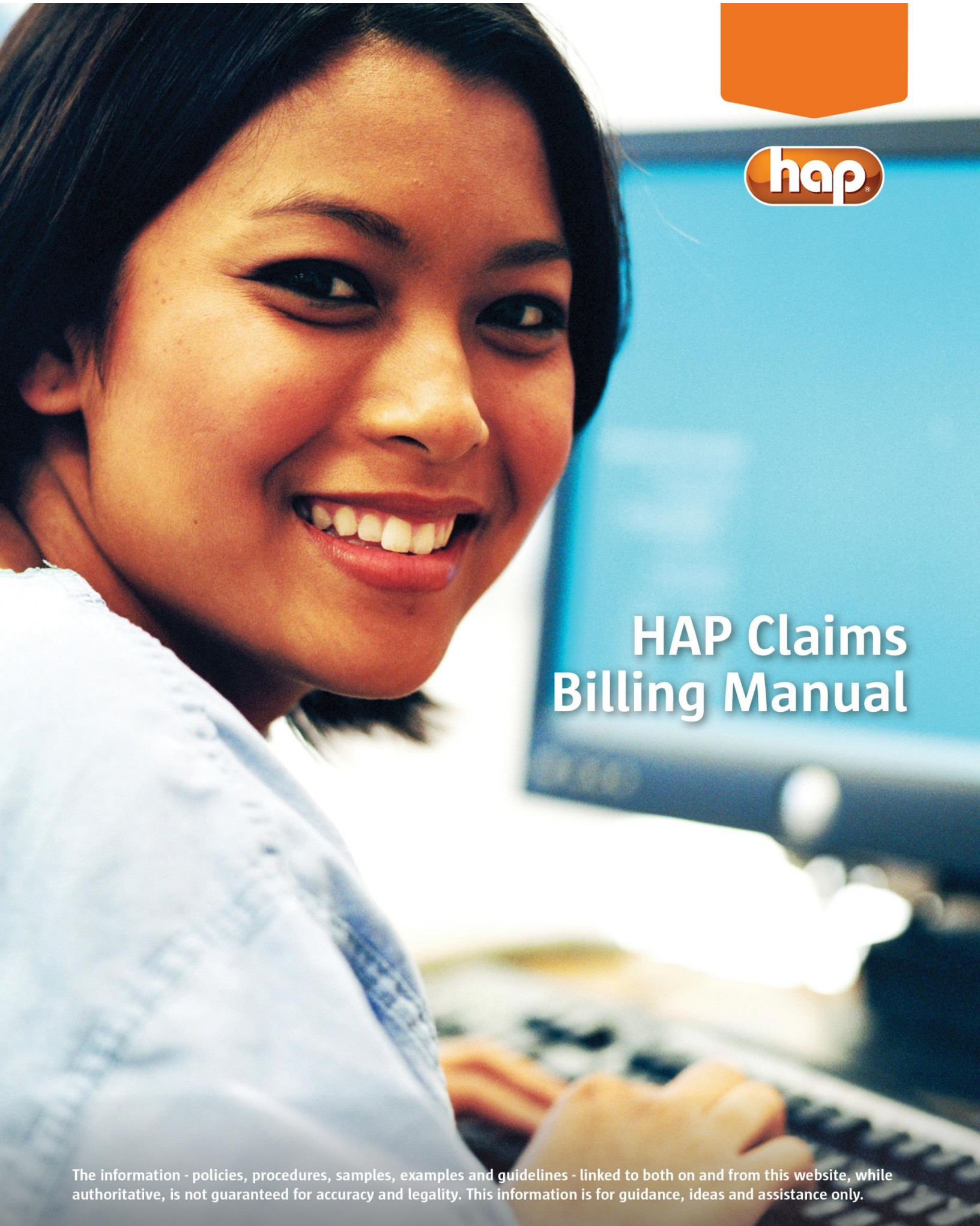

HAP Claims Billing Manual

The information - policies, procedures, samples, examples and guidelines - linked to both on and from this website, while authoritative, is not guaranteed for accuracy and legality. This information is for guidance, ideas and assistance only.

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Section I - Overview

The information contained in this manual applies to all providers for all products administered through HAP, Alliance Health and Life Insurance Company (Alliance) and HAP Preferred (PHP). Where specific requirements apply—HAP vs. HAP Preferred, electronic vs. paper claim, or professional vs. institutional—the guidelines are modified accordingly. **Please note: when the information in this manual and your contract differ, your contract supersedes.** This manual will be updated as needed but no less than annually.

Medicare Sequestration

HAP follows Medicare sequestration.

Medicare Advantage Physician Fee Schedule Update

Effective April 1, 2017 HAP will implement a site of service rate differential for services provided in facility or ambulatory settings. Using the CMS methodology, HAP will reimburse specific CPT/HCPCS codes with adjusted rates based on the site of service where the service was performed.

For a list of settings where a physician's services are paid at the facility rate refer to Chapter 12 of the Medicare Claims Processing Manual:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

Hospital DRG Grouper Updates

To align with CMS guidelines, HAP will update DRG grouper and weights every year on October 1. Base rates will be updated according to hospital contract terms.

Billing Rules for Qualified Medicare Beneficiary Program Enrollees

For information on billing for QMBs for Medicare A/B deductibles and coinsurance, visit https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf

Cigna Claims Submissions Process Change Reminder

Cigna customers have access to the HAP Preferred network in 20 counties in Michigan.

All claims for these patients must be sent directly to Cigna using Payor Code 62308

Any claims submitted directly to HAP will be rejected with error code 116 - Claims Submitted to Incorrect Payor. You will need to resubmit your claims to Cigna.

The HAP Pledge

HAP continually strives to ensure that its members receive all necessary services at the appropriate time and in the appropriate setting. Utilization management decision-making is based on the appropriateness of care and service and the existence of coverage. HAP does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Furthermore, HAP does not offer financial incentives to encourage underutilization of covered services.

To assist in the continual improvement of health care delivery, practitioners and physicians may obtain clinical criteria or discuss utilization management decisions. Note that certain clinical criteria or guidelines may be applicable only to governmental programs or only to commercial plans. Criteria used in decision-making may include InterQual, HAP Criteria, the HAP Benefit Administration Manual, eviCore healthcare criteria, pharmaceutical clinical criteria, national guidelines, landmark trials, peer-reviewed journal publications, Medicare national and local coverage guidelines, Medicare COMPENDIA such as DrugDex and American Hospital Formulary Service, medical resources such as UpToDate® and, at times, guidelines from other local/national health plans.

To discuss a utilization management decision or process with a physician reviewer or health care professional reviewer or to obtain a copy of the criteria used in the decision-making process, practitioners may contact HAP as follows:

For	Contact Information
• Outpatient Medical Services (Referral Management Team)	**(313) 664-8950 or (800) 926-3436, option 1** Or Visit **hap.org**
• Provider Appeals	**(313) 664-8950 or (800) 926-3436, option 2** Or Visit **hap.org**
• Urgent/emergent requests • Decisions within 24 hours • Inpatient Care Management • Admissions and Transfers • Inpatient Rehab • Skilled Nursing	**(313) 664-8833 or (800) 288-5959** Or Visit **hap.org**
• Pharmacy	**(313) 664-8837 or (313) 664-8940 or (888) 383-2535** Or Visit **hap.org**
• Coordinated Behavioral Health Management	**(800) 444-5755**
• eviCore healthcare Cardiology and Musculoskeletal programs	**(888) 564-5487 or (800) 575-4594** Or Visit **eviCore.com**
eviCore healthcare Sleep studies program	**Phone:(855) 736-6284** **Fax: (888) 693-3210**

Please have the member's name and HAP ID number available to assist in accessing the case. HAP physician reviewers are board certified and have current Michigan licenses to practice without restriction.

Utilization Management Hours of Operation

For utilization management inquiries, HAP staff is available by telephone as follows:

For	HAP Department	Contact Information
• Admissions • Inpatient review • Rehab • Skilled nursing facility • Transfers	Admissions Team	24/7; 7 days per week (313) 664-8833
• Outpatient authorizations and services • DME • Homecare • Home infusion • Hospice	Referral Management Team	Monday – Friday 8:00 a.m. – 4:30 p.m. (313) 664-8950
Case management	Case Management	Monday – Friday 8 a.m. – 5 p.m. (313) 664-8476
Pharmacy Services	Pharmacy	Monday – Friday 8:00 a.m. – 4:30 p.m. (313) 664-8940
Behavioral Health Services	Coordinated Behavioral Health Management (CBHM)	Monday – Friday 8 a.m. – 5 p.m. (800) 444-5755

Section II – HAP's Online Applications

HAP contracted providers that need access to HAP's online applications should:

1. Complete the attached Provider Portal Access Application OR
2. Contact Provider Services by:

   - Phone: **(866) 766-4708**
   - Email: prelweb1@hap.org

After a login and password are obtained, simply log in at **hap.org.**

PROVIDER PORTAL ACCESS AND PASSWORD RESET APPLICATION

This form is to be completed by the provider office ONLY! The provider office is responsible for giving access information to their billing service.

Please check appropriate box.

☐ **FORGOT MY PASSWORD.** Complete appropriate information below.

☐ **CONTRACTED HAP PROVIDER**
Access to all applications. **Note: RA can only be accessed with a Vendor ID and password.** Please complete information below for each provider in your office. Use separate page if necessary.

Please print

Individual Provider Name		**Individual NPI**	
Provider Group Name		**Group NPI**	
Tax ID			
Vendor ID (if known)		**Recent check number**	
Street Address (including suite)			
City, State, Zip			
Contact Person Name			
Phone		**Email**	
Fax			

☐ **NON-CONTRACTED PROVIDER**
Access to Claims and Remittance Advice only. Please complete information below.

Provider Name			
Individual NPI		**Group NPI**	
Tax ID			
Vendor ID (if known)		**Recent check number**	
Street Address (including suite)			
City, State, Zip			
Contact Person Name			
Phone		**Email**	
Fax			

Signature: _____ **Date** _____

Printed Name: _____ **Title:** _____

Email completed form to prelweb1@hap.org.

FOR HAP USE ONLY. We will return this form to you with your login and password.

INDIVIDUAL LOGIN INFORMATION	**Username/ID Number:** **Password:**
VENDOR LOGIN INFORMATION (for Remittance Advice)	**Username/ID Number:** **Password:**
You must take all reasonable precautions to safeguard your ID and password. This ID allows the user to access confidential information. Such access is provided solely to facilitate the performance of legitimate business functions. Please ensure that you share your ID and password only with those individuals who require such access to perform legitimate business functions on your behalf. You remain responsible for any use, or misuse, of your ID and password by you or your employees and/or agents.	

May 2018

Section III – Submitting Claims

Electronic Claim Submissions

We accept electronic claim submission, Electronic Data Interchange (EDI), for all HAP product lines. We do not charge for direct submission of electronic claims data or direct return of claim rejection data.

EDI Claims Submission

The HAP EDI Claim System allows providers to submit claims data electronically utilizing the HIPAA compliant version of the electronic claim. There are two methods of electronic claims submission: a Clearing House or Direct Connect.

HAP's payer ID is **38224**.

Clearing House

Providers can send their claims to a service provider (billing service or claim software vendor) or directly to a Clearing House that will route the claim to HAP.

Providers will receive a:

- Daily acknowledgement report that their claims have been received
- Daily preprocessing claims denial report from HAP*****
- Weekly claims status report from HAP*****

*Denotes reports produced by HAP. The Clearing House forwards these reports to the provider or the billing service. If you are submitting claims electronically but not receiving the reports, please contact the Clearing House or HAP's EDI Business Coordinator for assistance **eCommerce@hap.org**.

Direct Connect

With Direct Connect, providers or trading partners can submit their claims directly to HAP as long as HAP's Operation Requirements are met.

HAP's Operation Requirements

Standards

- **Format**: HIPPA compliant ANSI X12 837 (health care claim, professional or institutional). HAP will return a Claim Status file in response to the claim file. Please note**:** we may be able to return an ANSI X12 835 file (Health Care Claim/Payment Advice) upon request.
- **Version:** 4010 1A of the ANSI X12 837
- **Content**: Refer to the HAP 837 implementation guide, which HAP will provide. Or, the HIPAA 837 implementation guide that can be purchased from Washington Publishing Company at **wpc-edi.com**.

Communications

- FTP Server/Internet using F-Secure Shell software for Windows. This is a desktop FTP application. It allows for an encrypted file transmission over the internet. HAP will provide the software at no charge.
- Virtual Private Network (VPN) - Secure 2 way connections between HAP and a trading partner.
- ANX - Secure Internet and must be a member of ANX to use it.
- PGP - HAP to send or retrieve files only. Allows for an encrypted file transmission over the internet.

Testing Period

Before we can accept files electronically, we need to test with you. We will follow the guidelines outlined below.

- **Test Data**. HAP requires an initial test 837 claim file with a minimum of 10 claims that will be used to validate file format. Upon completion, we will request a full claim test file.
- **Data Resource***.* HAP will validate the content of the test file, communicate issues and assist in the activities related to implementation of the direct connect.
- **Communication Resource***.* HAP will coordinate data communication set up between HAP and the trading partner.

Before submitting any electronic claims to HAP, please contact HAP's EDI Business Coordinator at **eCommerce@hap.org**. You will be provided with the necessary information to submit electronic claims.

If an enrollee has Medicare coverage primary, all paid claims that have a remaining patient liability will be crossed over to HAP through Group Health Incorporated (GHI). You should receive a Remittance Advice (RA) that indicates the claim has been forwarded to HAP for consideration. Any denied Medicare claims must be submitted to HAP on paper with a copy of the Explanation of Medicare Benefits (EOMB).

Paper Claim Submission

If you are submitting paper claims to HAP, please be sure to mail them to the correct address as outlined below. You can also find the correct mailing address on the back of the member's ID card.

Product	Address
HMO	Health Alliance Plan 2850 W. Grand Blvd. Detroit, MI 48202
Alliance Health and Life Company	Alliance Health and Life Insurance Company PO Box 02459 Detroit, MI 48202-2459
ASO Self-Funded (for Henry Ford Health System employees)	Alliance Health and Life Insurance Company 2850 W. Grand Blvd. Detroit, MI 48202
PHP/HAP Preferred	HAP Preferred Operations PO Box 02399 Detroit, MI 48202

All HAP Preferred claims are priced and forwarded to the appropriate Third Party Administrator (TPA) for adjudication. The TPA information can be found on the patient's ID card.

When submitting a paper claim with attachments to HAP please do not:

- Submit handwritten claim forms
- Use red ink on the claim forms
- Circle any data on the claim forms
- Staple attachments to the claim
- Highlight any information on the claim forms
- Submit photocopied claim forms
- Submit carbon copied claim forms
- Submit claim forms via fax (unless advised by a HAP team member)
- Submit unnecessary attachments

General Requirements for Filing Claims

At a minimum, claims must be submitted with the information below in order to be accepted by HAP. Depending on your specialty, there may be further requirements as outlined in your provider contract.

1. HAP member ID number as it appears on his/her ID card
2. Member name as it appears on the ID card
3. Member's date of birth (mmddyyyy format)
4. Date of service
5. Valid diagnosis code(s) for date of service as referenced in ICD-10 coding manual
6. Valid procedure code(s) for date of service as referenced in CPT-4 or HCPCS coding manuals
7. Valid Place of Service code(s) for CMS-1500 claims
8. Valid Bill Type for UB-04 claims
9. Charge information and units
10. Your NPI – individual or group (if appropriate)
    - If you are a facility provider, you should use your Medicare Provider ID
11. Provider's Federal Tax Identification Number (TIN)
12. Vendor name and address
13. The member's Group Number as it appears on their ID card

Claims not submitted correctly with the above items, may be rejected and require resubmission. You will need to make the appropriate corrections and then re-submit your claim for consideration.

Claims must be submitted on UB-04 or CMS-1500 claim forms depending on your provider specialty. If you are unsure which form to submit, refer to your provider contract.

Use industry standard guidelines with CPT or HCPCS coding that is active for the date of service when submitting claims either on paper or electronically. Diagnosis codes for either type of claims must also be industry-standard ICD-10 codes. In addition to adhering to industry-standard coding, please note that certain plan specific information is required for all plans administered by HAP.

Claims forms can be found at the following websites:

- CMS-1500: **www.cms.gov**
- UB-04 – **www.nubc.org** (you can access the form by subscribing to the website)

Your claims may be rejected if not received on the appropriate forms.

Timely Filing Policy

HAP will accept claims for consideration up to one year from the date of service. Any claims received past this filing limit will be denied.

HAP will accept secondary claims for consideration up to one year from the other insurance carrier (OIC) payment date. Any claims received past this filing limit will be denied.

National Provider Identifier (NPI)

An NPI is a permanent, 10-digit, intelligence-free identification number assigned to each health care provider by the National Plan and Provider Enumeration System (NPPES)—an electronic enumeration system set up by CMS.

Your NPI is required in all HIPAA standard transactions. UPIN numbers are no longer valid for any use. Failure to report the appropriate NPI could result in your claim being processed under the incorrect contracted rate.

Use the "billing" NPI that you would expect to receive payment under. For example:

- If you are an individual provider and want to be paid under the individual NPI, then report the individual NPI in box 33a of the CMS-1500 claim form.
- If you are a physician group and want to be paid under the group NPI, then you should report this NPI in box 33a of the CMS-1500 claim form

The Federal Tax ID number is required in box 25.

If you do not have an NPI:

Apply for an NPI at CMS:

- Online: **https://nppes.cms.hhs.gov**

Submit your NPI to HAP by:

- Fax: (**248) 443-7761**
- Email: **IS_BCT_vendor@hap.org**

UB-04 Claim Requirements and Guidelines

While not all the fields below are required, we recommend that you provide as much information that is available at the time of submission. Field locations and requirements apply to electronic and paper submissions. Please refer to your EDI Clearing House or billing company for specific mapping requirements for claims submitted electronically.

Field	Information to Input	Comments
1	Name, address and phone number of the provider of service	**Required**
2	Pay to Name, address and phone number	
3a	Patient Control #	
3b	Medical Record #	
4	Type of Bill	**Required**
5	The hospital's Federal Tax ID Number (TIN)	**Required**
6	Date of service from and through	**Required**
7	Unlabeled	
8a	Patient Name – ID	**Required**
8b	Patient Name	**Required**
9a	Patient address	
9b	Patient City	
9c	Patient State	
9d	Patient Zip	
9e	Patient Country Code	
10	Patient Date of Birth	**Required**
11	Patient Sex	
12	Admission Date	**Required - if admitted**
13	Admission Hour	**Required - if admitted**
14	Admission Type	**Required - if admitted**
15	Source of Admission	**Required - if admitted**
16	Discharge Hour	**Required - if admitted**
17	Patient Status	
18-28	Condition Codes	
29	Accident State	
30	Unlabeled	
31-34 a-b	Occurrence codes and dates	
35-36 a-b	Occurrence Span Codes and Dates	
37	Unlabeled	
38	Responsible Party Name and Address	
39-41 a-d	Value Codes and Amounts	
42	Revenue Codes	**Required**
43	Revenue Code Description	
44	HCPCS or CPT for all revenue codes that have a technical and professional component	**Required**
45	Service Date	
46	Service Units (day, visit, or procedure count)	**Required**
47	Total Charges	**Required**
48	Non- Covered Charges	
49	Unlabeled	
50	Payer Name	
51	Health Plan ID	**Required**
52	Release of Information	

Field	Information to Input	Comments
53	Assignment of Benefits	
54	Prior Payments	
55	Estimated Amount Due	
56	NPI	**Required**
57	Other Provider ID	
58	Insured's Name	
59	Patient Relationship	
60	Insured's Unique ID	**Required**
61	Group Name	**Required**
62	Insurance Group Number	**Required**
63	Treatment Authorization Codes	
64	Document Control Number	
65	Employer Name	
66	DX Version Qualifier	
67	Principal diagnosis and qualifier: Patient's reason for visit	**Required**
67 a-q	Other Diagnoses and qualifiers (*qualifiers are required for each submitted diagnosis)	**Required***
68	Unlabeled	
69	Admitting Diagnosis	**Required** - **if admitted**
70 a-c	Patients reason for Visit code	
71	PPS Code – DRG Code	
72	External Cause of Injury Code	
73	Unlabeled	
74 a-e	Principal Procedure Code and Date	
75	Unlabeled	
76	Attending Physician- NPI, Qualifier, ID, Last Name, First Name	
77	Operating Physician- NPI, Qualifier, ID, Last Name, First Name	
78	Other ID- NPI, Qualifier, ID, Last Name, First Name	
79	Other ID- NPI, Qualifier, ID, Last Name, First Name	
80	Remarks	
81	Code- Code – Qualifier/ Code / Value	

CMS-1500 Claim Requirements and Guidelines

While not all fields are required, we recommend that you provide as much information that is available at the time of submission. Field locations and requirements apply to electronic and paper submissions. Please refer to your EDI clearing house or billing company for specific mapping requirements for claims submitted electronically.

