Claim Requirements

General Payment Guidelines

Tufts Health Plan processes completed claims that are subject to state or federal requirements within the time frames required. "Completed claims" are claims that have been submitted in industry standard electronic formats with all required fields accurately entered or on industry-standard paper claim forms and are legible with all required fields completed accurately (as described in this chapter).

Additional payment policies are available for many specific services on the Tufts Health Plan website. To ensure accurate claims processing, it is recommended that providers follow these documented payment policies and distribute them to office staff on a regular basis. For additional information, refer to the Payment Policies on our website.

Payment of Claims

The Conditions of Payment are described below.

1. The services must be:
    - Covered in accordance with the applicable Benefit Document provided to Tufts Health Plan members who meet eligibility criteria
    - Provided or authorized by the member's primary care provider (PCP) or the PCP's covering provider in accordance with the applicable benefit documents
    - Provided or authorized as identified elsewhere in your agreement with Tufts Health Plan or authorized by Tufts Health Plan and in compliance with your agreement.
    - Provided in an emergency in accordance with the member's benefit document
    - Medically necessary as defined in the member's benefit documents
2. Professional inpatient services billed in 837P format must be received by Tufts Health Plan, as evidenced by a Tufts Health Plan claim number, within the 90-day filing limit from the date of services. Professional inpatient services billed on a CMS-1500 form must be submitted to Tufts Health Plan within the 90-day filing limit from the date of service. Hospital inpatient services billed in 837I format must be received by Tufts Health Plan, as evidenced by a Tufts Health Plan claim number, within the 90-day filing limit from the date of discharge. Hospital inpatient services billed on a UB-04 form must be submitted within the 90-day filing limit from the date of discharge.
3. For those inpatient admissions and transfers for which Tufts Health Plan requires notification, the notification must be submitted in accordance with Tufts Health Plan's Authorization Policy found on our website.
4. The services were billed using the appropriate CPT-4 codes, Level 1 HCPCS codes, or other codes assigned by Tufts Health Plan.
5. In the case of professional services billed by the hospital, services were billed electronically or on CMS 1500 forms with a valid CPT-4 code (level 1 HCPCS code).

Electronic Data Interchange

Electronic data interchange (EDI) is a way providers can submit electronic transactions to Tufts Health Plan. This commonly refers to claim, referral and eligibility transactions, but can be applied to other transaction types as well.

Tufts Health Plan supports a number of EDI methods for claims, including:

- Direct submission (ANSI X12N 837 claim format) Reference the HIPAA 837 Companion Document for Direct Submitters for additional information.

- Submissions from a variety of external clearinghouse sources, including:
  - Capario (professional only)
  - Emdeon (WebMD) - Healthwire, Claim Master, and others (professional and institutional)
  - RelayHealth
  - Allscripts
  - MD On-Line[1]

Note: Providers must register their National Provider Identifier (NPI) directly with Tufts Health Plan.

Claims That Cannot Be Submitted Via Electronic Data Interchange

At this time, the following claim types cannot be loaded electronically into the Tufts Health Plan computer system:

- Providers who submit claims without a registered NPI.
- Dental (ADA form)
- Pharmacy

Note: Tufts Health Plan does not offer on-line claim submissions at this time.

Receipt of Claims

EDI Claims

The date of receipt is defined as the day the claim is processed at Tufts Health Plan and a Tufts Health Plan claim number is assigned to the claim. Proof of receipt is supported by the 277CA report, MD On-Line acceptance report or Explanation of Payment (EOP).

Note: Patient account ledgers are not considered appropriate proof of submission for electronic claim submissions.

Paper Claims

The "date of receipt" of paper claims is the earlier of:

- The date indicated on a receipt of delivery signed by a Tufts Health Plan representative when paper claims are sent via hand delivery, registered mail, or some other means requiring a signed receipt. The provider must maintain a log that clearly identifies all claims included in each filing which require a signed receipt. Such log must be available for inspection by Tufts Health Plan upon reasonable notice to the provider.

OR

- The date the claim is recorded as received by Tufts Health Plan or three business days after the day that the claim is recorded by the provider as sent to Tufts Health Plan when claims are not sent by a means requiring a signed receipt. Such recording must be documented by means of a written log or patient account ledger maintained by the provider in the ordinary course of business. Such log or patient account ledger must be available for inspection by Tufts Health Plan upon reasonable notice to the provider.

For additional information, refer to the Claims Submission Policy on our website.

Paper Claim Submission Requirements

Tufts Health Plan does not waive requirements for completing mandatory fields on paper claim forms. Those fields are noted in the detailed specifications for submitting UB-04 and CMS-1500 claims in this chapter.

All paper CMS 1500 and UB-04 claims must be submitted on official red claim forms. Black and white versions of these forms, including photocopied versions, faxed versions and resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning, will not be accepted and will be returned with a request to submit on the proper claim form.

[1] Professional claims only

Submitted forms deemed incomplete will also be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be resubmitted for processing.

For all commercial claims:

- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 4 diagnosis codes will be accepted on the CMS 1500 form, but consistent with our current policy, only the first code will be used for claim processing.
- Providers should submit industry-standard codes on all paper claims.
- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include but are not limited to the following:
  - Illegible claim forms
  - Member ID number
  - Date of service or admission date
  - Provider signature (box 31 in CMS 1500)
  - Provider Tax ID

If a claim is rejected, the provider must resubmit a corrected claim no later than 90 days from the date of service for all commercial products. Paper claims should be submitted on industry-standard paper claim forms, with all required fields completed accurately and clearly. All paper claims must be submitted on an original red claim form.

- Unreadable claims may be returned to the submitting provider.

Billing Requirements for Hospital Outpatient Services

The CMS-1500 and UB-04 forms are the acceptable standard for paper billing and the ANSI X12N 837 claim transaction is the acceptable standard for electronic billing. All providers must use ICD-CM diagnosis codes and valid HCPCS/CPT procedure codes.

To be appropriately compensated when a hospital bills for professional services in addition to facility and ancillary services for clinic visits, including mental health and substance abuse (MH/SA), claims must be submitted on the appropriate form types, as specified below.

Service	Paper	Electronic
Facility/Clinic/Room charges inclusive of professional component (outpatient only)	CMS-1500	837 Professional
Facility and/or ancillary services	UB-04	837 Institutional
Emergency Room professional services	CMS-1500	837 Professional
Emergency Room facility and ancillary services	UB-04	837 Institutional

Eligibility Inquiry

Providers and their office staff are required to use self-service channels to verify member effective dates and copayments. Calls from offices that elect not to use a self-service tool and continue to call the Provider Services Call Center for basic eligibility inquiries, will be transferred to our Interactive Voice Response (IVR) system to complete the eligibility verification. Cited below are some self-service channel options:

- Web-based eligibility status checking via Tufts Health Plan's website
- New England Healthcare EDI Network (NEHEN) and NEHENNET
- Status information via the Emdeon Office
- IVR — call 888-884-2404

Online Adjustment Requests

The Provider Services call center staff is not able to process claim adjustment requests. Registered providers may submit commercial claim adjustments using the secure provider website. If you are not a registered user of our website, go to Provider Login and follow the instructions. Adjustment requests can be made online for the following reasons:

- Corrected claims
- Dispute a denial or reimbursement amount
- Return funds to Tufts Health Plan

Follow the instructions when submitting online claim adjustments. After your transaction has been completed, you will receive a tracking number as your confirmation. If you are submitting paper documentation that corresponds to an online claim adjustment, be sure to submit the online tracking sheet so that the claim is processed accurately.

