

Health Plus Medical & Claims Payment Bulletin

Bulletin number: CL - 300

Original Bulletin Date: 3/01/06

Updated: 04/20/06

Subject: UB-92 Billing Requirements

Policy:

All providers are required to submit claims for services reimbursed according to fee-for-service rates and for services provided under capitation. Encounter data is essential for claims processing and utilization reporting as well as for complying with the reporting requirements of CMS, New York State and other governmental and regulatory agencies.

It is imperative that this information is submitted in a timely and accurate manner.

All claims are edited for completeness and correctness of the data elements required for claim processing. Providers are required to include their Health Plus Provider Number on all claims.

Following are instructions for completing the UB-92 form. This form can be used to bill fee-for-service and/or encounter information. Claims forms must be typed or printed with black ink to reduce delays in processing. Required data fields are shaded.

1. Untitled	Enter provider name, address and phone number.
2. Untitled	Not required.
3. Patient Control Number	Enter Patient Control Number.
4. Type of Bill	Enter three-digit numeric code.
5. Federal Tax ID	Required.
6. Statement Covers Period (From – Through)	Enter beginning and ending dates for the period of the bill (MMDDYY).
7. Covered Days	Enter total number of covered days for the period of the bill.
8. Non-Covered Days	Enter total number of non-covered days during the billing period.
9. Coinsurance Days	Enter the number of covered days that would fall under an applicable coinsurance.
10. Lifetime Reserve Days	Enter the number of applicable lifetime reserve days.
11. Untitled	Enter Newborn's Birth Weight, if applicable
12. Patient's Name	Enter the patient's last name, first name and middle initial.
13. Patient's Address	Enter the patient's full mailing address.
14. Patient's Birth Date	Enter the patient's date of birth MMDDYYYY.
15. Patient's Sex	Indicate 'M' or 'F'.
16. Patient's Marital Status	Not required.
17. Admission Date	Enter date of admission MMDDYY.

18. Admission Hour	Indicate the time the patient was admitted.
19. Type of Admission	Required on inpatient bills only. Enter code indicating priority of admission.
20. Source of Admission	Enter code indicating source of admission or outpatient registration.
21. Discharge Hour	Indicate the time the patient was discharged.
22. Patient Status	Enter code indicating the patient's status as of the 'through' date of the billing period.
23. Medical Record Number	Enter the number assigned to the member's health record.
24-30. Condition Codes	Enter appropriate code corresponding to condition.
31. Untitled	Not required.
32-35. Occurrence Codes and Dates	Enter code and associated date defining specific event relating to this billing period.
36. Occurrence Span code and Dates	Enter code and associated date defining specific event relating to this billing period.
37. Internal control Number (ICN) Document Control Number (DCN)	Enter control number assigned to original bill. Used for adjustment requests.
38. Untitled	Not required.
39-41. Value Codes and Amounts (Neonate Birth Weight Value Code and Neonate Birth Weigh in Grams Value Code Amount.)	Enter code and related dollar amount for the bill. All newborn encounters must have a value code of 54.
42. Revenue Code	Enter appropriate code.
43. Revenue Description	Not required.
HCPCS/Rates	Enter CPT-4 or HCPCS code describing the procedure.
45. Service Date	For outpatient claim providers, report a separate date for each day of service.
46. Service Units	Indicate number of covered days, visits treatments and applicable tests.
47. Total Charges	Enter total charges billed.
48. Non-Covered Charges	Enter total non-covered charges.
49. Untitled	Not required.
50A-C. Payer Identification	Enter the primary payer on line 'A', if appropriate and enter HealthPlus on line 'B'.
51A-C. Provider Number	Enter other payer on line 'A', if appropriate and enter HealthPlus' provider identification on line 'B'.
52A-C. Release of Information	Indicate 'Y' if the provider has a signed statement allowing the provider to release data, 'R' if the release is limited or restricted, and 'N' if no release on file.
53A-C. Assignment of Benefits Certification indicator	Not required.
54A-C. Prior Payments	For other than inpatient hospital or SNF, enter total amount collected from the patient in the last line.
55A-C. Estimated Amount Due	Enter estimated amount due.
56. Medicaid Clinic Code	Enter clinic code for all outpatient facility claims.
57. Untitled	Not required.
58A-C. Insured's Name	Enter insured's name.
59A-C. Patient's Relationship to Insured	Enter code indicating relationship of patient to insured.
60A-C. Certificate/Social Security Number/HI Claim/Identification Number	Enter patient's Medicare HIC number.
61A-C. Insurance Group Number	Enter name of insurance group or plan.
62A-C. Insurance Group Number	Enter ID number, control number, or code assigned by health insurance carrier.
63. Treatment Authorization Code	Enter authorization number for all approved admission or

	services.
64. Employment Status code	Enter code defining insured's employment status.
65. Employer Name	Enter name of insured's employer.
66. Employer Location	Enter specific location of insured's employer.
67. Principle Diagnosis Code	Enter ICD-9 code for diagnosis. Coded to the highest specificity.
68-75. Other Diagnoses Codes	Enter ICD-9 code for up to 8 additional coexisting diagnoses. Coded to the highest specificity.
76. Admitting Diagnosis	Enter ICD-9 code for diagnosis. Coded to the highest specificity.
77. E-Code	
78. Untitled	Enter Three Digit DRG Code, if appropriate.
79. Procedure Coding Method	Not required.
80. Principle Procedure Code and Date	Enter ICD-9 code for principle procedure.
81. Other Procedure Codes and Dates	Required for inpatient only. Enter ICD-9-CM codes for up to 5 additional significant procedures. Enter date as MMDDYY.
82. Attending/Referring Physician ID	Enter the attending provider license number and the state MMIS identification number of the attending provider.
83. Other Physician ID	Enter the license number of the physician who performed the principle procedure.
84. Remarks	Enter special notations where Medicare is not primary.
85. Provider Representative Signature	Not required.
86. Date	Not required.

Electronic Claims Submission

HealthPlus accepts claims filing through Electronic Data Interchange (EDI) utilizing the Emdeon Business Services clearing house.

In order to submit claims electronically the following information is needed:

- The Health Plus Payer ID Number **11324**;
- Complete Health Plus Member ID Numbers;
- Valid Health Plus Provider ID Number.
- Review the Companion Guide HIPAA 837 Institutional Claims document located in our Website: www.healthplus-ny.org.

To sign up for electronic billing, Providers must contact their software vendor and request that their Health Plus claims be submitted through WebMD. Providers can also direct their current clearinghouse to forward claims to WebMD.

Payment:

Payment is subject to verification that the member was enrolled in Health Plus at the time of service, the provider is in compliance with Health Plus' pre-authorization/referral policies, and all other applicable administrative requirements are met.

Policies in this manual are intended to reflect standard Health Plus procedures. In instances where a provider's contract contains other policies which may be more or less restrictive than those in this manual, these contractual provisions will apply.

Date Approved:	5-16-06	Approved By:	<i>Clifford D. Marlet, M.D., M.P.H.</i>
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