Field	Information to Input	Comments
1a	Patient's ID as appears on the ID card.	**Required**
2-5	Patient's name, birth date, address and insured name	**Required**
6	Patient relationship to insured	
7	Contract holder address	
8	Patient status	
9	Other insured name, if applicable	
10	Is patient's condition related to: employment or accident?	
11	Insured policy group or FECA number (must enter Social Security number of contract holder in this field)	
12	Patient's signature	
13	Insured's signature	
14	Date of injury or accident, if applicable	
15	Date of same or similar illness, if applicable	
16	Dates patient unable to work in current occupation, if applicable	
17	Referring Physician Name	
17a	Blank	
17b	Referring Physician NPI	
18	Hospital dates of service, if applicable	
19	Reserve for local use	**Supply industry standard when appropriate**
20	Outside laboratory used? Y/N	
21	Diagnosis or nature of illness or injury	**Required**
22	Medicaid resubmission code or original referral number	
23	Prior authorization or referral number	
24a	Date of service (submit separate forms for multiple year claims)	**Required**
24b	Place of Service (valid Medicare 2 character values): **11**-Physician Office **12**-Patient's Home **13**-Dialysis Center **20**-Urgent Care Facility **21**-Inpatient Hospital **22**-Outpatient Hospital **23**-Emergency Room **24**-Ambulatory Surgical Center **25**-Birthing Center **31**-Skilled Nursing Facility **32**-Nursing Home **33**-Custodial Care Facility **34**-Hospice **41**-Ambulance-land **42**-Ambulance Air or Water **51**-Inpatient Psychiatric Facility **52**-Psychiatric Facility Partial Hospitalization **53**-Community Mental Health **54**-Immediate Care Facility/Mental **55**-Residential Substance Abuse Treatment Center **56**-Psychiatric Residential Treatment Center **61**-Comprehensive Inpatient Rehab Facility **62**-Comprehensive Outpatient Rehab **65**-End Stage Renal Disease Treatment Facility **71**-State/Local Public Health Clinic **72**-Rural Health Clinic **81**-Independent Laboratory	**Required**
24c	EMG (Emergency Indicator)	
24d	Procedures, Services or Supplies (any/all applicable CPT or HCPCS modifiers)	**Required**
24e	Diagnosis Code Pointer	**Required**
24f	$ Charges – Total amount for each detail line	**Required**
24g	Days or Units	**Required**
24h	EPSDT / Family Plan	
24i	ID Qualifier	
24j	Rendering Provider ID # (can be used to display anesthesia time)	
25	Federal Tax Identification Number (TIN) of the entity to which claims are to be paid	**Required**
26	Patient's account number	
27	Accept Assignment? Y/N	

Field	Information to Input	Comments
28	Total Charge	**Required**
29	Amount Paid, if applicable	
30	Balance Due, if applicable	
31	Signature of servicing physician	**Required**
32	Name and address of facility where services were rendered	**Required**
32a	NPI of the facility / group	**Required**
32b	Other ID #	
33	Billing Provider Info and PH#- Indicate the vendor name, address and telephone # where payments should be made. Include the Group name, if applicable	**Required**
33a	NPI of the billing provider	**Required**
33b	Blank	

Submitting Secondary Claims

Medicare Primary

If an enrollee has Medicare coverage primary and Medicare has issued payment, the claim (UB-04 or CMS-1500) should be crossed over to HAP through Group Health Incorporated (GHI). You will receive an RA that indicates the claim has been forwarded to HAP for consideration. If Medicare denied the services, then the claim must be submitted on paper with a copy of the EOMB.

The following Medicare non-covered CMS-1500 codes do not require other insurance carrier (OIC) explanation of payment or denial. HAP accepts these services and will be processed according to the enrollees HAP contract.

0066T	72159	92551	97811	99383	99403	G9014
0074T	73225	92559	97813	99384	99404	G9016
55970	75556	92560	97814	99385	99411	S9500
55980	76390	92590	98943	99386	99412	S5497
58300	78351	92591	98960	99387	99420	J7799
61630	90669	92592	98961	99391	99429	S9501
61635	90875	92593	98962	99392	99450	S9502
61640	90876	92594	99026	99393	G0122	S9503
61641	90882	92595	99027	99394	G0219	S9326
61642	92310	93668	99075	99395	G0235	S9342
65760	92340	93760	99172	99396	G0255	S9343
65765	92341	93762	99173	99397	G0282	S9367
65767	92342	96155	99381	99401	G0295	S9490
65771	92370	97810	99382	99402	G9013	S9537

There are additional codes that Medicare does not cover and HAP may consider for payment. These procedures can be submitted to HAP electronically with no other denials.

Other Carrier Primary

When another insurance company pays as primary, submit the claim to HAP electronically with the primary insurer's pricing and payment values included in the electronic file format.

HAP will accept secondary claims for consideration up to one year from the other insurance carrier (OIC) payment date. Any claims received past this filing limit will be denied.

Please refer to the COB section of this manual for additional information regarding the submission of secondary claims.

Section IV - HAP Specific Coding/Claim Requirements

Ambulance

Ambulance claims must be submitted on a CMS-1500 claim form with an appropriate modifier to indicate the location, both from and to. The mileage for each run is also required. For Medicare primary claims, a copy of the Medicare EOMB must be submitted.

Anesthesia Services

Clinical Registered Nurse Anesthesiologist (CRNA) and Anesthesia

All anesthesia/CRNA claims must be submitted on a CMS-1500 claim form. All anesthesia/CRNA ABU claims must include one of the modifiers listed below along with the applicable ASA code.

Code	Description
AA	Physician personally performs service
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures with CRNA's or other qualified anesthesia providers
QY	Medical direction of one CRNA or other qualified anesthesia provider
QX	CRNA service with medical direction by a physician
QZ	CRNA service without medical direction by a physician

Anesthesia/CRNA ABU claims submitted without one of the modifiers above will deny and will be returned to the provider for resubmission.

Anesthesia Time

Anesthesia time is defined as the continuous presence of the anesthesia provider. It starts when the patient enters the specific anesthetizing location where the surgical procedure occurs, and ends when the patient is placed under post-operative supervision. Anesthesia time should be submitted to HAP in total time minutes versus fifteen (15) minute Time Units. HAP will convert the total time billed by the provider into fifteen (15) minute Time Units, rounding up to after 8 minutes.

For example, if a procedure takes 37 minutes, HAP would convert this to 2 Time Units (37 minutes/15 minute units = 2.4 time units rounded, or 2 time units). If a procedure takes 38 minutes, HAP would convert this to 3 time units (38 minutes/15 minute units = 2.53 time units rounded, or 3 time units.

Bill Types

Late Charges (xx5)

Late Charge bill types represent services occurring after or not charged or credited to a patient account from admission to discharge dates or through the last interim bill, necessitating a re-submission of the claim with only the late charges.

Do not repeat charges listed on the original claim.

Late charges will be processed in conjunction with the original claim.

Replacement (xx7)

Professional replacement billing should be used when there are **data changes** to a claim which would result in **additional payment or corrections to the claim.** To ensure proper payment, please follow the process outlined below.

- Resubmit the **entire** claim
- Include the original HAP claim number
- Enter 7 in box 22 on the CMS-1500 or field 4 – Type of Bill on the UB-04

HAP will:

- Deny the original claim
- Make full payment on the new replacement claim

Example:

Original Claim			Replacement Claim		
Lines and procedure	**Units**	**Outcome**	**Lines and procedure**	**Units**	**Outcome**
1.99213	1	Paid*	1.99213	1	Paid
2.81000	1	Paid*	2.81000	1	Paid
3.81003	1	Paid*	3.81003	1	Paid
4.81005	1	Paid*	4.81005	1	Paid
5.72486	1	Paid*	5.72486	**2**	Paid

Important
For reconsiderations on a claim outcome with no update or change in data, you can:

- Contact HAP Provider Inquiry at **(866) 766-4661** OR
- Follow the online Claims Adjustment process (see process in this manual)

Cancel (xx8)

Cancel bill types reflect the elimination of a previously submitted claim in its entirety for a specific provider, patient, payer, insured and "Statement Covers Period."

HAP will process cancel bill types by denying them with a cancel claim denial code and the original claim will be adjusted in full. This indicates that the submission should not have been submitted

Submitting Replacement and Cancel Bill Types

- **CMS-1500**
  Enter the 7 or 8 frequency code in box 22 along with the claim number that you want HAP to replace. HAP will deny the original claim and process the new submission.
- **UB-04**
  Use field 4 - Type of Bill

Coding Well-Child Visits

For information on coding well-child visits, please review the most current HEDIS Reference Guide when you log in at **hap.org.**

Durable Medical Equipment (DME)

Bill DME claims on a separate line with RT and LT modifier for services that are site specific.

Example:

01/1/11	L3000RT
01/1/11	L3000LT

DME claims should also be submitted with the appropriate modifier:

- Use modifier RR if the equipment was rented
- Use modifier NU if the equipment was purchased

Please make sure that the quantity billed is relative to the description of the item.

Herceptin Billing

In November 2013, the Office of Inspector General (OIG) published a report regarding the units providers billed for Herceptin (J9355-injection, trastuzumab 10 mg). It found that 77 percent of the lines billed with units that were multiples of "44" (full vials) were billed in error. Providers attributed the inaccurate payments to clerical errors and to billing systems that could not prevent or detect the incorrect billing of units of service.

Herceptin (J9355-10 mg/unit) comes in a multi-use vial that contains 440 mg or 44 units. It's important to report the units actually administered and not the entire content of the vial.

HAP has identified a high frequency of billing full vials (based on units) of Herceptin. Our audits found that providers billed a higher number of units of Herceptin than what was actually administered. This has resulted in recovery of the units billed in excess of what was supported by the medical record documentation.

Home Health Claims Billing with 033X

Home Health claims with UB-04 Bill type 033X will no longer be accepted and will be denied if submitted. Instead, please use one of the following codes for Home Health services.

- 032 Home Health Inpatient, Medicare Part B only
- 034 Home Health Lab Services provided to non-patient

Home Health Providers and Skilled Nursing Facilities

CMS requires Health Insurance Prospective Payment System (HIPPS) codes on all Skilled Nursing Facilities and Home Health claims submissions for dates of service on or after July 1, 2014. HIPPS codes should come from admission assessments during a Medicare Advantage (MA)-covered stay.

Please continue to bill as follows:

- All Skilled Nursing Facility and Home Health claim submissions will include the appropriate Health Insurance Prospective Payment System/Resource Utilization Group (HIPPS/RUG) codes and related revenue code for HAP Senior Plus (HMO-POS) and Alliance Medicare PPO patients, regardless of the date of service.
  - The HIPPS/RUG codes must be submitted along with the appropriate revenue code, i.e., 0022 for SNF and 0023 for Home Health, according to CMS guidelines.
  - The HIPPS/RUG codes should not be submitted on any other revenue code line, nor should revenue codes 0022 and 0023 be submitted using a non-HIPPS/RUG code (HCPCS or CPT).
  - Revenue codes 0022 and 0023 should be submitted as the first claim lines and should reflect a billed amount of $0.00 (zero).
  - These criteria are required regardless of the provider's contractual agreement.
  - Failure to submit these codes will result in claims denial.
- Home Health providers must bill on institutional claims (UB 04 submissions).

Billing Guidance for Admission Assessments Not Completed During an MA-Covered Stay

- **Stay of more than 14 days:** In the order below, submit the HIPPS code:
  - From another assessment completed during the MA-covered portion of the stay
  - From the most recent assessment that was completed prior to the MA-covered portion of the stay
- **Stay of 14 days or less**: In the order below, submit:
  - The HIPPS code from another assessment from the stay
  - A default HIPPS code of AAA00. Do not use this default code in any other situations.

Hospital Acquired Conditions/Present on Admission Indicators (POA)

HAP requires hospitals to complete all UB-04 claim fields regarding POA indicators. Claims received without this information will be rejected.

On paper claims the POA indicator is the eighth digit of each of the diagnosis fields 67 and 67 A-Q on a UB-04. The code reason should be present in the shaded grey area of the field(s).

HAP does not require a POA Indicator for an external cause of injury code unless it is being reported as "other diagnosis."

CMS POA Indicator Reporting Options and Definitions

Y Diagnosis was present at the time of inpatient admission

N Diagnosis was not present at time of inpatient admission

U Documentation insufficient to determine if condition was present at the time of inpatient admission

W Clinically undetermined; provider unable to clinically determine whether the condition was present at the time of inpatient admission

1 Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04; however, it was determined that blanks were undesirable on Medicare claims when submitting this date via the 004010/00410A1.

Electronic claims submission:

- Be sure to complete the "**2300 loop segment K3- data element K301.**
- POA is always required first, followed by a single indicator for every diagnosis reported on the claim (as indicated above)
- The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element.

  Example: POAYNNZ

Any claim that contains services for any of the condition indicators below will be processed following the CMS guidelines for non-payment.

- Injuries sustained through falls
- Infection from indwelling bladder catheter (not present on admission)
- Stage 3 or 4 decubitus ulcers
- Infection from vascular catheters
- Chest wound infection following coronary artery bypass surgery
- Objects left in patient during surgery
- Blood product incompatibility
- Air embolism

If you submit your claims on a UB-04 claim form and are a CMS defined exempt facility, HAP still requires the POA indicator to be populated. The POA indicator of "1" for exempt will allow your claim to be accepted and processed accordingly.

The hospitals below are exempt from the POA Indicator and Hospital-Acquired Conditions (HAC):

- Critical Access Hospitals (CAHs)
- Long-term Care Hospitals (LTCHs)
- Maryland Waiver Hospitals
- Cancer Hospitals
- Children's Inpatient Facilities
- Veterans Administration/Department of Defense Hospitals
- Rural Health Clinics
- Federally Qualified Health Centers
- Religious Non-Medical Health Care Institutions
- Inpatient Psychiatric Hospitals
- Inpatient Rehabilitation Facilities

For more information on HAC POA visit **www.cms.gov.**

Inpatient Admissions

If an inpatient admission request is denied, the facility may bill for an observation. The claim will be reviewed and if it's considered complete from a claims perspective, observation rates will be paid.

Interim Bills

HAP does not accept claims billed with an interim bill type, i.e., a type of bill containing a 2, 3, or 4 in the 3rd digit, unless the claim is for continuing services provided by a Skilled Nursing Facility (bill types 212, 213, 214). All other facility claims must be billed with the "admit through discharge" information.

For continuing care, (i.e. physical therapy) facilities can use their best judgment in identifying a span of service over which all services occurring during that span are billed on one claim, with service from and to dates, and as an admit through discharge bill. HAP recommends weekly periods but will accept any period that is satisfactory to the provider.

J-Codes to be Audited for Quantity Limitations

Effective September 1, 2015, the J-codes identified below will have a maximum unit amount. Units billed beyond the customary usage on a single date of service will require medical notes for payment.

Procedure Code	Billable Unit Limit Value
J2505	1
J9019	55
J9033	275
J9041	35
J9171	220
J9305	130
J9306	840

Maternity Care and Delivery

All facilities must submit mom and baby charges on two separate claims:

- One claim should contain all charges for mom from “date of admission through discharge”
- One claim for the newborn from “date of birth through discharge”

Professional claims for services rendered to newborns must be billed using the baby's name and HAP ID number. This includes any services provided while the baby is inpatient with the mother immediately following birth, and any services provided while the baby stays on as a boarder baby. You must verify that the baby has been enrolled in HAP, and use the unique HAP ID number assigned to the baby to bill for professional services rendered to a newborn.

This affects your HAP and Alliance Health and Life Insurance Company patients.

Antepartum care, delivery and postpartum care

For antepartum care and delivery, HAP requires global codes inclusive of antepartum and delivery (59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622, 59425 and 59426, depending on type of delivery). Although the codes indicate the postpartum care, the reimbursement will be based only on the prenatal and delivery care provided.

Prenatal services only (no delivery with the visits)

Please follow the guidelines below:

- **Box 14 of CMS1500**
  Enter the EXACT LMP
- **Dates of Service From/To**
  Enter first prenatal visit and last prenatal visit as “from/to” date
- **Quantity field**
  Bill quantity of one

Global maternity package: Prenatal services with delivery and postpartum care (7 or more prenatal visits)

- **Box 14 of CMS1500**
  Enter the EXACT LMP
- **Dates of Service From/TO**
  Enter first prenatal visit and date of delivery as “from/to” date
- **Quantity field**
  Bill quantity of one

Postpartum claims should not be submitted to HAP until the care has been rendered. Bill them separately using CPT-4 code **59430**. This code can be used in addition to any codes that correspond to accompanying services (i.e. 58300 for IUD insertion; 88147 for cervical/vaginal cytopathology, etc.).

If a physician (or group practice) provides part, but not all the antepartum care, postpartum care, and/or delivery, only use the CPT-4 code for the specific services rendered by each physician.

Boarder Baby

For non-contracted DRG reimbursement providers, if the mom is discharged and the baby remains inpatient (boarder baby):

- A separate claim for the services provided to the baby from the discharge date of the mother through the discharge date of the baby should be submitted.
- The baby must be enrolled in HAP.
- Bill with the baby's HAP ID number. Please note that you will need to obtain the necessary eligibility information.

This is consistent with HAP's requirement for all professional charges incurred from the baby's birth. Please see the professional claim section for further clarification.

Multiple Births

For multiple births, please bill for each subsequent child as follows:

- Use the appropriate delivery only code (59409, 59514, 59612, and 59620), depending on the type of delivery) followed by modifier 59 in the first modifier position and modifier 51 in the second modifier position
- If both twins are delivered via cesarean delivery, report code 59510 or 59514 one time; append modifier 22 if the cesarean delivery is significantly more difficult.

Reimbursement is allowed at 50 percent of the contracted fee for each additional birth occurring within the delivery. This is in addition to the fees normally paid when one baby is born vaginally and the other by cesarean delivery. No additional fees will be due for cesarean delivery only.

Newborns

All professional non-inpatient claims must be submitted to HAP under the newborn's contracted HAP ID number for any services rendered from their birth. Physicians must verify eligibility and network assignment prior to each visit by one of these methods:

- Online at **hap.org** via the Member Eligibility Application. Remember to use your NPI or vendor number to log in. If you cannot find the member using his/her ID number, try searching by last name using the magnifying glass icon.
- Call the Provider Automated Service (PAS) line at **(800) 801-1766** (24/7)
- Call the Provider Verification line at **(313) 664-8995**, Monday-Friday, 8 a.m. to 4 p.m.

Medicare Preventive Exams – Use Correct Codes

HAP covers preventive/wellness exams billed in conjunction with an office visit for HAP Medicare members when they meet the following:

- Billed with appropriate modifiers and
- Medically necessity

Covered preventive/wellness exams and office visit codes include:

- Preventive/wellness visit codes: G0402, G0438, G0439
- Office visit codes: 99201-99205 and 99211-99215

Exam Description	Appropriate Code to Bill
Initial Preventive Physical Examination (IPPE). Also known as the "Welcome to Medicare" visit for new Medicare beneficiaries who are within the first 12 months of their Medicare Part B coverage. This is a one-time benefit.	G0402
Annual Wellness Visit. With a personalized prevention plan of service (PPS), initial visit	G0438
Annual Wellness Visit. With a personalized prevention plan of service (PPS), subsequent visit	G0439
New patient office visit	99201-99205
Established patient office visit	99211-99215

There are no copays for preventive visits; however, any applicable copays may apply to office visits.