Note: Some claims may not be adjustable online. If your claim cannot be adjusted online, a message will appear indicating the claim is not adjustable.

Providers who do not use the online claim adjustment tool must submit their adjustment requests by mail following the Provider Payment Dispute process, outlined in the Provider Payment Dispute Payment Policy on our website.

Explanation of Payment (EOP)

The EOP is a weekly report of all claims that have been paid, pended, or denied to that provider. This form is identified as Health Maintenance Organization (HMO), Point of Service (POS), or Preferred Provider Organization (PPO) by the Tufts Health Plan logo and shading. Your EOP will also include a summary of claims in process. This summary indicates the claims that Tufts Health Plan has received, however, may require additional review or information before being finalized in the system. EOPs can be viewed electronically by logging on to the PaySpan Health website and electronic versions of EOPs are available for download and printing on the PaySpan website.

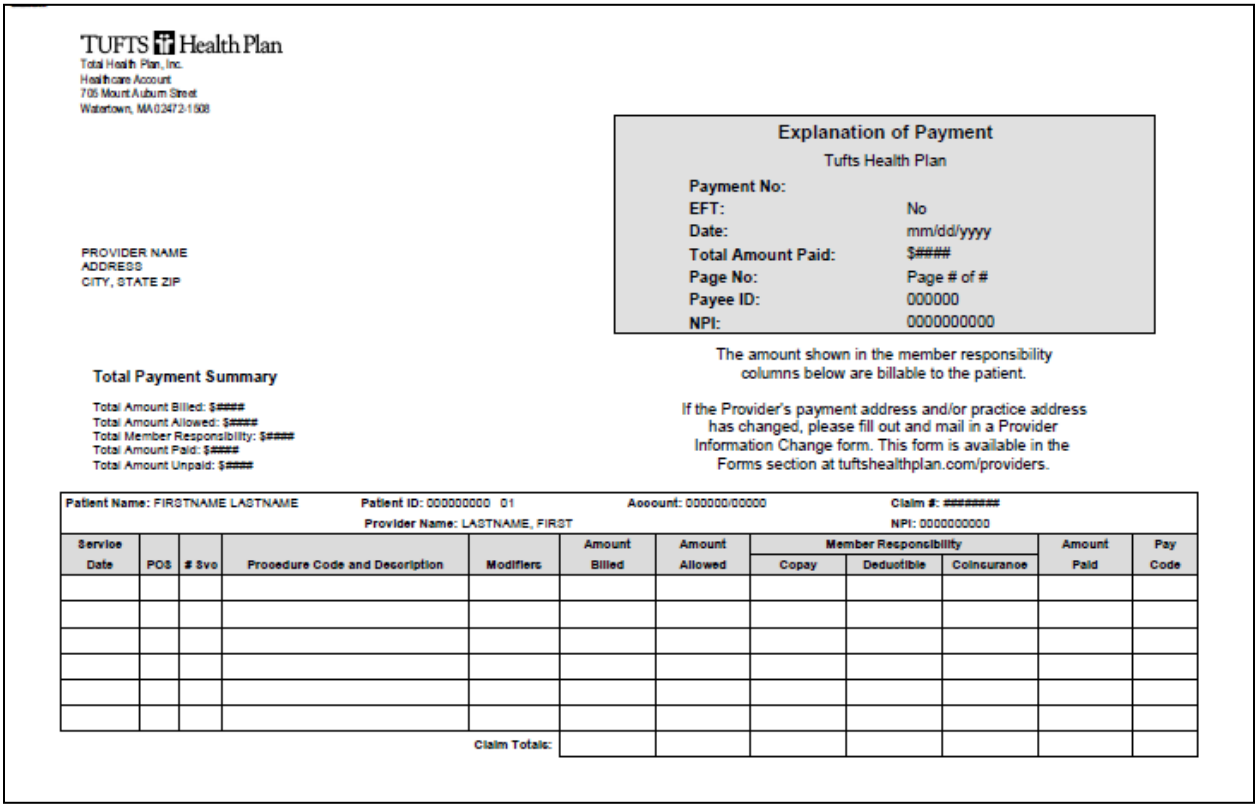
Electronic Remittance Advice

Tufts Health Plan offers the 835 Health Care Claim Payment Advice through PaySpan Health. This electronic remittance advice (ERA) includes paid and denied claims submitted either via EDI or on paper forms and uses HIPAA standard reason codes.

PaySpan Health provides support for this process. All registration and support questions for retrieving your 835 from PaySpan Health and for ongoing support will be handled by PaySpan Health Provider Support Team either through their website at www.payspanhealth.com or phone by dialing 1-877-331-7154 option 1. Provider Support Team Specialists are available to assist Monday through Friday from 8am to 8pm, EST.

For information about the HIPAA Standard 835 transaction, refer to Tufts Health Plan's HIPAA 835 Companion Guide.

Claims Requirements – Figure 1: Sample Explanation of Payment (EOP)



TUFTS Health Plan
Total Health Plan, Inc.
Healthcare Account
705 Mount Auburn Street
Watertown, MA 02472-1508

PROVIDER NAME
ADDRESS
CITY, STATE ZIP

Explanation of Payment
Tufts Health Plan

Payment No:	
EFT:	No
Date:	mm/dd/yyyy
Total Amount Paid:	$####
Page No:	Page # of #
Payee ID:	000000
NPI:	0000000000

The amount shown in the member responsibility columns below are billable to the patient.

If the Provider's payment address and/or practice address has changed, please fill out and mail in a Provider Information Change form. This form is available in the Forms section at tuftshealthplan.com/providers.

