Claims Procedures

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At a Glance

The MedStar Select plan pledges to provide accurate and efficient claims processing. To make this possible, MedStar Select requests that providers submit claims promptly and include all necessary data elements.

A key to controlling administrative costs is reducing excess paperwork, particularly paperwork generated by improperly completed claims.

- Type claims or submit them electronically. Handwritten claims may be returned. *Electronic claims submission is recommended.*
- Claims with eraser marks or white out corrections may be returned.
- If a mistake is made on a claim, the provider must resubmit a corrected claim. Claims must be submitted by the established filing deadlines or they will be denied.
- Services for the same patient with the same date of service may not be unbundled. For example, an office visit, a lab workup and a venipuncture by the same provider on the same day must be billed on the same claim.
- Only clean claims containing the required information will be processed within the required time limits. Rejected claims, those with missing or incorrect information, may be resubmitted as corrected claims. A new claim form must be generated to resubmit the claim.
- The status of a claim can be checked online or by calling Provider Services 30 days after submission. If the claim is not on file, it can be resubmitted. Prior to resubmission the provider should validate that all information on the claim is correct and that it was not rejected by a Clearinghouse if originally submitted electronically. If the claim was originally submitted on paper, the mailing address should be verified.
- Use proper place of service codes for all claims.
- Use Modifier 25 when a provider performs a significant separately identifiable evaluation and management of a patient on the same date of service as the original visit.
- Bill anesthesia claims with the correct codes from the American Society of Anesthesiologists with the appropriate anesthesia modifiers and time units, if applicable.
- Submit only one payee address per tax identification number.
- Submit all appeals in writing within 120 (administrative) or 180 (medical necessity) business days of receipt for the notice indicating the claim was denied.

Submission Guidelines

Electronic Filing

The MedStar Select plan's claims processing system allows providers access to submit claims, in addition to the ability to view claim details through the Provider OnLine portal.

Electronically filed claims may be submitted in the following ways:

Provider OnLine

Network providers can enter claims through MedStar Select's Provider OnLine. Provider OnLine allows direct submission of both professional (CMS-1500) and institutional (UB-04) claims via a web interface, with the highest level of security and HIPAA compliance, to allow the process to be safe, secure and user-friendly.

In order to use Provider OnLine, providers must complete a brief e-learning course and a short post-course assessment. Upon successful course completion, the provider's office can enter claims and verify acceptance. For further information on Provider OnLine, including registration, please use the following link:

http://medstarprovidernetwork.com/provider-login

Electronic Data Interchange (EDI) 2 Options:

MedStar Select also accepts electronic claims in data file transmissions. Electronic claim files sent directly to the MedStar Select plan are permitted only in HIPAA standard formats.

Direct EDI Submission

Providers are able to submit claims directly without incurring clearinghouse expenses. These claims are loaded into batches and immediately posted in preparation for adjudication. Via the Provider OnLine EDI tools, these batches can be viewed in several standard report formats.

To submit EDI files directly to MedStar Select, providers must

- Have an existing Provider OnLine account or register for a new provider or submitter account by filling out the application form at **www.MedStarProviderNetwork.com**
- Use billing software that allows a HIPAA-compliant 837 professional or institutional file to be generated
- Have a sample 837 file exported from their billing system containing only MedStar Select claims
- Have a computer with Internet access
- Have the ability to download and install a free Active-X secure FTP add-on
- Complete testing with MedStar Select

EDI Submission via Clearinghouse

Providers who have existing relationships with clearinghouses such as Emdeon, Relay Health and others **(MedStar Select Payer ID: 251MS)** can continue to transmit claims in the format produced by their billing software. These clearinghouses are then responsible for reformatting claims to meet HIPAA standards and passing the claims on to MedStar Select. Clearinghouses must be connected with MedStar Select to submit claims. Please verify before starting EDI transmission. Providers interested in using a clearinghouse should contact the respective "Customer Service Office" and ask them how to enroll. For all EDI submissions, the NPI (National Provider Identifier) number is required. When care is coordinated, the referring provider's name and NPI are required.

Since it is possible for multiple clearinghouses to be involved in passing a claim from a provider's billing software to MedStar Select, it is important to collect and analyze the acceptance and rejection reports from every clearinghouse involved to determine if claims have been successfully transmitted.

Paper Claim Filing

CMS-1500 Forms

These forms are for professional services performed in a provider's office, hospital or ancillary facility. (Provider-specific billing forms are not accepted.)

UB-04 Forms

These forms are for inpatient hospital services or ancillary services performed in the hospital. (Hospital-specific billing forms are not accepted.)

Corrected or Voided Claims and Late Charges

Facility UB04 Claims:

Corrected claims must have a bill type of XX7 in Field Locator 4. In addition, the original claim number must be documented in Field Locator 64.

If the resubmitted claim does not contain all of the required information, the corrected claim will be denied indicating to resubmit claim with all required information. If MedStar Select is unable to identify the original claim, the claim submitted with the XX7 Bill Type will be denied indicating that we received a replacement claim with no original on file.

All corrected claims must be received within 180 days from the date of service.

