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SECTION 10: CLAIMS SUBMISSION

CLAIMS MANAGEMENT

A key component of quality health care is accurate, timely and efficient claims processing. HPSJ utilizes recognized industry standard billing codes and guidelines in the processing of paper and electronic claims.

MEMBER BILLING

As a Medi-Cal plan, many of the same rules that apply to Medi-Cal fee-for-service apply to HPSJ. If the services provided are Covered Services, then HPSJ's reimbursement to Provider constitutes full payment and the Member cannot be balance billed for these services. In addition, neither co-pays nor deductibles are permitted in Medi-Cal.

If a Member is willing to compensate a Provider for a non-covered service and the Provider is willing to accept a negotiated payment between the parties, that agreement is considered outside of Medi-Cal and thus outside the supervision of HPSJ. However, the service must clearly not be for a Covered Service or covered benefit under Medi-Cal.

Violation of the Medi-Cal or HPSJ payment rules could result in the immediate termination of the Provider's Agreement.

REQUIREMENTS FOR A COMPLETE CLAIM

A Complete Claim is a complete and accurate claim form that includes all Provider and Member information, as well as Members records, information, or documents needed to enable HPSJ to process the claim. The Complete Claim date is the date on which all such required information has been received.

CLAIMS AND PAYMENT TIMELINES

The timely filing guideline for HPSJ claims is three hundred and sixty-five (365) days from the date of service. If a claim is not submitted within the appropriate time frame, the claim will be denied unless disputed pursuant to C.C.R. Section 1300.71.38 and a good cause for delay can be presented. Requests for a claims adjustment, corrections, or reconsideration of an adjudicated claim must also be received no later than three hundred sixty-five (365) days following the date of payment or denial of the claim.

Extenuating circumstances causing delay would include but not be limited to:

- A catastrophic event that substantially interferes with normal business operations of the Provider
- Administrative delays or errors by HPSJ or the California Department of Health Care

Services (DHCS) and/or the California Department of Managed Care (DMHC)

- Other special circumstances reviewed and approved by HPSJ

Consideration will be given for extenuating circumstances provided that complete documentation is submitted to HPSJ justifying the delay.

ADVANTAGES OF ELECTRONIC CLAIMS SUBMISSION

To submit claims electronically Providers must establish an account with *Office Ally* or *Emdeon*. Please contact one of these vendors to set up electronic claims submission, using the contact numbers listed in the table. For assistance in setting up the account with either vendor, contact the Provider Services Department at (209) 942-6340.

Submitting claims electronically has substantial benefits including:

- **Expedited claims processing:** Electronic submission allows HPSJ to begin adjudicating claims faster than if the claim is submitted by paper.
- **Cost effectiveness:** Electronic submission eliminates the cost of purchasing billing forms, envelopes and postage.
- **Claims Submission Confirmation:** Electronic submission provides fast electronic confirmation of a claim submission from the clearinghouse.

CLAIM FORMS AND CLAIM SUBMISSIONS

Claims can be submitted in either paper form or electronically. The standard forms accepted are Form 1500 (formerly CMS 1500), UB04, and any successors to these forms. HPSJ will acknowledge the receipt of electronic claims within two (2) Working Days of receipt and acknowledge receipt of paper claims within fifteen (15) Working Days.

Before filing a claim, be sure to verify the Member's eligibility (see Eligibility Verification, Enrollment, and Customer Service section). Our clearinghouse vendors for electronic claims submission are *Emdeon* and *Office Ally*. Information on where to file claims is indicated below:

Paper Claims for HPSJ	Electronic Claims	Claims Disputes
HPSJ PO BOX 30490 Stockton, CA 95213-0490	**Office Ally** (866) 575-4120 info@officeally.com Payer ID: HPSJ1 **Emdeon** (877) 469-3263 Payer ID: 68035	HPSJ PO BOX 30490 Stockton, CA 95213- 0490