Total Payment Summary

Total Amount Billed: $####
Total Amount Allowed: $####
Total Member Responsibility: $####
Total Amount Paid: $####
Total Amount Unpaid: $####

Patient Name: FIRSTNAME LASTNAME **Patient ID:** 000000000 01 **Account:** 000000/00000 **Claim #:** ########
Provider Name: LASTNAME, FIRST **NPI:** 0000000000

Service Date	POS	# Svc	Procedure Code and Description	Modifiers	Amount Billed	Amount Allowed	Member Responsibility			Amount Paid	Pay Code
							Copay	Deductible	Coinsurance		
				Claim Totals:							

Claims Requirements – Table 1: Explanation of Payment Field Definitions

Field Name	Explanation
Total Payment Summary:	Breakdown of services billed
Total Amount Billed:	Total amount billed for services
Total Amount Allowed:	Total amount allowed for services billed listed on the EOP
Total Member Responsibility:	Total amount of member responsibility applied for services billed
Total Amount Paid:	Total amount paid for services billed
Total Amount Unpaid:	Total amount unpaid for pending services only, this field excludes finalized denied services
Patient Name:	Patient's name
Patient ID:	Patient's Tufts Health Plan ID number
Account:	Patient's account number assigned by the provider
Claim#:	Tufts Health Plan assigned claim number
Provider Name:	Provider who rendered the service
NPI:	Provider who rendered the service
Service Date:	Date of service
POS	Place of Service
#Svc	Number of Services
Modifiers	Modifiers billed for services
Amount Billed	Amount billed
Amount Allowed	Contractual reimbursement amount
Total Retention	Retention amount held until year-end to protect against incurred deficits. Retention does not apply to Total Health Plan members Note: This field displays when applicable.
Member Responsibility	Copayment, deductible and/or coinsurance charges

Field Name	Explanation
Amount Paid	Tufts Health Plan assigned claim number
Pay Code:	Most claims will be identified by a pay code and message for paid, denied and pending claims. Note: Not all claims will have a Pay Code listed if the claim is in a pending status.

Claims Follow-Up

Tufts Health Plan generates a weekly Summary of Claims in Process report that shows all claims received to date and in the payment process. The Summary of Claims in Process report looks like the Explanation of Payment (EOP) reports, except for:

- Summary of Claims in Process appears at the top of the barred section.
- Pay codes display a pending message rather than a payment or denial message.

All entries on the Summary of Claims in Process appear on the EOP upon claim adjudication. If a submitted claim has not appeared on either the EOP or the Summary of Claims in Process reports within 30 to 45 days, then verify if the claim was received by logging on to the Tufts Health Plan's website or by contacting the Provider Services Department. If the website or the Provider Services Department confirms that Tufts Health Plan has not received the claim, resubmit another claim electronically or on paper to the appropriate initial claims submission addresses. Refer to the Claims Submission Policy for this information.

Electronic Claims Follow-Up — 999 and 277CA Reports

- Direct Submission — Reports are posted online within 24 hours of transmission to Tufts Health Plan. The reports must be reviewed for error messages daily and stored for future reference. If a claim is rejected, it must be corrected and submitted before the 90-day filing limit.

  If the claim has not appeared on your EOP or electronic remittance, review the original transmission report.

- MD On-Line — Claims accepted or rejected by MD On-line can be reviewed in your **LinkMail Box**.
  - For more information, refer to the user manual on the MD On-Line website

- Clearinghouses — Clearinghouses offer the following reports:
  - Claims accepted or rejected by the clearinghouse - This report is typically available one to two business days after the electronic submission.
  - Claims accepted or rejected by Tufts Health Plan — Thisreport is typically available through the clearinghouse three to five business days after the initial claims submission.

Note: Providers are responsible for retrieving transaction reports from Tufts Health Plan and the clearinghouse.

Filing Deadline Policy

Professional or Outpatient Services

The filing deadline for claims submission for all commercial products Health Maintenance Organization (HMO), Exclusive Provider Options (EPO), Point of Service (POS), and all Preferred Provider Organization (PPO) products) is 90 days from the date of service.

For additional information, refer to our Claims Submission Policy on our website.

Inpatient/Institutional Services

The filing deadline for institutional claims submission for all commercial products (HMO, EPO, POS, PPO) is 90 days from the date of hospital discharge.

Coordination of Benefits

In the case of multiple insurance carriers, the filing limit for claims submissions is 90 days, as stated above, from the date of the primary insurer's explanation of benefits (EOB). The EOB from the primary insurer must be submitted with the claim when Tufts Health Plan is the secondary payer.

Note: Tufts Medicare Complement (TMC) and Medicare Complement Plan (MCP) do not have a filing limit.

Filing Deadline Adjustments

Documented proof of timely submission must be submitted with any request for review and payment of a claim that was previously denied due to the filing deadline.

The following are considered acceptable proof of timely submission for paper claims submissions:

- Copy of EOB/EOP from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of patient account ledger that shows the date that the member was billed, when insurance information is not made available by the member
- Copy of EOP from another carrier— if the member did not identify him/herself as a Tufts Health Plan member at the time of service
- Copy of a personal injury protection (PIP) letter received by Tufts Health Plan within 90 days of the date on the letter
- Copy of a Worker's Compensation denial received by Tufts Health Plan within 90 days of the date of the denial.

The following are considered acceptable proof of timely submission if the claim was submitted electronically:

- Providers who submit claims through a clearinghouse or MD On-Line must send a copy of the report that shows that the claim was accepted at Tufts Health Plan with a claim number.
- Providers who submit directly to Tufts Health Plan or through a clearinghouse must send the corresponding EDI vendor or clearinghouse claim acknowledgement report or HIPAA 277CA showing that the claim was received by Tufts Health Plan as evidenced by a Tufts Health Plan claim number.

The following are not considered to be valid proofs of timely submission:

- Copy of original claim form
- Copy of transmission report indicating a rejection or error

Note: If acceptable proof of timely submission is received, the claim will be reprocessed. When the disputed claim is reprocessed, a subsequent denial may be generated. In this instance, a new dispute must be submitted with the appropriate proof since each denial is based on the current message code on the claim.

Corrected Claims and Disputes of Duplicate Claim Denials

Corrected claims and provider payment disputes of duplicate claim denials must be received no later than 180 days from the date of the original adjudication.

Corrected claims and duplicate claim denial disputes received after that time will not be considered.

Late Charges

Services submitted after initial submission of the claim are considered late charges.

Late charges applied to Tufts Health Plan commercial claims must be submitted within 90 days of the date of service (for outpatient claims) or date of discharge (for inpatient or institutional claims).

Provider Compensation/Reimbursement Disputes

If a provider disagrees with the reimbursement, methodology, or maximum number of units allowed for a procedure, the provider can submit a payment dispute with a copy of the EOP and the appropriate documentation, using the online claim adjustment process described earlier in this chapter or follow the paper dispute process outlined in the Payment Dispute Policy.

Provider Appeals

If a provider disagrees with Tufts Health Plan's decision regarding the denial of a claim that was not allowed due to the lack of prior authorization or inpatient notification, the provider can file a request for reconsideration, using the online claim adjustment process. When submitting a paper request for reconsideration (appeal) of a denied claim, you must include a completed Request for Claim Review Form and follow the process outlined below.

Provider Appeals Procedure

1. Required documentation

   Letters requesting reconsideration must include or be accompanied by the following or your appeal will be returned to you pending receipt of the necessary information:

   - A typed request detailing all information pertinent to the particular case, as well as any necessary clinical documentation
   - A copy of the claim and EOP
   - Any pertinent information, such as an explanation indicating why the proper procedure to obtain notification or prior authorization was not followed, or an explanation and proof indicating how the proper procedure was followed

   For the proper handling of written requests from any in-plan provider for reconsideration of any claim that was denied due to the lack of prior authorization or inpatient notification, refer to the Payment Dispute Policy on our website.