For UAW Retiree Medical Benefits Trust Medicare HMO members

Comprehensive preventive medicine E&M codes 99381-99387 and 99391-99397 are only covered for Chrysler, Ford and General Motors UAW Retiree Medical Benefits Trust Medicare HMO members with the group numbers below and can be billed with an office visit if appropriate.

- 10000671 (first eight digits)
- 10000672 (first eight digits)
- 10000673 (first eight digits)

For more information about Medicare Preventive Services, visit **www.cms.gov.**

Comparing the IPPE: Welcome to Medicare exam, Initial AWV and Subsequent AWV

	Initial Preventive Physical Exam: Welcome to Medicare Exam Note: The IPPE and Initial AWV is a one-time benefit	Initial Annual Visit	Subsequent Annual Visit
Eligibility	All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period may get an IPPE	Medicare covers an AWV for all beneficiaries who are no longer within their first 12 months of Part B coverage and have not gotten an IPPE the past 12 months (and at least 11 months have passed since the IPPE)	Medicare pays for one subsequent AWV every year after the first AWV (each AWV mush be 11 full months after the last AWV)
Billing Codes	G0402	G0438	G0439
Who can perform?	A physician, a qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist)	A physician, a qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist), or a medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician	
Requirements (at a minimum)		Health Risk Assessment (HRA)[2]	Update Health Risk Assessment (HRA)[2]
	Review and document medical and social history[1]	Review and document medical and family history[2]	Update medical and social history[2]
	Review risk factors for depression and mood disorders[1]	Review risk factors for depression and mood disorders[2]	
	Review functional ability and level of safety[1]	Review functional ability and level of safety[2]	
	Document height, weight, blood pressure, visual acuity screen, body mass index and other factors deemed appropriate[1]	Document height, weight, blood pressure, body mass index (or waist circumference, if appropriate) and other factors deemed appropriate[2]	Document weight, blood pressure, (or waist circumference, if appropriate) and other factors deemed appropriate[2]
		Assess the patient's cognitive function[2]	Assess the patient's cognitive function[2]
		Establish a list of current providers and suppliers involved in the patient's care[2]	Updated list of current providers and suppliers involved in the patient's[2]
	End-of-life planning, upon consent of patient[1]		
		Establish list of risk factors, conditions and treatments[2]	Update list of risk factors, conditions and treatments[2]
	Provide education, counseling and referrals as needed[1]	Provide personalized health advice and referrals as needed[2]	Provide personalized health advice and referrals as needed[2]
	Establish a written plan for preventive screenings (EKG/ECG)[1]	Establish a written screening schedule for preventive screenings for the next 5-10 years[2]	Update written screening schedule[2]

References:

1. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf
2. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

Mental Health and Chemical Dependency

Mental Health and Chemical Dependency facility services should be submitted with the appropriate bill type, revenue code and HCPCS combination based on the servicing provider location. The provider's individual contract may supersede the information listed as some providers have unique contracts and their billing criteria may be different.

Mental Health Services	Bill Type	Revenue	HCPCS
MH Inpatient	111	124	
MH/IOP (Intensive Outpatient)	131	905	S9480*
MH/DIOP (Domiciliary Intensive Outpatient)	111	905	H2013*
Residential Treatment (Short-Term Specialty Unit, Non-Hospital)	861 or 131	1001	H0018*
Partial Hospitalization (Day Treatment)	131	912	H0035*
Partial Hospitalization (Day Treatment Overnight)	111	913	H0035*
23 Hour Hold (Observation)	131	762	G0378*
ECT (Electroconvulsive Therapy)		901	90870*

Mental Health Diagnoses Codes: 290 - 302.9, 306 - 319, 331 - 32.89
* HCPCS Codes are required on the UB-04 claim form, Field Locator 44

Chemical Dependency Services	Bill Type	Revenue	HCPCS
CD Inpatient	111	126	
CD/IOP (Intensive Outpatient)	131	906	H0015*
CD/DIOP (Domiciliary Intensive Outpatient)	111	906	H0017*
Residential Treatment (Short-Term Specialty Unit – Non-Hospital)	861 or 131	1002	H0018*
Partial Hospitalization (Day Treatment)	131	912	S0201*
Partial Hospitalization (Day Treatment Overnight)	111	913	H0017*
23 Hour Hold (Observation)	131	762	G0378*
Halfway House	111	1004	H2034*

Chemical Dependency Diagnoses Codes: 303 - 305.93
* HCPCS Codes are required on the UB-04 claim form, Field Locator 44

Modifier Usage

HAP requires that the appropriate modifier be used to identify who provided medical care. Modifiers include, but are not limited to:

- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Nurse Specialist
- Clinical Psychologist
- LPN
- Nurse Practitioner
- Nurse Midwife
- Physician Assistant
- RN

These modifiers should be used on every claim that is submitted to HAP. According to your HAP provider contract, HAP reserves the right to perform a retrospective audit of medical records to determine that the caregiver was appropriately represented on the claim submitted.

Modifier 24: Unrelated Evaluation and Management Service by the Same Physician

(same specialty using same Tax ID) during a postoperative period)

Use modifier 24 for E/Ms that are not related to the surgery within the global period. There should be a new diagnosis for the new problem. Documentation should support that the E/M service is not related to the postoperative care of the surgical procedure.

Inpatient hospital care provided during the hospital stay in which a surgery occurs is not paid unless the doctor(s) in the same specialty under the same Tax ID is also treating the member for another medical condition that is unrelated to the surgery. All care provided during the inpatient stay, in which the surgery occurred, is compensated through the global surgical payment. Supporting medical necessity must be clearly documented in the patient's medical records.

Modifier 25

Modifier 25 is used to indicate that, on the day of a procedure or service identified by a CPT code, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided. The separate E/M service must go beyond the usual preoperative and postoperative care associated with the procedure that was performed, or beyond the usual work associated with a preventive E/M code (99381-99397).

Use of modifier 25 also applies to physicians in the same group and/or same specialty as the operating physician.

HAP will not pay for an E/M code on the same day, same visit as a preventive E/M code (99381-99397) unless the problem or abnormality meets the requirements in item 4 below.

Reporting an E/M service with modifier 25 is only appropriate if at least one of the following conditions has been met:

1. The patient requires evaluation "above and beyond" what is typically expected as part of the evaluation prior to the procedure.
2. The patient's condition has changed or worsened and the patient needs to be reevaluated.
3. The patient presents with a new, separate problem other than the problem that prompted the procedure.
4. On the same day, same visit as a preventive E/M service (99381-99397) there is a problem or abnormality significant enough to require the additional work to perform the key components of a problem-oriented E/M service.

The E/M service must require additional history, exam, knowledge, skill, work time, and/or risk above and beyond what is usually required for the procedure or preventive E/M service.

Modifier 26

Certain procedures are a combination of a physician component and a technical component. HAP requires modifier 26 when the physician component is submitted separately for all professional services if performed in an inpatient/outpatient facility.

Example	**Procedure**	**Modifier**	**Quantity**
	88291	26	1

Modifier 50: Bi-Lateral Procedures

Procedures performed bilaterally with a Medicare Physician Fee Schedule Database (MPFSDB) indicator of 1 or 3 should be reported once, with modifier 50 appended.

Modifier 51: Multiple Procedures

When using modifier 51, submit two claim lines with the CPT procedure codes. Bill the first code without the modifier and the second code with modifier 51. The quantity should be one (1) on each line. The primary procedure will be reimbursed at 100 percent of the contracted rate and the secondary at 50 percent of the contracted rate.

Example	**Procedure**	**Modifier**	**Quantity**
	69436		1
	69820	51	1

According to the CPT-4 coding manuals, certain codes are exempt from using modifier 51. These codes can be found in Appendix E of the CPT-4 Manual. If you find the procedure code in Appendix E, then modifier 51 should not be submitted.

According to the CPT-4 manuals certain "add on" codes may also be exempt from using modifier 51. The codes can be found in Appendix D of the CPT-4 Manual. When in doubt, reference the Clear Claim Connection Application.

Modifier 52: Reduced Services – Physician

Surgical services that are discontinued at the physician's discretion must be submitted with modifier 52. Do not use modifier 52 for a procedure that was discontinued for extenuating conditions (see modifier 53). Medical documentation is required and a fee reduction applies.

Modifier 53: Discontinued Service – Physicians

Use modifier 53 for surgical or diagnostic services that are terminated by the physician due to extenuating circumstances or those that threaten the well-being of the patient. Medical documentation is required and a fee reduction applies.

Modifier 54: Surgical Care Only

Use modifier 54 with the surgical code when a surgeon only performs the surgery and the member goes to another provider for follow up care.

HAP follows CMS guidelines for reimbursement based on intra operative percentage value of the global surgery fee for CPT codes with a 10-90 day post-op period.

Modifier 55: Postoperative Management Only

Use modifier 55 with the surgical procedure when a surgeon, other than the surgeon who performed the surgery, provides the follow-up care.

HAP follows CMS guidelines for reimbursement based on post-operative percentage value of the global surgery fee for CPT codes with a 10-90 day post op period.

Modifier 56: Preoperative Management Only

Use modifier 56 with the surgical procedure being performed when a different surgeon performs the preoperative care only.

HAP follows CMS guidelines for reimbursement based on preoperative management percentage value of the global surgery fee for CPT codes with a 10-90 day post op period.

Modifier 59: Distinct Procedural Service

The CPT Manual defines Modifier 59-Distinct Procedural Service as follows:
Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.

This may represent:

- A different session or patient encounter
- A different procedure or surgery
- A different site or organ system
- A separate incision/excision
- A separate lesion
- A separate injury (or area of injury in extensive injuries)

These circumstances are not ordinarily encountered or performed on the same day by the same physician. When another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Incorrect Use of Modifier 59
Modifier 59 is not allowed when the following occurs:

- A procedure/service was not independent or distinct from any other service performed on the same day, same session, same site or lesion
- There is another existing modifier that better represents the service or procedure
- It is appended to an E/M service

Clinical Information Requirements
Claims submitted with Modifier 59 that do not pass the clinical edits will not be processed for benefits until medical documentation is received to support use of the modifier. Documentation must be specific to the distinct procedure or service and clearly identified in the medical record. It must also support the circumstances identified above.

Modifier 62: Two Surgeons

When two surgeons work together as primary surgeons on a distinct procedure, each surgeon must submit modifier 62 with all the same procedure codes as long as they are working together as primary surgeons.

If one surgeon is acting as an assistant, submit the appropriate modifier (80, 81 or 82).

If providers are with the same specialty, submit modifier 62. Documentation is required to support the medical necessity of the same specialty.

Medical records must be clearly documented to support medical necessity when billing modifier 62.

Providers will be reimbursed a percentage rate of fee based on CMS guidelines.

Modifier 73: Facility Billing Only

Referred by outpatient hospital ASC facility

Use modifier 73 for extenuating circumstances or those that threaten the well-being of the patient. The physician may cancel a surgical diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia.

If a procedure is interrupted before the induction of anesthesia and before the patient is taken to the procedure room, the procedure should not be reported. A diagnosis code from the V64.X series should be included to indicate the reason for cancellation.

Payment for modifier 73 is paid at 50 percent of the facility rate, subject to the ASC payment calculations only if the procedure is an approved ASC service.

Modifier 74: Facility Billing Only

Referred by outpatient hospital ASC facility

Use modifier 74 for extenuating circumstances or those that threaten the well-being of the patient. The physician may interrupt a surgical diagnostic procedure after anesthesia was administered or after the procedure was started. Supporting medical documentation must include:

- Reason for termination of the surgery
- Services actually performed
- Supplies actually provided
- Services not performed that would have been performed if surgery had not been terminated
- Supplies not provided that would have been provided if the surgery had not been terminated
- Time actually spent in each stage, (e.g., pre-operative, operative, and post-operative)
- Time that would have been spent in each of these stages if the surgery had not been terminated
- HCPCS code for procedure had the surgery been performed

A modifier should not be used when surgery is cancelled by the physician or patient's choice.

Modifier 76

(not applicable to repeat clinical diagnostic laboratory tests)

Modifier 78: Return Trip to Operating Room

Use modifier 78 when there is a return to the operating room for a related procedure during the postoperative period. It should also be reported when complications from surgery requires a return visit to the operating room. A different CPT code should be submitted. A new global period will not begin.

HAP follows CMS guidelines for reimbursement based on intra operative percentage value of the global surgery fee for CPT codes with a 10-90 day post op period.

Modifier 79: Unrelated Procedure or Service by the same physician

(same specialty under same Tax ID) during the postoperative period

Use modifier 79 when a procedure or service is unrelated to the original procedure during the postoperative period. Supporting documentation must be clearly documented in the patient's medical records.

Modifier 91: Repeat Clinical Diagnostic Laboratory Test

Use modifier 59 when distinct and separate multiple services are performed for different specimens/sites. Medical necessity must be documented.

Use modifier 91 when there is a need to repeat the same laboratory test on the same day to obtain multiple test results. The modifier should not be used:

- To confirm initial test results
- For testing problems encountered with specimens or equipment
- For any other reason when a normal, one-time, reportable result is all that is required
- When another code describes the test results

Medical necessity must be documented.

Co-Management: Modifiers used with surgical procedures only

GE Modifier for Resident Performing Services

The Evaluation and Management services outlined below must be billed with a GE modifier which means that they can be performed by a resident without the presence of a teaching physician under the primary care exception.

- 99201
- 99202
- 99203
- 99211
- 99212
- 99213
- G0344
- G0402
- G0438
- G0439

Modifiers KX, KY: Diabetic Supply

Diabetic Supply claims should be submitted as follows:

- Modifier KX for insulin dependent
- Modifier KS for non-insulin dependent

Modifiers KX, EY, GA, GZ: CPAP BIPAP Supply

CPAP BIPAP supply claims must be submitted with the appropriate modifiers.

KX: Requirements specified in the medical policy have been met
EY: No physician or licensed health care provider order for this item or service
GA: Waiver of liability statement issued, as required by payer policy
GZ: Item or service expected to be denied as not reasonable and necessary

Modifiers PA, PB, PC

(Never Events for Outpatient, Ambulatory Surgical Centers, other bill types and practitioners)

Use modifiers PA, PB, or PC when a practitioner erroneously performs a different procedure; a correct procedure but on the wrong body part; or the correct procedure but on the wrong patient.

Modifiers RT and LT- Bi-Lateral X-Rays

When submitting bi-lateral X-ray services, you must use modifiers RT (right) and LT (left). Modifier 50 should not be used. The quantity should be one on each line.

Example	**Procedure**	**Modifier**	**Quantity**
	73080	RT	1
	73080	LT	1

Modifier TC

Certain procedures are a combination of a physician component and a technical component. HAP requires modifier TC when the technical component is submitted separately from the professional services if performed in an inpatient/outpatient facility.

Example	**Procedure**	**Modifier**	**Quantity**
	88291	TC	1

Technical Surgical Assistant (TSA) Services

Submit claims for TSA services with the appropriate TSA modifier. The surgical CPT procedure code and billed amount should match what the primary surgeon has submitted.

Documentation is required when billing an unlisted procedure code. TSA claims will be reduced based on industry standard guidelines.

TSA modifiers:	80	81	82	AS	Y1	Y2
	Y3	Y4	Y5	Y6	Y7	

Modifiers UN, UP, UQ, UR, US - Transport of Portable X-rays

When more than one Medicare patient is X-rayed at the same location, the single fee transportation payment is prorated among all the patients receiving the services. The following modifiers must be used with procedure code R0075 when the X-ray is transported to a location:

UN: Two patients	UQ: Four patients	US: Six patients or more
UP: Three patients	UR: Five patients	

Modifiers for DME

Durable Medical Equipment claims must be submitted with the appropriate modifiers.

- MS: Maintenance and Servicing
- UE: Used
- NR: New when rented, subsequently purchased
- NU: New equipment
- RR: Rental
- RA: Replacement of DME item
- RB: Replacement part, DME item furnished as part of a repair
- KC: Replacement of Special Power Wheelchair interface
- KE: Bid under Round 1 or DMEPOS competitive Bid Program
- KF: Class III Device
- KL: DMEPOS item delivered via mail

Please ensure that the quantity billed is relative to the description of the item.

Multiple Surgical Services on Outpatient Facility Claims

When billing surgical procedures, each unit must be billed on a separate line with its own separate charge. Procedure codes should not be billed with $1 or $0 charges. Rolling charges into a single charge is not acceptable and will result in a denial of charges. In the event a claim is denied, an adjustment bill type will be required.

National Drug Code (NDC) Billing Requirement for Outpatient Drugs

Effective September 1, 2017 all claims for outpatient, drug-related HCPCS codes and CPT codes must also include the following information:

- NDC code of the product that was administered
- Unit of measure
- Quantity

Claims submitted without a valid NDC will reject.

This information is required for CMS-1500 and UB-04 claim forms and Electronic Data Interface transactions. This applies to all HAP products, excluding Medicare crossover claims and claims where HAP is **not** the primary payer. Please see attached list of affected codes. In the future, you can find this list when you log in at **hap.org.** Select *Procedure Reference Lists* under *Quick Links* and look for:

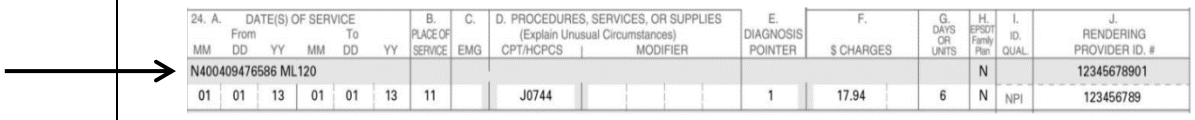
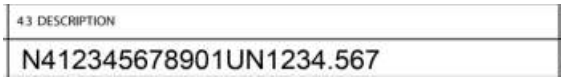
- *Codes that require an NDC*
- *Services that Require Prior Authorization List* or the *DME Services that Require Authorization List* (NDC will be indicated in the *Key* column if it is required)

Format

NDCs must contain a valid 11-digit number (no spaces, hyphens or extra characters) in a 5-4-2 format. The first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The other digits, which are assigned by the manufacturer of the drug, identify the specific product and package size. If an NDC is less than 11 digits, add leading zeros to the appropriate segment to create the 5-4-2 configuration. Please see table below for format details.

NDC format on label	Convert to 5-4-2 format
4-4-2: xxxx-xxxx-xx	0xxxxxxxxxx
5-3-2: xxxxx-xxx-xx	Xxxxx0xxxxx
5-4-1: xxxxx-xxxx-x	Xxxxxxxxx0x

Submitting the NDC

Claim	How to Submit
Electronic claims	Follow the 5010 837 X12 standard
CMS-1500 claim form	**In box 24A-24G – in the shaded portion** • Enter the NDC qualifier of N4 • Followed by the NDC number (see format above) • Enter one space for separation • Enter appropriate unit of measure (F2, GR, ML or UN) • Enter the quantity 
UB-04 claim form	**In box 43** 

If you have questions, please contact Provider Inquiry at (866) 766-4661.

Nurse Practitioner/Physician Assistant Midlevel Participation and Payment

HAP will credential nurse practitioners and physician assistants with whom it has an independent relationship and who work in conjunction with a HAP credentialed contracted physician.

Procedures

1. The NP/PA must meet HAP credentialing standards. NP/PA providers must be credentialed in areas of specialty approved by HAP.
2. If the supervising practitioner's PO/PHO acknowledges NP/PAs provider types, they will be credentialed through that PO/PHO agreement.
3. If the PO/PHO does not acknowledge NP/PA provider types, participation will be at HAP's discretion.
4. If the supervising practitioner does not participate with a PO/PHO, the NP/PA can be credentialed and contracted directly with HAP.
5. If requested, a PCP NP/PA can be included in the directory and allowed to have member assignment. If no member assignment is preferred, the PCP NP/PA can be included in the directory but will be noted "not accepting new patients".