Late Charges must be submitted with a claim type of XX5 to indicate late charges. The date of service date(s) must match exactly to what was submitted on the original claim. If the dates do not match, the late claim will be denied requesting that you resubmit with all of the corrected information present.

If the Rev Codes billed on the late claim are the same as what was billed on the original claim, we will deny the late charges and request that the provider submit a corrected claim with all of the charges on a single claim. If the Rev Codes are different or used with different HCPCs codes, MedStar Select will accept the late charges.

For Providers billing for contracted services that will be paid as a Per Diem or an APR-DRG, MedStar Select will deny the late charges requesting that a corrected claim be submitted with

all of the charges on a single claim.

MedStar Select requests that all of the facilities bill the Corrected, Late Charges or Voided claims electronically. Please refer to the EDI Institutional Companion Document for any questions concerning which loop and segments need to be completed. MedStar Select recognizes and accepts all valid electronic claims following the standards that were set for EDI billing.

Professional CMS1500 Claims:

When submitting corrected or voided claims, MedStar Select prefers to receive them electronically. When submitting these claims, in the 2300Loop using the CLM segment 3rd digit should be a 7 for a corrected claim or an 8 for a voided claim. REF Segment Original must contain the original claim number.

If billing a corrected claim by paper, use Claim type in field locator 22: Left side will contain either a 7 for corrected claim or 8 for a voided or cancelled claim. Right side will contain the original claim number entered on the claim. If this information is missing from the corrected claim, MedStar Select will deny requesting the provider resubmit with all of the corrected information.

MedStar Select requests that all of the providers bill the Corrected, Late Charges or Voided claims electronically. Please refer to the Professional Companion Document for any questions concerning which loop and segments need to be completed. MedStar Select recognizes and accepts all valid electronic claims following the standards that were set for EDI billing.

Deadlines

The MedStar Select plan accepts new claims for services up to 180 days after the date of service for MedStar Select.

When MedStar Select is the secondary payer, claims are accepted with the explanation of benefits (EOB) from the primary carrier. This claim must be received within 180 days of the primary EOB remittance date or up to the new claim timely filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing.

Associates or covered dependents cannot be billed for the MedStar Select plan's portion of the claims submitted after these deadlines; however, they may be billed for copayments, coinsurance and/or deductibles.

Claims Address

Claim forms should be submitted to the following address:

MedStar Select Claims
Claims Department
P.O. Box 1200
Pittsburgh, PA 15230-1200

Appeals Address

Appeal forms should be submitted to the following address:

MedStar Select
P.O. Box 269
Pittsburgh, PA 15230-0269

Clean claims will be paid within 30 days, in accordance with Maryland law. To inquire about claims status, please contact MedStar Select Provider Services or review the claim on the Provider OnLine portal.

MedStar Select follows the CMS National Correct Coding Initiative when adjudicating claims.

Diagnosis Codes

Claims must be submitted with a valid diagnosis code indicating the associate or covered dependent's medical condition or circumstances necessitating evaluation or treatment. The diagnosis codes submitted on claim forms must correlate to the documentation contained within the associate or covered dependent's medical record and reflect or support the reason services have been provided.

Follow these guidelines to avoid the most common claims coding problems:

- New POA (Present on Admission Indicator)
- Diagnosis should be coded using ICD-10-CM. Make sure the diagnosis code is valid and complete (i.e., includes all digits).
- The primary diagnosis should describe the chief reason for the associate or covered dependent's visit to the provider.
- When a specific condition or multiple conditions are identified, these conditions should be coded and reported as specifically as possible.
- For coding of services provided on an outpatient basis, do not code the diagnosis as "rule out," "suspect" or "probable" until such time as the condition is confirmed. Code the condition to the highest degree of certainty, such as symptoms, signs or abnormal test results.
- When addressing both acute and chronic conditions, assign codes to all conditions for which the associate or covered dependent is seeking medical care.
- When coding ongoing or chronic conditions, do not assume the code used at a previous visit is appropriate for a current visit.
- In coding diabetes, be certain to identify the current status of the associate or covered dependent's condition as Type I or Type II, controlled or uncontrolled, referring to the direction of ICD-10-CM.
- Use caution in coding injuries, identifying each as specifically as possible.
- Refer to guidelines throughout ICD-10-CM for "late effect" coding and sequencing.
- "Well" vs. "sick" visits — If a preventive visit was scheduled, but symptoms of illness or injury exist at the time of the visit, code the primary diagnosis as "preventive." The conditions for which the associate or covered dependent is being treated should be coded as a secondary diagnosis.
- V-codes are used for circumstances affecting an associate or covered dependent's health status or involving contact with health services that are not

classified under ICD-10. In general, they do not represent primary disease or injury conditions and should not be used routinely. V-codes used to describe personal and/or family history of medical conditions are covered when used for a screening procedure; however, V-codes that pertain to mental health, learning disorders or social conditions are not covered.

Claims Resubmission

The status of a claim can be checked online or by calling Provider Services 30 days after submission. If the claim is not on file, it can be resubmitted. Claims may be resubmitted if MedStar Select has not paid them within 30 days of the initial submission..

