

Policy 1210

NHP/NHIC ~ Claim Submission Policy

Purpose: This policy outlines Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) guidelines for claim submission.

Policy and Procedure: NHP/NHIC's goal is to process all claims at initial submission. Before we can process a claim, it must be a "clean" or complete claim submission, which includes the following information when applicable:

- Patients NHP/NHIC identification number
- Patients first and last name
- Patients date of birth (month, day and year)
- Subscribers full name and address
- Patient's Signature or Indication of Signature on file
- Standard International Classification of Diseases (ICD) codes
- Dates of Service
- Place of Service/Bill Type (Facility)
- Standard Current Procedural Terminology (CPT) code sets and modifiers/Revenues Codes (Facility)
- Standard Health Care Procedure Coding System (HCPCS) code sets and modifiers
- Diagnosis-related group (DRG)
- Resource Utilization Groups (RUG)
- Charges for each billed service
- Units billed
- Providers NPI number
- Facility/Provider name, address and telephone number
- Billing name, address and telephone number
- Accident state
- Provider tax identification number
- Providers signature
- Primary carrier Explanation of Benefits (EOB) when NHP/NHIC is the secondary payer
- For miscellaneous circumstances such as corrected claim, covering MD and unlisted CPT/HCPCS please indicate explanation.

If any of the above information is missing from the claim, NHP/NHIC will not be able to process your claim. If you have questions regarding required fields on a

claim, please contact the NHP/NHIC Customer Service Department at (920) 720-1300 or 1-800-826-0940.

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

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

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

If the necessary information is required from the member, the member may be billed by the provider until the time the member supplies NHP/NHIC the appropriate information. An example would be other insurance information from the member. NHP/NHIC can not determine benefits until we have verified NHP/NHIC is the members' primary carrier.

NHP/NHIC will routinely request clinical documentation for a submitted claim to be considered in the following categories:

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

A type of clinical documentation that may be requested includes:

- ER notes
- facility notes
- anesthesia notes and time
- facility/MD notes

- operative notes
- radiology interpretation and report
- lab results
- MD office notes
- Trip notes for ambulance transport

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

This policy is not designed to limit NHP/NHIC right to require submission of medical records for precertification purposes.

This policy is not a guarantee of coverage or payment. The claim(s) will be denied if it does not meet with all the terms and provisions of the members Certificate of Coverage. Actual benefits will be determined when the claim(s) or bill(s) are submitted to NHP/NHIC. NHP/NHIC reserves the right to periodically review and update all claims policies and procedures.

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