COMPLETE CLAIM DEFINITION

A complete claim is a claim, or portion of a claim that is submitted on a complete format adopted by the National Uniform Billing Committee and which includes attachments and supplemental information or documentation that provide reasonably relevant information or information necessary to determine payer liability.

IMPORTANT NOTE: We require that all facility claims be billed on the UB-04 form.

We use the ***National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual*** as the standard source for codes and code descriptions to be entered in the various form locators (FL). National Uniform Billing Committee's *UB-04 Data Specifications Manual,* is available at www.nubc.org**.**

CODING
Correct coding is key to submitting valid claims. To ensure claims are as accurate as possible, use current valid diagnosis, procedure codes, and modifier codes and code them to the highest level of specificity (maximum number of digits) available.

Diagnosis Coding
The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), is currently used to code diagnostic information on claims. Multiple entities publish ICD-10-CM manuals and the full ICD-10-CM is available for purchase from the AMA Bookstore on the Internet.

Procedure Coding
Use Healthcare Common Procedure Coding System (HCPCS) Level I and II codes to indicate procedures on all claims, except for inpatient hospitals. ICD-10-CM codes are used for procedure coding on inpatient hospital Part A claims.

For all other uses, Level I Current Procedural Terminology (CPT-4) codes describe medical procedures and professional services. CPT is a numeric coding system maintained by the AMA. The CPT code book is available from the AMA Bookstore on the Internet.

CLAIMS SUBMISSION INFORMATION INSTRUCTIONS

Mandatory Items for Claims Submission

All institutional claims require the following mandatory items:

- Bill on a UB-04 form
    - Consolidated Billing: All charges for the patient stay should be included on the same bill, this includes therapy/treatment and ancillary services. Do not split bills by type of service or submit separate bills for overlapping dates of service for a component of treatment, including substance abuse toxicology testing.
- Type of Bill - Enter the appropriate three- or four-digit code that indicates the type of bill you are submitting. The type of bill code used must correspond to the facility, Medicare certification and state license held by the billing entity.

    - Original submission is indicated with a 1 in claim frequency box or resubmission code (box 22).
    - Codes 7 and 8 should be used to indicate a corrected, void or replacement claim with the original claim ID, if available.
- Billing provider tax identification number (TIN), address and phone number.
- Billing provider National Provider Identifier (NPI).
- Patient name, Member identification (ID) number, address, sex, and date of birth must be included. If the subscriber is also the patient, only the subscriber data needs to be submitted. If different, then submit both subscriber and patient information.
- Employer group number: The number assigned to the subscriber's employer group located on the member's ID card.
- UPIN or state license number: Six-digit universal provider identification number (UPIN) or state license number of all attending providers.
    - When billing for more than one attending provider, indicate each UPIN on the appropriate detail line.
    - For physicians, the state license number should be entered as a seven-digit number "A0nnnnn." When "a" is the alpha character shown on the state license (A, C, G), "0" is the filler zero and "nnnnn" are the five numeric characters in the state license number.
    - All other providers use their state-assigned license number without modifications
- Other health insurance information and other payer payment, if applicable.
- Patient or subscriber medical release signature/authorization.
- Referring provider name and NPI.
- Rendering/attending provider NPI (only if it differs from the billing provider) and authorized signature.
- Primary diagnosis code and all additional diagnosis codes (up to 24 for institutional) with the proper ICD indicator (only ICD 10 codes are applicable for claims with dates of service on and after October 1, 2015).
- Diagnosis codes, revenue codes, CPT, HCPCS, modifiers, or HIPPS codes that are current and active for the date of service. Claims with incomplete coding or having expired codes will be contested.
    - **Revenue Code** – Enter the appropriate four-digit code that identifies the specific accommodation and specific ancillary services billed. Bills should use revenue codes to indicate the accommodation code and the specific therapy/ancillary services provided on each date of service. For outpatient, there must be date specific, line item specific detail on the bill, meaning, that each service on each date of service must be documented with the appropriate revenue code. Additionally, revenue codes used should correspond to the facility Medicare certification and state license.
    - **Procedure Code** – Enter the appropriate HCPCS procedure code and all applicable modifiers. All claims must specify the corresponding service provided to the patient on each day of service. This should include the number of units provided on each date of service.
- Authorization, if applicable, should be sent in the 2300 Loop, REF segment with a G1 qualifier for electronic claims (box 63 for UB-04).
- Referral information, if applicable.