Prior to resubmission, the provider should validate that all information on the claim is correct and that it was not rejected by a clearinghouse if originally submitted electronically. If the claim was originally submitted on paper, the mailing address should be verified.

Claims Documentation

Clean vs. Unclean Claims

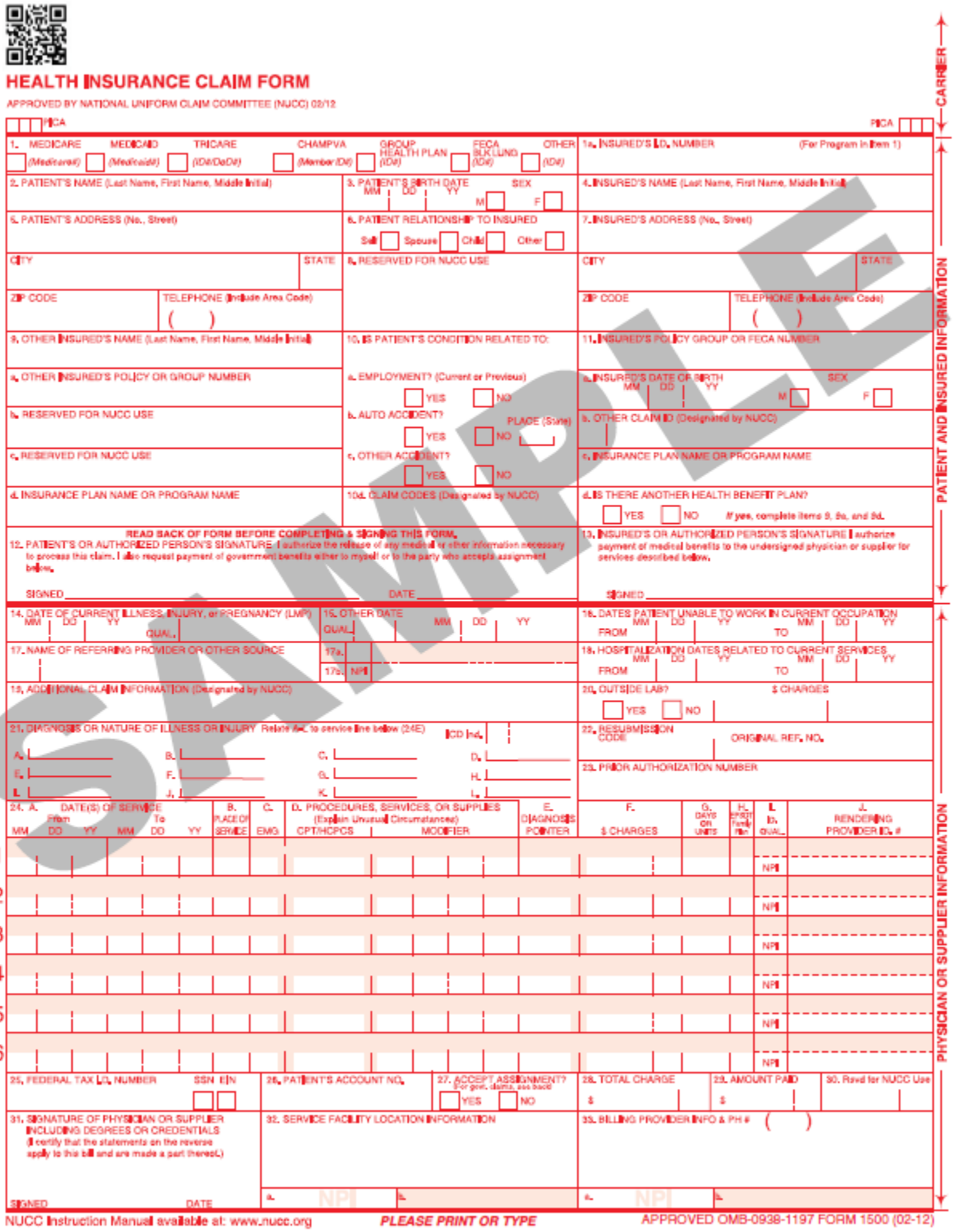
The MedStar Select plan defines a “clean” claim as a one with no defects or improprieties. A defect or impropriety may include, but is not limited to, the following:

- Lack of required substantiating documentation
- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim
- Any required fields where information is missing or incomplete
- Invalid, incorrect or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes)
- A missing explanation of benefits (EOB) for an associate or covered dependent with other coverage
- Claims requiring medical review before payment
- Claims requiring authorization that was not obtained

Required Fields on a CMS-1500 Claim Form

The following CMS-1500 claim form is standard in the insurance industry; however, MedStar Select requires providers to complete only those fields noted in the figure below. Each field is explained in the numbered key that follows this illustration.

CMS-1500 Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Explanation of Required Fields on a CMS-1500 Claim Form

If a numbered field is not included, it is not required by MedStar Select in order to process a claim.