SECTION 10: CLAIMS SUBMISSION

CLAIMS FORMS AND REQUIRED FIELDS FOR FORM 1500

Form 1500 Formerly CMS 1500			
BOX #	**FIELD NAME**	**INSTRUCTIONS**	**REQUIRED (Y, N)**
1	MEDICAID/ MEDICARE/ OTHER ID	For Medi-Cal, enter an "X" in the Medicaid box. Billing Tip: If billing Medicare crossover, there is no need to submit a paper/electronic claim. HPSJ receives crossover claims from CMS.	N
1a	INSURED'S ID NUMBER	Enter the recipient's ID number from the HPSJ Identification Card. **NOTE:** When submitting a claim for a newborn infant under the mother's eligibility, use the newborn infants HPSJ ID number. This number is available 24-48 hours after receipt of the newborn face sheet. **Billing Tip:** Use the HPSJ Portal to verify that the recipient is eligible for the services rendered.	Y
2	PATIENT'S NAME	Enter the recipient's last name, first name and middle initial (if known). A comma is required between recipient's last name, first name and middle initial (if known). **Billing Tip: Newborn Infant:** When submitting a claim for a newborn infant under the mother's eligibility, use the mother's last name followed by BABY BOY or BABY GIRL. Avoid nicknames or aliases.	Y
3	PATIENT'S BIRTH DATE (MM/DD/CCYY) and SEX	Enter the recipient's date of birth in six-digit MMDDYY format (month, day, year). If the recipient is 100 years or older, enter the recipient's age and the full four-digit year of birth in Box 19. Enter an "X" in the M or F box. **Billing Tip**: **Newborn Infant:** Enter the infant's sex and date of birth in Box 3.	Y
4	INSURED'S NAME	Not Required.	N
5	PATIENT'S ADDRESS	Enter the recipient's complete address and telephone number.	Y
6	PATIENT'S RELATIONSHIP TO INSURED	Not Required.	Y
9	OTHER INSURED'S NAME	This field should only be used when the primary insurance is Medicare or private and the policy holder's name differs from the patient's name.	Y
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	This field should only be used when the primary insurance is Medicare or private.	Y
9d	INSURED PLAN NAME OR PROGRAM NAME	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
10a, b or c	PATIENT'S CONDITION	Complete this field if services were related to an accident or injury. Enter an "X" in the Yes box if accident/injury is employment related. Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the Date of Current Illness, Injury or Pregnancy field (Box 14).	Y
11	INSURED'S POLICY GROUP OR FECA NUMBER	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	N

SECTION 10: CLAIMS SUBMISSION

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
11a	INSURED'S DATE OF BIRTH	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	Y
11c	INSURANCE PLAN NAME OR PROGRAM NAME	Complete this field if patient has Other Health Coverage (OHC) as primary. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, providers must bill the recipient's other health coverage prior to billing Medi-Cal Managed Care Plan (MCP). Eligibility under Medicare is not considered OHC.	N
11d	ANOTHER HEALTH PLAN BENEFIT	Enter an "X" in the Yes box if the recipient has Other Health Coverage (OHC). Enter the amount paid (without the dollar or decimal point) by the other health insurance in the right side of Box 11d. **Billing Tip:** Medi-Cal guideline requires that, with certain exceptions, providers must bill the recipient's other health coverage prior to billing Medi-Cal. Eligibility under Medicare is not considered OHC.	N
14	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP)	Enter the date of the onset of the recipient's illness, the date of accident/injury or the date of the Last Menstrual Period (LMP).	Y
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Enter the name of the referring provider in this box. When the referring provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the NMP must be entered. However, the NPI of the supervising physician needs to be entered in box 17b, below.	Y
17b	NPI (OF REFERRING PHYSICIAN)	Enter the 10-digit NPI. The following providers must complete Box 17 and Box 17b: Audiologist, Clinical laboratory (services billed by laboratory), Durable Medical Equipment (DME) and medical supply, Hearingaid dispenser, Nurse anesthetist, Occupational therapist, Orthotist, Pharmacy, Physical therapist, Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B, Portable imaging services, Prosthetist, Radiologist, Speech pathologist	Y
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.	Y
19	ADDITIONAL CLAIM INFORMATION	Use this area for procedures that require additional information, justification or an Emergency Certification Statement. **Billing Tip:** "By Report" codes, complicated procedures, modifier breakdown, unlisted services and anesthesia time require attachments. If the rendering provider is an NP/PA or locum, there last name, first name and NPI should be documented in this field (for informational purposes only). Box 19 may be used if space permits. Please do not staple attachments.	Y
20	OUTSIDE LAB	If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X." Outside laboratory refers to a lab not affiliated with the billing provider. Indicate in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank, if not applicable.	Y