Claims Processing and Reimbursement

- NP/PAs will be reimbursed at 85% of the supervising practitioner contracted rate with the PO/PHO or at 85% of HAP fee schedule for the independent midlevel provider. For Medicare Advantage (HMO and PPO), the midlevel provider will be reimbursed at 85% of the prevailing HAP Medicare regional fee schedule.
- This policy does not apply to providers who bill claims using a type 2 NPI (i.e. pathology, physical/occupational/speech therapy, anesthesiology, emergency medicine, urgent care, radiology, diagnostic radiology, psychology, psychiatry, optometry).
- Exceptions to the 85% reimbursement are 'incident to' services which will be reimbursed to the PCP at 100% of contracted rate per CMS guidelines. This will be audited periodically.

Oxygen Rental

HAP aligns itself with Medicare guidelines for oxygen equipment rental. Payment is made over a 36-month period for oxygen and oxygen equipment needs for up to five years. See the table below for details.

During Months	What you can bill for
1-36	Oxygen equipment rental which includes: • Accessories • Maintenance and repairs • Delivery back-up equipment
37-60	Oxygen content-if a member has portable oxygen that requires a tank (and not a concentrator) Maintenance service charges are allowed

After 60 months, an evaluation to confirm that the patient still meets criteria or oxygen services is required. Then, the equipment is replaced and a new payable rental period of 36 months begins.

Physical, Occupational, and Speech Therapy

Therapy services must be billed with a separate line for each unique procedure or modality for each specific date of service and must contain the CPT or HCPCS procedure code performed in addition to the appropriate hospital revenue code.

For example: if two unique therapy services were performed on two different dates of service, four individual lines are required, each of which should also reflect the quantity of unique procedures or modalities performed.

Example

Date of Service	Revenue	Procedure	Quantity
3/8/2007	424	97001	1
3/8/2007	420	97110	1
3/25/2007	424	97001	1
3/25/2007	420	97110	1

HAP follows Medicare billing guidelines and requires a modifier for Physical, Occupational and Speech Therapy services for all HAP, Alliance and HAP Preferred members. All claims submitted on a CMS-1500 form must include the applicable modifier for the CPT or HCPCS code. Claims submitted without a modifier will be denied as non-clean and returned to the provider.

Modifier	Description
GN	Services delivered under an outpatient speech language pathology plan of care
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care

Preventive Services Billed with Pap Smears, Breast Exams, Prostate Screening

Preventive services include a comprehensive review of systems, family and social history, ordering of immunization, laboratory/diagnostic procedures, examination, counseling and comprehensive assessment/history of pertinent risk factors. Discussion of common issues related to age is also included in the exam.

Payment for the E/M or the preventive exam service includes allowing for the Pap smear when performed during the same visit. Modifier 59 should not be billed with codes Q0091, G0101, G0102, or G0103 when a preventive service is provided.

Quantities

A quantity is required for each line on a CMS-1500 claim form. Please ensure that the quantity you bill is relative to the description of services performed.

Examples

- Billing injectables with the quantity of cc's dispensed when the procedure description already indicates "vial" or "50 cc's".
- Billing repeat procedures with a quantity of 2. Instead bill separate lines with the correct modifier describing the service as a repeat.

Reimbursement for Discarded Biologic and Non-Biologic Drugs

HAP reimburses for discarded biologic and non-biologic drugs up to the dosage amount indicated on the vial or package label as well as the dose administered if:

- The drug is supplied in a single use vial or single use package.
- The drug is administered to the patient to appropriately address the patient's condition and any unused portion is discarded.
- Note: A provider cannot bill HAP for discarded drugs if none of the drug was administered to a patient (e.g. member misses an appointment, not clinically safe to administer drug).
- The amount discarded, date, time, and reason for the wasted amount is documented in the patient's medical record.
- The amount billed to HAP as discarded is not administered to another patient.
- The physician's orders for the drug must be clearly and completely documented in the medical record.
- The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
- The drug cannot be safely rounded up to full vial size.

How to bill

Physicians, hospitals and health care providers must bill with modifier JW on a separate line. The JW modifier:

- Will provide payment for the amount of discarded drug
- Is only applied to the amount of drug that is discarded (e.g. drug vial portion that could not be safely administered to the same patient that the provider is billing HAP for the used drug vial portion)
- Is not used when the actual dose of the drug administered is less than the billing unit defined in the HCPCS descriptor

Note: Multi-use vials are not subject to payment for discarded amounts of drug.

For more information, please see the *Discarded Biologic and Non-Biologic Drugs* policy when you log in at **hap.org** and select the *Working with HAP* tab, then *Policies and Procedures*.

Reimbursement for Medication Reconciliation Post Discharge for Medicare Advantage Members

Effective with dates of service January 1, 2018 and forward, HAP will reimburse providers for medication reconciliation within 30 days of inpatient discharge for Medicare Advantage members. To receive reimbursement for medication reconciliation, it must be:

- Conducted by the prescribing physician, clinical pharmacist or registered nurse
- Billed with CPT code 1111F

For more information on using 1111F, please see the frequently asked questions below.

What are the medical record documentation requirements?
The outpatient medical record must include:

- The hospital discharge date.
- The date the medication reconciliation was completed.
- Documentation indicating that the patient's current list of medications was reconciled against the hospital discharge list of medications.

Why use 1111F when submitting claims for Medicare Advantage members?
The 1111F code will help reduce the number of medical record review requests you receive from HAP.

How should 1111F be billed on a claim?
The same way as any other CPT code. The reimbursed amount for 1111F is $8.

Is there a frequency or time limitation for billing 1111F?
It must be billed within 30 days of each inpatient discharge to home, one per discharge (except when billed retroactively to January 1, 2018 due to the new policy).

Will 1111F be reimbursed separately in addition to the office visit?
Yes.

Is the $8 reimbursement for 1111F an incentive?
No. The $8 reimbursement for 1111F is a separately payable service for conducting medication reconciliation within 30 days of the inpatient discharge.

Can I submit claims with 1111F for HAP commercial members?
No, it is only for Medicare Advantage members.

Is there any patient cost sharing for 1111F?
No.

Room Charges

HAP allows coverage for a semi-private room rate unless a private room is specifically authorized. When an authorization is not granted and a private room is submitted for consideration, the private room rate will be adjusted to the semi-private rate.

Therapeutic, Prophylactic, or Diagnostic Injection – 96372

When billing injections, the appropriate substance or drug must be specified. If the member presents the drug and is only requiring administration, submit the appropriate J code that defines the drug being supplied with a $0.00 billed amount. Box 19 must contain the description of the drug and NDC. Any claim that does not specify the drug will deny CXT01 – add on without base.

Therapy Limits for Medicare Members

Medicare has eliminated dollar limits on payment for medically necessary outpatient therapy services per year that includes:

- Physical therapy
- Occupational therapy
- Speech-language pathology therapy

However, additional information is required when therapy services reach certain amounts. Please see the table below for details.

Dollar limits reached	Requirements
$2,010 for PT and SLP services combined $2,010 for OT services	• Therapist will add information to patient's medical record • Therapist will add a modifier KX to therapy claim that confirms: – Therapy services are reasonable and necessary – Medical record includes information explaining why the services are medically necessary
$3,000 for PT and SLP services combined in 2018 $3,000 for OT services in 2018	The therapist or provider can contact HAP to request an organization determination prior to services being rendered to ensure that services will be approved as medically necessary. They can do this by: • Calling HAP's Referral Management Team at (313) 664-8950, option 1. • Entering a request in our online authorization application, CareAffiliate. If the pre-service organization determination is denied and the member receives the services after receipt of the denial notice, the member may be responsible for payment of the denied services.

Urgent Care

According to the provider contracts, services must be billed with the specific contracted CPT code to receive the appropriate reimbursement rate.

When billing for services in an urgent care setting, please be sure to use:

- The urgent care group NPI number in Box 33a on the CMS-1500 claim form or the equivalent field on the electronic claim form, whether or not it is listed in the facility field, Box 32a
- Each urgent care address or site's group NPI number
- Procedure code S9083, Place of Service code 20 and appropriate diagnosis codes

Following these guidelines will help to ensure your claims get priced and paid appropriately.

Vision Claims

If the patient receives eyeglass lenses with a different prescription for each eye, bill on two separate claim detail lines with a quantity of one each.

If the patient has the same prescription for both eyes, bill on one claim line with a quantity of two.

When submitting claims electronically be sure to complete the "**2300 loop CRC segment CRC*E1*Y*L1~.**" This comes right before the HI segment with the diagnosis code.

Unilateral Ophthalmic Services

When submitting unilateral ophthalmic services, you must use modifiers RT (right) and LT (left). Modifier 50 should not be used. The quantity should be one on each line.

Example

Procedure	Modifier	Quantity
92135	RT	1
92135	LT	1

Section V – HAP's Wellness Programs

Reward Your Health

Many HAP members are participating in HAP's Reward Your Health wellness program through their employer. The program is designed to promote healthy lifestyles and prevent future health conditions. Members are rewarded for their healthy behaviors.

Important!

Employer groups customize the program to meet their specific needs. For example, one employer may require testing for tobacco use while other employers don't. **It's very important to read the instructions on the form so you know what tests are required for each member.**

Member Requirements

To qualify for rewards, members are required to submit biometric requirements. Here are the steps for members.

1. Download their Physicians Results form.
2. Schedule an appointment with their primary care physician.
3. Complete the "Know your Numbers" section with their physician.

Primary Care Physician Requirements

Primary care physicians need to:

1. Follow the instructions on the Physician Results Form.
2. Complete sections two and three of the form.
3. Sign the form.
4. Submit the form following the guidelines below.
   - If you're a member of the Henry Ford Medical Group:
     - **Do not fax the form.** The screening tests will be uploaded from EPIC to HAP.
   - If you're **not** a member of the Henry Ford Medical Group:
     - Fax the form to the number on the bottom of the form.
     - Bill with CPT code 99199. Faxed forms will receive a $15 reimbursement.
5. Return a copy of the completed form to the patient. Please do not bill the patient for completing the form.

If you have any questions, please contact Provider Services at (866) 766-4708.

Reward Your Health Sample Form

Physician Results Form

All information is required to process your Physician Results form.
Incomplete, illegible or past-deadline forms will not be processed.

By submitting this form I am requesting my primary care physician to report my biometric results to BioIQ, HAP's iStrive® for Better Health data provider. These results are used for Reward Your Health, a HAP wellness program.

Member Instructions

1. Print this form and ask your physician to complete sections 2 and 3.
2. Review the form for completeness before submitting it to BioIQ. Incomplete forms will not be processed.
3. Please fax the completed form to BioIQ at (888) 288-0377 and keep a copy for your records.

Physician Instructions

1. To qualify for our Reward Your Health wellness program, your patient's biometric data must be reported to us.
2. Please complete sections 2 and 3. Please be sure to sign and date the form.
3. Please return the completed form to your patient and keep a copy for your records.
4. For billing purposes, please use CPT code 99199.

Section 1. Patient Information

First Name: _____ Email Address: _____

Last Name: _____ BioIQ Patient ID: _____

Gender: _____

Phone Number: _____

Section 2. Biometric Results (Must be Completed by Physician)

For individual results, write the numeric value in the box and fill in the corresponding circle below each number.

Fasting ☐ YES ☐ NO

Height ☐ FT ☐ IN

Weight ☐ LBS

Date of Exam ☐ MM ☐ DD ☐ YYYY

Blood Pressure Systolic	Blood Pressure Diastolic	Glucose (mg/dL)	A1C (mg/dl)	Total Cholesterol (mg/dL)	LDL Cholesterol (mg/dL)

Section 3. Physician Information (All Information is Required)

By providing Physician Information below, I certify that the Biometric Results provided in Section 2 belong to the Patient identified in Section 1 of this form.

Physician Signature _____ Physician Phone Number _____ Date _____

Physician Name (Please Print) _____ UPIN/NPI _____

DO NOT SUBMIT THIS FORM TO YOUR HUMAN RESOURCES DEPARTMENT
Please fax completed form to 1-888-288-0377
For questions email support@bioiq.com

PRF v3.0

WebMD health services hap bioIQ

Aspire and Achieve Programs – Member Qualification Form

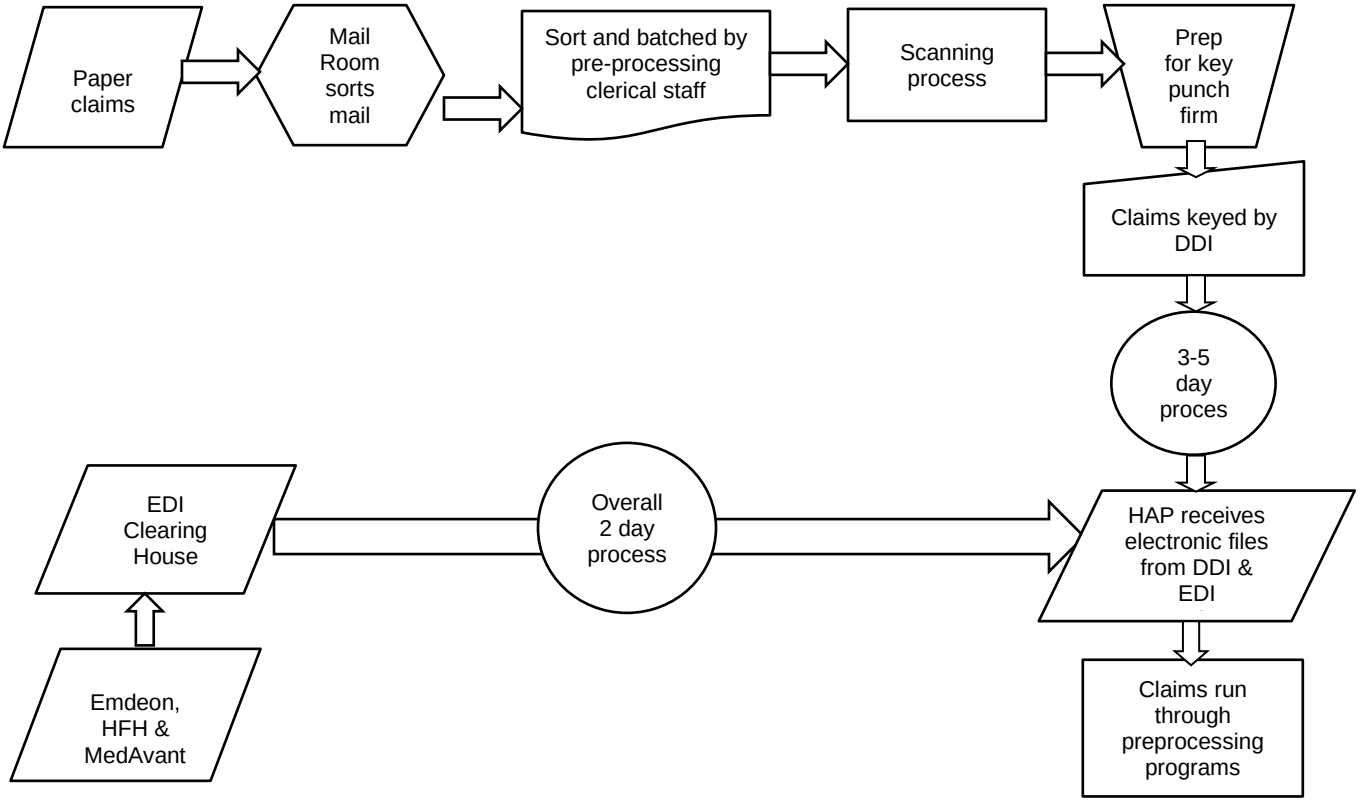
Some employer groups will have HAP's health engagement program—Aspire and Achieve. Members in either option must see a HAP-affiliated primary care physician or approved specialist (cardiologist, endocrinologist, OB/Gyn, geriatric specialist only) to complete and submit their Member Qualification Form that attests to their healthy lifestyle or efforts to achieve this status.

Instructions for completing the MQF are found on the back of the form. Forms submitted online will receive a $30 reimbursement. Faxes are acceptable but aren't eligible for reimbursement. Please use 99080 when billing.

Section VI- HAP Processing

Pre-Processing

The flow chart below provides a breakdown of both the EDI and paper claims submission process. All paper claims, where HAP is billed as the primary insurer, are sorted, scanned and entered into an electronic file format, typically within two to five days of receipt. Claims submitted via EDI are already in the electronic file format and therefore the two to five day processing time is eliminated.



Electronic claim files are sent through "Pre-Processing" where they are screened for completeness and accuracy. Pre-processing also determines whether a member is eligible or has other primary coverage.

When a claim fails one of the edits in our Pre-Processing program, it is classified as a "non-clean" claim and will not be accepted as billed. If a claim fails the Pre-Processing program and was submitted on paper and HAP is the primary carrier, the provider will receive an unaccepted claim report with the following information:

- Patient name
- Dates of service
- Provider account number with identification of the issue that needs correcting

For paper claims where HAP is the secondary carrier, the claim will be returned to the provider with a letter outlining the reason for the claim return. Refer to Appendix A of this manual for a sample of this letter.

For claims submitted electronically, HAP will record the information in an electronic file and send it to the providers' EDI Clearinghouse. The Clearinghouse is responsible to communicate the findings directly to the provider. In some cases, HAP may also produce and send a paper report in addition to the electronic file.

It is the provider's responsibility to correct any errors identified on the Unaccepted Claims Report (or letter) and resubmit the claim to HAP. All resubmissions are subject to Pre-Processing edits that may again identify errors or require further correction. Some errors are correctable via the online Provider Claim Status Application. Refer to Appendix B of this manual for a listing of Unaccepted Claims Report reason codes.

Claim Prepayment Review Process

HAP has a robust pre-payment review process to ensure compliance and accurate billing. We are contracted with TC3 Health, an Emdeon company to perform these claim reviews.

Claims are sent nightly to TC3 where they go through an algorithm with an outcome in one of the categories below.

1. Claims pay with no issues
2. Claims deny with a reason code
3. Claims pend for investigation and:
   - TC3 sends a letter to the physician asking for medical records
   - TC3 reviews the medical records and makes a payment decision
   - If you do not agree with the TC3 decision records, contact HAP's Provider Inquiry department at (866) 766-4661 to request an appeal.

For more information on TC3 and the pre-payment process, please log in at **hap.org**, then *Payment Integrity* under *Quick Links*.

Adjudication

Once a claim has been screened and accepted via HAP's Pre-Processing programs, it enters the adjudication system. All HAP primary claims are adjudicated in a batch processing environment. In that process, claims are edited a second time to determine benefit eligibility and whether authorizations are required. They are screened for other insurance coverage (worker's compensation or auto) and priced according to the provider's contract with HAP. Professional claims are also screened for appropriate coding.

If the batch process does not identify any exceptions and the services were authorized and correctly submitted, the claim is approved as it enters the adjudication environment.

The most common reasons for claims being held are:

- The claim requires an authorization, but an appropriate match was not found
- Issues with the provider ID and contract periods
- Validation of primary coverage
- Possible duplicate submissions

HAP's adjudication staff reviews claims that are held. Claims are worked in the order of receipt and processors are responsible for validating all available information in making an adjudication decision. When claims are approved or denied, they will appear on a Remittance Advice (RA) with a description of HAP's actions. HAP will provide a specific reason for the denial. HAP's performance is measured by the time that elapses between receipt of the clean claim and the date a check is produced with the RA.

If a claim is for a member of a self-funded plan for which the payer of record is an employer designated Third Party Administrator (TPA), HAP's role is ensuring that the claim is priced according to our contract terms and promptly forwarded to the TPA for adjudication and payment advice. For questions about this process or who to contact for issue resolution, please refer to the HAP Preferred section of this manual.

