Claims

General Payment Guidelines

An important element in claims filing is the submission of current and accurate codes to reflect the provider's services. HIPAA-AS mandates the following code sets:

- The Internal Classification of Disease – Tenth Revision – Clinical Modification (ICD-10-CM)
- The Provider's Current Procedural Terminology, Fourth Edition (CPT)*
- The Healthcare Common Procedure Coding System (HCPCS)

Claims should be submitted in one of three formats:

- Electronic claims submission
- CMS 1500 Form
- UB04 Form

Harvard Pilgrim covers the professional and technical components of global CPT procedures. Therefore, the appropriate professional component modifiers and technical component modifiers should be included on the claim form. Providers are required to use the standard CMS codes for ICD-10, CPT, and HCPCS services, regardless of the type of submission. Claims processing is subject to change based upon newly promulgated guidelines and rules from CMS.

For payment of Medicare claims, Harvard Pilgrim has adopted all guidelines and rules established by CMS. Harvard Pilgrim Medicare Members may only be billed for their applicable co-payments, co-insurance, and non-covered services.

Claims Submission

This section provides information about claims submission, processing and payment. Providers should submit all claims for Harvard Pilgrim Medicare Advantage members, except for certain services that must be billed to Original Medicare (e.g. certain clinical trial services CMS determines and hospice care). If a provider submits a claim to Harvard Pilgrim but should have sent it to Original Medicare, Harvard Pilgrim will return the claim to the provider for submission to the local carrier or fiscal intermediary.

Harvard Pilgrim Medicare Advantage claims should be submitted using Medicare billing guidelines and format (CMS-1500 or UB-04), and the National Provider Identifier (NPI). Additional information is available from CMS at: www.cms.hhs.gov/Manuals/IOM/list.asp. Search for publication #100-04.

Providers should include the member's complete and accurate identification number when submitting a claim. The complete identification number includes the alpha prefix, if any, and subsequent numbers as they appear on the member's ID card. Harvard Pilgrim cannot process claims with incorrect or missing alpha prefixes and member identification numbers. Claims submitted without all required information will be returned (paper submission) or denied (electronic submission).

When to Submit Claims

Harvard Pilgrim encourages providers to submit all claims as soon as possible after the date of service to facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements. Exceptions may be made to the timely filing requirements of a claim when situations arise concerning other payer primary liability such as Original Medicare, Medicaid or third-party insurers, or legal action and/or an error by Harvard Pilgrim.

Harvard Pilgrim must submit encounter data and medical records to certify completeness and truthfulness of information submitted to CMS, [42 CFR 422.50(a) (8); CFR 422.50(1), (2) and (3)]. In turn, Harvard Pilgrim Medicare Advantage

network providers must submit complete and accurate coded claims, and assist Harvard Pilgrim in correcting any identified errors or omissions.

Timely Submission of Claims

Harvard Pilgrim abides by CMS Prompt Payment Guidelines. Timely submission is subject to statutory changes. Therefore, claims should be submitted within the timely filing period established by regulatory statute (365 days), unless your contract stipulates something different. Providers should reference their contract with Harvard Pilgrim for the stipulated claims submission guidelines.

Plan members cannot be billed for services denied due to a lack of timely filing. Claims appealed for timely filing should be submitted with proof along with a copy of the Explanation of Benefits (EOB) and the claim.

Acceptable proof of timely filing will be in the form of a registered postal receipt signed by a representative of the Plan, or a similar receipt from other commercial delivery services.

Electronic Claims Submission

Electronic data filing requires billing software through which you can electronically send claims data to a clearinghouse. Since most clearinghouses can exchange data with one another, you can continue to use your existing clearinghouse even when it is not the clearinghouse selected by Harvard Pilgrim. Prior to submitting claims through a clearinghouse exchange, you must check with your existing clearinghouse to make sure they can complete the transaction with the Harvard Pilgrim vendor. If you do not have a clearinghouse, or have been unsuccessful in submitting claims to your clearinghouse, please contact Provider Services for assistance. Our trading partner, Change Healthcare, can help establish electronic claims submissions connectivity with our Plan. You will need our payer number (distinct for each plan), which is 04245 for Harvard Pilgrim Stride (HMO).

Tips on successfully submitting electronic claims:

- Ensure your clearinghouse can remit information to our trading partner, Change Healthcare. You may reach Change Healthcare at 800-845-6592.
- Use the billing name and address on the electronic billing format that matches our records.
- Please notify our office of any name and address changes in writing.
- Field NM1 relates to box 33 of a CMS1500 or the UB04 for all electronic claims transmissions and 837‘s.

Contact Change Healthcare with any transmission questions at 800-845-6592.