   Tufts Health Plan considers relevant supporting documentation to be the copy of the provider's original information faxed/submitted to Tufts Health Plan, as well as any relevant medical records. If authorization is applicable, include the authorization number received verbally or in writing from Tufts Health Plan.

2. Within 10 business days of receipt of an appeal, a letter is sent to the provider acknowledging receipt and explaining that a written response will be forthcoming that explains the decision.
3. A written response outlining the decision is sent to the provider within 45 days of the receipt of the appeal. In certain situations, this time frame can be extended to allow for information gathering, chart review, and claims adjudication.

Coordination of Benefits

Coordination of Benefits (COB) applies to members who are covered by more than one health insurance plan. Tufts Health Plan-affiliated hospitals and providers are required to advise Tufts Health Plan of information they have concerning other insurance coverage. Tufts Health Plan follows the regulations promulgated by the Massachusetts Division of Insurance (DOI) to determine which plan has the primary obligation to provide benefits. The rules determining primacy are outlined below.

At the time of service, if the patient is covered by more than one health plan and Tufts Health Plan is the secondary plan, do not take a copayment up front. Submit the claim to the primary insurer, then submit with the primary insurer's explanation of benefits (EOB) to the secondary plan (Tufts Health Plan). If a copayment is still due, it will appear on your Tufts Health Plan's EOP at the time of payment and you can then bill the patient.

Whether Tufts Health Plan is the primary or secondary insurer, the member must follow plan procedures to receive benefits.

For additional information, refer to our COB Payment Policy on our website.

No Coordination of Benefit Rules

If only one of a member's plans has a COB rule, the plan with no rules is the primary plan. If one of the plans has rules permitted by law and the other does not, the latter plan is the primary plan.

Note: These rules do not apply to Medicare COB. For information on Medicare COB, call the Tufts Health Plan COB Department at 617-972-1098.

Coordination of Benefit Rules

The following applies to all plans with COB rules that are consistent with regulations:

- Employee/Dependent Rule

  The plan that covers a member as an employee or subscriber is primary to the plan that covers the member as a dependent.

- Birthday Rule

  If two or more plans cover a dependent child, the primary plan is that of the parent whose birth date (month and day, not year) occurs earlier in the calendar year. If parents share a birth date, the primary plan is the plan of the parent whose coverage has the earlier effective date.

- Children of Separated/Divorced Parents Rule

  If two or more plans cover a dependent child of divorced or separated parents, the order of payment is as follows:

  – Plan of the custodial parent
  – Plan of the custodial parent's spouse
  – Plan of the non-custodial parent

- Court Decree Rule

  There may be a court decree stating that one of the divorced or separated parents is responsible for the child's health care. If so, and if that plan has actual knowledge of the terms of the court decree, that plan is primary. In cases of joint custody without specific terms regarding health care, the birthday rule applies.

- Active/Inactive Rule

  The plan that covers an employee or employee's dependent who is not laid-off or retired is primary to the plan that covers the member as a laid-off or retired employee. If the other plan does not share this rule, this rule is ignored.

- Longer/Shorter Rule

  If none of the above rules apply, the primary plan is the plan that has covered the member longer.

Claim Processing

When a patient has more than one health plan and Tufts Health Plan is secondary, bill the primary carrier. After the primary carrier's first EOB is received, bill Tufts Health Plan, attaching a copy of the primary carrier's EOB to the claim when submitting on paper. Do not submit a claim without the primary carrier's EOB. When submitting electronically, after the electronic remittance advice is received from the primary carrier, send a valid secondary 837 electronic claim to Tufts Health Plan with complete information in the "other payer" and "COB" claim segments; this will satisfy the primary carrier's EOB requirements. The claim must be submitted within the appropriate filing limit from the date of issue of the EOB.

Patients who have two active Tufts Health Plan coverages will follow the same COB rules. Providers should first submit the claim under the primary coverage number. Any balances or member responsibility should then be sent as a second claim under the secondary coverage number with the Tufts Health Plan EOP attached.

Direct questions regarding COB to Tufts Health Plan's COB Department at 617-972-1098, Monday through Thursday 8:30 am to 5:00 pm, and Friday 10:00 am to 5:00 pm.

Coordination of Benefit Adjustments

When submitting COB adjustments do not send in a new claim. Send a copy of the claim and EOP with the Request for Claim Review Form and the original claims will be adjusted. Clearly mark "COB Adjustment" on the envelope.

Subrogation

Subrogation is another liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party (and/or his insurer). Tufts Health Plan has outsourced subrogation recovery services to The Rawlings Company in Louisville, Kentucky. As a result you could receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries relating to correspondence received must be directed to The Rawlings Company representative at the number indicated. All other subrogation questions must be directed to Provider Services at 888-884-2404.

Note: Do not bill the member or the member's attorney directly even if requested by either of them.

If you choose to bill the member or attorney directly, you do so at your own risk. You cannot require the member to pay up-front. However, if it is a motor vehicle claim, you can bill the member's motor vehicle insurer under PIP and/or Medpay benefits. If you choose to obtain payment from the motor vehicle insurer, bill the insurer directly. After you receive the insurer's statement or check, you must bill Tufts Health Plan within the appropriate filing limit from the date the statement or check was issued, if further payment is requested.

In addition, under your Tufts Health Plan contract, you cannot balance bill the member or file a lien against the member's third party settlement or judgment.

Direct questions to Tufts Health Plan's Provider Services Department at 888-884-2404.

Workers' Compensation

Patients who require services due to an employment-related injury or illness should have bills directed to the patient's workers' compensation carrier.

Services not Covered

Tufts Health Plan does not cover or coordinate payments for employment-related injuries. If a member indicates that services received are employment related, Tufts Health Plan will deny claims related to the illness or injury, even if the member has not filed a workers' compensation case with his or her workers' compensation carrier or if the proper authorization was not obtained from the workers' compensation carrier. The member is responsible for the charges. Although Tufts Health Plan may deny coverage, we may not always have the most up-to-date information regarding the carrier that will be covering the claims.

Collect Sufficient Information

Providers treating a Tufts Health Plan member who has indicated the diagnosis is employment-related should collect sufficient information regarding the member's employer, in addition to the injury or illness, to submit a claim to the appropriate workers' compensation carrier. When the service is considered urgent or emergent, the patient should be instructed to file a claim with his or her employer as soon as possible. In some cases, the workers' compensation carrier may require authorization for services to be covered. Please work with the member and/or workers' compensation carrier to understand the requirements.