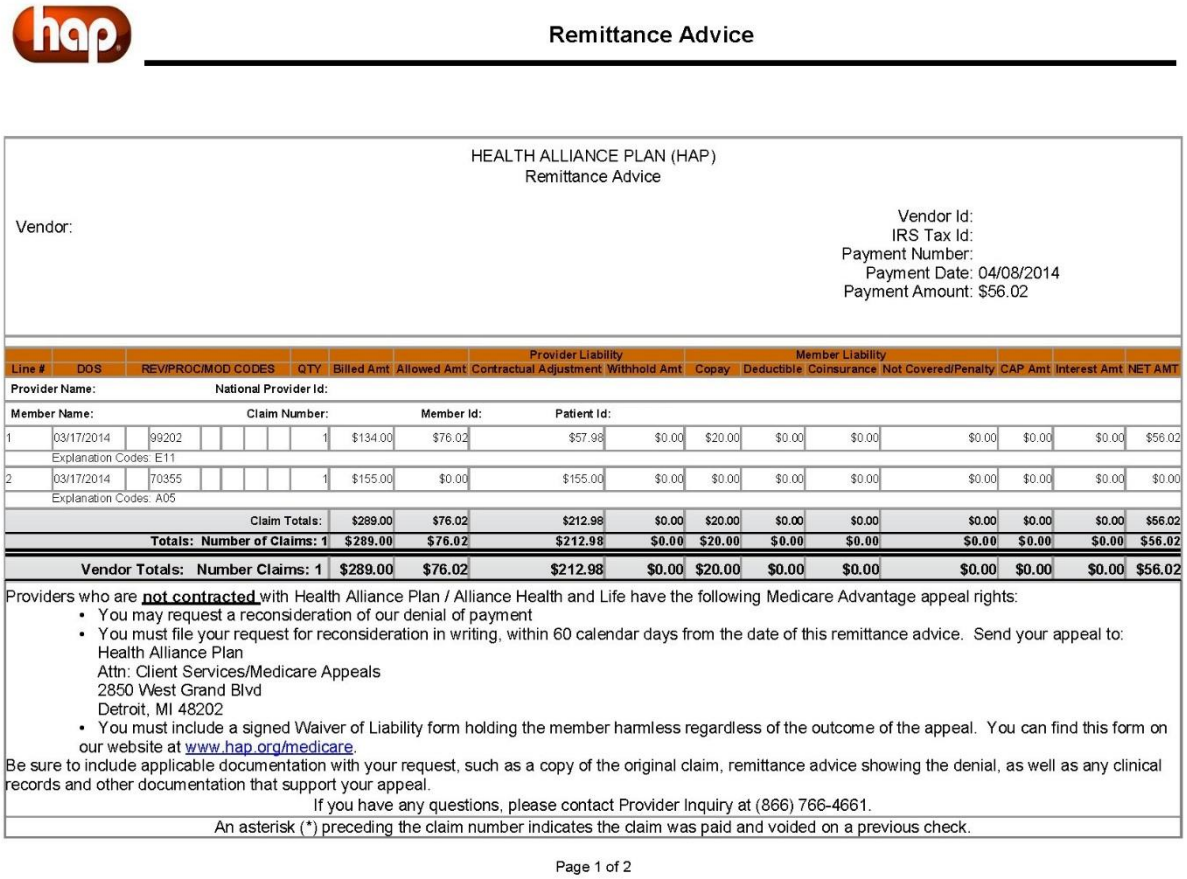
Claims Processing Lines

Claims won't process until all lines are resolved.

Remittance Advice (RA)

An RA is available online with all claim checks. It is a detailed description of all claims that have been paid on the check as well as all claims that have been denied. Checks and the corresponding RA are issued weekly. Below is a sample of an RA. Reason codes for payments and denials are listed for each claim line. A reason code explanation is located on the last page of the RA. See Appendix C for a complete listing of the denial reasons.

If you have any questions, contact our Provider Inquiry department at **(866) 766-4661**.



Remittance Advice

HEALTH ALLIANCE PLAN (HAP)
Remittance Advice

Vendor:

Vendor Id:
IRS Tax Id:
Payment Number:
Payment Date: 04/08/2014
Payment Amount: $56.02

Line #	DOS	REV/PROC/MOD CODES	QTY	Billed Amt	Allowed Amt	Provider Liability: Contractual Adjustment	Provider Liability: Withhold Amt	Member Liability: Copay	Member Liability: Deductible	Member Liability: Coinsurance	Member Liability: Not Covered/Penalty	CAP Amt	Interest Amt	NET AMT
Provider Name:		National Provider Id:												
Member Name:		Claim Number:		Member Id:		Patient Id:								
1	03/17/2014	99202	1	$134.00	$76.02	$57.98	$0.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	$56.02
	Explanation Codes: E11													
2	03/17/2014	70355	1	$155.00	$0.00	$155.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Explanation Codes: A05													
		Claim Totals:		$289.00	$76.02	$212.98	$0.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	$56.02
		Totals: Number of Claims: 1		$289.00	$76.02	$212.98	$0.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	$56.02
		Vendor Totals: Number Claims: 1		$289.00	$76.02	$212.98	$0.00	$20.00	$0.00	$0.00	$0.00	$0.00	$0.00	$56.02

Providers who are **not contracted** with Health Alliance Plan / Alliance Health and Life have the following Medicare Advantage appeal rights:

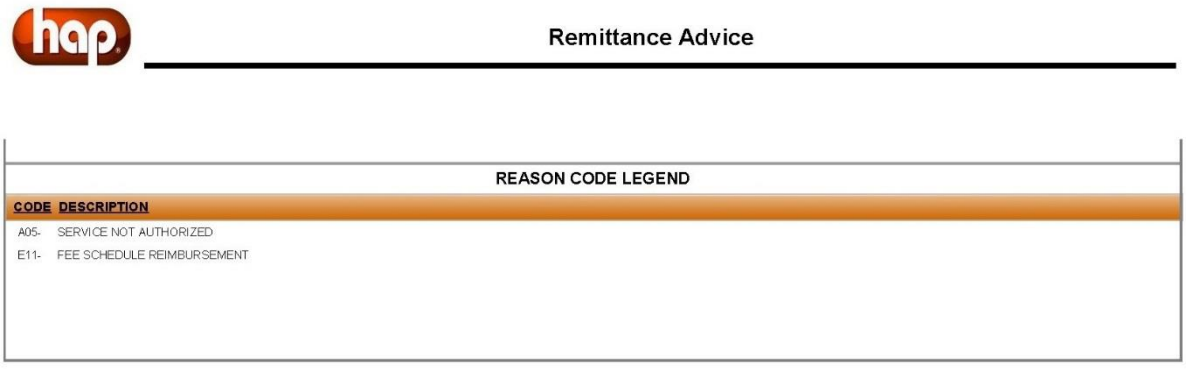
- You may request a reconsideration of our denial of payment
- You must file your request for reconsideration in writing, within 60 calendar days from the date of this remittance advice. Send your appeal to:
  Health Alliance Plan
  Attn: Client Services/Medicare Appeals
  2850 West Grand Blvd
  Detroit, MI 48202
- You must include a signed Waiver of Liability form holding the member harmless regardless of the outcome of the appeal. You can find this form on our website at www.hap.org/medicare.

Be sure to include applicable documentation with your request, such as a copy of the original claim, remittance advice showing the denial, as well as any clinical records and other documentation that support your appeal.

If you have any questions, please contact Provider Inquiry at (866) 766-4661.

An asterisk (*) preceding the claim number indicates the claim was paid and voided on a previous check.

Page 1 of 2



Remittance Advice

REASON CODE LEGEND

CODE	DESCRIPTION
A05-	SERVICE NOT AUTHORIZED
E11-	FEE SCHEDULE REIMBURSEMENT

835: Electronic Remittance Advice

The 835, or Electronic Remittance Advice, is intended to meet the needs of the health care industry for the payment of claims and transfer of remittance information.

HAP does generate the 835. It is a file of all payments, denials, etc., for a specific claim payment/check and contains information about the payee, the payer, the amount, and any identifying information of the payment.

The purpose of this file is to auto-post claim payments to patient accounts. Please note that the 835 cannot be printed as a report.

For more information, send an e-mail to ecommerce@hap.org.

Electronic Funds Transfer HAP Gateway

Electronic Funds Transfer (EFT) is a payment option offered to HAP vendors. You may elect to have your payments electronically deposited to the financial institution of your choice. Your RA will also be sent to this address.

Payment(s) can be directed to the U.S. bank of your choice. The U.S. bank must be an Automated Clearinghouse (ACH) member.

How to Enroll

1. The vendor completes the EFT application. (The U.S. bank routing number or ABA number can be obtained from the customer's account officer at the banking institution).
2. Have a financial officer of the company sign the application.
3. The vendor submits the completed form to AP/Disbursements at the address included on the form.

Account Validation

HAP will send an electronic pre-notification (pre-note) file to the Receiving Depository Financial Institution (RDFI) to ensure that the receiver's bank account information is correct. A pre-note is a one-cent entry that tests the accuracy of account data at the RDFI before live entries are sent.

Once HAP receives confirmation that the transfer was a success, all future payments will be electronically transferred. Any vendor payment inquiries should be directed to the Provider Inquiry department at **(866) 766-4661**.

Direct Deposit Application
Electronic Funds Transfer (EFT)

Electronic Funds Transfer is a payment option offered to vendors of HAP. You may elect to have your payments electronically deposited to the financial institution of your choice. Your Remittance Advice (RA) representing this payment will be forwarded to the address on record. Payment(s) can be directed to your United States bank of choice. The U.S. bank must be an Automated Clearinghouse (ACH) member.

How to Enroll

- The provider/vendor completes the EFT application. (The U.S. bank routing number or ABA number can be obtained from the customer's account officer at the banking institution).
- An authorized signer for the company must sign the application.
- The vendor submits the completed form to AP/Disbursements. (Address below)

Account Validation

- HAP will send an electronic prenotification (prenote) file to the Receiving Depository Financial Institution (RDFI) to ensure that the Receiver's bank account information is correct. A prenote is a one-cent entry that tests the accuracy of account data at the RDFI before live entries are sent.
- Once HAP has received confirmation from the bank that the transfer was a success, all future payments will be electronically transferred. Any provider/vendor payment inquiries should be directed to Accounts Payable at (248) 443-4435.

Provider/Vendor EFT

Provider/Vendor Tax ID No: _____

Provider/Vendor Name: _____

Provider/Vendor Address:_____

City, State, and Zip: _____

EFT Contact Person: _____

EFT Contact Phone #: _____ Email address (required): _____

Type: ☐ **Initial Electronic Funds Application** ☐ **Change Electronic Funds Transfer Information**

Name of Financial Institution: _____

City, State:_____

Checking Account Number:_____

U.S. Bank Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___
(mandatory 9 digits)

****REQUIRED** (Please complete.)****

Will payments made via Direct Payment pursuant to this Authorization be funded/forwarded to a foreign (non-U.S.) institution? ____ Yes _____ No (If yes, please complete the Foreign Financial Institution section below.)

Mail, Fax or Email Completed Form to:

Mail: HAP
AP/Disbursements
2850 W. Grand Blvd
Detroit, Michigan 48202
Fax: (313) 664-5362
Email: accountspayable@hap.org

_____
(EFT Authorized Signature) (Date)

_____
(EFT Authorized Name) (Please Print)

Foreign Financial Institution

Institution Name: _____ Branch: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

Identification Number: _____Account Number: _____

Patient Liabilities

With the variety of health care products on the market and the variances in the plan benefit options, most members are responsible for some of their health care expenses. These include the following:

Copay

A fee charged to a member at the time of service for certain covered services and benefits in the amount set forth in the schedule of benefits. Example: $10.00 copay for an office visit.

Collect copays at the time of service. It is important to confirm the copay amount with HAP prior to collecting it from the member.

Deductible

A fixed amount of health care dollars that a person must pay 100 percent before his or her health benefits begin. **Example: $100.00 for member/$200.00 for family.** Once the deductible is met, the payer will pay benefits at the next level of benefits. The deductible is cleared and starts over again at every new calendar or employer anniversary date.

Coinsurance

A percentage of the medical service charges that the member is responsible for paying after the deductible is met. Coinsurance can vary depending on the member's contract. Options typically range at 20, 30, 40 or 50 percent. The coinsurance is cleared and starts over again at every new calendar or employer anniversary date.

Example: 20% coinsurance for a service that allowed $100.00 equates to the member owing $20.00.

Section VII – Claims Status

To status a claim, you can use one of the options below.

1. **Claim Status Application**
    - The application is available 24 hours a day, seven days a week
    - Log in at **hap.org** and select *Claims*
    - Enter appropriate information and search
    - Select appropriate claim number for details

2. **Call HAP's Provider Inquiry department**

    - **(866) 766-4661**
    - Available Monday through Friday from 8 a.m. to noon and 1 p.m. to 5 p.m.
    - Please have the following information available when calling:
        - Provider Name
        - Provider NPI
        - Provider Tax Identification Number (TIN)
        - Member's Name
        - Date of Service
        - Total Amount Billed

All HAP Preferred PPO status inquiries should be made directly to the Third Party Administrator (TPA).

Section VIII – Claims Adjustment/Appeals

Claims Appeal Process

To eliminate duplication and ensure a more efficient, timely means of resolution, please use one of the options below when appealing claims. **Important: Please do not fax claims appeals and do not submit medical records.**

1. Call HAP's Provider Inquiry department at **(866) 766-4661**
   - Available Monday through Friday from 8 a.m. to noon and 1 p.m. to 5 p.m.
   - Please have the following information available when calling:
     - Provider Name
     - Provider NPI
     - Provider Tax Identification Number (TIN)
     - Member's Name
     - Date of Service
     - Total Amount Billed

2. Use HAP's online claims application. Simply:
   - Log in at **hap.org**
   - Select *Claims*
   - Search for the claim(s) that you wish to appeal and select the *Claim Number*
   - Select *Appeal* from the Request Appeal column
   - Select from one of the options below.
   - Follow the onscreen instructions

Appeal Type	Definition
Authorization	Authorization was obtained for the service or no authorization was required for the service.
Pricing Dispute	The claim was not processed at the correct contracted rate. (Overpayment /Underpayment)
Provider Participation Status Incorrect	The claim was processed as non contracted with HAP but provider is contracted, or the claim was processed as in network and the provider is not contracted with HAP.
Member Liability	Copay/deductible/coinsurance should not have applied or should have applied to the claim, or the member's liability should be more or less.
Service is not a duplicate	The service is not a duplicate of a previously submitted claim
Cigna/Multiplan Pricing Dispute	The claim was not processed at the correct contracted Cigna/Multiplan rate.
Pricing Sheet	A copy of the Explanation of Payment was not received from the TPA.
Code Editing	The claim was not processed as expected, based on results received from the Code Editing Tool (Clear Claim Connection).
Coordination of Benefits	The member had no other insurance coverage or dispute the COB calculation that was used to pay the claim.
Provider NPI/TIN	The Provider NPI or Tin on the claim submitted was incorrect.
Member Eligibility/Incorrect Member ID	Disputing the member's eligibility status or the member ID was entered on the claim incorrectly.
Filing Limit	The claim was denied for filing limit in error and proof of previous submission will be submitted.

Code Editing

HAP offers Clear Claim Connection, a McKesson code editing program that allows providers to look up coding rationale. This tool was designed to "mirror" how HAP evaluates code combinations during the editing of claims. You can access this tool when you log in at **hap.org**.

Recoveries

As part of our fiduciary responsibility, we routinely monitor claim processing accuracy. In some instances, this is done retrospective to payments being made to providers. As a result of these efforts, it may be necessary to adjust the payment amount to a previously paid claim. It is HAP's policy to pursue the recovery of all overpayments identified either by HAP, a HAP business associate, or a government entity.

Overpayment recoveries include but are not limited to:

- Adjudication errors
- Benefit configuration changes
- Coding errors
- Contract term adjustments
- Duplicate payments
- Eligibility changes
- Fraud, waste and abuse investigations
- Other sources of primary payment responsibility

HAP reserves the right to make adjustments to previously processed claims without prior written notice. HAP may contact providers in advance of claim adjustments being made.

The claim recovery process is usually performed via a debit adjustment to the original claim. The dollar amount being recovered is deducted from a future check and will appear on a future Remittance Advice with parentheses in front of the dollar figure. The reason for the recovery is provided. If the amount to be recovered exceeds the amount payable to a provider, a delay may occur in receiving a future Remittance Advice until a sufficient positive claim payment amount is available to recoup the recovery balance. For more information regarding the status of a recovered claim or to inquire about a potential negative balance, contact HAP's Provider Inquiry department at **(866) 766-4661**.

Claim recoveries may also be pursued via a recovery invoice. Providers are expected to take one of the following actions within 30 days of receipt of the invoice:

1. Reimburse HAP the amount invoiced
2. Return the invoice to HAP with an explanation and supporting documentation indicating the reason for the non-payment

Failure to respond to the recovery invoice may result in further collection efforts.

Negative Balances on Remittance Advices

We've made improvements on negative balance reporting for both the 835 and the paper and PDF remittance advices.

Effective July 24, 2018, providers in a negative balance will no longer see the same claims repeated each week. Following 835 standards, we will only report claims that contributed to the negative balance one time.

You can access your remittance advice by:

- Logging in at **hap.org** with your vendor ID
- Selecting *Remittance Advice*

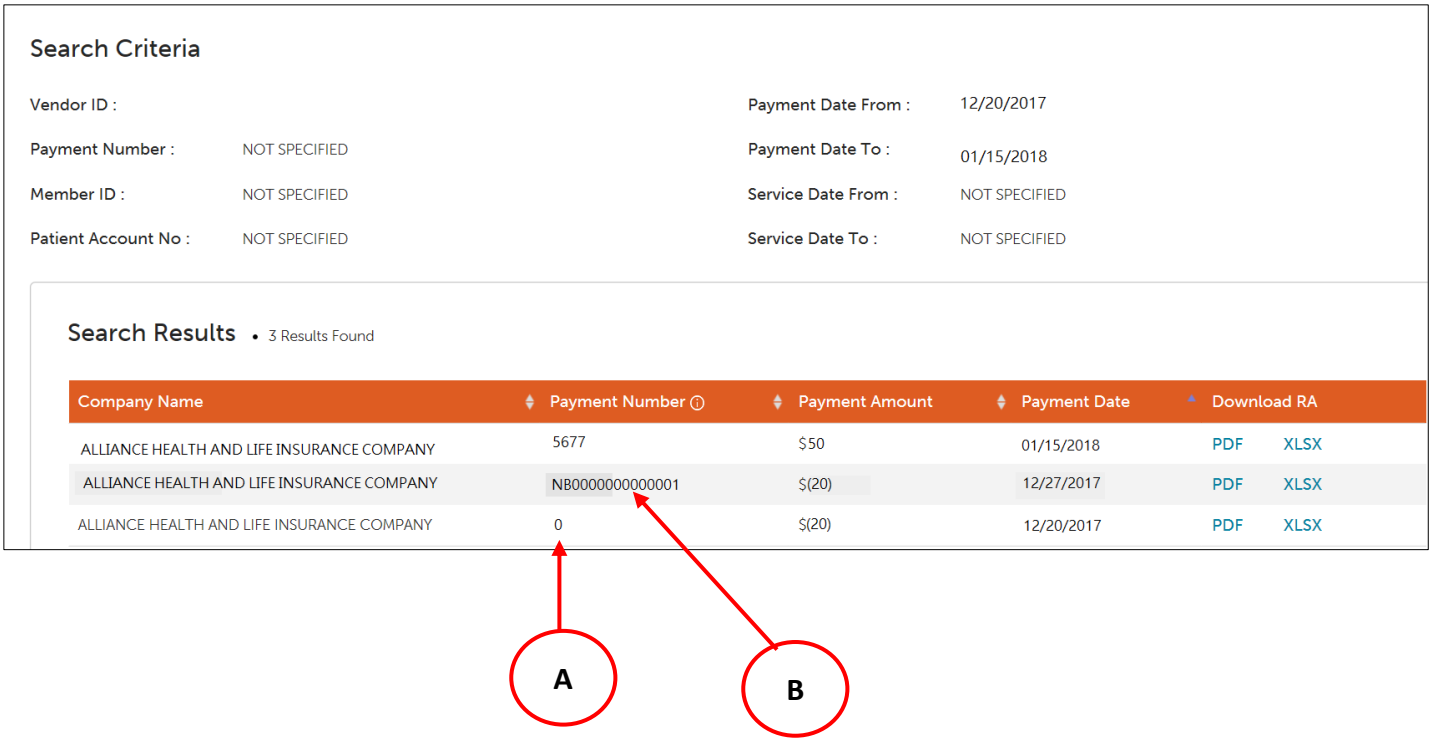
Identifying a Negative Balance on the Remittance Advice