SECTION 10: CLAIMS SUBMISSION

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
21a-l	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter all letters and/or numbers of the ICD-10-CM (or latest version) diagnosis code, diagnosis code(s) should be in order of severity/illness presented, include fourth through seventh characters, if present. (Do not enter decimal point.) Relate A-L to service line(s) below (24e).	Y
22	RESUBMISSION CODE	Use to identify a corrected claim and add the original claim number when possible. In all other circumstances, these codes are optional.	Y
23	PRIOR AUTHORIZATION NUMBER	Use for HPSJ authorization number. **Billing tip:** Only one authorization number can cover services billed on any one claim.	Y
24a	DATE(S) OF SERVICE	Enter the date the service was rendered in the From and To boxes in the six-digit, MMDDYY (month, day, year) format in the unshaded area. When billing for a single date of service, enter the date in From box in Field 24A.	Y
24b	PLACE OF SERVICE	Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered. **Billing Tip:** The national Place of Service codes are listed in the CMS-1500 Completion section (cms comp) of the Medi-Cal Provider Manual, Part 2.	Y
24c	EMG	Emergency Code: Only one emergency indicator is allowed per claim and must be placed in the bottom-unshaded portion of Box 24C. Leave this box blank unless billing for emergency services.	Y
24d	PROCEDURES, SERVICES OR SUPPLIES/MODIFIER(S)	Enter the appropriate procedure code (CPT-4 or HCPCS) and modifier(s). For additional information on how to bill modifiers, please refer to the Medi-Cal Provider Manual. **Billing Tip:** The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple National Correct Coding Initiative (NCCI)-associated modifiers on the same claim line. If necessary, the procedure description can be entered in the Additional Claim Information field (Box 19). **Billing Tip:** Do not submit a National Correct Coding Initiative (NCCI)-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted.	Y
24e	DIAGNOSIS POINTER	Use the diagnosis designations (A-L) listed in field 21, as the reference pointers in this field. The primary reason (primary diagnosis) for the service must be the first diagnosis pointer listed in the field. Use multiple pointers for secondary diagnoses related to the service line, if appropriate.	Y
24f	$ CHARGES	In the unshaded area of the form, enter the usual and customary fee for service(s) in full dollar amount. Do not enter a decimal point (.) or dollar sign ($). For example, $100 should be entered as “10000.”	Y
24g	DAYS OR UNITS	Enter the number of medical “visits” (days) or procedures, surgical “lesions,” units of anesthesia time, items or units of service, etc. The field permits entries up to 999 in the unshaded area. **Billing Tip:** Providers billing for units of time should enter the time in 15-min increments. For example, one hour should be entered as “4.”	Y

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
24h	EDSDT FAMILY PLANNING	Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave	Y
24j	RENDERING PROVIDER ID#	Enter the NPI for a rendering provider (unshaded area) if the provider is billing under a group NPI. **Billing Tip:** If the rendering provider is an NP/PA or locum, enter the supervising physicians NPI in this field.	Y
25	FEDERAL TAX ID#	Enter the Rendering/Supervising physicians Federal Tax ID in this field.	Y
26	PATIENT'S ACCOUNT NUMBER	Field use for provider's unique patient account number.	N
27	ACCEPT ASSIGNMENT	"Yes" or "No" entry is required.	Y
28	TOTAL CHARGE	Enter the full dollar amount for all services without the decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000." **Billing Tip:** If billing more than 1 claim form (or more than 6 lines) only enter total charge on the last claim form.	Y
29	DOLLAR AMOUNT	Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient's Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($). **Billing Tip:** Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare EOMB/MRN/RA when submitted with the claim.	Y
31	SIGNATURE OF PHYSICIAN OR SUPPLIER	The claim must be signed and dated by the provider or a representative assigned by the provider, in black ballpoint pen only. **Billing Tip:** If the rendering physician/provider is PA/NP or locum, enter the supervising physicians name in this field. Signatures must be written, not printed and should not extend outside the box. Stamps, initials or facsimiles are not accepted.	Y
32	SERVICE FACILITY LOCATION INFORMATION	Enter the provider name. Enter the provider's address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. **Billing Tip:** Use the name and address of the facility where the services were rendered if other than a home or office.	Y
32a	SERVICE FACILITY NPI	Enter the NPI of the facility where the services were rendered.	Y
33	BILLING PROVIDER INFORMATION AND PHONE NUMBER	Enter the provider name. Enter the provider address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. Enter the telephone number.	Y
33a	BILLING PROVIDER NPI	Enter the billing provider's NPI.	Y

SECTION 10: CLAIMS SUBMISSION

CLAIMS SUBMISSION NOTIFICATION

Upon submission of a Complete Claim, payment or denial will be made within forty-five (45) Working Days. HPSJ shall notify Providers in writing no later than forty-five (45) Working Days after receipt of a claim by HPSJ if HPSJ intends to contest or deny the claim. The notice will identify the portion of the claim that is contested and the specific reason HPSJ is contesting the claim. If the claim is contested because HPSJ has not received the information necessary to determine HPSJ liability for the claim, then Providers will have forty-five (45) Working Days from the date of the notice to provide the information requested. HPSJ will then complete its consideration of the claim within forty-five (45) Working Days after receiving the requested information.

CLAIMS PEND/REVIEW

Claims that cannot be auto adjudicated, or that fail an edit, or audit check, may be "pended" for review by a claims analyst who will identify the reason for the pended status. For paper claims, the claims analyst will examine the scanned image of the claim and attachments.