CMS-1500 Claim form fields

Field #	Required Field Explanation
1A	Insured's ID number—11-digit member ID number (combination of the 9-digit member number and the 2-digit relationship code on the front of the member ID card)
2	Member's name—member's last name, first name, and middle initial
3	Member's birth date—Member's date of birth in month/day/year format; also, member's gender
4	Insured's name—last name, first name, and middle initial of policy-holder
5	Member's address—member's current address, including city, state, and zip code; also member's telephone number
6	Member's relationship to the insured—applicable relationship box marked
7	Insured's address—insured's current address, including city/state/zip code; also insured's telephone number
9	Other insured's name—if the member is covered by another health insurance plan, please list the insured's last name, first name, and middle initial here; also list the insured's policy or group number, date of birth, gender, employer's name or school name, and insurance plan name or program name
10	Member's condition related to— check boxes if condition is related to employment, auto accident or other accident.
12	Member's release—indicates if member has signed release of information from provider
13	Authorized signature—indicates if member's signature authorizing payment to provider is on file
17	Referring provider's name—first, and last name of referring provider; If member is self-directed, please print "NONE"

CMS-1500 Claim form fields (continued).

Field #	Required Field Explanation
17A	Referring provider's ID number—Universal Physician Identification Number (UPIN)
17B	Provider's NPI
21	Diagnosis or nature of illness or injury—minimum of one diagnosis code (ICD-9 coding)
24A	Date(s) of service (from/to) in month/day/year format
24B	Place of service—2-digit CMS standard code indicating where services were rendered
24D	Procedures, services, and modifier—CPT or HCPCS code and modifier (if applicable)
24E	Diagnosis Pointer—indicates diagnosis code or diagnoses that apply to service on a given line
24F	Charges—amount charged for service
24G	Days or units—number of times service was rendered
25	Federal tax ID number— tax ID number of provider rendering service
26	Member's account number—provider-specific ID number for member (up to 12 digits)
28	Total charge—total of all charges on bill
29	Amount paid—amount paid by member and third-party payers
30	Balance due—current balance due from insured
31	Signature of provider/supplier— should include degree or credentials (Please make sure the signature is legible.)
32	Name and address of facility—name of facility where services were rendered (if other than home or provider's office)
33	Provider's billing information—billing provider's name, address, and telephone number; also list the PIN number (6-digit ID number assigned to the provider by MedStar Select plan)

Required Fields on a UB-04 Claim Form

The following UB-04 claim form is standard in the insurance industry. Each field is explained in the numbered key that follows this illustration.

UB-04 Claim Form

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
1	Required by Medicare	Billing Provider Name	1	AN	25
	Required by Medicare	Billing Provider Street Address	2	AN	25
	Required by Medicare	Billing Provider City, State, Zip	3	AN	25
	Required by Medicare	Billing Provider Telephone, Fax, Country Code	4	AN	25
2	May be required by another payer when applicable / not required by Medicare	Billing Provider's Designated Pay-to Name	1	AN	25
	May be required by another payer when applicable / not required by Medicare	Billing Provider's Designated Pay-to Address	2	AN	25
	May be required by another payer when applicable / not required by Medicare	Billing provider's Designated Pay-to City, State	3	AN	25
	May be required by another payer when applicable / not required by Medicare	Billing provider's Designated Pay-to ID	4	AN	25
3a	Required by Medicare	Patient Control Number	1	AN	24
3b	May be required by another payer when applicable / not required by Medicare	Medical/Health Record Number	2	AN	24
4	Required by Medicare	Type of Bill (TOB)	1	AN	4
5	Required by Medicare	Federal Tax Number	1	AN	4
	Required by Medicare	Federal Tax Number	2	AN	10
6	Required by Medicare	Statement Covers Period - From/Through	1	N/N	6/6
7	Field not used	Unlabeled	1	AN	7
	Field not used	Unlabeled	2	AN	8
8a	Required by Medicare	Patient Name/ID	1	AN	19
8b	Required by Medicare	Patient Name	2	AN	29
9a	Required by Medicare	Patient Address - Street	1	AN	40
9b	Required by Medicare	Patient Address - City	2	AN	30
9c	Required by Medicare	Patient Address - State	2	AN	2
9d	Required by Medicare	Patient Address - Zip	2	AN	9
9e	May be required by another payer when applicable / not required by Medicare	Patient Address - Country Code	2	AN	3
10	Required by Medicare	Patient Birthdate	1	N	8
11	Required by Medicare	Patient Sex	1	AN	1

UB-04 Data Elements, continued.