Today, negative balances are identified by a payment number of 0. (See A below)

After the change, negative balances will be easily identified on the Remittance Advice Summary page by:

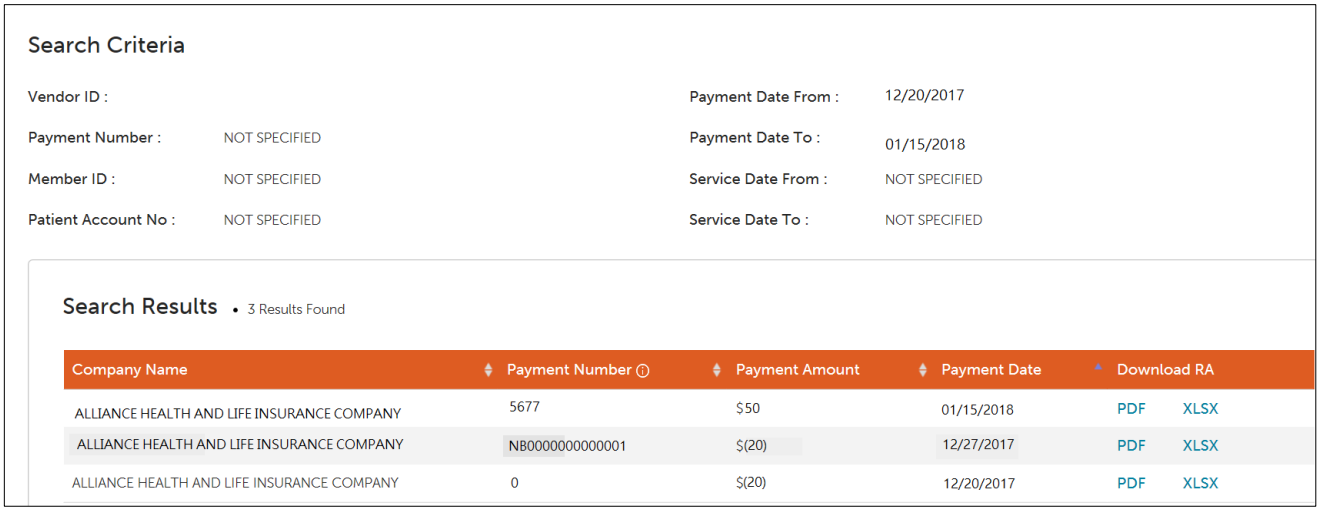
- A ***Payment Number* starting with "NB"** (see B below)

Note: Negative balances are specific to **line of business** as designated in the ***Company Name*** column. In the example below, the RA for payment date 12/20/2017 is for Alliance Health and Life Insurance Company (Alliance). The next RA for Alliance would be the RA dated 12/27/2017.



For illustration purposes, the examples below follow the Alliance Health and Life Insurance Company.

- Select the PDF (or Excel) file with the first negative balance from the RA Summary page. In our example, we will open the RA dated 12/20/2017 with the amount ($20.00) with payment number 0. (Note: this is what negative balances looked like prior to the change).



Search Criteria

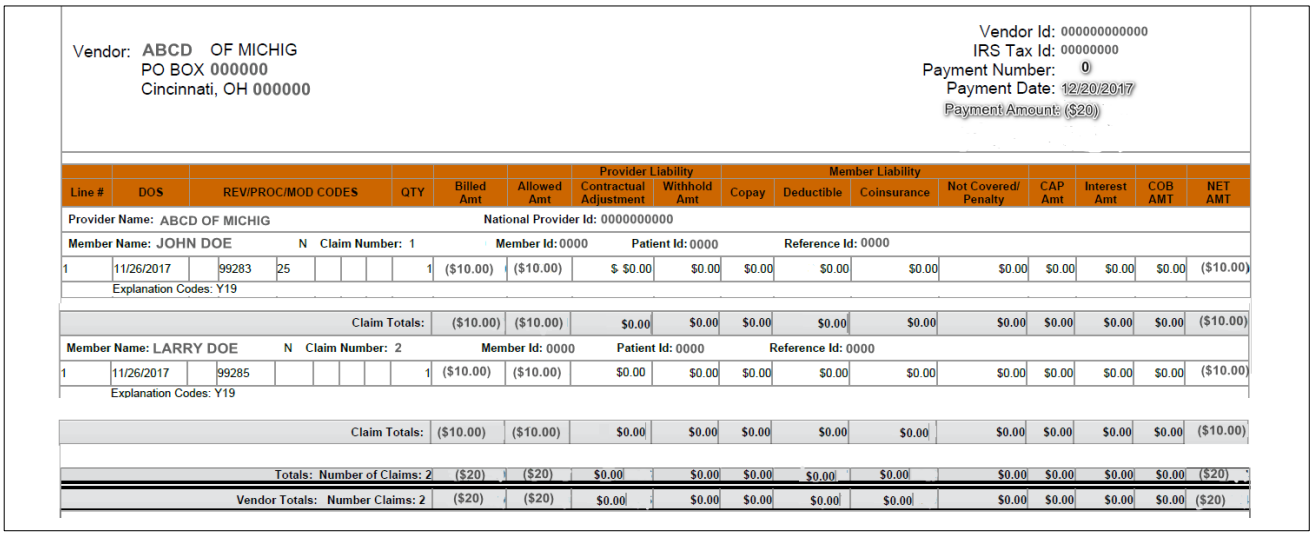
Vendor ID :		Payment Date From :	12/20/2017
Payment Number :	NOT SPECIFIED	Payment Date To :	01/15/2018
Member ID :	NOT SPECIFIED	Service Date From :	NOT SPECIFIED
Patient Account No :	NOT SPECIFIED	Service Date To :	NOT SPECIFIED

Search Results • 3 Results Found

Company Name	Payment Number	Payment Amount	Payment Date	Download RA	
ALLIANCE HEALTH AND LIFE INSURANCE COMPANY	5677	$50	01/15/2018	PDF	XLSX
ALLIANCE HEALTH AND LIFE INSURANCE COMPANY	NB0000000000001	$(20)	12/27/2017	PDF	XLSX
ALLIANCE HEALTH AND LIFE INSURANCE COMPANY	0	$(20)	12/20/2017	PDF	XLSX

Week 1

- Claims 1 and 2 are causing the negative balance of $20 in week 1.



Vendor: ABCD OF MICHIG
PO BOX 000000
Cincinnati, OH 000000

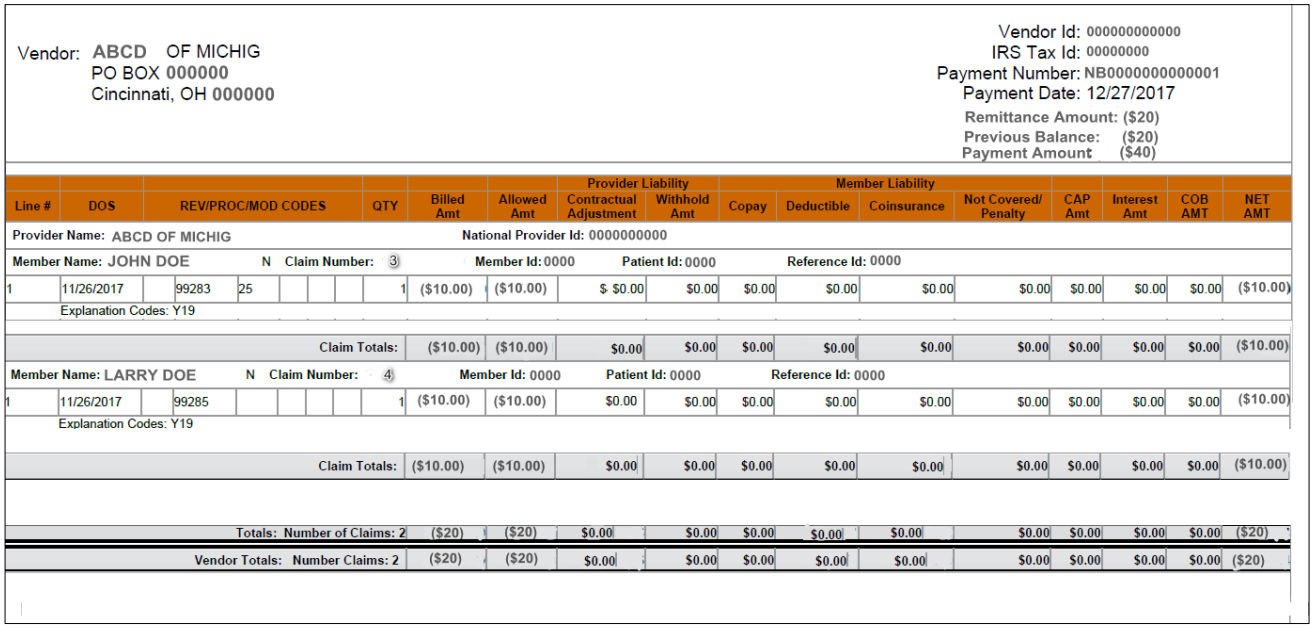
Vendor Id: 000000000000
IRS Tax Id: 00000000
Payment Number: 0
Payment Date: 12/20/2017
Payment Amount: ($20)

Line #	DOS	REV/PROC/MOD CODES	QTY	Billed Amt	Allowed Amt	Provider Liability: Contractual Adjustment	Provider Liability: Withhold Amt	Member Liability: Copay	Member Liability: Deductible	Member Liability: Coinsurance	Not Covered/ Penalty	CAP Amt	Interest Amt	COB AMT	NET AMT
Provider Name: ABCD OF MICHIG				National Provider Id: 0000000000											
Member Name: JOHN DOE	N	Claim Number: 1		Member Id: 0000		Patient Id: 0000		Reference Id: 0000							
1	11/26/2017	99283 25	1	($10.00)	($10.00)	$ $0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
Claim Totals:				($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Member Name: LARRY DOE	N	Claim Number: 2		Member Id: 0000		Patient Id: 0000		Reference Id: 0000							
1	11/26/2017	99285	1	($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
Claim Totals:				($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Totals: Number of Claims: 2				($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)
Vendor Totals: Number Claims: 2				($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)

What does the RA look like after the changes are implemented?

Week 2

- Claims 3 and 4 are causing further negative balance of $20 in week 2.
- There were two new fields added in the RA header:
  - Remittance Amount: This field shows the total NET_AMT of the claims in current Remittance Advice (RA).
  - Previous Balance: This field shows the forward balance from previous week (week 1 in this case) for the vendor.
- The Payment Amount shows the difference between the Remittance Amount and the Previous Balance.



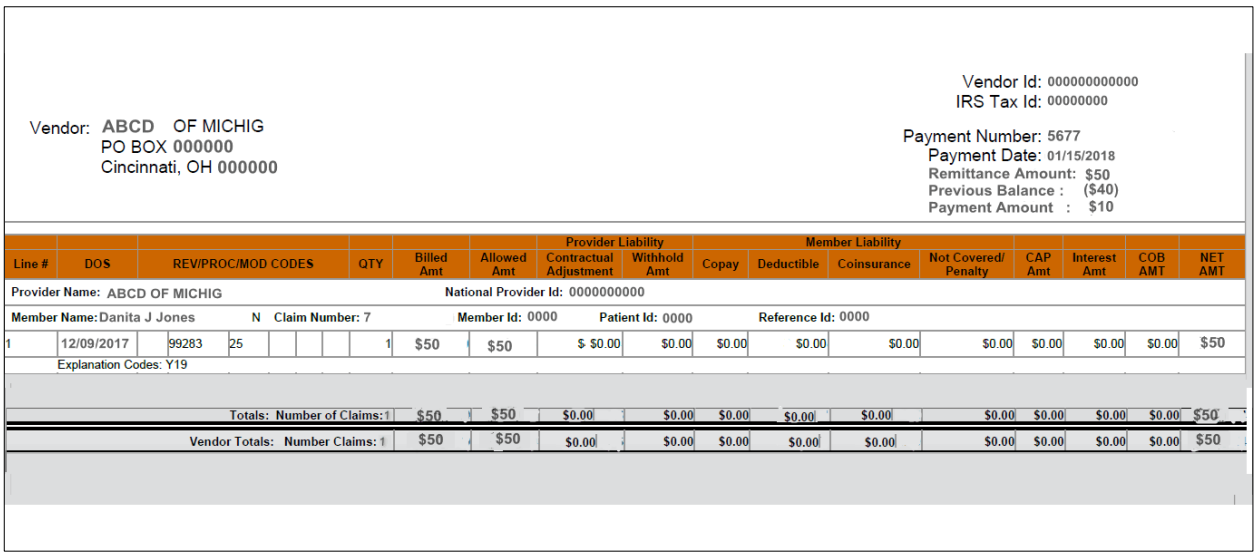
Vendor: ABCD OF MICHIG
PO BOX 000000
Cincinnati, OH 000000

Vendor Id: 000000000000
IRS Tax Id: 00000000
Payment Number: NB0000000000001
Payment Date: 12/27/2017
Remittance Amount: ($20)
Previous Balance: ($20)
Payment Amount ($40)

Line #	DOS	REV/PROC/MOD CODES	QTY	Billed Amt	Allowed Amt	Provider Liability: Contractual Adjustment	Provider Liability: Withhold Amt	Member Liability: Copay	Member Liability: Deductible	Member Liability: Coinsurance	Not Covered/ Penalty	CAP Amt	Interest Amt	COB AMT	NET AMT
Provider Name: ABCD OF MICHIG					National Provider Id: 0000000000										
Member Name: JOHN DOE		N Claim Number: 3			Member Id: 0000		Patient Id: 0000		Reference Id: 0000						
1	11/26/2017	99283 25	1	($10.00)	($10.00)	$ $0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
		Claim Totals:		($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Member Name: LARRY DOE		N Claim Number: 4			Member Id: 0000		Patient Id: 0000		Reference Id: 0000						
1	11/26/2017	99285	1	($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
Explanation Codes: Y19															
		Claim Totals:		($10.00)	($10.00)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($10.00)
		Totals: Number of Claims: 2		($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)
		Vendor Totals: Number Claims: 2		($20)	($20)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($20)

Week 3

Claim 7 is offsetting the previous negative



Vendor: ABCD OF MICHIG
PO BOX 000000
Cincinnati, OH 000000

Vendor Id: 000000000000
IRS Tax Id: 00000000
Payment Number: 5677
Payment Date: 01/15/2018
Remittance Amount: $50
Previous Balance : ($40)
Payment Amount : $10

Line #	DOS	REV/PROC/MOD CODES	QTY	Billed Amt	Allowed Amt	Provider Liability: Contractual Adjustment	Provider Liability: Withhold Amt	Member Liability: Copay	Member Liability: Deductible	Member Liability: Coinsurance	Not Covered/ Penalty	CAP Amt	Interest Amt	COB AMT	NET AMT
Provider Name: ABCD OF MICHIG					National Provider Id: 0000000000										
Member Name: Danita J Jones		N Claim Number: 7			Member Id: 0000		Patient Id: 0000		Reference Id: 0000						
1	12/09/2017	99283 25	1	$50	$50	$ $0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50
Explanation Codes: Y19															
		Totals: Number of Claims: 1		$50	$50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50
		Vendor Totals: Number Claims: 1		$50	$50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$50

Provider Refund Checks

If you discover an overpayment, please contact the Provider Inquiry department at **(866) 766-4661**. If HAP has not already identified the recovery, you may either request that HAP initiate the recovery or remit payment to HAP using the report on the following page.

All refunds for HAP and Alliance Health and Life Insurance Company business can be sent to:

HAP
Attn: Accounts Receivable
2850 W. Grand Blvd.
Detroit, MI 48202

In the event of an overpayment, providers are expected to promptly refund HAP the amount overpaid or contact HAP to inquire if HAP has already identified the overpayment. By doing so, providers can avoid potential MSP demands, HAP initiated claim recoveries on future payments or other collection efforts. By law, providers are obligated to refund overpayments involving Medicare and other carriers.

Please forward this information to your billing department and/or billing company.

Note: For HAP Preferred business, please contact the TPA listed on your Explanation of Pricing.

PROVIDER REFUND REPORT

Patient Name	Patient HAP ID #	Date of Service	Claim #	Overpayment Amount	Reason for the Refund

Return form to:

HAP
Attn: Accounts Receivable
2850 West Grand Blvd.
Detroit, MI 48202

Section IX – Medical and Behavioral Health Appeals

HAP supports high quality health care and encourages providers to appeal when they feel a decision is contrary to the well-being of the member.

Providers may appeal adverse organization determinations—denials—if they present additional information to support their case.

While determinations in standard appeal cases are expected to be less than 60 days, pre-service appeals are processed within 72 hours. The Medical Appeal Process applies to both medical and behavioral medicine providers.

The following are examples of denials that may be appealed:

- **Referral/Pre-certifications**: Failed medical appropriateness, out-of-network service, non-covered benefit, no prior authorization, units exceeded
- **Admissions**: Failed medical appropriateness, late notification

Appeals are defined as:

- **Administrative:** requests from providers to review an adverse determination of a decision involving contract or HAP rules (no prior authorization, late notification, out-of-network services, etc.)
- **Medical:** requests from a provider to review an adverse determination of a decision involving medical necessity.

Submitting appeals

- For an adverse organization determination decision made by HAP:

  Fax: (313) 664-5904
  In writing: HAP Medical Appeals – Mail Code 010
  2850 West Grand Blvd.
  Detroit, Michigan 48202

- For an adverse organization determination decision made by HAP for psychiatric or chemical-dependency related decisions:

  Fax: (313) 664-8686
  In writing: HAP
  Attn: Medical Dir for Behavioral Services
  Coordinated Behavioral Health Management Appeals
  2850 West Grand Blvd.
  Detroit, Michigan 48202

Level 1 Appeals

The provider has sixty (60) calendar days from the date of the denial letter or remittance advice to appeal HAP issued denials.* All cases that do not contain clinical information will be denied, reconsiderations require providers to file a Level 2 appeal.

The table below outlines the appeal type and process to follow.

Appeal Type	Process
Medical	1. The medical director, pharmacist or designated clinical staff review the appeal. Note: • The decision maker may consult, as necessary, with board-certified licensed physicians or other clinical professionals from the appropriate specialty. 2. Decisions are based on medical necessity.
Administrative	1. HAP staff reviews the appeals using HAP business rules.
eviCore	1. eviCore processes commercial Level 1 appeals only. 2. Medicare Advantage Level 1 and Level 2 appeals must be submitted to HAP. 3. Appeals are processed using the eviCore contracted timeframe of 45-days.

Level 2 Appeals

The provider has sixty (60) days from receipt of the Level 1 appeal decision notice to submit a Level 2 appeal.

Appeal Type	Process
Medical	1. A HAP medical director not involved in the first level appeal will review the Level 2 appeal. 2. Clinical information is presented, reviewed, and a determination is made.
Administrative	1. The Level 2 appeal will be reviewed for additional information submitted as to why HAP rules and policies were not followed.
eviCore	HAP processes all Level 2 appeals

***Appeals received after 60 days from the date of the denial will not be accepted.**

All determinations will be communicated to practitioners by mail.

For questions regarding the appeal process, contact HAP's Provider Inquiry department at (866) 766-4661.

Section X – Submitting Appeals to HAP via Mail and Fax

To ensure timely and accurate review of appeals, please follow the process below when **mailing or faxing** appeals.