CLAIMS REIMBURSEMENT

Claims for Providers will be reimbursed according to the terms specified in the Provider's Agreement. Claims for non-contracted providers will be adjudicated primarily in accordance with Medi-Cal guidelines for Medi-Cal patients. All providers will receive a Remittance Advice (RA), indicating payment or the denied reason if the claim is denied.

CLAIMS OVERPAYMENT

Providers should inform HPSJ of any claims overpayment and return the overpayment to HPSJ within thirty (30) business days from the date the Provider identifies the overpayment. This is particularly true for overpayments resulting from subsequent payments made by California Children's Services (CCS).

If HPSJ determines that it has overpaid a claim, either in connection with an audit or otherwise, HPSJ will notify the Provider in writing through a separate overpayment notice clearly identifying:

- Claim
- Member
- Date of service
- Explanation of overpayment
- Interest and penalties that may be due on the claim

The overpayment notice will be issued within:

- Three hundred sixty-five (365) days of the date of payment on the overpaid amount for claims arising from Benefit Plans regulated by the DMHC; or
- At any time, in the event of fraud and/or misrepresentation

Overpayment notices will be sent to the Provider's address of record with HPSJ for the receipt of claim related correspondence and payments unless the Provider informs HPSJ in writing of an alternative address to which such notices are to be sent at least thirty (30) days in advance of the address change.

Non-Contested Overpayment

If the Provider does not contest HPSJ's overpayment notice, the Provider must reimburse HPSJ within thirty (30) business days from the date of receipt of the overpayment notice. If the Provider fails to reimburse HPSJ within those thirty (30) business days, then, beginning on the first calendar day after the expiration of this thirty (30) business day time period, HPSJ will offset the amounts due against future payments and including interest at the rate of ten percent (10%) per annum.

Contested Overpayment

If the Provider wishes to contest the overpayment notice, it must be done within thirty (30) business days from the date of receipt of the overpayment notice, by sending to HPSJ a written appeal clearly stating the basis upon which he/she believes that the claim was not overpaid. HPSJ will review and make a decision with respect to this appeal, and notify the Provider of its decision in writing within forty-five (45) business days from the date HPSJ receives the written appeal.

Offsetting Against Future Claims

If HPSJ denies the Provider's appeal, the Provider must reimburse HPSJ for the overpayment within thirty (30) business days from the date it receives the written notice of HPSJ's denial of the written appeal. If the Provider fails to reimburse HPSJ within those thirty (30) business days, then beginning on the first calendar day after the expiration of this thirty (30) business day time period, HPSJ may offset this amount, plus interest at ten percent (10%) per annum, against future claims. HPSJ will provide written notice and details identifying the specific overpayments that have been offset against the specific current claims.

INTEREST ON UNPAID CLAIMS

HPSJ will pay interest on each uncontested claims not paid timely, frivolous contested claims, and claims where HPSJ supplies late notice or no notice of the claim being contested or denied. HPSJ will also pay interest on payment adjustments made if a Provider dispute involves a claim and the dispute is determined in whole or in part in favor of the Provider.

Interest payments will apply to both contracted and non-contracted providers. The interest rate is fixed at a fifteen percent (15%) annual rate. For claims from an emergency services facility, the minimum amount of interest is the greater of fifteen dollars ($15) or the fifteen percent (15%) per annum. Interest will be paid for each day beginning with the first day after the deadline through the date payment is mailed.

If HPSJ fails to pay the interest due on the late claim payment within 5 business days, HPSJ will pay a ten dollar ($10.00) penalty for that late claim in addition to any amounts due. In determining the timelines, HPSJ will use the receipt date of the original claim, or the receipt date of the dispute, whichever is appropriate.

Capitated Providers are also subject to the payment of interest at the amounts outlined above for any fee-for-service claims that are not covered under the capitation agreement.

CLAIMS DENIAL AND REJECTS

HPSJ requires that all claims be submitted using codes that are current and are accepted by both Medi-Cal and Medicare. Providers should use the most current versions of ICD, ASA, DRG, CPT4, and HCPCS Level II for the date of service rendered. Should either Medi-Cal or Medicare mandate a new set of medical codes for common use, Providers will be required to bill accordingly. For claims for Medi-Cal Members, HPSJ reimburses using the most current Medi-Cal fee contract and processes claims using Medi-Cal billing guidelines.

Below are some common reasons that a claim may be denied or rejected:

- National Correct Coding Initiative (NCCI) edits
- Edits for procedure code frequency
- Missing or invalid codes
- Incorrect modifiers
- Missing or incorrect diagnosis codes
- Procedure codes that indicate a diagnosis inconsistent with what is billed
- Code billed is part of a more comprehensive code billed on the same date of service
- Code is inappropriate for the specialty or location billed
- Code is inappropriate for age or sex of patient
- Claims requiring “consent” submitted without consent forms (i.e., sterilization)

HPSJ issues a denial when the claim has passed initial edits but has been billed with invalid codes or miscellaneous information that causes the system to deny. Elimination of these errors results in prompt payments to Providers.