FL	Requirement	Description	Line	Type	Size
12	Required for Types of Bill	Required for Types of Bill 011X,	1	N	6
13	May be required by another payer when applicable / not required by Medicare	Admission Hour	1	AN	2
14	Required for Types of Bill 011X, 012X, 018X, 021X, and 041X	Priority (Type) of Admission or Visit	1	AN	1
15	Required by Medicare	Point of Origin for Admission or Visit	1	AN	1
16	May be required by another payer when applicable / not required by Medicare	Discharge Hour	1	AN	2
17	Required for Types of Bill 011X, 012X, 013X, 014X, 018X, 021X, 022X, 023X, 032X, 033X, 034X, 041X, 071X, 073X, 074X, 075X, 076X, 081X, 082X, 085X	Patient Discharge Status	1	AN	2
18-28	Required if applicable	Condition Codes		AN	2
29	May be required by another payer when applicable / not required by Medicare	Accident State		AN	2
30	Field not used	Unlabeled	1	AN	12
	Field not used	Unlabeled	2	AN	13
31-34	Required if applicable	Occurrence Code/Date	a	AN/N	2/6
	Required if applicable	Occurrence Code/Date	b	AN/N	2/6
35-36	Required if applicable	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6
	Required if applicable	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6
37	Field not used	Unlabeled	a	AN	8
	Field not used	Unlabeled	b	AN	8
38	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	1	AN	40
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	2	AN	40

UB-04 Data Elements, continued.

FL	Requirement	Description	Line	Type	Size
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	3	AN	40
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	4	AN	40
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	5	AN	40
39-41	Required if applicable	Value Code	a-d	AN	2
	Required if applicable	Value Code Amount	a-d	N	9
42	Required by Medicare	Revenue Codes	1-23	N	4
43	May be required by another payer when applicable / not required by Medicare	Revenue Code Description/Investigational Device Exemption (IDE) Number/Medicaid Drug Rebate	1-23	AN	24
44	Required if applicable	Healthcare Common Procedure Coding System (HCPCS)/Accommodation Rates/Health Insurance Prospective Payment System (HIPPS) Rate Codes	1-23	AN	14
45	Required if applicable	Service Dates	1-23	N	6
46	Required if applicable	Service Units	1-23	N	7
47	Required by Medicare	Total Charges	1-23	N	9
48	Required if applicable	Non-Covered Charges	1-23	N	9
49	Field not used	Unlabeled	1-23	AN	2
		Page _ of Creation Date _	23	N/N	3/3
50	Required by Medicare	Payer Identification - Primary	A	AN	23
	Required by Medicare	Payer Identification - Secondary	B	AN	23
	Required by Medicare	Payer Identification - Tertiary	C	AN	23
51	Required by Medicare	Health Plan ID	A	AN	15
	Required if applicable	Health Plan ID	B	AN	15
	Required if applicable	Health Plan ID	C	AN	15
52	Required by Medicare	Release of Information	A	AN	1
	Required by Medicare	Release of Information - Secondary	B	AN	1
	Required by Medicare	Release of Information - Tertiary	C	AN	1

UB-04 Data Elements, continued.					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
53	May be required by another payer when applicable / not required by Medicare	Assignment of Benefits - Primary	A	AN	1
	May be required by another payer when applicable / not required by Medicare	Assignment of Benefits - Secondary	B	AN	1
	May be required by another payer when applicable / not required by Medicare	Assignment of Benefits - Tertiary	C	AN	1
54	Required if applicable	Prior Payments - Primary	A	N	10
	Required if applicable	Prior Payments - Secondary	B	N	10
	Required if applicable	Prior Payments - Tertiary	C	N	10
55	May be required by another payer when applicable / not required by Medicare	Estimated Amount Due - Primary	A	N	10
	May be required by another payer when applicable / not required by Medicare	Estimated Amount Due - Secondary	B	N	10
	May be required by another payer when applicable / not required by Medicare	Estimated Amount Due - Tertiary	C	N	10
56	Required by Medicare	National Provider Identifier (NPI) - Billing Provider	1	AN	15
57	Required if applicable	Other Provider ID	A	AN	15
	Required if applicable	Other Provider ID	B	AN	15
	Required if applicable	Other Provider ID	C	AN	15
58	Required by Medicare	Insured's Name - Primary	A	AN	25
	Required by Medicare	insured's Name - Secondary	B	AN	25
	Required by Medicare	insured's Name - Tertiary	C	AN	25
59	Required if applicable	Patient's Relationship - Primary	A	AN	2
	Required if applicable	Patient's Relationship - Secondary	B	AN	2
	Required if applicable	Patient's Relationship - Tertiary	C	AN	2
60	Required by Medicare	Insured's Unique ID - Primary	A	AN	20
	Required by Medicare	Insured's Unique ID - Secondary	B	AN	20
	Required by Medicare	Insured's Unique ID - Tertiary	C	AN	20
61	Required if applicable	Insurance Group Name - Primary	A	AN	14
	Required if applicable	Insurance Group Name - Secondary	B	AN	14
	Required if applicable	Insurance Group Name - Tertiary	C	AN	14
62	Required if applicable	Insurance Group No. - Primary	A	AN	17

UB-04 Data Elements, continued.

