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Procedure 1210- Claim Submission

Lines of Business: All

Purpose: This guideline outlines Network Health's procedure for claim submission.

Procedure: Network Health's goal is to process all claims at initial submission. Before Network Health can process a claim, it must be a "clean" or complete claim submission, which includes the following claim elements when applicable:

- Patients' Network Health identification number
- Patients' first and last name
- Patients' date of birth (month, day, and year)
- Subscribers' full name and address
- Patients' signature or indication of signature on file
- Standard International Classification of Diseases (ICD) codes
- Dates of service
- Place of service/bill type (Facility)
- Standard Current Procedural Terminology (CPT) code sets
- Standard Health Care Procedure Coding System (HCPCS) code sets
- Revenue codes (Facility)
- Modifiers
- Diagnosis-related group (DRG)
- Resource Utilization Groups (RUG)
- Charges for each billed service
- Units of services
- Providers' National Provider Identifier (NPI) number
- Facility/provider name, address, and telephone number
- Billing name, address, and telephone number
- Accident state
- Provider tax identification number
- Providers' signature
- Primary carrier Explanation of Benefits (EOB) when Network Health is the secondary payer
- For miscellaneous circumstances (corrected claim, covering MD, and unlisted CPT/HCPCS) please indicate explanation.

If any of the above information is missing from the claim, Network Health will not be able to process your claim. If you have questions regarding required fields on a claim, please contact Network Health's Customer Service Department.

Claim Form Criteria

New CMS-1500 Form Effective April 1, 2014
The Centers for Medicare and Medicaid (CMS) released a new CMS-1500 (02/12) claim form to replace form CMS-1500 (08/05) effective as of April 1, 2014. Claims with dates of services prior to and spanning through April 1, 2014 may still be submitted under the CMS-1500 (08/05) form.

Claims with dates of services on or after April 1, 2014 must be submitted with the new form CMS-1500 (02/12).

Incomplete and Unclean Claims: If a claim does not include all the information set forth under the minimum claim elements listed above, the claim will be considered unclean and will be denied with the appropriate National ANSI code indicating additional information is required. This denial holds the provider liable. Patients should not be billed when the provider does not bill appropriately.

Incomplete Claims: If a claim contains all the information necessary to be processed, but lacks information necessary for Network Health to make a decision on the claim, Network Health will notify both the patient (via Explanation of Benefits) and providers (via Remittance Advice) that additional information is necessary to make a benefit determination.

Patients should not be billed when the provider does not bill appropriately or when information is needed from the provider.

If the necessary information is required from the patient, the patient may be billed by the provider until the time the patient supplies Network Health the appropriate information. An example would be other insurance information from the patient. Network Health cannot determine benefits until we have verified Network Health is the patients' primary carrier.

Clinical Documentation

Network Health will routinely request clinical documentation for a submitted claim to be considered in the following categories:

- an "unlisted code" as defined in the CPT/HCPCS code book for unlisted services and procedures
- a code that is not elsewhere classified (NEC)
- a code that is not otherwise specified (NOS)
- a code that is not otherwise classified (NOC)
- procedures that are potentially cosmetic
- procedures that may be experimental/investigational/unproven
- procedures that are medically necessary for some indications and not for others
- services performed in an unexpected place of service, such as office services performed in an outpatient surgery center
- codes appended with a modifier indicating additional or unusual services
- codes to which an assistant or co-surgeon modifier is attached that do not normally require assistant or co-surgeons

Types of clinical documentations that may be requested include:

- Ambulance transport and trip notes
- Anesthesia records
- Emergency Room records
- Facility notes
- Facility/MD notes
- Laboratory results
- Operative notes
- Physician office notes
- Radiology interpretation and report

Beyond the above categories, Network Health may require submission of clinical records before or after payment of claims for the purpose of identifying improper billings and detecting suspicious claims, but only as long as there is reasonable basis for believing such investigation is warranted.

This guideline is not designed to limit Network Health's right to require submission of medical records for precertification purposes.

Revised/approved: 10/2010; 04/2012; 11/2012; 02/2014; 10/2014; 05/2016