Electronic Format

Filing claims electronically is the most effective way to submit claims for processing and receive payment.

The Health Insurance Portability and Accountability Act-Administrative Simplification (HIPAA-AS) passed by Congress in 1996 sets standards for the electronic transmission of health care data. Electronic submitters must submit claims using the ANSI 837x4010A1 format. The HIPAA-AS Implementation Guide provides comprehensive information providers need to create an ANSI 837 transaction.

To download this guide from the Internet, go to: www.wpc-edi.com/hipaa/HIPAA_40.asp.

Electronic Transactions and Code Sets

To improve the efficiency and effectiveness of the health care system, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA includes a series of administrative simplification provisions including the adoption of national standards for electronic health care transactions.

On October 16, 2003, the Electronic Transaction and Code Set provision of HIPAA went into effect. Law requires payers to have the capability to send and receive all applicable HIPAA-compliant transactions and code sets.

One requirement is that the payer must be able to accept a HIPAA-compliant 837 electronic claim transaction, in standard format, using standard code sets and standard transactions. Specifically, claims submitted electronically must comply with the following Provider-focused transactions:

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response
- 276/277–Health Care Claim Status Request & Response
- 278–Health Care Services Review – Request for Review and Response
- 835–Health Care Claim Payment/Advice. The X12N-837 claims submission transactions replaces the manual CMS 1500/UB92 forms. All files submitted must be in the ANSI ASC X12N format, version 4010A, as applicable.

Completion of "Paper" Claims

Paper claims should be completed in their entirety including but not limited to the following elements:

- The Plan member's name and their relationship to the subscriber
- The subscriber's name, address, and insurance ID as indicated on the member's identification card
- The subscriber's employer group name and number (if applicable)
- Information on other insurance or coverage
- The name, signature, place of service, address, billing address, and telephone number of the provider performing the service
- The tax identification number, NPI number, for the provider performing the service
- The appropriate ICD-10 codes at the highest level
- The standard CMS procedure or service codes with the appropriate modifiers
- The number of service units rendered
- The billed charges
- The name of the referring provider
- The dates-of-service
- The place-of-service
- The referral and/or authorization number
- The NDC for drug therapy
- Any job-related, auto-related, or other accident-related information, as applicable

Mail Medicare claims to:

Harvard Pilgrim Health Care, Inc.
c/o Stride Claims Processing
P.O. Box 211067
Eagan, MN 55121

Provider Services can be contacted at 888-609-0692.

Submitting Claims

Claim Type	Address	Payer ID
Medical Services	HPHC Inc. c/o Stride Claims Processing P.O. Box 211067 Eagan, MN 55121	Payer ID 04245
Behavioral Health Services	Optum/UBH P.O. Box 30602 Salt Lake City, UT 84130-0602	Payer ID 87726

National Provider Identifier

Providers submitting claims electronically must include their 10-digit, unique National Provider Identifier (NPI) numbers. The NPI replaced all legacy provider identifiers (e.g., UPIN and Harvard Pilgrim numbers) and identifies a health care provider in all standard transactions.

CMS-1500 Claim Form

The chart below identifies the required fields a provider must complete in order for the CMS-1500 claim form to process correctly. The numbers to the left of the chart correspond to those on the claim form. If any of the "required" fields are left blank or are incomplete, Harvard Pilgrim will return the claim (if paper) or deny it (if electronic).

Field Number	Field Name	Explanation
1a	Insured's ID Number	Enter the policyholder's ID number as shown on his or her identification card.
2	Patient's Name	Enter the patient's full "given" last and first name and middle initial.
3	Patient's Date of Birth	Enter the correct date of birth (MM/DD/YY) and sex of the patient.
4	Insured's Name	Enter the policyholder's last and first name and middle initial.
5	Patient's Address	Required if it is not the same as the policyholder's address.
6	Patient Relationship to Insured	Check the appropriate box. Do not use the box for "Other."
7	Insured's Address	Enter the complete address of the policyholder.
8	Patient Status	Check the appropriate box.
9	Other Insurance Information	Required if the answer to 11d is "yes." If the patient has other coverage, enter the name of the other insured.
9a	Other Insured's Policy or Group Number	Enter the other insured's policy or group number inthis field.
9b	Other Insured's Date of Birth	Enter the other insured's date of birth and sex.
9c	Employer's Name or School Name	Enter the employer's or school's name.
9d	Insurance Plan	Enter the insurance plan name or program. Use block 9d to indicate that a Medicare-eligible patient elected not to purchase Medicare Part A and/or Part B coverage. Enter "No Medicare Part A and/or Part B Coverage," depending on the patient's situation.
10	Is Patient's Condition Related To	Check the appropriate box if the patient's condition is related to employment or an auto accident, or check "other."
11d	Another Health Benefit Plan	Request this information from the member. If the answer is "yes," go back and complete blocks 9-9d.
14	Date of Current Illness/Injury/ Pregnancy	Enter the date (MM/DD/YY) for accident and medical emergency situations. If you submit services that relate to more than one accident or medical emergency, please submit separate claims for each situation.
17	Name of Referring Provider or Other Source	Enter the name of the referring provider for out-of-network services. For lab and X-ray claims, enter the provider's name who ordered the diagnostic services.