When Workers' Compensation Claims Deny

If a member seeking treatment indicates the services are employment-related and the workers' compensation carrier denies the charges as being unrelated to employment, Tufts Health Plan will consider payment when the appropriate denial from the workers' compensation carrier is submitted with the claim. Tufts Health Plan policies regarding referrals and authorizations will be applied. The denial should be on the workers' compensation carrier's letterhead and should specifically state that the injury is not related to a worker's compensation case. Filing limits apply in these cases. Claims must be sent to Tufts Health Plan within 90 days from the date of the denial from the worker's compensation carrier.

Miscellaneous Billing Tips and Guidelines

Use these helpful hints to expedite your claim processing:

- All paper CMS-1500 and UB-04 claims must be submitted on official red claim forms. Black-and-white versions of these claim forms (including photocopied versions, faxed versions, and resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning) will not be

accepted and will be returned to the address listed in Box 33 (on CMS-1500 forms) or Box 1 (on UB-04 forms) with a request to resubmit on the proper claim form.

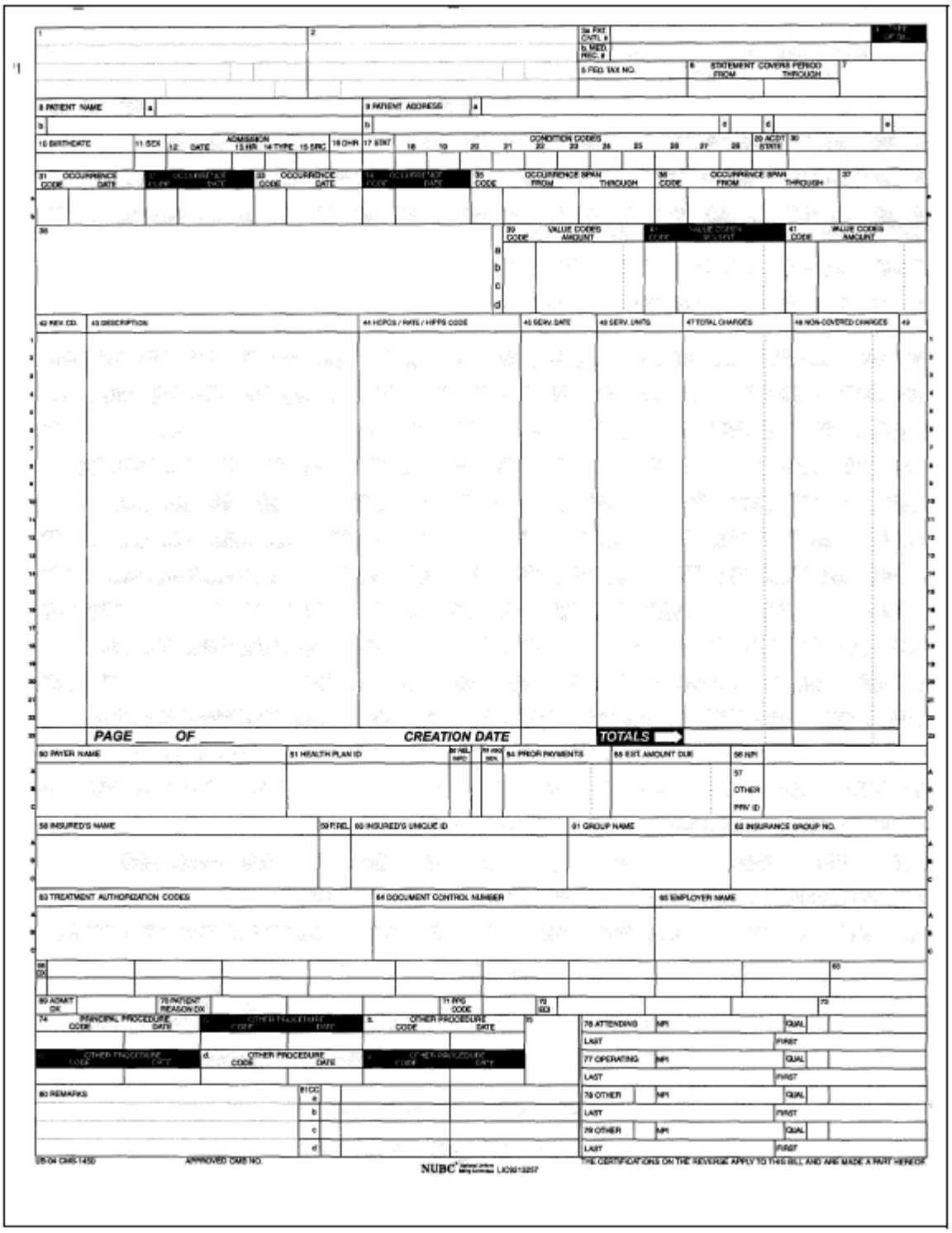
- Please do not highlight (e.g., on attachments). When scanned, highlighting becomes black and renders the document illegible. An alternative would be to circle the relevant information.
- New technology for scanning/imaging claims and referrals require that print is legible for a quality image (not too light or too dark). Please change ribbons regularly. It is also important for the print to be "on line." This means the type should fit within the appropriate box and that the numbers should not cross lines.
- Avoid sending carbon copies, faxes and attachments that are smaller than $8^{1/2}$ by 11 inches.

UB-04 Claims

The following pages contain information regarding UB-04 claims, including:

- A copy of the UB-04 form
- Specifications for each field of the UB-04 form
- The Type Column indicates whether a particular field is M (mandatory), O (optional) or N/A (not applicable)

Claim Requirements – Figure 2: UB-04 Claim Form



Claim Requirements – Table 2: UB-04 Claim Form Field Definitions

BOX #	FIELD NAME	TYPE	INSTRUCTIONS
1	Untitled	M	Enter the name and address of the hospital/provider.
2	Untitled	M	Enter the address of payee if different from the address in box 1.
3a–b	Patient Control Number	O	3a: Enter patient account number. 3b: Enter medical record number.
4	Type of Bill	M	Enter the 3-digit code to indicate the type of bill. **Note**: Claim will be returned if the Type of Bill is missing.
5	Federal Tax Number	M	Enter the hospital/provider federal tax ID. Claim will be returned if federal tax ID is not on the claim.
6	Statement Covers Period	M	Enter the beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims. For services received on a single day, both the "from" and "through" dates will be the same. If the "from" and "through" dates differ, then Tufts Health Plan requires these services be itemized by date of service (see Box # 45).
7	Untitled	N/A	Not applicable
8a	Patient ID and name	M	8b: Enter the patient's last name, first name and middle initial, if any, as shown on the patient's Tufts Health Plan member ID card.
9a–e	Patient address	M	Enter the patient's mailing address from the patient record.
10	Birth date	M	Enter the patient's date of birth (MMDDYYYY).
11	Sex	M	Indicate (M)ale or (F)emale.
12	Admission Date	M	Enter date of admission/visit.
13	Admission Hour	M	Enter the time (hour: 00–23) of admission/visit.
14	Admission Type	M	Enter the code indicating the type of this admission/visit.
15	Source of Admission (SRC)	M	Enter the code indicating the source of this admission/visit
16	Discharge Hour	M	Enter the time (hour: 00–23) the patient was discharged.
17	STAT (Patient discharge status)	M	Enter the code to indicate the status of the patient as of the through date on this billing. Interim billing is not allowed and the *patient status* cannot be patient.
18–28	Condition Codes	O	Enter the code used to identify conditions relating to this bill can affect payer processing.
29	Accident State	M	Enter the state in which accident occurred
30	Untitled	N/A	Not applicable
31–34	Occurrence Codes and Dates	M (if applicable)	Enter the code and associated date defining a significant event relating to this bill that can affect payer processing. **Note:** Tufts Health Plan requires all accident-related occurrence codes to be reported.
35–36	Occurrence Span Code and Dates	O	Enter a code and the related dates that identify an event that relates to the payment of the claim.
37	Untitled	N/A	Not applicable
38	Untitled	N/A	Not applicable