Provider Appeal Type	Description	Submit
Claims	Claims denials for code editing, modifiers, paid amount, copays, and no prior authorization, units exceeded on an authorization, etc.	**Mail (only)** 2850 West Grand Blvd. Attn: Claims Adjustments 2850 West Grand Blvd. Detroit, MI 48202
Medical Appeal	Pre- and post- service appeals for medical services	**Fax** (**313) 664-5904** **Mail** HAP Attn: Medical Appeals Mail Code 010 2850 West Grand Blvd. Detroit, MI 48202
Behavioral Health Appeals	Pre- and post- service appeals for behavioral health services	**Fax** (**313) 664-8686** **Mail** HAP Attn: Medical Dir for Behavioral Services Coordinated Behavioral Health Mgmt. 2850 West Grand Blvd. Detroit, MI 48202
Prescription Services	Appealing a denied claim for a medical drug	**Fax** **(313) 664-5338** If denial is due to no authorization, please include: • A letter of appeal with explanation of why proper authorization was not obtained • The remittance advice showing the denial of the claim • A completed Medication Request Form (found on **hap.org/mrf**) • Clinical information to show medical necessity
Member Appeals	Pre-service appeals where the provider is appealing services or prescriptions on behalf of the member	**Fax** **(313) 664-5866** **Mail** HAP Attn: Member Appeals and Grievances 2850 West Grand Blvd. Detroit, MI 48202

Section XI – Coordination of Benefits

Coordination of Benefits (COB) is a system for determining which health insurer pays for services first when more than one insurer covers a patient.

NOTE: The information that is provided in this Billing Manual should be considered general guidelines for COB purposes. When coverage exists among multiple carriers, there are a number of variables that are considered before a determination is made on who should be billed as primary, secondary, etc.

HAP's COB department conducts a thorough investigation of each case and updates our system accordingly. To verify primary responsibility or to determine whether a COB investigation has been completed on the patient, you may contact the Provider Inquiry department at **(866) 766-4661**. COB information is also available on HAP's Membership Eligibility Application (MEA) when you log in at **hap.org.**

To notify HAP of new or updated COB information or to request a COB investigation, you may use HAP's COB Provider Inquiry form which can be found when you log in at **hap.org.**

Provider Role

Providers are encouraged to:

1. Collect health insurance information for each carrier that provides coverage to a member
2. Confirm that the health coverage for each carrier is in effect for the date services provided
3. Help members understand how their benefits are coordinated
4. Coordinate appropriate referrals and authorizations for each carrier as needed
5. Determine which carrier has primary payment responsibility **prior to billing**
6. Submit primary and secondary claims to each carrier with applicable COB and payment information

Provider Responsibilities

As a contracted provider, you are responsible to:

1. Understand applicable laws, regulations, industry guidelines, etc., that determine which carrier is primary
2. Wait to submit a claim to the secondary carrier until after receiving a payment or rejection from the primary carrier
3. Make sure to include a copy of the Remittance Advice from the primary carrier when billing the secondary carrier and include the other insurance carrier (OIC) denial explanation, if applicable
4. Promptly contact each carrier as appropriate to arrange for a refund of the overpayment amount in the event either the primary or secondary carrier has made an overpayment
5. Submit secondary claims or related adjustment requests within each carrier's filing limit
6. Share other health carrier information with each health carrier providing coverage to help avoid claims from being paid or rejected in error
7. Work with members and each health carrier to resolve disputes of primary payment responsibility

HAP COB guidelines

1. HAP will coordinate benefits when multiple insurers cover a HAP member.
2. If HAP is the primary insurer, HAP pays the full extent of covered medical services, up to the HAP fee schedule minus applicable copayments, coinsurance or deductibles.
3. When HAP is the primary insurer and there is a balance remaining, the secondary carrier may be billed for the balance.
4. When you are a participating provider with HAP, the member should not be billed for any balance above HAP's fee schedule.
5. If HAP is the secondary insurer, you must first bill the primary carrier before submitting claims to HAP. HAP will coordinate benefits for **covered medical services when all of HAP's guidelines are met** and an Explanation of Benefits (EOB) from the primary carrier is received with the claim. Primary payments sent directly to the member will also be considered when coordinating secondary payment responsibility.
    a. Together, the two plans will pay no more than 100 percent of the allowable charges according to HAP's fee schedule or other insurers' fee, whichever is less.
    b. If HAP is the secondary insurer and there is a balance due after the primary insurer pays, the member may not be billed for any amount in excess of the HAP fee schedule. The member is liable for any applicable copays, deductibles or coinsurance.
    c. As secondary carrier, HAP will not pay more than if it were the primary carrier. HAP is not responsible for and should not be expected to consider:
        1) The primary carriers negotiated discount amount
        2) The primary carrier's negotiated adjustments
        3) The primary carrier's contractual adjustments
        4) Provider liability resulting in a payment denial from the primary carrier
        5) Non-covered charges (if also not covered by HAP)
        6) Provider withholds
        7) Contingency reserve

COB Provider Inquiry Form

Health Alliance Plan - COB Inquiry Form for Providers

Return via fax to COB Dept: 248-443-4922 or by Mail: HAP COB Dept., 2850 W. Grand Blvd, Detroit MI, 48202

Please Print Clearly

Today's Date: _____ Telephone #: _____ Fax #: _____

Provider Name: _____ Provider Id: _____ Contact Name: _____

COB Inquiry for:

First Name: _____ HAP ID: _____ Group # _____

Last Name: _____ Date of Birth: _____ SS#: _____

COB Inquiry Type: (Select One)

Medicare ____ Auto ___

Blue Cross ____ Workers Comp ___

Dual HAP/PHP ____ Other Commmercial ___

Inquiry Initiated as a result of: (Select One)

_____ New COB information or change to COB information

_____ Verification of COB determination is needed

_____ Possible Workers Comp Review

_____ Possible Auto Accident Review

Action Requested: (Select One)

Add COB Information: _____

Other Carrier Information you have:
(please send copy of card, if possible)

_____ Copy of Card or Voucher Y/N

_____ Name of Other Carrier

_____ Policy # or Claim #

_____ Employer Name

_____ Coverage Effective Date

_____ Coverage Term Date

_____ Adjuster name & Phone #

_____ Name of Policyholder

_____ Other:

Update/Verify existing COB record _____

Indicate reason you believe record may need to be changed:

_____ Change in other carrier effective/term dates

_____ The COB order (primary/secondary) is not correct*

_____ Other Carrier Name is incorrect*

_____ Medicare effective dates incorrect

_____ Change in employment status or other criteria

_____ Other: _____

_____

_____

* Indicate below the reason you believe the information is not correct:

Additional comments you may have or information to share:

Do You Need to Hear Back From Us? ____ **Yes** ____ **No**

HAP Internal Use Only: **Cob Determination/Status of Inquiry:**

Date Returned: Inititals: Inquiry #

Determining Primary and Secondary Coverage

Public Act 64 of 1984, the Coordination of Benefits Act, passed by the Michigan legislature, specifies how primary and secondary insurers are determined.

The following are general HAP guidelines for determination of primary and secondary coverage.

Non-Dependent or Dependent

When a patient is covered as an employee under one plan and a dependent under another, the plan where the member is an employee is the primary plan.

Active or Inactive Employee

When a member has two employer group health plans and one plan is a retirement plan and under the other plan the person is an active employee, the plan where the member is an active employee is the primary plan.

If both plans are through active and/or retiree employment, the plan that has been in effect the longest is the primary plan.

Child Covered Under More Than One Plan

When children are covered under two plans through parents who are married or who are not married but living together, the birthday rule applies. Primary coverage is provided by the plan of the parent whose birthday falls earliest in the year.

If both parents have the same birthday, the plan of the parent whose coverage has been in effect the longest is the primary plan.

In situations of divorce or separation, if one or the other parent has been determined by the court to have financial responsibility, his/her plan is primary.

If financial responsibility has not been established, the specific terms of the court order or divorce decree pertaining to custody must be reviewed to determine which plan is the primary plan.

Continuation Coverage

When coverage exists under both a Continuation Omnibus Reconciliation Act (COBRA) policy and another plan, the coverage under the other plan is primary and the continuation coverage is secondary.

ERISA Exempt Employer Groups

For those groups who are exempt from the Employee Retirement Income Security Act of 1974 (ERISA) law (self-funded/self-insured), the specific plan language pertaining to COB must be reviewed to determine the primary/secondary plan.

Medicare

When coordinating services with more than one carrier, HAP requires providers to comply with Medicare billing requirements and Medicare Secondary Payer (MSP) policies. The CMS MSP Manual is available online at **www.cms.gov/manuals.**

To learn more about MSP determinations, providers can access computer-based training material provided via the CMS Medicare Learning Network at
http://www.cms.hhs.gov/MLNProducts/01_Overview.asp#TopOfPage

The following Medicare information has been provided as a general guide and should not be used as a sole resource for determining Medicare primacy.

The provider is responsible for verifying COB order before submitting a claim to either Medicare or HAP. Medicare often assumes secondary payment responsibility; however, this is not always the case. It is important that providers are familiar with the MSP rules for the following:

- Automobile Insurance
- End Stage Renal Disease
- Liability Insurance
- Veterans Administration
- Working Aged
- Worker's Compensation
- Working Disabled

Automobile Insurance

When a Medicare beneficiary is injured in an automobile accident, the claim should be sent directly to the automobile insurer. Medicare is the secondary insurer when payment for covered items or services has been made or can reasonably be expected to be made under an automobile liability, medical or no-fault insurance policy.

You should ask your patient whether the services are for treatment of an injury or illness that resulted from an automobile accident. The provider must bill the auto insurance company as the primary insurer.

End Stage Renal Disease (ESRD)

If your patient is eligible for Medicare due to ESRD and the claim date of service is within the first 30 months of entitlement (coordination period), Medicare is the secondary payer. The coordination period begins with Medicare hospital insurance entitlement. Individuals of any age who receive dialysis of renal transplantation for ESRD are eligible for hospital insurance and are deemed eligible for supplementary medical insurance if they file an application.

After the thirty-month coordination period, Medicare becomes the primary coverage, HAP is secondary. As the secondary payer, HAP will consider the difference between Medicare's allowed amount and Medicare's payment.

Liability Insurance

Liability insurance is any insurance that provides payment based on legal liability for injury or illness.

Medicare has priority right of recovery and may bring direct action against the entity responsible or required to pay for damages. A liability claim is based on an alleged negligent act of an individual and is usually a claim for money damages. The physician or supplier has no direct standing with the liability plan under which the insured must be proven liable for negligence; therefore, the direct relationship is with the injured party only.

Veteran's Administration (VA)

Patients entitled to both Medicare and VA benefits have discretion over which program to bill first when services are received from a non-VA physician or a supplier has not been authorized in advance by the VA. Primary claims should not be filed to both programs.

Working Aged

If your patient is over 65 years of age, is eligible for Medicare due to age and either the patient or their spouse is actively working, Medicare is the secondary payer to group health plans that employ 20 or more employees.

Worker's Compensation (WC)

WC is an employer-supported system for compensating employees for injury or disease suffered in connection with their employment whether or not the injury was the fault of the employer.

No Medicare payment may be made if WC has paid an amount which:

- Equals or exceeds the gross amount payable by Medicare without regard to any deductible and co-insurance
- Equals or exceeds the provider's charges for Medicare covered services
- The provider is required to accept the amount paid by WC as payment in full

Payments made under WC cannot be applied toward the Medicare deductible.

If the WC claim is contested, a claim may be filed with Medicare for conditional payment. The insurers EOB and a statement stating that the claim is being contested should accompany the submission.

Medicare remains the primary carrier for services not related to the work injury or illness.

Working Disabled

If your patient is under 65 years of age, is eligible for Medicare based on a disability and the patient (or a member of the patient's family) has health plan coverage by virtue of the individual's current employment status, Medicare is the secondary payer to large group health plans employing over 100 employees. An individual has current employment status if he or she is:

- Actively working as an employee, is the employer, or is associated with the employer in a business relationship.
- Not actively working but meets all of the following requirements:
  - Retains employment rights in the industry
  - Has not had employment terminated by the employer
  - Is not receiving disability benefits from an employer for more than six months
  - Is not receiving Social Security disability benefits
  - Has employment-based group health plan (GHP) coverage that is not COBRA

Medicare Secondary Payer (MSP) Demands

It is extremely important to verify whether Medicare is the primary or secondary payer before billing Medicare. Medicare is not always the primary payer; however, if they are billed as primary they often pay. A MSP demand is generated when Medicare discovers that they should have considered the claim as the secondary payer. This can occur many years later and include accrued interest. In certain circumstances, this can result in Medicare pursuing recovery directly from the provider.

If HAP knows that a member has Medicare coverage and that HAP is the primary carrier based on MSP rules, HAP will not coordinate with the EOMB. The claim will be paid at the contracted HAP rate. This will create a credit on your patient's account. It is your responsibility to reimburse Medicare directly.

Billing HAP as Secondary to Medicare

HAP requires the submission of the Explanation of Medicare Benefits (EOMB) information with all Medicare secondary claims. The filing limit for Medicare secondary claims is based on the EOMB date and the date HAP receives the claim.

As the secondary payer, HAP will consider any remaining copayments and/or deductibles for covered services up to Medicare's allowed amount. The member is still required to follow HAP guidelines for services.

If you are a Medicare assigned provider and/or HAP participating provider, the difference between the billed amount and Medicare's allowed amount must be written off.

Worker's Compensation, Auto, Subrogation

The following are brief summaries of special claims policies. They are described as informational only and are not to be relied upon as definitive legal statements.

Worker's Compensation (WC)

Worker's Compensation is an employer-supported system for compensating employees for injury or disease suffered in connection with their employment whether or not the injury was the fault of the employer. If a patient has been injured in a work-related incident, coverage provided under WC laws, occupational disease laws, or other employer liability laws become the primary coverage.

HAP Plans exclude all expenses incurred by a member as a result of injury or illness that occurs on the job. The expenses are covered under State WC laws.

If HAP mistakenly pays a claim on a work-related injury or illness, steps will be taken to collect the expenses paid to the provider who submitted the claim.

If a long delay is expected in settlement of the WC claim, HAP may pay the claim; however, HAP will recover the benefits it has paid on the claim once a settlement has been reached.

Auto

Michigan is a no-fault state. The member's auto insurance is responsible for injuries suffered by the member as a result of an auto-related accident.

When there is health insurance coverage through an employer group and an auto insurer, the member has the right to choose which carrier they want to be primarily responsible for medical claims. If the member has chosen a coordinated medical policy with their auto carrier, the group health insurance policy is primary.

The steps below are taken when HAP receives a possible COB claim.

- A questionnaire is sent to the member asking about the accident and requesting information regarding the auto carrier.
- HAP will contact the auto carrier and verify the type of medical coverage the member has and HAP's system will be updated to indicate which carrier is primary.
- If the auto carrier is primary, all claims related to the specific injuries suffered in the accident must be sent directly to the auto carrier. All unrelated services should be sent directly to HAP for consideration.

When a potential subrogation case is identified, HAP follows this procedure:

- A questionnaire is sent to the member asking about the circumstances surrounding the incident and to determine whether a suit will be filed against a third party.
- HAP will continue to process claims for payment.
- If a determination is made that the accident was caused by third party negligence, a lien letter with attachments containing a summary of paid claims and their corresponding diagnosis is sent to the member's attorney.

Communication is maintained with the member's attorney. Upon settlement of the case, HAP will negotiate with the third party, through the member's attorney, to obtain reimbursement of claims paid.

SECTION XII – Benefit Administration Manual (BAM)

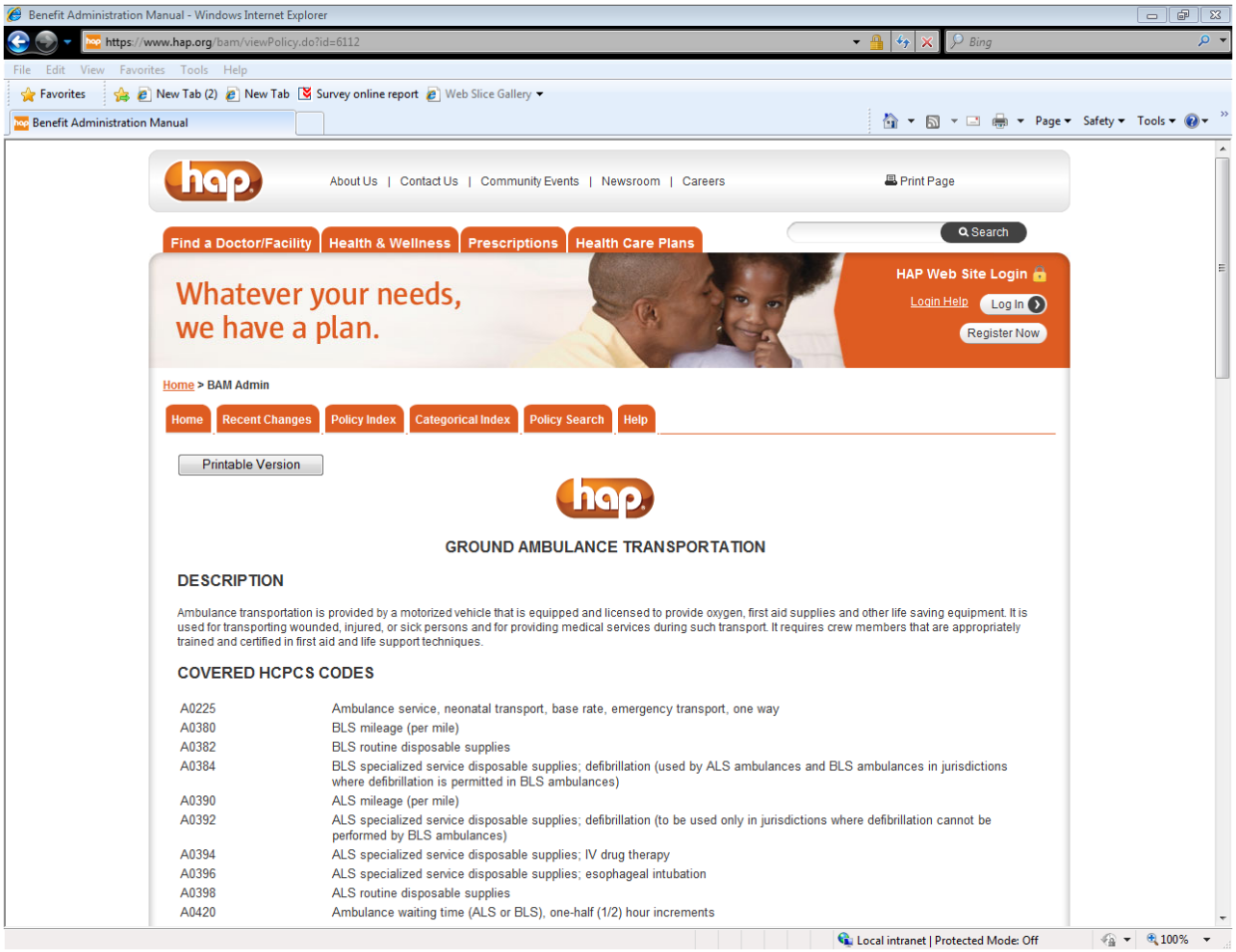
HAP's online **Benefit Administration Manual** allows you to review all policies and view changes the same day they are released.

