit claims to a different address.