BOX #	FIELD NAME	TYPE	INSTRUCTIONS
39–41	Value Codes and Amounts	N/A	Not applicable
42	Revenue Code	M	Enter the most current uniform billing revenue codes.
43	Revenue Description	M	Enter a narrative description that describes the services/procedures rendered. Use CPT-4/HCPCS definitions whenever possible.
44	HCPCS/Rates	M	For outpatient services, use CPT and HCPCS Level II codes for procedures, services, and supplies. Do not use unlisted codes. If an unlisted code is used, then supporting documentation must accompany the claim. Do not indicate rates.
45	Service Date	M	Enter the date the indicated service was provided.
46	Units of Service	M	Enter the units of service rendered per procedure.
47	Total Charges	M	Enter the charge amount for each reported line item. A negative amount will not be accepted.
48	Non-Covered Charges	O	Enter any non-covered charges for the primary payer pertaining to the revenue code.
49	Untitled	N/A	Not applicable
50 A–C	Payer	M	List all other health insurance carriers on file. If applicable, attach an EOB from other carrier.
51	Health Plan ID	O	List provider number assigned by health insurance carrier.
52	Rel. Info (release of information)	N/A	Not applicable
53	Asg Ben (assignment of benefits)	N/A	Not applicable
54	Prior Payments (payer and patient)	M	Report all prior payment for claim. Attach EOB from other carrier, if applicable. A negative amount will not be accepted.
55	Est. Amount Due	N/A	Not applicable
56	NPI	M	Enter valid NPI number of the servicing provider.
57 a-c	Other Prv ID (other provider ID)	N/A	Not applicable
58 a-c	Insured’s Name	M	Enter the name of the individual who is carrying the insurance
59	P. Rel (patient’s relationship to insured)	M	Enter the code indicating the relationship of the patient to the identified insured/subscriber.
60 a-c	Insured’s Unique ID(health insurance claim/identification #)	M	Enter the patient's Tufts Health Plan identification number, including the suffix, as shown on the patient's Tufts Health Plan membership identification card.
61 a-c	Group Name	M	Enter the name of the group or plan through which the insurance is proved to the insured.
62 a-c	Insurance Group Number	M	Enter the identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.
63 a-c	Treatment Authorization Code	O	Enter the Tufts Health Plan referral/authorization number for outpatient surgical day care services.
64 a-c	Document Control Number	N/A	Not applicable

BOX #	FIELD NAME	TYPE	INSTRUCTIONS
65 a-c	Employer Name	M (if applicable)	Enter the name of the employer for the individual identified in box #58.
66	DX Version Qualifier	N/A	Not applicable
67 a-q	Principal Diagnosis Code	M	Enter the most current ICD-CM code describing the principal diagnosis chiefly responsible for causing this admission/visit. The code must be to the appropriate digit specification, if applicable. If the diagnosis is accident related, then an occurrence code and accident date is required. Present on Admission (POA) indicator should be entered as the 8th character.
68	Other Diagnosis Codes	M (if applicable)	Enter the ICD-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or develop subsequently. The code must be to the appropriate digit specification, if applicable.
69	Admit DX	M	Enter the ICD-CM diagnosis code provided at the time of admission as stated by the provider.
70	Patient Reason DX	O	Optional
71	PPS Code (Prospective Payment System)	O	Optional
72	ECI (external cause of injury code)	M (if applicable)	Enter the ICD-CM code for the external cause of an injury, poisoning or adverse effect.
73	Untitled	N/A	Not applicable
74 a–e	Principal Procedure Code (code and date)	M	Enter the most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for this service billed. Also, enter the date the procedure was performed. Date must be recorded as month and day (MMDD).
75	Unlisted	N/A	Not applicable
76	Attending Physician	M	Enter the ordering physicians NPI, physician's last name, first name and middle initial.
77	Operating Physician	M (if applicable)	Enter the name and NPI number of the physician who performed the principal procedure.
78–79	Other Provider Types	O	Optional
80	Remarks	N/A	Not applicable
81a–d	ICC	O	Optional

Claim Specifications: CMS-1500 (02/12)

The CMS-1500 (02/12) form[2] can be used by:

1. Independent providers, non-MDs, and other suppliers, e.g., laboratories, physical therapists, chiropractors, and durable medical equipment (DME) suppliers.
2. Hospital Outpatient/Emergency Room Departments
    - The professional component only must be billed on an CMS-1500 form for MDs, DOs, and podiatrists with the exception of clinical services. If there are physician extenders, i.e., nurse practitioners, physician assistants, or certified registered nurse anesthetists participating in a professional group for whom the hospital does billing, then these professional services must also be billed on a CMS-1500 form. For billing instructions, see 2B.

[2] The red form – photocopies of the form and resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning are not acceptable.

- As always, if you are only billing the technical component only of any of the services mentioned above, use a UB-04 claims form.
- Both the professional and technical/facility components for a clinic service must be billed on a CMS-1500 form as a global charge on one claim line, regardless of the type of provider. A clinic service is defined as follows:

CPT Code Range2[3]	General Definition
99201–99215	Office or other Office of Professional Discipline (OPD) Service
99241–99245	Office or other OPD Consultations
99271–99275	Confirmatory Consultations
99381–99397	Preventive Medicine
99401–99429	Counseling and/or Risk Factor Reduction Intervention
92002–92014	Ophthalmology

Requirements for Completing the CMS-1500 (02/12) Form

Note the following requirements for the CMS-1500 form:

1. Claims cannot be processed without completing the following fields: 1a, 2, 3, 9-14, 21, 24a, 24b, 24d, 24g 24j, , 25, 27-33, 32a, 33a..
2. If using unlisted or miscellaneous codes, attach notes or a description of services rendered. Claims that are submitted with unlisted codes that do not have attachments will be denied.
3. The CMS-1500 can be prepared according to Medicare guidelines as long as the mandatory fields (see #1) are complete.
4. Note the separate CMS-1500 Billing Specifications for hospital owned free-standing facilities in Table 18, CMS-1500 Claim Form Specifications.