SECTION 10: CLAIMS SUBMISSION

CLAIMS STATUS AND QUESTIONS

You can view the status of the claims that you have submitted through DRE. To access DRE, please go to the HPSJ website, www.hpsj.com. If you are unable to obtain satisfactory answers regarding claims status or other claim questions, please contact our Customer Service Department at (209) 942-6320 or (888) 936-7526. The Claims Department Fax number is (209) 461-2555.

CALIFORNIA CHILDREN'S SERVICES (CCS)

HPSJ is not financially responsible to reimburse providers for services to patients who qualify for CCS-eligible services. Providers must bill CCS instead of HPSJ for CCS-eligible services by submitting Service Authorization Requests (SARs) to a CCS county or State office, except in an Emergency. To render CCS-eligible services to Medi-Cal patients and to receive reimbursement from CCS, providers must be CCS paneled and the facility must be a CCS certified facility.

For more information about the CCS program, please visit the CCS website at www.dhcs.ca.gov/services.

IMPORTANT BILLING TIPS

- Be sure you obtain prior Authorization for any Covered Services that require prior Authorizations. DRE has a list of codes that require prior Authorization.
- File your claims within the required timely filing requirements.
- File your claims electronically if at all possible.
- Use the standard and most updated Current Procedural Terminology (CPT) codes, International Classification of Diseases (ICD) codes, Health care Procedure Coding System (HCPCS) codes, or Revenue Codes. Please refer to the Medi-Cal manual and website at www.medi-cal.ca.gov for billing guidelines.
- Use the National Provider Identifier Standard (NPI) correctly and appropriately:
- A valid 10-digit NPI must be entered in the billing provider field on the paper claim form or electronic claim submission.
- The NPI must belong to the correct Provider. (A Provider rendering medical care cannot use the Group's NPI and vice versa. Providers who render medical care in a Facility cannot use the Facility's NPI, and vice versa. An individual Provider cannot use another individual Provider's NPI).
- A valid NPI is entered in the attending, admitting, or operating provider ID field.
- A valid NPI is entered in the referring provider field.
- The complete 9-digit ZIP code must be entered in the billing provider address field.

- A valid NPI of the inpatient Facility where medical care is rendered is entered in the service facility NPI field.
- National Drug Code (NDC) numbers are required for certain medical supplies.
- Invoices are also required for certain HCPCS codes.
- Preventative exams for Medi-Cal Members under nineteen (19) years of age must be billed on 1500 claim forms.
- When submitting paper claims:
    - Send the original claim form and retain a copy for your records.
    - Do not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.
    - Carbon copies, photocopies, facsimiles, or forms created on laser printers are not acceptable for claims submission and processing.

FACILITY CLAIMS

Newborns

Please note that Hospitals must notify HPSJ of Member newborns within twenty-four (24) hours of birth. Under HPSJ rules, newborns are covered using the mother's Member number for one (1) month after birth or until the newborn is issued their own number. Also:

- Claims should be filed under newborn baby's id number issued under mother's coverage. Do not file charges for the newborn on the same claim form as the mother.
- Submit the newborn claim after the mother's claim has been submitted. A healthy newborn is submitted with the newborn baby's id number, newborn information, and the delivery Authorization.
- If the newborn requires a longer stay, submit claim with the same information except with a new Authorization.
- In the case of multiple births, each child's information should be submitted on a separate claim. If the newborns require further hospitalization, each child will have a separate Authorization number which must be used on each claim.

REQUIRED FIELDS FOR THE UB FORM

The following form outlines only the REQUIRED Field Information:

UB REQUIRED FIELD INFORMATON			
BOX #	**FIELD NAME**	**INSTRUCTIONS**	**REQUIRED (Y, N)**
1	ADDRESS, ZIP CODE	Enter the provider name, hospital and clinic address, without a comma between the city and the state, and the nine-digit ZIP code without a hyphen. A telephone number is optional in this field. **NOTE:** The nine-digit ZIP code entered in this box must match the billing provider's ZIP code on field for claims to be reimbursed correctly.	Y
3a	PATIENT CONTROL NUMBER	Enter the patient's financial record number or account number in this field.	N
3b	MEDICAL RECORD NUMBER	Use Box 3a to enter a patient control number.	N
4	INSURED'S NAME	Not Required.	Y
6	STATEMENT COVERS PERIOD (FROM-THROUGH)	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the dates of service for this claim in six-digit MMDDYY (month, day, year) format. The date of discharge should be entered in the THROUGH box, even though this date is not reimbursable (unless the day of discharge is the date of admission). **NOTE:** For "From-Through" billing instructions, refer to the UB-04 Special Billing Instructions for Inpatient Services section (ub spec ip) in the Part 2 portion of the Medi-Cal provider manual.	Y
8b	PATIENT NAME	Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases. **Newborn infant:** When submitting a claim for a newborn infant using the mother's eligibility, enter the infant's name in Box 8b. if the infant has not yet been named, use the mother's last name followed by "Baby Boy" or "Baby Girl" (for example, JONES, BABY GIRL). **Billing Tip:** If the billing for the newborn infants form a multiple birth, each newborn must also be designated by a number or a letter (for example, JONES, BABY GIRL TWIN A) on separate claims. Enter infant's date of birth/sex in boxes 10 and 11. **Organ Donors:** When submitting a claim for a patient donating an organ to a HPSJ recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the HPSJ recipient's name in the Insured's Name field (Box 58) and enter "11" (Donor) in the Patient's Relationship to Insured field (Box	Y
10	BIRTH DATE	Enter the patient's date of birth, using an eight-digit MMDDYYY (month, day, year) format (for example, September 16, 1967 = 09161967). **NOTE:** If the recipient's full date of birth is not available, enter the year preceded on 0101. For newborns and organ donors, see item 8b).	Y
11	SEX	Enter the capital letter "M" for male or "F" for female	Y
12 and 13	ADMISSION DATE AND HOUR	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the date of hospital admission, in a six-digit format. Convert the hour of admission to the 24-hour (00-23) format. Do not include the minutes. **Billing Tip:** The admit time of 1:45p.m. will be entered on the claims as 13.	Y

SECTION 10: CLAIMS SUBMISSION

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
14	ADMISSION TYPE	**Outpatient Claims:** Enter an admit type code of "1" when billing for emergency room-related services (in conjunction with the facility type "14" in Box 4). This field is not required by HPSJ for any other use. **Inpatient Claims:** Enter the numeric code indicating the necessity for admission to the hospital. **NOTE:** If the delivery was outside the hospital, use admit type code "1" (emergency) in the Type of Admission and admission source code "4" (extramural birth) in the Source of Admission field (Box 15).	Y
15	ADMISSIOM SOURCE	**Outpatient Claims:** Not required. **Inpatient Claims:** If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. Enter code "1" or "3" in Box 14 to indicate whether the transfer was an emergency or elective. When the type of admission code in Box 14 is "4" (newborn; baby born outside of hospital), submit claim with source of admission code "4" in Box 15 and appropriate revenue code in Box 42.	Y
31 through 34a and b	OCCURRENCE CODES AND DATES	Occurrence codes and dates are used to identify significant events related to a claim that may affect payer processing. Occurrence codes and dates should be entered from the left to right, top to bottom in numeric-alpha order starting with the lowest value. Example: If billing for two occurrence codes "24" (accepted by another payer) and "05" (accident/no medical or liability coverage), enter "05" in Box 31a and "24" in Box 32a. Enter the accident/injury date in corresponding box (6-digit format MMDDYY). **NOTE:** Enter code "04" (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related**. Outpatient Claims:** Discharge date in not applicable. **Inpatient Claims**: Discharge Date: Enter occurrence code "42" and the date of hospital discharge (in six-digit format) when the date of discharge is different from the "THROUGH" date in Box 6.	N
37a	UNLABELED (USE FOR DELAY REASON CODES)	If there is an exception to the billing limit, enter on the delay reason codes in Box 37a and include the required documentation. **NOTE:** Documentation justifying the delay reason must be attached to the claim for review. **For hospitals that are not reimbursed according to the diagnosis related groups (DRG) model:** Providers must use claim frequency code "5" in the Type of Bill field (Box 4) of the claim when adding a new ancillary code to a previous stay, if the original stay was already billed.	N
42	REVENUE CODE	**Outpatient Claims:** Revenue codes are required (for instance, for organ procurement). **Inpatient Claims:** Enter the appropriate revenue or ancillary code. Refer to the Revenue Codes for Inpatient Services section (rev cd ip) in the appropriate Part 2 of the Medi-Cal provider manual. Ancillary codes are listed in the Ancillary Codes section (ancil cod) of the Part 2 MediCal provider manual. **Billing Tip:** For both outpatient and inpatient claims (single-page claims), enter code "001" in Box 42, line 23 to designate the total charge line. Enter the total amount in Box 47, line 23.	Y