Field Number	Field Name	Explanation
17B	ID Number of Rendering Provider	Enter the NPI of the referring/ordering provider listed in item 17. All participating providers who order services or refer Medicare beneficiaries must report this data.
21	Diagnosis or Nature of Illness/Injury	Enter an ICD-10-CM code with at least three digits of the code. List the primary diagnosis first. If there is more than one diagnosis, indicate in field 24E which diagnoses apply to the procedure you are billing for on each line item of the claim form. Harvard Pilgrim will not accept narrative descriptions alone.
24A	Date of Service From/To	If you submit office or hospital outpatient services, submit each service and/or each date of service on a separate line with the same "From" and "To" dates. Harvard Pilgrim allows date spanning on a line for a practitioner billing inpatient services within a month, a home medical equipment (HME) supplier billing for the monthly rental of equipment, or a home infusion therapy (HIT) provider. Inpatient charges may be submitted using a date span if: • The services provided within the date span are the same procedure code. • The dates of service are consecutive. • Services were provided within the same month. To bill HME rentals, submit the appropriate HCPCS (HCFA Common Procedure Coding System) code with an "-RR" modifier. List each month's rental on a separate line with one unit of service.
24B	Place of Service	Enter the place-of-service code using the two-digit codes found in the HCPCS manual. If the place-of-service code on the claim does not match the procedure code, or if you leave this field blank, Harvard Pilgrim will return the claim.
24D	Procedure Codes/ Modifiers	Enter the place-of-service code using the two-digit codes found in the HCPCS manual. If the place-of-service code on the claim does not match the procedure code, or if you leave this field blank, will return the claim.
24F	Total Charge	Submit charge for each line.
24G	Days or Units	Enter the appropriate number of services (in whole numbers) based on the time period or amount the procedure code designates. You must enter at least one unit. To bill anesthesia, submit the actual time (in minutes) spent administering anesthesia services.
24J	Rendering Provider ID	Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a provider or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.
25	Federal Tax ID Number	Enter your practitioner/supplier federal taxpayer identification number (TIN). If you are a sole proprietor, your Social Security Number is your TIN. If you are an entity other than a sole proprietor, please submit your employer identification number (EIN). Note: If you do not give your federal tax number, or if the number you give is less than nine digits, Harvard Pilgrim will return the claim to you.
26	Patient's Account No.	Required field for electronic submission.
27	Accept Assignment	Required for Harvard Pilgrim Medicare Advantage claims.
28	Total Charges	Enter the total charges from 24F. The line items you submit must equal the Total Charge in field 28 or Harvard Pilgrim will return the claim. If you submit a paper

Field Number	Field Name	Explanation
		claim that has more than six-line items, do not total the charge on the first claim form. Indicate "continued" in this field and attach additional claim forms until you have submitted all services. On the final claim form, submit the total charge.
31	Signature of Provider	Either the provider's signature, a computer-printed name, a stamped facsimile or the signature of an authorized person is acceptable. The signature identifies that the practitioner (or someone under the personal supervision of the practitioner) provided services reported on the claim.
32	Name and Address of Facility	Enter the name and address of the facility where the practitioner rendered services.
33	Provider/Supplier's Billing Number and Address	Indicate the complete billing name and address of the practitioner/supplier. The practitioner's/supplier's billing number is also required in this area. If billing as a group, the group provider number is required.
33a	Billing Provider/ Group NPI	Enter the NPI of the billing provider or group. This is a required field.

How to Submit a Late Charge of a CMS-1500

A late charge is a claim for additional services that is submitted after the original submission of a claim. To submit a late charge, send Harvard Pilgrim a new claim showing only the additional services. Do not re-submit the original claim with the additional late charges.

When a provider determines that a claim was submitted in error, the provider should submit a copy of the original claim with corrected claim information (noting the changes) to correct the patient's records.

UB-04 Billing Guides

The National Uniform Billing Committee (NUBC) offers a UB-04 billing guide published by the American Hospital Association, called the National Uniform Billing Guide. To order a copy of the guide and updates, visit www.nubc.org/guide.html and select "*Become a Subscriber.*"

Required Fields on the UB-04

The following chart identifies the required fields a provider must complete in order for the UB-04 claim form to process correctly. The numbers to the left of the chart correspond to the form locator (FL) field on the claim form. If one or more of the "required" fields are left blank or are incomplete, Harvard Pilgrim will return the claim (if paper) or deny it (if electronic).