- Inpatient institutional claims must include admit date and hour and discharge hour (where appropriate), as well as any Present on Admission (POA) indicators, if applicable.
- Admission type code for inpatient claims.
- Admitting diagnosis required for inpatient claims.
- Outpatient claims must include a reason for visit.
- Statement from and through dates for inpatient.
- Service line date required for outpatient procedures.
- National Drug Code (NDC) for drug claims as required.
- Universal product number (UPN) codes as required.
- Accommodation code is submitted in Value Code field with qualifier 24, if applicable.
- Share of cost is submitted in Value Code field with qualifier 23, if applicable.
- Charges for listed services and total charges for the claim.
    - **Itemization** – There must be a single line item date of service for every revenue code on all bills. If a particular service is rendered five times during the billing period, the revenue code and HCPCS code must be entered five times, once for each service date.
    - **Billed Charges**: – The provider's billed charges for each component of the claim should be listed separately. The charges must identify the accommodation charges (where applicable) and the charge for each service.
    - **Non-covered services** must be identified using revenue code 099X, include a description of the non-covered service and the corresponding charge for that service. Non-covered services include services, such as peer-led groups (for example AA meetings), and other items, such as massage therapy, surfing/gym/exercise activities, luxury facility items, such as fine linens, hot tubs, whirlpool bath tubs, private rooms.
- Days or units.
- Name and address of service location.

This is not meant to be a fully inclusive list of claim form elements. Additional fields may be required, depending on the type of claim, line of business and/or state regulatory submission guidelines.

To avoid possible denial or delay in processing, the above information must be correct and complete.

Specific Billing Requirements

- **Ambulatory/outpatient surgery claim:** If implantable devices are included on the claim, one of the following must be submitted for each implant billed on the claim form:
    - Copy of the manufacturer invoice; or
    - Copy of the medical record's implant log
- **Coordination of benefits (COB):** When we are the secondary payer; the provider must submit the claim and a copy of the explanation of medical benefits/explanation of benefits (EOMB/EOB) from the primary carrier to Health Net for payment consideration.
- **Drug testing – Dates of service on and after January 1, 2017:** We follow the Centers for Medicare & Medicaid Services (CMS) coding guidelines for reporting drug testing

procedures as outlined in the 2017 CMS Clinical Laboratory Fee Schedule (CLFS) Final Determinations document posted on the CMS website (CMS8).

ONLY ONE PRESUMPTIVE AND ONE DEFINITIVE TEST MAY BE BILLED PER DAY, WITH A MAXIMUM OF THREE EACH PER WEEK.

- **Presumptive Drug Testing Codes**
  - **Code: 80305** – Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (such as immunoassay) capable of being read by direct optical observation only (for example, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
  - **Code: 80306** – Drug test(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures, (such as immunoassay) read by instrument assisted direct optical observation (for example, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
  - **Code: 80307** – Drug test(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures by instrument chemistry analyzers (such as utilizing immunoassay [for example EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (such as GC, HPLC), and mass spectrometry either with or without chromatography, (such as DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF), includes sample validation when performed, per date of service.
- **Definitive Drug Testing Codes:**
  - **Code: G0480** – Drug test(s), definitive, utilizing: 1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (such as IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (for example alcohol dehydrogenase)), 2) stable isotope or other universally recognized internal standards in all samples (such as to control for matrix effects, interferences and variations in signal strength), and 3) method or drug-specific calibration and matrix-matched quality control material (such as to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1–7 drug class(es), including metabolite(s) if performed.
  - **Code: G0481** – Drug test(s), definitive, same as above; 8–14 drug class(es).
  - **Code: G0482** – Drug test(s), definitive, same as above; 15–21 drug class(es).
  - **Code: G0483** – Drug test(s), definitive, same as above; 22 or more drug class(es).
  - **Code: G0659** – Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (such as IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (for example alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes.

- **Injectable medications:** When billing for injectable medications, list appropriate HCPCS code identifying medication name, NDC number, strength, dosage, and method of administration.
- **Lab collection fee:** A collection and handling fee may only be billed for laboratory work sent to an outside laboratory. The name of outside laboratory and tests performed must be entered on claim form.
- **Multiple diagnoses:** Indicate specific diagnosis for each procedure billed.
- **Sigmoidoscopy:** Claims must include the length of the exam in centimeters. If the exam is over 35 centimeters, include modifier -22 (no report is required).
- **Trauma:** When billing a claim or itemization that is stamped trauma or with revenue code 208, an emergency room (ER) and Trauma Team Activation sheet/report must be attached to the claim.