

Provider Notice

To: All HealthChoices Providers
From: Sheryl M. Swanson, MBA, Director, Provider Network Development
Date: August 19, 2015
Subject: AD 15 107 HIPAA 5010 X12 Format Requirements

As of April 1, 2015, new standards became effective per the Health Insurance Portability and Accountability Act (HIPAA) and the United States Department of Health and Human Services (HHS). This federal mandate requires health plans, clearinghouses and providers to use new standards when electronically submitting information. Thus, PerformCare must convert paper claims data into electronic claims information.

In order to properly comply with requirements, paper claims completed improperly will be rejected effective immediately. PerformCare is obligated to adopt the required HIPAA 5010 X12 electronic claims submission format for both the CMS-1500 and UB-04 paper claim forms. Since implementing this billing requirement to align the conversion of paper claims to the mandated 5010 837 electronic formats, we have identified a problem area that must be addressed immediately.

The issue is related to the billing address on the claim. Please be aware that claims submitted must not include a PO Box as the Provider Billing Address. Providers may provide a payment address to their account executive or at the time of credentialing which can be a PO Box. This address would be used in our system for mailing paper checks if the provider is not signed up for EFT. This address, however, should not be sent on claims. See detail below.

CMS 1500 Claims

Paper claims for professional services should be billed on the CMS 1500 claim form and follow the National Uniform Claim Committee (NUCC) manual. Box Number 33 recommends that payers require the "Billing Provider Address" to be a street address or physical location in order to align with 5010A1.

UB04 Claims

Institutional claims should be billed on the UB04 and follow the National Uniform Billing Committee (NUBC) manual. Form locator number 01 for "Billing Provider Address" requires a street address.

Claims submitted with a PO Box in the billing address box will be rejected. All claim rejection letters dated **June 30, 2015 and later** are **valid letters** and providers should correct and resubmit. As a reminder rejected claims are considered **originals** and **timely filing limits** are in place. Any questions on rejected claims please refer to memo **AD 12 110R**.

Action Required:

Please refer to the attached grids for both the CMS-1500 and UB-04 required fields and billing guidelines for the mandated 5010 837 formats to ensure your claims are submitted correctly. Please note that these data elements for the 837 format will be required. Paper claims will be rejected if the required information is missing or inaccurate.

CMS-1500 (02/12) AND UBO4 PAPER CLAIMS REJECT CRITERIA Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
1a	Insured's ID Number	Insured Medicaid recipient number is required (If ID is invalid or missing claim will be rejected)
2	Patient's Name	"Member name is missing or illegible." (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"Member date of birth (DOB) is missing." (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	"Member's sex is required." (If no box is checked, the claim will be rejected.)
4	Insured's Name	"Insured's name missing or illegible." (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address (number, street, city, state, zip) phone	"Patient address is missing." (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"Patient relationship to insured is required." (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address	Enter the insured's address. The first line is for the street address; the second line, the city and state; the third line, the ZIP code.
9	Other Insured's Name	If Item Number 11d is answered as "Yes" complete fields 9, 9a, and 9d, otherwise leave blank.
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
9d	Insurance Plan Name or Program Name	Enter the other insured's insurance plan or program name.
11d	Is there another Health Benefit Plan?	When appropriate, enter an X in the correct box. If marked "YES" , complete 9, 9a, and 9d. Only one box can be marked.

12	Patient's or Authorized Person's Signature	Enter " Signature on File, " " SOF, " or legal signature. When legal signature, enter date signed in 6-digit (MM DD YY) or 8-digit format (MM DD YYYY) format.
21	Diagnosis or Nature of Illness or Injury	" Diagnosis code is missing or illegible. " (The claim will be rejected.)
24A	Date of Service	" Date of service (DOS) is missing or illegible. " (The claim will be rejected if both the "From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	" Place of service is missing or illegible. " (Claim will be rejected.)
24D	Procedure, Services or Supplies	" Procedure code is missing or illegible. " (Claim will be rejected.)
24E	Diagnosis Pointer	" Diagnosis (DX) pointer is required on line __ " [lines 1-6]. (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	" Line item charge amount is missing on line __ " [lines 1-6]. (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	" Days/units are required on line __ " [lines 1-6]. (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering Provider identification	" National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible. " (If NPI is missing or illegible, claim will be rejected.) The rendering provider should be the provider that holds the license with DHS to perform the service.
27	Assignment Number	" Assignment acceptance must be indicated on the claim. " (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	" Total charge amount is required. " (If a value greater than or equal to zero is not present, the claim will be rejected.)
31	Signature of physician or supplier including degrees or credentials	" Provider name is missing or illegible. " (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)