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
43	DESCRIPTION	**Outpatient Claims:** Information entered into this field will help separate and identify the descriptions of each service. The description must identify the service code indicated in the HCPCS/Rate/HIPPS Code field (Box 44). This field is optional, except when billing for physician-administered drugs. Refer to the Physician-Administered Drugs-NDC UB-04 Billing Instructions section (physician MDC ub) of the Part 2 Medi-Cal provider manual for more information. **Inpatient Claims:** Enter the description of the revenue or ancillary code listed in the Revenue Code field (Box 42). **NOTE:** If there are multiple pages of the claims, enter the page numbers on	Y
44	HCPCS/RATE	**Outpatient Claims:** Enter the applicable procedure code and modifier. Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Attach reports to the claims for "By Report" codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures. Non-payable CPT codes are listed in the TAR & Non-Benefit List: Codes (10000-99999) sections in the appropriate Part 2 Medi-Cal provider manual. All modifiers must be billed immediately following the HCPCS code in the HCPCS/Rate field (Box 44) with no spaces. Up to four modifiers may be entered on the outpatient UB-04 claim form. **Inpatient Claims**: Not required.	Y
45	SERVICE DATES	Outpatient Claims: Enter the date the service was rendered in six-digit format. Inpatient Claims: Not required. Billing Tip: For "From-Through" billing instructions, see the UB-04 Special Billing Instructions for Outpatient Services section (ub spec op).	Y
46	SERVICE UNITS	**Outpatient Claims:** Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units on two or more lines**. Inpatient Claims:** Enter the number of days of care by revenue code. Units of service are not required for ancillary services. If billing for more than 99 units, divide the units between two or more lines. **Billing Tip:** Although Service Units is a seven-digit field, only two digits are allowed.	Y
47	TOTAL CHARGES	In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents, even if the amount is even (e.g., if billing for $100, enter "10000" not "100"). Enter the total charge for all services on the last line or on line 23. Enter "001" in Revenue Code field (Box 42, line 23) to indicate this is the total charge line. **Outpatient Claims:** If an item is a taxable medical supply, include the applicable state and county sales tax. To delete a line, mark with a thin line through the entire detail line (Box 42-49), using a black ballpoint pen. **NOTE:** Up to 22 lines of data (fields 42-49) can be entered. It is acceptable to skip lines.	Y

SECTION 10: CLAIMS SUBMISSION

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
50a through 50c	PAYER NAME	**Outpatient Claims:** Enter insurance plan name to indicate claim payer. **NOTE:** If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Health Plan of San Joaquin. **Billing Tip:** When completing Boxes 50-65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: HPSJ). Do not enter information on Lines A and B for other insurance (or Medicare) if payment was denied by these carriers. If HPSJ is the only payer billed, all information in Boxes 50-65 (excluding Box 56) should be entered on Line A.	Y
51	HEALTH PLAN ID	Enter the 9-digit HPSJ ID number. **NOTE:** If recipient is a newborn infant covered under the mother's eligibility, enter the newborn infant HPSJ ID number. This ID is available 24-48 hours after receipt of the newborn infant face sheet.	Y
54a through 54c	PRIOR PAYMENTS (OTHER COVERAGE)	Leave blank if not applicable. Enter the full dollar amount of the payment received from the OHC, on line A or B that corresponds with OHC in the Payer field (Box 50). Do not enter a decimal point (.), dollar sign ($), plus (+) or minus (-) sign. **NOTE:** For instruction about completing this field for Medicare/Medi-Cal recipients, refer to the Medicare/Medi-Cal Crossover Claims: UB-04 section (med cr ub) in the Medi-Cal provider manual.	N
55a through 55c	ESTIMATED AMOUNT DUE (NET AMOUNT BILLED)	In full dollar amount, enter the difference between "Total Charges" (Box 47, line23) and any deductions. Do not enter a decimal point (.) or dollar sign ($). **Example:** Patient's SOC Value Codes Amount and/or OHC Prior Payments.	N
56	NPI	Enter the appropriate 10-digit National Provider Identifier (NPI) number.	Y
57a through 57c	OTHER PROVIDER ID	Not Required	N
58a through 58c	INSURED'S NAME	Enter the last name and first name of the policyholder, using a comma or space to separate the two. Do not leave a space between a prefix (e.g., MacBeth). Submit a space between hyphenated names rather than a hyphen (e.g., Smith Simmons). If the name has a suffix (e.g., Jr., III) enter the last name followed by a space and then the suffix (e.g., Miller Jr. Roger). **NOTE:** If billing for an organ donor, enter the recipient's name and the patient's relationship to the recipient in the Patient's relationship to Insured field.	N
60a through 60c	INSURED's UNIQUE ID	Enter the recipient's HPSJ 9-digit ID number as it appears on the HPSJ Identification Card. **NOTE:** HPSJ does not accept the 14-digit ID number on the Benefits Identification Card (BIC). **Billing Tips:** When submitting a claim for a newborn infant for the month of birth or the following month, under the mother's eligibility, use the newborn infant HPSJ 9-digit ID number. (This ID number is available 24-48 hours after receipt of the newborn infant face sheet.)	Y