FL	Requirement	Description	Line	Type	Size
	Required if applicable	Insurance Group No. - Secondary	B	AN	17
	Required if applicable	Insurance Group No. - Tertiary	C	AN	17
63	Required if applicable	Treatment Authorization - Primary	A	AN	30
	Required if applicable	Treatment Authorization - Secondary	B	AN	30
	Required if applicable	Treatment Authorization - Tertiary	C	AN	30
64	Required if applicable	Document Control Number (DCN)	A	AN	26
	Required if applicable	Document Control Number (DCN)	B	AN	26
	Required if applicable	Document Control Number (DCN)	C	AN	26
65	Required if applicable	Employer Name (of the insured) - Primary	A	AN	25
	Required if applicable	Employer Name (of the insured) - Secondary	B	AN	25
	Required if applicable	Employer Name (of the insured) - Tertiary	C	AN	25
66	Required by Medicare	Diagnosis and Procedure Code Qualifier (International Classification of Diseases [ICD] Version Indicator)	1	AN	1
67	Required for Types of Bill 011X. 012X, 013X, 014X, and 021X	Principal Diagnosis Code and Present on Admission (POA) Indicator	1	AN	8
67A-Q	Required if applicable	Other Diagnosis and POA Indicator	A-O	AN	8
68	Field not used	Unlabeled	1	AN	8
	Field not used	Unlabeled	2	AN	9
69	Required for Types of Bill 011X, 012X, 021X, and 022X	Admitting Diagnosis Code	1	AN	7
70a	Required if applicable	Patient Reason for Visit Code	1	AN	7
70b	Required if applicable	Patient Reason for Visit Code	1	AN	7
70c	Required if applicable	Patient Reason for Visit Code	1	AN	7
71	May be required by another payer when applicable / not required by Medicare	Prospective Payment System (PPS) Code	1	AN	3
72a	May be required by another payer when applicable / not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8

UB-04 Data Elements, continued.					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
72b	May be required by another payer when applicable / not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
72c	May be required by another payer when applicable / not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
73	Field not used	Unlabeled	1	AN	9
74	Required if applicable	Principal Procedure Code/Date	1	N/N	7/6
74a	Required if applicable	Other Procedure Code/Date	1	N/N	7/6
74b	Required if applicable	Other Procedure Code/Date	1	N/N	7/6
74c	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
74d	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
74e	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
75	Field not used	Unlabeled	1	AN	3
	Field not used	Unlabeled	2	AN	4
	Field not used	Unlabeled	3	AN	4
	Field not used	Unlabeled	4	AN	4
76	Required if applicable	Attending Provider - NPI/QUAL/ID	1	AN	11/2/9
	Required if applicable	Attending Provider - Last/First	2	AN	16/12
77	Required if applicable	Operating Physician - NPI/QUAL/ID	1	AN	11/2/9
	Required if applicable	Operating Physician - Last/First	2	AN	16/12
78	Required if applicable	Other Provider - QUAL/NPI/QUAL/ID	1	AN	2/11/2/9
	Required if applicable	Other Provider - Last/First	2	AN	16/12
79	Required if applicable	Other Provider - QUAL/NPI/QUAL/ID	1	AN	2/11/2/9
	Required if applicable	Other Provider - Last/First	2	AN	16/12
80	Required if applicable	Remarks	1	AN	21
	Required if applicable	Remarks	2	AN	26
	Required if applicable	Remarks	3	AN	26
	Required if applicable	Remarks	4	AN	26
81	Required if applicable	Code-Code - QUAL/CODE/VALUE	a	AN/AN/AN	2/10/12
	Required if applicable	Code-Code - QUAL/CODE/VALUE	b	AN/AN/AN	2/10/12
	Required if applicable	Code-Code - QUAL/CODE/VALUE	c	AN/AN/AN	2/10/12
	Required if applicable	Code-Code - QUAL/CODE/VALUE	d	AN/AN/AN	2/10/12

Place-of-Service Codes

All providers are required to submit CMS-1500 claim forms with CMS standard two-digit place-of-service codes entered in Box 24B. Forms submitted without these codes will be rejected with no adjudication and returned to the provider for resubmission.

Commonly Used Place-of-Service Codes

Code	Description
11	Office
12	Home
15	Mobile
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Chemical Dependency Treatment Facility
56	Psychiatric Residential Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory

Codes and Modifiers

Claims Coding

Providers who are reimbursed for professional and ancillary services on a fee-for-service basis agree to accept the network reimbursement, less deductibles, coinsurance and copayments, as payment in full for covered services provided to MedStar Select associates and covered dependents.

Unlisted Codes

- **Procedures**
  When necessary and appropriate, a provider may bill for a procedure that does not have an existing CPT/HCPCS code. The provider should use the “miscellaneous” or “not otherwise classified” code that most closely relates to the service provided. When using “unlisted” or “not otherwise classified” codes for billing, providers should supply all supporting documentation.

- **Medications**
  “Unlisted” or “not otherwise classified” drugs must be submitted with applicable HCPCS codes. The claim must include a description of the item/drug supplied, the correct dosage, and the National Drug Classification Code number (NDC#).

- **Modifiers**
  Frequently used provider modifiers are listed in the following table. For a complete list of modifiers, refer to the CPT manual and the HCPCS Level II manual.

Provider Modifiers

Modifier	Description
24	Unrelated evaluation and management service by the same provider during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same provider on the same day of the procedure or other service
33	Preventive services
50	Bilateral procedure
57	Decision for surgery
59	Distinct procedural service
62	Two surgeons
76	Repeat procedure by same provider or other qualified healthcare professional
77	Repeat procedure by another provider or other healthcare professional
80	Assistant surgeon
82	Assistant surgeon (when qualified resident and surgeon not available)
91	Repeat clinical diagnostic laboratory test
LT	Left side
RT	Right side

Anesthesia Modifiers

Anesthesia claims for all associates and covered dependents should be billed with the correct codes from the American Society of Anesthesiologists (ASA) — 00100–01999 — which are included in the CPT manual.

