

Health Plus Medical & Claims Payment Bulletin

Bulletin number: CL - 301

Original Bulletin Date: 03/01/06

Updated: 04/20/06

Subject: CMS 1500 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 CMS 1500 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.

Patient and Insured (Member) Information

Type of Insurance	Enter an 'X' to indicate 'other' type of insurance.
1a. Insured's ID Number	Enter the member's Health Plus ID number
2. Patient's Name	Enter the patient's last name, first name and middle initial.
3. Patient's Birth Date/Sex	Enter two-digit numbers, MMDDYY.
4. Insured's Name	Enter the insured's name.
5. Patient's Address/Telephone Number	Enter the patient's complete address: number and street, city, state, zip code, area code and telephone number.
6. Patient's Relationship to Insured	Enter an 'X' in the appropriate field.
7. Insured's Address	Enter Insured's address.
8. Patient Status	Leave this field blank unless you enter yes in field 11d.
9a. Other Insured's Policy or Group Number 9b. Other Insured's Date of Birth/Sex 9c. Employer's Name or School 9d. Insurance Plan Name or Program Name	Leave these fields blank unless there is other Health Benefit Plan (see field 11d).
10. Is Patient's condition relate to:	If the condition being treated is not related to patient employment, auto accident and/or other accident, leave these boxes blank.
10a. Employment (current or previous)	Enter an 'X' to indicate illness was employment-related and therefore covered by workers' compensation. Leave this box blank if condition is related to patient's employment, but not

	to worker's compensation.
10b. Auto Accident	Enter an 'X' to indicate illness/injury was related to an auto accident. Indicate the state where the accident occurred. Leave this box blank if condition is related to an auto accident other than No Fault or if No Fault benefits are exhausted.
10c. Other Accident	Enter an 'X' to indicate that the condition was related to an accident other than in 10a or 10b above.
11. Insured's Policy Group or FECA Number 11a. Insured's Date of Birth 11b. Employer's Name or School Name 11c. Insurance Plan Name or Program Name 11d. Is there another Health Benefit Plan?	If applicable, enter other insured's Policy Group or FECA number. Enter in two-digit numbers MMDDYY. Enter employer's name or school name. Indicate name of other plan. Indicate if patient has other medical insurance. If yes, complete items 9a through 9d. If other medical insurance is involved either through payment or denial of a claim, the explanation of benefits from the other insurance carrier must accompany the claim form.
12. Patient's or Authorized Person's Signature/Date	Entering 'Signature on File' is acceptable, provided physician or supplier actually has patient's or authorized person's signature on file.
13. Insured's or Authorized Person's Signature	Entering 'Signature on File' is acceptable, provided physician or supplier actually has patient's or authorized person's signature on file.
14. Date of Current: Illness (First symptom) OR Injury (Accident) OR Pregnancy (LMP)	Enter in two-digit numbers, MMDDYY.
15. If patient has had same or similar illness, give first date	Enter in two-digit numbers, MMDDYY.
16. Dates patient unable to work in current occupation	Enter in two-digit numbers, MMDDYY.
17. Name of Referring Physician or Other Source	Enter the referring physician's first and last name.
17a. ID Number of Referring Physician	Enter the referring physician's Health Plus ID number.
18. Hospitalization Dates Related to Current Services	Enter the dates that apply to the current services. If code 21 is entered in field 24b, field 18 and 32 are required.
20. Outside Lab/Charges	Leave this field blank.
21. Diagnosis or Nature of Illness	Using the ICD-9-CM coding system, enter the appropriate code (coded to the highest specificity) that best describes the main condition or symptom of the patient. Relate items 1, 2, 3 and 4 to item 24 by line. List all appropriate diagnoses. Codes with subcategories must be entered with the subcategories indicated after the decimal point. A three-digit diagnosis code (no entry following the decimal point) will only be accepted when the diagnosis code has no subcategories. All coding should be at the greatest level of specificity.
22. Medicaid Resubmission/Original Reference number	Leave this field blank.
23. Prior Authorization	Enter the approval number specified by Health Services.
24a. Date of Service	Enter the date(s) the service(s) was rendered.
24b. Place of Service	This code indicates the type of location where each service

	<p>was rendered. Enter the appropriate CMS two-digit codes from the list below:</p> <ul style="list-style-type: none"> 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 62 Comprehensive Outpatient Rehabilitation Facility 81 Independent Lab 00 – 99 Other
24c. Type of Service	
24d. Procedures, Services or Supplies	<p>CPT/HCPCS: Enter the appropriate five-digit number using the current CPT-4 codes corresponding to the service date.</p> <p>All anesthesia claims must be submitted with anesthesia CPT-4 codes not surgical codes. Time must be in hours and minutes.</p> <p>HCPCS should only be used when no CPT-4 code exists.</p> <p>Modifier. The 5-digit code identifying a specific procedure may be expanded by two additional characters called a modifier to further define the nature of the procedure. Enter the appropriate two-digit number in this space.</p>
24e. Diagnosis Code	For each line enter the appropriate number that corresponds to the code which best describes the main condition or symptom of the patient for which the procedure was performed.
24f. Charges	Enter amount billed for the procedure.
24g. Days or Units	If a procedure was performed more than one time on the same date of service, enter the number of times it was performed in this field. If the procedure was performed one time, enter one.
24h. EPSDT	Leave this field blank.
24i. EMG	Leave this field blank.
24j. COB	Enter yes or no to indicate coordination of benefits.
24k. Leave this field blank	
25. Federal Tax ID Number	Enter your Federal Tax ID Number.
26. Patient's Account Number	Enter the patient's account number in this field. The provider, for record-keeping purposes, may wish to identify a patient by using an office account number. If this office account number is indicated on the claim form, Health Plus will print this number on the remittance statement for the convenience of the provider.
27. Accept Assignment	Check appropriate box.
28. Total Charge	Enter the total amount billed.
29. Amount Paid	Enter if other coverage. If payment from other medical insurance is received, attach the Explanation of Benefits form to the claim.
30. Balance Due	Enter the amount billed.

31. Certification (Signature of Physician or Supplier including Degrees or Credentials) and Date. The physician must sign the claim form or a signature stamp may be used. Please note that the certification statement is on the back of the claim form.	Indicate in two-digit numbers the MMDDYY on which the claim form is signed.
32. Name and Address of Facility Where Services Were Rendered	Enter the name and address where the service was rendered.
33. Physician's Supplier's Billing Name, Address, Zip Code and Phone Number	Enter the provider's Health Plus provider number, the provider's license number, billing name, address, zip code and phone number.

Electronic Claims Submission

Health Plus 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 Professional 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>
Date Approved:	5-22-06	Approved By:	<i>[Signature]</i>