Understanding the Policy

Each policy may contain different elements of information pertaining to the benefit. The following pages provide an example of a BAM policy—Ground Ambulance Transportation. Please note that any images displayed in this example may not be the most current version from BAM and should not be used to determine benefits. Refer to the actual BAM application to obtain the most recent benefit descriptions. You can access BAM when you log in at **hap.org.**

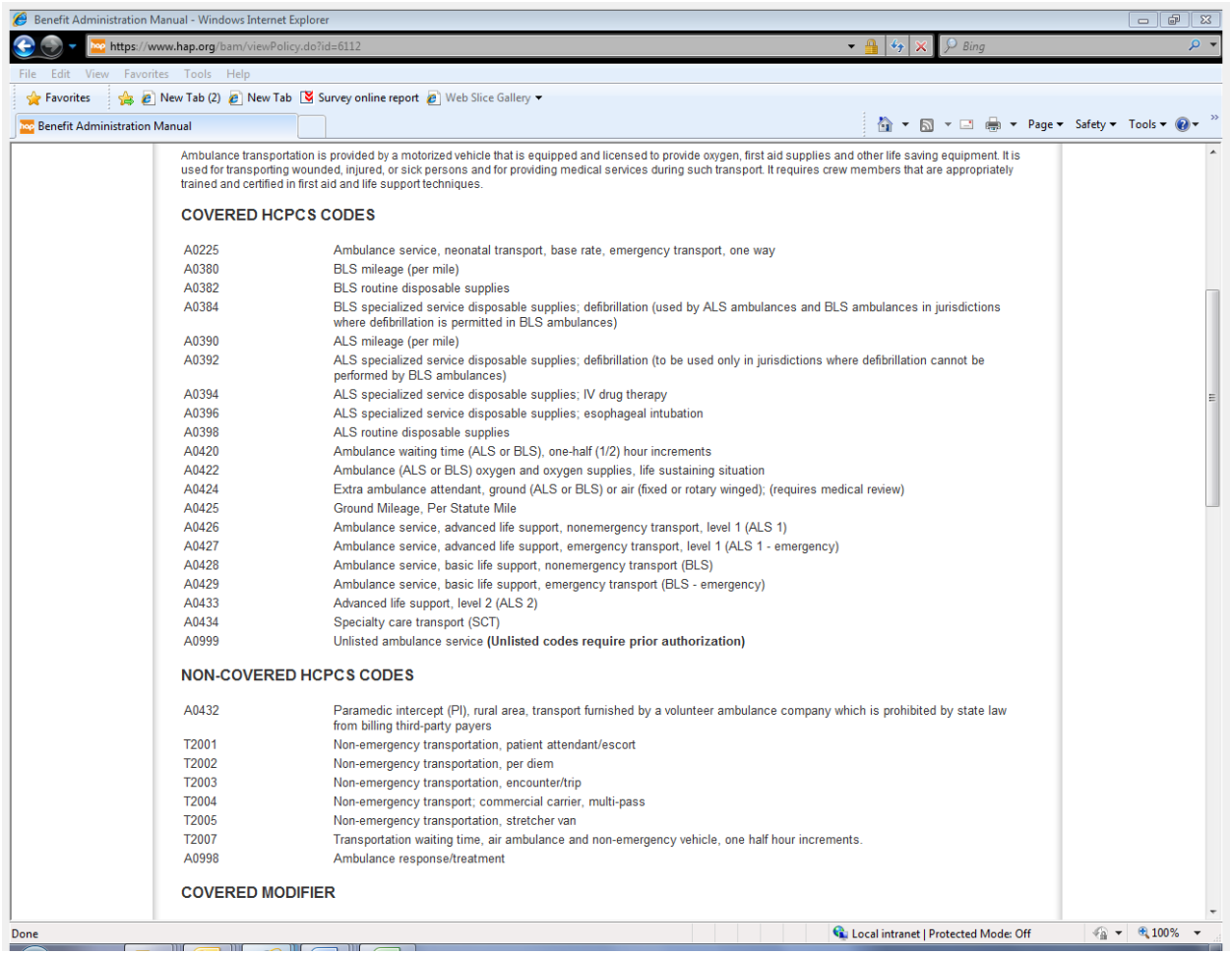
Description

Every policy should begin with a description of the benefit.



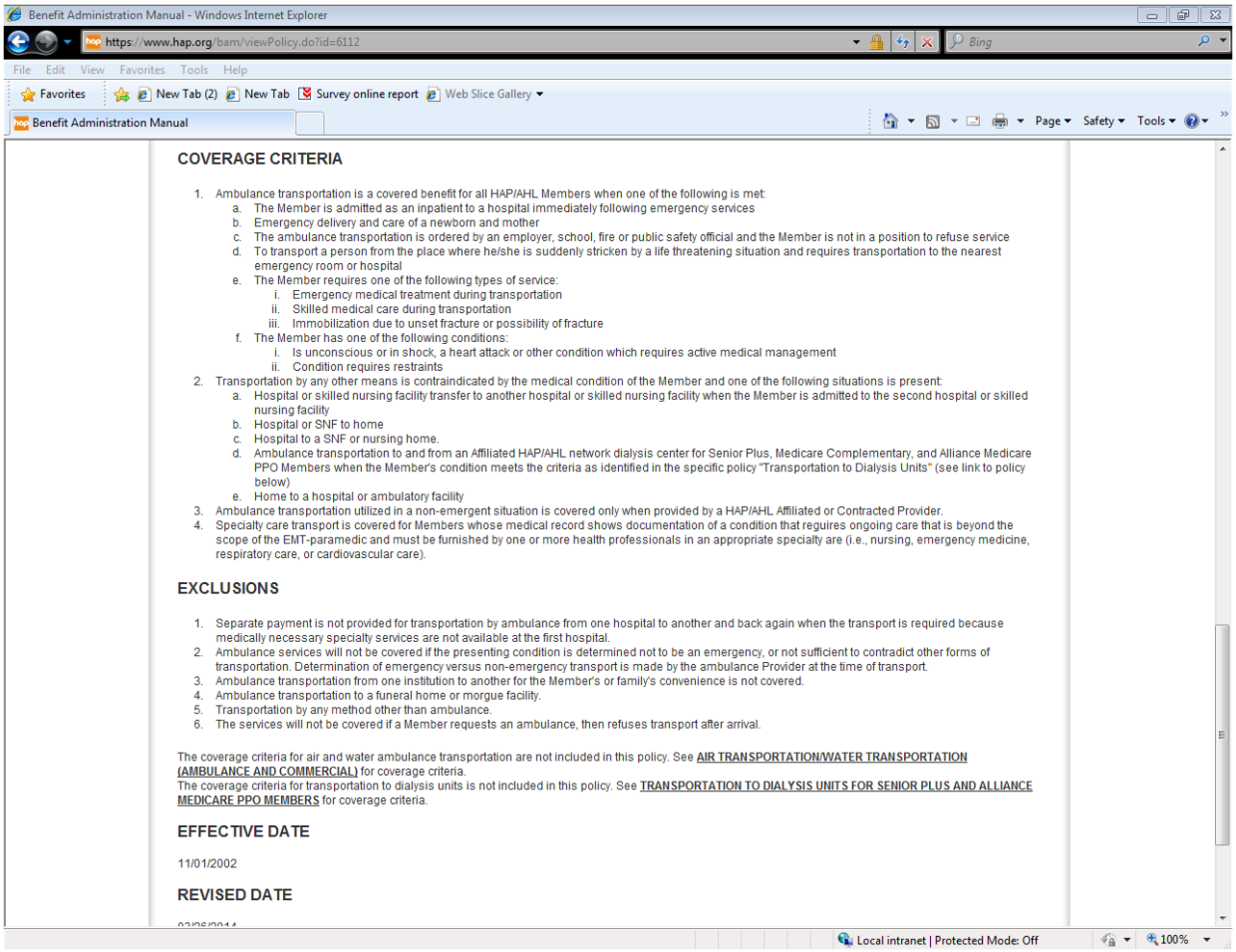
Covered and Non-Covered HCPCS Codes

Some policies contain specific codes that will be covered.



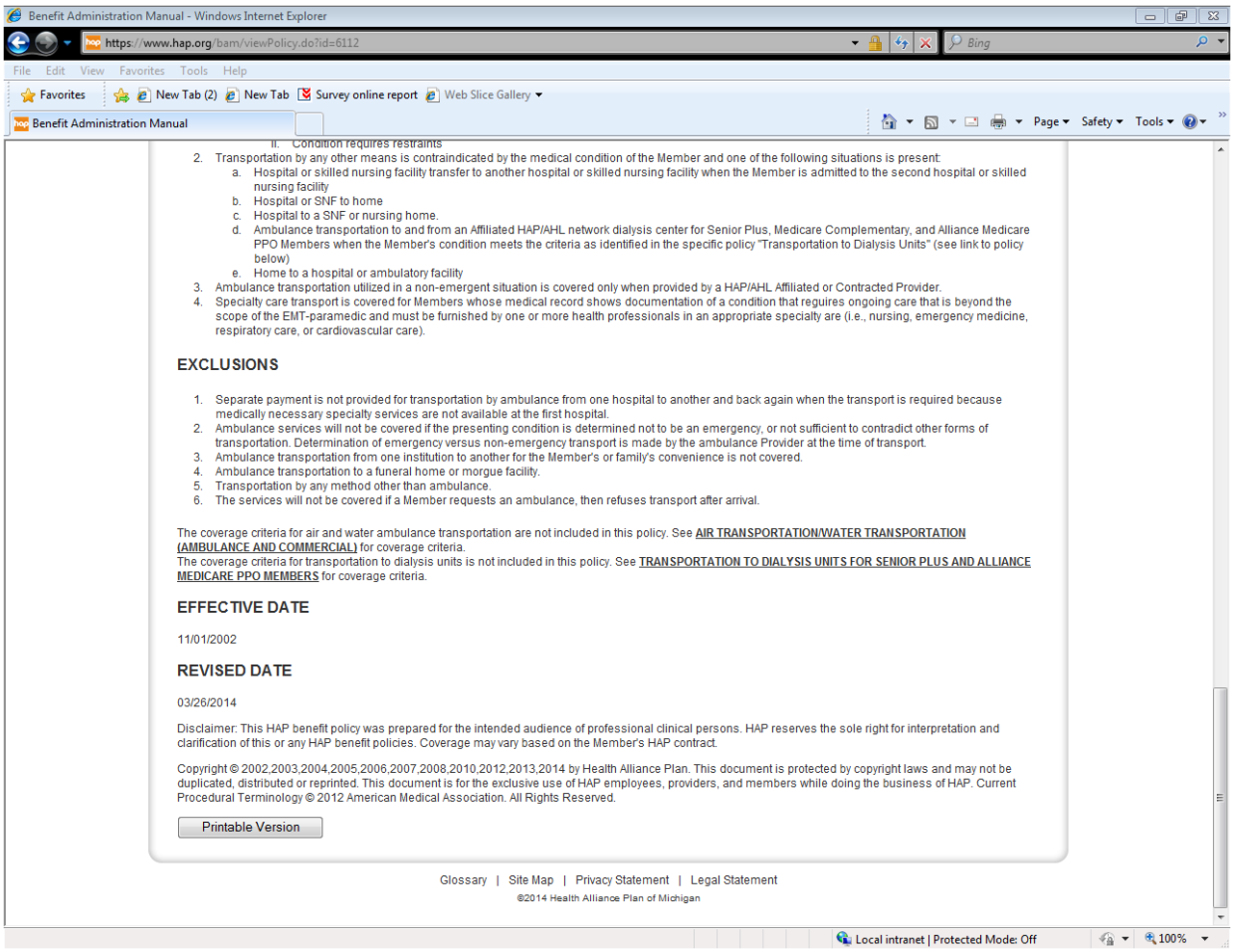
Coverage Criteria

Every policy should contain a description of the coverage criteria—what requirements have to be met to be a covered benefit.



Exclusions

Some policies contain a description of exclusions for the benefit—under certain circumstances the service may not be covered.



Claims Unaccepted Report

Appendix A-Pre-Processing Form Letter

Dear Provider:

Enclosed please find the HAP Claims Unaccepted Report for services that you have submitted to HAP that we were unable to process. To enhance and expedite our adjudication process, we do not accept claims that do not include accurate and complete information, such as procedure and diagnosis codes, and member first and last names.

The HAP Claims Unaccepted Report does NOT constitute a denial; it simply means your claim(s) did not successfully validate through our pre-processing edits. A complete listing of the Edit Codes and their explanations are available in the HAP Provider Billing Manual on **hap.org**. Please refer to this list of codes to assist you with your claim resubmission.

Please note that we **do not retain a copy of your original claim submission.** We therefore request that you re-submit updated claims via EDI or to the appropriate address based on the line of business once corrections have been made.

Health Alliance Plan Claims Department 2850 W. Grand Blvd. Detroit, MI 48202	Alliance Health & Life Claims Department P.O. Box 02459 Detroit, MI 48202	HAP Preferred Operations Third Party Administrator P.O. Box 02399 Detroit, MI 48202

We encourage you to update your billing system as you receive accurate information for coding issues. Please refer to the appropriate coding manual (CPT®, ICD-10, MUPC, HCPCS) of the service year for which you are billing.

If you have any questions regarding your HAP Claims Unaccepted Report or any of the information in this letter, please contact our Provider Inquiry department at **(866) 766-4661**.

For membership information, please call our automated verification line PAS at (800) 801-1766, 24 hours a day, seven days a week. Or visit our Member Eligibility Application (MEA) online at **hap.org** under the provider link. For HAP Preferred Membership errors please refer to the TPA Contact Listing on **hap.org**.

Thank you,

HAP Claims Division

Appendix B-Unaccepted Claims Report Reason Codes

ERROR CODE	SHORT DESCRIPTION	LONG DESCRIPTION	HIPAA CATEGORY CODE	HIPAA STATUS CODE
1000	Unable to locate member based on submitted ID and name information	Based on the submitted subscriber and patient information, the patient could not be determined. An ID was submitted.	A3	33
1001	Claim accepted and forwarded to payer	Claim is being redirected to another payer for payment.	A0	17
1002	Patient eligibility not located	Patient eligibility not located	A3	97
1003	Unable to locate provider based on submitted information	Unable to locate provider based on submitted information	A3	133
1004	Facility Name Required on claim for consideration	Facility Name Required on claim for consideration	A6	125
1005	Unable to locate member based on submitted name information	Based on the submitted subscriber and patient information, the patient could not be determined. NO ID was submitted.	A3	32
1006	Procedure code invalid	Procedure code invalid	A7	454
1007	Interim bill types are not accepted	Interim bill types are not accepted	A7	228
1008	Member not eligible for medical benefits on submitted date of service	Member not eligible for medical benefits on submitted date of service	A3	90
1009	Submitted diagnosis code is not valid for date of service	Submitted diagnosis code is not valid for date of service	A7	255
1010	Submitted procedure code not valid for date of service	Submitted procedure code not valid for date of service	A7	454
1011	Place of Service code is missing or invalid	Place of Service code is missing or invalid	A7	249
1012	Detailed charges not equal to total billed amount	Detailed charges not equal to total billed amount	A7	400
1013	Procedure code modifier not valid	The submitted procedure code modifier was not valid.	A7	453
1014	Valid TAX ID required	The submitted billing-level provider tax ID was a dummy value.	A7	128
1015	Invalid discharge status submitted	The submitted discharge status is not valid.	A7	234
1016	Detail service outside submitted header service date range	The line-level service date is outside of the claim-level service dates.	A7	187
1017	TAX ID is required for consideration	No billing-level provider tax ID was submitted.	A6	128
1018	Facility Type Code is required for submission	Facility Type Code is required for submission	A6	228
1019	Claim Frequency Code is required for submission	Claim Frequency Code is required for submission	A6	228
1020	Diagnosis is required for consideration	Diagnosis is required for consideration	A6	255
1021	Invalid date of birth for patient	Invalid date of birth for patient	A7	158
1022	Member does not have medical coverage for date of service	Member does not have medical coverage for date of service	A3	90
1023	Future dates of service not accepted	Future dates of service not accepted	A7	187

Appendix B-Unaccepted Claims Report Reason Codes

ERROR CODE	SHORT DESCRIPTION	LONG DESCRIPTION	HIPAA CATEGORY CODE	HIPAA STATUS CODE
1024	The admission date on your claim is greater than claim received date	The admission date on your claim is greater than claim received date	A7	189
1025	An admission date or begin date was not submitted	An admission date or begin date was not submitted	A6	188
1026	The end date or discharge date of service was not submitted	The end date or discharge date of service was not submitted	A6	188
1027	The claim-level begin date or admission date is after the claim-level end date or discharge date	The claim-level begin date or admission date is after the claim-level end date or discharge date	A7	187
1028	The total claim charges were not submitted	The total claim charges were not submitted	A6	178
1029	The procedure code as billed is not active for the date of service	The procedure code as billed is not active for the date of service	A7	666
1030	Claim received with surgical procedure date but a surgical procedure code was not submitted	Claim received with surgical procedure date but a surgical procedure code was not submitted	A7	666
1031	The submitted DRG code is invalid	The submitted DRG code is invalid	A7	256
1032	A line level Revenue Code was not submitted	A line level Revenue Code was not submitted	A6	455
1033	Invalid detail line quantity submitted	Invalid detail line quantity submitted	A7	258
1034	The admission date is not equal to the service from date	The admission date or first date of service is not the same or equal to the first date of service in the detail lines.	A7	189
1035	The admission Type or Source Code was not submitted	The admission Type or Source Code was not submitted	A6	229
1036	The admit hour was invalid or not formatted properly	The admit hour was invalid or not formatted properly	A7	230
1037	The discharge hour was invalid or not formatted properly	The discharge hour was invalid or not formatted properly	A7	233
1038	The date of service does not fall within the admission or discharge dates of the claim level	The date of service does not fall within the admission or discharge dates of the claim level	A7	187
1039	A detail level procedure code was not submitted	A detail level procedure code was not submitted	A6	454
1040	The service from date is after the claim received date	The service from date is after the claim received date	A7	187
1041	The service thru date is after the claim received date.	The service thru date is after the claim received date.	A7	187
1042	The line-level begin date or admission date is after the line-level end date or discharge date	The line-level begin date or admission date is after the line-level end date or discharge date	A7	187
1043	No charges submitted for the detail line of the claim	No charges submitted for the detail line of the claim	A6	178
1044	The claim contains ICD-9 codes for dates of service after the ICD-10 cutover.	The claim contains ICD-9 codes for dates of service after the ICD-10 cutover.	A7	577
1045	The claim contains ICD-10 codes for dates of service prior to the ICD-10 cutover.	The claim contains ICD-10 codes for dates of service prior to the ICD-10 cutover.	A7	577
1046	The claim contains both ICD-9 and ICD-10 codes.	The claim contains both ICD-9 and ICD-10 codes.	A7	577

Appendix B-Unaccepted Claims Report Reason Codes

ERROR CODE	SHORT DESCRIPTION	LONG DESCRIPTION	HIPAA CATEGORY CODE	HIPAA STATUS CODE
1047	The line-level repriced allowed amount was negative	The line-level repriced allowed amount was negative	A7	705
1048	Facility Type Code is invalid	Facility Type Code is invalid	A7	228
1049	Claim Frequency Code is invalid	Claim Frequency Code is invalid	A7	228
1050	Revenue code is invalid	Revenue code is invalid	A7	455
1051	Revenue code is not active for date of service	Revenue code is not active for date of service	A7	455
1052	Admission date is required on inpatient claims	Admission date is required on inpatient claims	A6	186
1053	No billing-level NPI was submitted	No billing-level NPI was submitted	A6	562
1054	Invalid POA indicator submitted	Invalid Present On Admission (POA) indicator submitted	A7	688
1055	Other insurance carrier primary. Must submit primary carrier EOB/EOMB	COB records indicate another insurance carrier is primary. Must submit primary carrier EOB/EOMB	A6	171
1056	Secondary claims are not accepted electronically. Please re-submit on paper.	Secondary claims are not accepted electronically. Please re-submit on paper.	A7	742
1057	Claims for dates of service prior to 01/01/2011 are not accepted electronically	Claims for dates of service prior to 01/01/2011 are not accepted electronically. Please re-submit on paper.	A3	187
1058	ICD-9 codes cannot be billed for dates of service after the ICD-10 encounter	ICD-9 codes cannot be billed for dates of service after the ICD-10 cutover	A7	255
1059	ICD-10 codes cannot be billed for dates of service prior to the ICD-10 cutover	ICD-10 codes cannot be billed for dates of service prior to the ICD-10 cutover	A7	255
1060	Claim cannot contain a mix of ICD coding methodologies	Claim cannot contain a mix of ICD coding methodologies	A7	255
1061	Facility Type Code 73 cannot be submitted with ICD-10 codes	Facility Type Code 73 cannot be submitted with ICD-10 codes	A7	610
1062	Claim cannot have gaps in diagnosis numbers	Claim cannot have gaps in diagnosis numbers	A7	255
1063	Claims cannot have gaps in surgical procedure numbering	Claim cannot have gaps in surgical procedure numbers	A7	666