Services performed for MedStar Select associates and covered dependents by a certified registered nurse anesthetist (CRNA) are eligible for reimbursement and can be billed in conjunction with the anesthesiologist's charges, provided the appropriate modifier is used.

Appropriate anesthesia modifiers also should be billed including, but not limited to, the following:

Anesthesia Modifiers

Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a provider; more than four concurrent anesthesia procedures
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	Certified registered nurse anesthetist (CRNA) service with medical direction by a provider
QY	Medical direction of one CRNA by an anesthesiologist
QZ	CRNA service without medical direction by a provider

Home Medical Equipment Modifiers

Home medical equipment (HME) modifiers include, but are not limited to, the following:

Modifier	Description
RR	Rental
NU	New purchase
UE	Used durable medical equipment

Code-Specific Policies

Blood Draw/Venipuncture

MedStar Select does not reimburse for blood draw/venipuncture when that service is provided in conjunction with any other laboratory or evaluation and management service on the same date of service.

Immunizations

The injection is included with the office evaluation and management code (EM) if billed together or on the same date of service. Eligible vaccines are reimbursable based on an associate or covered dependent's benefits. If an administration code is billed and the claim also includes an office evaluation and management (E&M) code, the administration code will not be separately reimbursable.

Surgical Procedures

Providers must note surgical procedures performed during the same operative session by the same provider on a single claim form or electronic equivalent. Billing on separate claim forms may result in delayed payments, incorrect payments or payment denial.

Reimbursement

The MedStar Select plan processes all clean claims within 30 days from the date they are received. Applicable state regulations stipulate that a claim is paid when MedStar Select mails the check.

ER Auto-Pay List

The MedStar Select utilizes an ER auto-pay list. Claims for emergency services with ICD-10-CM diagnosis codes on the auto-pay list will be paid without further documentation. MedStar Select reserves the right to audit claims in accordance with Maryland regulations for consistency between clinical documentation and information presented on the bill (including the reported diagnosis). ER visits not included on the auto-pay list require medical documentation for payment. Providers may also obtain a copy of this auto-pay list by contacting the Provider Relations department.

High Dollar Claim Edit

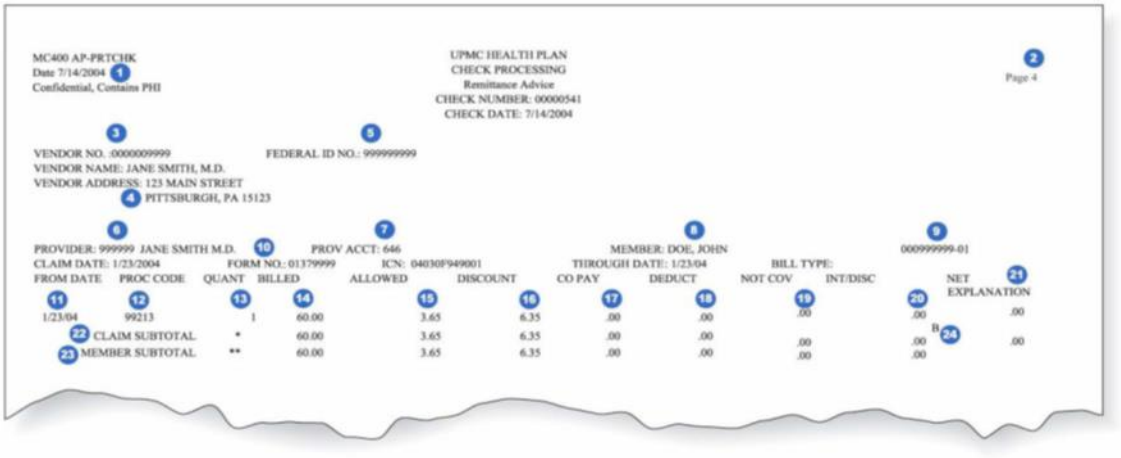
MedStar Select has a process to review High Dollar Claims prior to payment to verify accuracy of reimbursement. A High Dollar Claim is defined as any claim with a total payment amount that is determined to be equal to or greater than $25,000. Once claims are received via electronic or paper format, those exceeding the dollar threshold amount are held for the Quality Assurance Department to complete a comprehensive review prior to payment distribution. Within two (2) business days of receipt, the representative from the Quality Assurance Department reviews the High Dollar Claim for accuracy. After the claim is reviewed, remarks are added stating if corrections to the claim are required prior to the claim being released. If the claim is correct, it is routed back to the Claims Department to be released if the total payment amount is less than $100,000. Claims $100,000 or greater are routed back to the Claims Department to be released by a Manager. If corrections are needed, it is routed back to the Claims Department for corrections prior to release. A small subset of claims also undergo a coding and/or clinical review. The claims forwarded for review include (but are not limited to) when the allowed amount exceeds the billed amount on the claim; or when pharmacy or supply charges seem unusually high. These reviews could result in a request for medical records to support the services billed, which must be received in order to approve payment. Three outreach attempts will be made. If the information is not

received after three attempts, the claim could be denied. Audits are performed on a sample of claims on both a weekly and monthly basis to validate that High Dollar Claim reviews are being performed accurately and appropriately. For more information on the High Dollar Claim review process, please contact Provider Services 855-222-1042.