SECTION 10: CLAIMS SUBMISSION

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
63a through 63c	PRIOR AUTHORIZATION	For services requiring a Prior Authorization, enter the alpha-numeric number in this field. It is not necessary to attach a copy of the Prior Authorization. Recipient information on the claim must match the Authorization. Multiple claims must be submitted for services that have more than one Authorization. Only one Authorization can cover services billed on any one claim. **Inpatient Claims:** Inpatient claims must be submitted with an Authorization.	Y
66	DIAGNOSIS CODE HEADER	Claims with a diagnosis code in Box 67 must include the ICD indicator "0" for ICD-10-CM diagnosis codes, effective October 1, 2015.	Y
67	UNLABELED (PRIMARY DIAGNOSIS CODE)	Include all letters and numbers of the ICD-10-CM diagnosis code to the highest level of specificity (when possible) including fourth through seventh digits if present for the primary diagnosis code. Do not include decimal point. Present on Admission (POA) indicator. Each diagnosis code may require a POA indicator. Hospitals must enter a POA indicator (unless exempt) in the shaded portion of boxes 67 and 67a, to the right of the diagnosis field, to indicate when the condition occurred, if known. When the condition is present, use "Y" for yes. When the indicator is "N" for no, it means that the condition was acquired while the patient was in the	Y
67a	UNLABELED (SECONDARY DIAGNOSIS CODE)	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM diagnosis code to the highest level of specificity (when possible). Do not include a decimal point. **NOTE:** Paper claims accommodate up to 18 diagnosis codes.	N
74	OTHER PROCEDURE CODES AND DATES	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. In six-digit format, enter the date the surgery or delivery was performed. **Billing Tip:** Inpatient providers must enter ICD-10-PCS code in this field (not CPT-4/HCPCS surgical procedure code).	Y
74a through 74e	OTHER PROCEDURE CODES AND DATES	**Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. **NOTE:** For OB vaginal or cesarean delivery and transplants, enter a suitable ICD-10-PCS code in Box 74 or 74a-e.	Y
76	ATTENDING	**Outpatient Claims:** Enter the referring or prescribing physician's NPI in the first box. This field is mandatory for radiologists. If the physician is not a Medi-Cal provider, enter the state license number. Do not use a group provider number. Referring or prescribing physician's first and last names are not required. **Billing Tip:** For atypical referring or prescribing physicians, enter the Medicaid Identifier "1D" in the Qual ID box and enter the Medi-Cal provider number next to it. **Inpatient Claims:** Enter the attending physician's NPI in the first box. Do not enter a group number. The attending physician's first and last name is not required. **Billing tip:** For inpatient claims, do not enter the operating or admitting physician NPI in this field.	Y

BOX #	FIELD NAME	INSTRUCTIONS	REQUIRED (Y, N)
77	OPERATING	**Outpatient Claims:** Enter the NPI of the facility in which the recipient resides or the physician providing services. Only one rendering provider number may be entered on claim. Do not use a group number or state license number. **Billing Tip:** For atypical rendering physicians, enter the Medicaid Identifier "1D" in the Qual ID box and enter the Medi-Cal provider number next to it. **Inpatient Claims:** Enter the operating physician's NPI in the first box. Do not enter a group number. The operating physician's first and last name is not required.	N
78	OTHER	Outpatient Claims: Not required. Inpatient Claims: Enter the admitting physician's NPI in the first box. Do not enter a group provider number. The admitting physician's first and last name is not required by Medi-Cal.	N
80	REMARKS	Use this area for procedures that require additional information, justification or an Emergency Certification Statement. This statement must be signed and dated by the provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in this area, attach the statement to the claim. Billing Tip: If additional information cannot be completely entered in this field, attach the additional information to the claim on single-sided 81/2 by 11-inch white paper. "By Report" claim submissions do not always require an attachment. For some procedures, entering information in the Remarks field (Box 80) of the claim may be sufficient. Eligibility Verification Confirmation (EVC) numbers, are not required as attachments unless the claim is over 1 year old.	N

ANCILLARY CLAIMS

Billing for ancillary Covered Services should be in accordance with Medi-Cal guidelines. Specific information for all ancillary Covered Services can be found in the online Medi-Cal Provider Manual at www.medi-cal.ca.gov under "Publications."

Below are the forms that should be used for billing the following ancillary services:

PROVIDER TYPE	BILLING FORMS
Diagnostic Services	1500 Form
Skilled Nursing Facilities	UB Form
Ambulatory Surgery Center	UB Form, include correct place of service
Ambulance Services	1500 Form
Durable Medical Equipment	1500 Form
Home Health/Hospice	UB Form; use bill type 32X