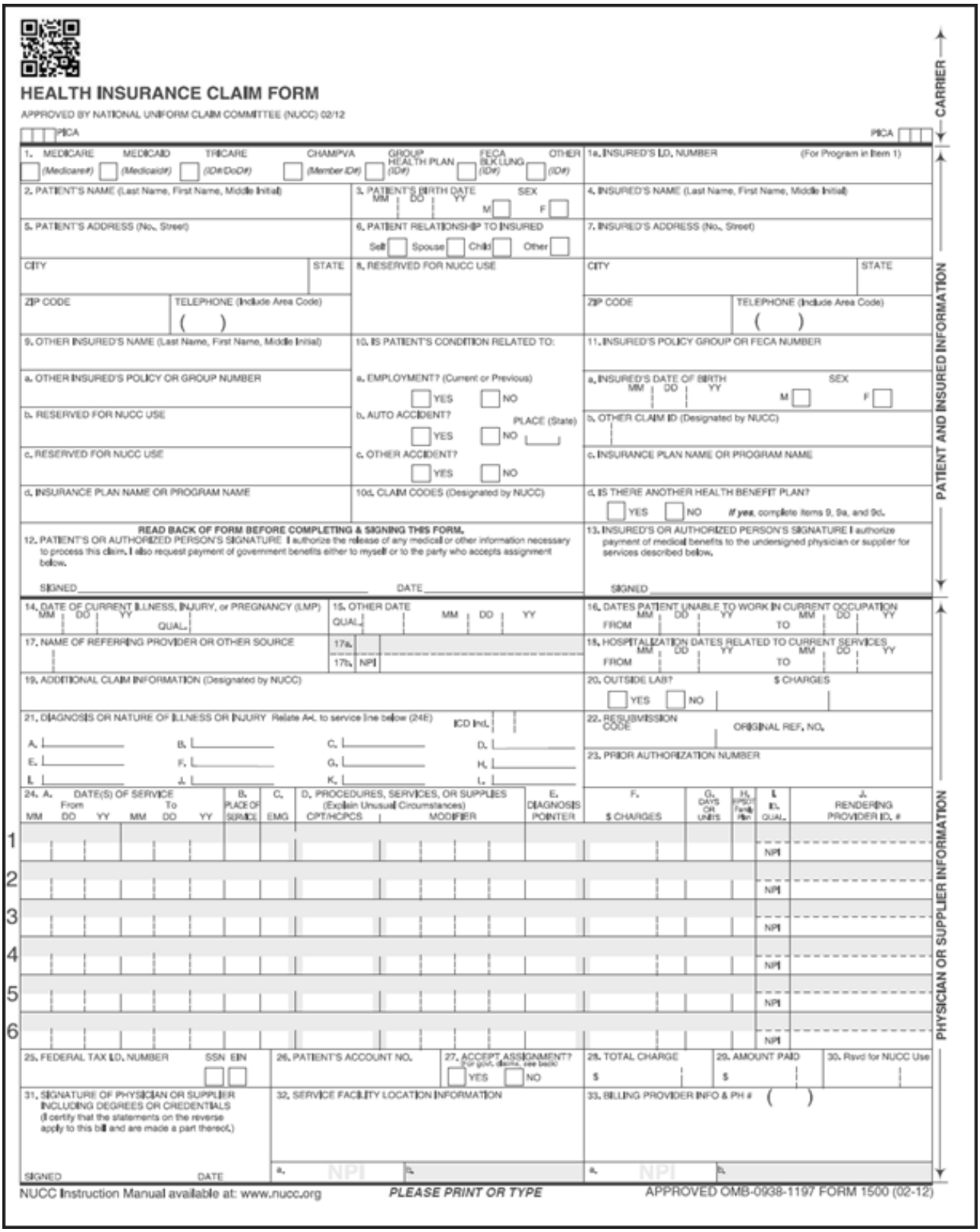
Completion Instructions

The following pages contain the following information regarding CMS-1500 claims:

- A copy of the CMS-1500 (02/12) form
- Specifications for each field of the CMS-1500 (02/12) form
- Specifications for hospital-owned free-standing facilities are identified in Table 18, CMS-1500 (02/12) Claim Form Specifications. If you do not have a provider identification number specific to the free-standing site, contact Allied Health Services at (888) 880-8699, ext. 3145.
- The Type Column indicates whether a particular FIELD is M (Mandatory), O (Optional) or N/A (Not applicable)

[3] CPT codes are subject to change through annual updates. Follow the current CPT coding guidelines at all times.

Claim Requirements – Figure 3: CMS-1500 (02/12) 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? PLACE (State) YES NO

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 govt. 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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Claim Requirements – Table 3: CMS-1500 (02/12) Claim Form Specifications

BOX #	FIELD NAME	TYPE	INSTRUCTIONS
1	Type of Insurance Coverage	O	Indicate all types of health insurance coverage applicable to this claim by checking the appropriate boxes. If the "Other" box is checked, complete box #9.
1a	Insured's ID Number	M	Enter the patient's current ID number exactly as it appears on the Tufts Health Plan ID card, including the appropriate suffix. Inaccurate or incomplete ID numbers causes a delay in processing the claim and can result in a denial.
2	Patient's Name	M	Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Tufts Health Plan ID card.
3	Patient's Date of Birth	M	Enter the patient's date of birth and sex.
4	Insured's Name	M	Enter the name of the insured except when the insured and the patient are the same. In those cases, enter the word SAME.
5	Patient's Address	M	Enter the patient's permanent mailing address and telephone number: On the first line, enter the street address. On the second line, enter the city and state. On the third line, enter the zip code and phone number.
6	Patient Relationship to Insured	M	Check the appropriate box for patient's relationship to insured. Check only one box.
7	Insured's Address	M	Enter the insured's permanent mailing address and telephone number. When the address is the same as the patient's, enter the word SAME.
8	Reserved for NUCC use	O	No entry required
9	Other Insured's Name	M	Enter the last and first name, and middle initial of the insured except when the insured is the same as shown in box #4. In these cases, enter the word SAME.
9a	Other Insured's Policy or Group Number	M	If the patient is covered under another health benefit plan, enter the other insured's policy or group number.
9b	Reserved for NUCC use	O	No entry required
9c	Reserved for NUCC use	O	No entry required
9d	Insurance Plan Name or Program Name	M	Enter the other insured's insurance plan name or program name. Attach an EOB from primary insurer to the claim.
10a–10c	Is Patient's Condition Related To:	M	For each category (Employment, Auto Accident, Other), enter an "X" in the YES or NO box. When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection benefits have been exhausted. Enter the state postal code where the auto accident occurred.
10d	Claim Codes	O	Enter up to 4 claim condition codes
11	Insured's Policy Group or FECA #	M	If the patient has other insurance, enter the insured's policy or group number.
11a	Insured's Date of Birth and Sex	M	Enter the insured's date of birth and sex if different from box #3.