Explanation of Payment (Remittance Advice)

The Explanation of Payment (EOP), referred to on the statement as a "remittance advice," is a summary of claims submitted by a provider. It shows the date of service, diagnosis and procedure performed, as well as all payment information (i.e., money applied to the associate or covered dependent's deductible or copayment, and denied services).

For additional questions pertaining to the EOP, contact Provider Services at **855-222-1042.**



#	Description	#	Description	#	Description
1	Run date – date printed	9	Member number	17	Copayment applied (member liability)
2	Page number	10	Form number – claim ID number assigned by MedStar Select	18	Deductible applied (member liability)
3	Provider vendor number	11	Date of service	19	Amount not covered
4	Provider name and address	12	Procedure code	20	Interest applied

#	Description	#	Description	#	Description
5	Federal tax ID number – Provider tax ID number	13	Number of units billed	21	Net explanation – amount paid
6	Servicing provider number and name	14	Billed amount	22	Claim subtotal line – subtotal for fields 14-21
7	Member account number	15	MedStar Select allowed amount	23	Member subtotal line

8	**Member name – last name, first name**	**16**	**Discount applied (not member liability)**	**24**	**Explanation codes**

Process for Refunds or Returned Checks

The MedStar Select plan accepts overpayments two ways:

- Providers may refund additional money directly to MedStar Select, *or*
- MedStar Select will take deductions from future claims.

Refunds

If MedStar Select has paid in error, providers may return the check or write a separate check from their account for the full amount paid in error. Providers should include a copy of the remittance advice, supporting documentation noting the reason for the refund and the explanation of benefits (EOB) from other insurance carriers, if applicable.

Refunds should be sent directly to the General Accounting department at this address:

Attn: General Accounting
MedStar Select
24th Floor
600 Grant St.
Pittsburgh, PA 15219

Overpayment

If the MedStar Select plan has paid in error and the provider has not sent a refund or returned the check, money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount. Providers will be notified of overpayment and/or retraction of funds. Providers are required to report overpayments to MedStar Select if errors are identified prior to receiving plan notification.

Claims Follow-Up

To view claim status online, go to the Provider OnLine portal:

http://medstarprovidernetwork.com/provider-login

New users will be asked to register. For login information, contact Provider Services at **855-222-1042** or email **Provider_Support@TogetherForYourHealth.com**

To check the status of a claim without going online, call Provider Services at **855-222-1042** Monday through Friday, 8 a.m. to 5 p.m.

Denials and Appeals

All denied claims are reported on the EOP, referred to on the statement as a “remittance advice.” This indicates whether the provider has the right to bill the associate or covered dependent for the denied services and/or if the associate or covered dependent is financially responsible for payment.

If a provider disagrees with the MedStar Select plan’s decision to deny payment of services, the provider must appeal in writing to the appeals coordinator within 120 (administrative) or 180 (medical necessity) days of receipt of the denial notification. The request must include the reason for the appeal and any relevant documentation, which may include the member’s medical record. More detailed information on this subject can be found in the *Provider Standards & Procedures* section of this manual.

Appeals should be submitted to

MedStar Select - Provider Appeals
P.O. Box 269
Pittsburgh, PA 15230-0269

All appeals undergo MedStar Select’s internal review process, which meets all applicable regulatory agency requirements. The provider will receive written notification in all situations in which the decision to deny payment is upheld.

False Claims

The False Claims Act (31 U.S.C. § 3729) makes it illegal to present or cause to be presented to the federal or state government a false or fraudulent claim for payment. This would apply to U.S. government programs such as Medicaid, Medicare and Medicare Part D and the Federal Employees Health Benefit Plan (FEHBP). Any person in violation of this act could be liable to the U.S. government for not less than $5,000 and not more than $10,000 per false claim, plus three times the amount of any other damages the U.S. government sustains because of the fraudulent claims.

- **Qui tam** lawsuits can be filed by private citizens referred to as whistle-blowers against any healthcare provider allegedly violating the federal and state False Claims Act.
- **Whistle-blowers** are protected if they are discharged because of their involvement with a suit; they are entitled to reinstatement and damages double the amount of their lost wages.

Best Practices

Best practices to help prevent fraud and abuse include

- Develop and follow the elements of a compliance program.
- Audit claims for accuracy.
- Review medical records for accurate documentation of services rendered.
- Take action if you identify a problem (i.e., contact Fraud, Waste, and Abuse at **855-222-1046**).
- Ask for photo identification when registering associates at the point of service.

Consider disabling the functionality within EMR systems that would allow one to copy and paste notes from visit to visit.