33	Billing Provider Information and Phone number	"Billing provider name and/or address is missing or incomplete." (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.) PO Box is not acceptable.
33	Billing Provider Information and Phone number	"Field 33 of the CMS1500 claim form requires the provider's physical service address." (If a PO Box is present, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
1	Billing Provider Name, Address and Telephone Number	"Billing provider name and/or address missing or incomplete." (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.) PO Box is not acceptable.
1	Billing Provider Name, Address and Telephone Number	"Field 1 of the UB04 claim form requires the provider's physical service address." (If a PO Box is present, the claim will be rejected.)
8b	Patient Name	"Member name is missing or illegible." (If first and/or last name are missing or illegible, the claim will be rejected.)
9a-e	Patient Address	"Patient address is missing." (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
10	Patient Birth Date	"Member DOB is missing." (If missing month and/or day and/or year, the claim will be rejected.)
11	Patient Sex	"Member's sex is required" (If missing, the claim will be rejected.)
12	Admission Date	"Admission Date is missing or illegible." (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If it is OP, claim will not be rejected. If it is IP and a valid date is not billed, the claim will be rejected.)
12	Admission Date	"Based on the date the claim was received, the admission date is a future date." (Use bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject claim. If it is IP and a future date is billed, reject the claim.)
13	Admission Hour	"Admission hour is required." (Use bill type table to identify if it is an IP or OP claim. If it is OP, claim will not be rejected. If it is IP and bill type is anything except 21x and a numeric value is not billed on the claim, the claim will be rejected.)
14	Admission Type	"Admission type is required." (If a numeric value is not present, claim will be rejected.)
15	Source of Referral for Admission or Visit	"Source of referral for admission or visit is missing." (If claim has any bill type except 14x and the field is blank, claim will be rejected.)

16	Discharge Hour	" Discharge hour is required. " (Use type if bill table to determine if it is an IP or OP bill type. If IP, the frequency code is either 1 or 4, and this field is blank, claim will be rejected.)
17	Patient Discharge Status	" Patient discharge status is required. " (If left blank, claim will be rejected.)
42	Revenue Code	" Revenue code is missing or illegible. " (If the revenue code is missing or illegible, the claim will be rejected.)
45	Service Date	" DOS is missing or illegible. " (Claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type . If service is not OP field should be left blank .)
45	Creation Date	" Creation date is missing or illegible. " (If the creation date is missing or illegible, the claim will be rejected.)
46	Service Days/Units	" Days/units are required on line __. " [lines 1-22]. (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)
47	Line Item Charges	" Line item charge amount is missing on line__. " [lines 1-22]. (If a value greater than or equal to zero is not present, the claim will be rejected.)
47	Total Charges	" Total charge amount is missing. " (If a value greater than or equal to zero is not present, the claim will be rejected.)
50	Payer	" Payer name is required. " (If left blank, the claim will be rejected.)
52	Release of Information	" Release of information certification indicator is required. " (If blank, the claim will be rejected.)
53	Assignment of Benefits	" Assignment of benefits certification indicator is required. " (If left blank, the claim will be rejected.)
58	Insured's Name	" Member name is missing or illegible. " (If first and/or last name are missing or illegible, the claim will be rejected.)
59	Patient's Relationship	" Patient's relationship to insured is required. " (If blank, the claim will be rejected.)
67A-Q	Other Diagnosis Codes and Present on Admission Indicator	" Diagnosis codes are missing or illegible. " (If diagnosis codes are missing or illegible, the claim will be rejected.)

69	Admitting Diagnosis Code	"Admitting diagnosis code is missing or illegible." (If it is an IP claim and field is blank or illegible, the claim will be rejected.)
70	Patient's Reason for Visit	"Patient's reason for visit is missing." (If the claim is OP and field is blank, the claim will be rejected.)
74	Other/Procedure Date	"Based on the date the claim was received, procedure date is a future date." (Use the bill type table to identify if it is an IP or an OP claim; If it is OP, do not reject the claim; If it is IP and a future date is billed, reject the claim.)
74	Other/Procedure Date	"Procedure date is missing or illegible." (Use bill type table to identify if it is an IP or and OP claim. If OP, do not reject the claim. If IP and a valid date are not billed, reject the claim.)
76	Attending Provider Identifiers: Name and NPI	"Attending physician name and/or number is missing." (If attending physician name or NPI number is missing, the claim will be rejected.)
76	Attending Provider Qualifier	"Attending provider qualifier is missing/ invalid." (The claim will be rejected if the "Other provider ID" is present and either: 1.) The 'Qualifier' box is blank or 2.) A qualifier other than 0B/1G/G2 is present.
76	Attending Provider Other ID#	"Attending Provider NPI is missing." (The claim will be rejected if qualifier is present and NPI box is blank.)

Thank you for your time and attention to this matter. Please direct questions to your assigned Account Executive.

cc: James A. Laughman, MSW, Executive Director, PerformCare
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