BOX #	FIELD NAME	TYPE	INSTRUCTIONS
11b	Other claim ID	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter claim number from other insured's plan to the right of the dotted line
11c	Insurance Plan Name or Program Name	M	Enter the insurance plan or program name, if applicable. This is used to determine if supplemental or other insurance is involved. If the supplemental or other insurer is Blue Cross Blue Shield plan, provide the name of the state or geographic area, e.g., Blue Shield of (name of state).
11d	Is There Another Health Benefit Plan?	M	Check YES or NO to indicate whether there is another primary health benefit plan. For example, the patient could be covered under insurance held by a spouse, parent, or some other person.
12	Patient's or Authorized Person's Signature	M	If the signature is not on file, the patient or authorized representative must sign and date this box. If the patient's representative signs, the relationship to the patient must be indicated.
13	Insured's or Authorized Person's Signature	M	The insured's or authorized person's signature or "Signature on File" must be in this box to authorize payment of benefits to the participating physician or supplier.
14	Date of current illness, injury or pregnancy (LMP)	O	Enter date of current illness, injury or pregnancy in the designated MM/DD/YY space. Enter the qualifier found in the 837 electronic claim to the right of the QUAL dotted line
15	Other date	O	Enter the qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL. Enter the date in the designated MM/DD/YY space.
16	Dates Patient Unable to Work In Current Occupation	O	Enter the date if the patient is unable to work. An entry in this field indicates employment related insurance coverage.
17	Name of referring provider or other source	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter the name of the referring and/or ordering physician or other source if the patient : • Was referred to the performing physician for consultation or treatment • Was referred to an entity, such as clinical laboratory, for a service • Obtained a physician's order for an item or service from an entity, such as a DME supplier
17a–b	Provider ID Number of Referring Physician	O	Enter the NPI-assigned physician identification number of the referring or ordering physician. Referring physician information is required if another physician referred the patient to the performing physician for consultation or treatment. Ordering physician information is required if a physician ordered the diagnostic services, tests, or equipment. **Note**: Inclusion of the NPI number will expedite claims processing

BOX #	FIELD NAME	TYPE	INSTRUCTIONS
18	Hospitalization Dates Related to Current Services	M	Complete this block when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Additional Claim Information (Designated by NUCC)	O	Enter additional claim information
20	Outside Lab	O	This item indicates whether laboratory work was performed outside the physician's office.
21	Diagnoses	M	Enter the diagnosis/condition of the patient indicated by ICD-CM code number. Enter up to 12 codes in priority order (primary, secondary condition). Codes are arrayed across the box.
22	Resubmission Code	O	This item identifies a resubmission code.
23	Prior Authorization Number	O	If applicable, enter the Tufts Health Plan inpatient notification or referral number.
24a	Date(s) of Service	M	Enter the day, month, and year for EACH service. Itemize each date of service; do not use a date range. For hospital-owned free-standing facilities, always enter 11 for the place of service[4]. Anesthesia providers should enter anesthesia duration in minutes with start and end times in the shaded area. **Note**: Claims missing dates of service will be returned
24b	Place of Service	M	Enter the appropriate HIPAA Standard place of service code only. **Note**: Claims missing a place of service will be returned
24c	EMG	N/A	Check this item if the service was rendered in a hospital or emergency room.
24d	Procedure, Services, or Supplier	M	Enter valid CPT/HCPCS procedure code and any modifiers. For hospital-owned free-standing facilities, enter valid procedure codes as per your contract with Tufts Health Plan[1].
24e	Diagnosis pointer	M	Enter the diagnosis reference letter for up to 4 ICD-CM codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis. Enter a maximum of four letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service.
24f	Charge	M	Enter the charge for each listed service.
24g	Days or Units	M	Enter the days or units of service rendered for the procedures reported in box #24d. For hospital-owned free-standing facilities, always enter 1 for the number of units.
24h	EPSDT Family Plan	O	Check this if early and periodic screening, diagnosis and treatment, or family planning services were used.

[4] All free-standing facilities require a separate Tufts Health Plan-assigned, free-standing provider ID number in addition to an NPI number. If you do not have an ID number specific to the free-standing site, contact the Allied Health Services Department at 888-880-8699, x3145

BOX #	FIELD NAME	TYPE	INSTRUCTIONS
24i	ID Qualifier	O	Optional
24j	Rendering Provider ID#	M	Enter valid NPI number if the rendering provider is not the billing provider.
25	Federal Tax Number	M	Enter your physician/supplier federal tax ID, employer ID number or social security number. The claim will be returned if Federal Tax Number field is blank.
26	Patient's Account Number	O	Enter the patient's account number that the physician's/supplier's accounting system assigned. This is an optional field to enhance patient identification by the physician or supplier.
27	Accept Assignment	M	Check **YES** or **NO** to indicate whether the physician accepts assignment for the claim. By accepting assignment, the physician agrees to accept the amount paid by the third party as payment in full for the encounter.
28	Total Charges	M	Enter the total charges for the services, i.e., total of all charges in box #24f.
29	Amount Paid	M	Enter the total amount paid on the submitted charges in box #28.
30	Reserved for NUCC use	O	No entry required
31	Signature of Physician or Supplier Including Degrees or Credentials	M	Have the physician/supplier or authorized representative sign, or write "Signature on File". Include the date of the signature. **Note**: Claims with a blank signature box will be returned
32, 32a–b	Name and Address of Facility Where Services Were Rendered, NPI Number	M	Enter the name and address where the services were rendered. a. Enter valid NPI number b. Enter other ID number (if applicable)
33, 33a	Physician's Supplier's Billing Name, Address, Zip Code, NPI Number	M	Enter name and address for billing provider / supplier. a. Enter the NPI of the entity (payee) associated with the TIN. b. If no NPI for the payee, leave Box 33a blank.

Note: Claims submitted with a discrepancy between the service line charges (Box 24f) and the total charges may be returned.

Billing Requirements for Hospital Owned Free-standing Facilities for UB-04 and CMS 1500 Claims

Definition

Any inpatient or outpatient service associated with a hospital that meets either one of the following criteria is subjected to free-standing reimbursement rates, policies, and procedures.

- If the services being rendered are not physically located with the acute care/rehabilitation/chronic hospital building

OR

- If there is a partial or full ownership by an entity other than the acute care hospital itself. For example, if a sister company to the acute care hospital, or the holding company which owns the hospital, owns an associated inpatient or outpatient entity, the entity is considered free-standing

Notwithstanding the foregoing definition, hospital-based fees can, in certain circumstances, be the same as free-standing fees. The following table indicates when a hospital owned free-standing facility should bill on a UB-04 claim form, a CMS-1500 claim form, a 837 Institutional claim, or an 837 Professional claim.

Facility/Service	Claim Form	Electronic Format
Outpatient facility/clinic/room charges inclusive of professional component (Global Billing)	CMS-1500	837 Professional
Facility and/or ancillary services	UB-04	837 Institutional
Professional physician services	CMS-1500	837 Professional

Last updated 09/2015. Chapter revision dates may not be reflective of actual policy changes.

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