The UB-04 Required Field Information chart provides basic filing instructions providers need to submit services for payment.

FL Number	Form Locator Name	Explanation
1	Provider Name and Address	Required
2	Pay-To Name and Address	Situational
3a	Patient Control Number	Required
3b	Medical Record Number	Situational
4	Type of Bill	Required
5	Federal Tax Number	Required
6	Statement Covers Period	Required

FL Number	Form Locator Name	Explanation
7	Future Use	N/A
8a	Patient ID	Situational
8b	Patient Name	Required
9	Patient Address	Required
10	Patient Date of Birth	Required
11	Patient Sex	Required
12	Admission Date	Required
13	Admission Hour	Required
14	Type of Admission/Visit	Required
15	Source of Admission	Required
16	Discharge Hour	Required
17	Patient Discharge Status	Required
18-28	Condition Codes	Required, if applicable
29	Accident State	Situational
30	Future Use	N/A
31-34	Occurrence Codes and Dates	Required, if applicable
35-36	Occurrence Span Codes and Dates	Required, if applicable
37	Future Use	N/A
38	Responsible Party Name and Address	Required, if applicable
39-41	Value Codes and Amounts	Required, if applicable
42	Revenue Code	This field allows for a four-digit revenue code that represents a specific accommodation, ancillary service or billing calculation. Revenue codes must be valid for the Type of Bill (FL4) indicated on the claim form.
43	Revenue Description	Complete this field with the standard description assigned each revenue code. You can find a list of revenue codes and their descriptions in the National Uniform Billing Guide.
44	HCPCS/Rates	Enter HCPCS codes if your provider contract requires them.
45	Service Date	Required on all outpatient claims when you give a date span in the Statement Covers Period (FL 6). You must provide a specific date for each service you bill on a line.
46	Service Units	This field identifies the number of services the patient received (e.g., the number of days in a particular accommodation) or the time required to provide at least one unit of service for each revenue code billed. For accommodations, the unit of service field must match the total number of days indicated in FL 6. Calculate each 24-hour period as one day. To calculate units, round up to the nearest whole number.
47	Total Charges	Submit a charge for each billed revenue code. If there is no charge, enter either 0.00 or N/C on the line item or Harvard Pilgrim will return the claim.

FL Number	Form Locator Name	Explanation
50	Payer	Enter your local Harvard Pilgrim Health Plan name followed by the Plan Code.
51	Provider Number	Enter your facility's Harvard Pilgrim provider billing number. The provider number you enter must correlate with the Type of Bill (FL 4) or Harvard Pilgrim will return the claim.
56	NPI	Enter your facility's NPI number.
58	Insured's Name	Enter the last and first name of the policyholder, using a comma or space to separate the two. Do not leave a space between a prefix (e.g., MacBeth). Submit a space between hyphenated names (e.g., Smith Simmons) rather than a hyphen. If the name has as suffix (e.g., Jr., III), enter the last name followed by a space and then the suffix (Miller Jr., Roger).
59	Patient Relationship	Enter a code that indicates the relationship of the patient to the policyholder. Refer to the UB-04 Data Element Manual for a complete list of appropriate codes you should use to complete this field.
60	Insured's Unique ID	Enter the identification (ID) number as it appears on the patient's ID card.
67	Principal Diagnosis Code/Other Diagnoses	Submit a valid principal ICD-10-CM diagnosis, including the fourth and fifth digits when appropriate.
69	Admitting Diagnosis Code	Enter the ICD-10-CM diagnosis code for the patient at the time of admission.
74	Principal Procedure Code	Inpatient Services: An ICD-10-CM Volume 3 procedure code and the date the practitioner performed the procedure are required in this field when you bill revenue codes 036X, 049X and 075X.
76	Attending Provider/ID- Qualifier 1G	Enter the Unique Provider Identification Number (UPIN) and the name of the licensed provider who Harvard Pilgrim normally expects to certify and recertify the medical necessity of the services the patient received and/or who has primary responsibility for the patient's medical care and treatment during an inpatient stay.
77	Operating ID	Required, if applicable
78-79	Other ID	Required, if applicable
80	Remarks	Required, if applicable
81	Code-Code Field/Qualifiers	Required, if applicable

Common Claims Filing Errors

Proper payment of Medicare Advantage claims is a result of efforts of the provider, employee clinicians and billing personnel, and of adherence to national and local payment policy requirements. This section: (a) describes common claim filing errors that can result in claim rejections or claim denials, (b) includes general requirements for properly resubmitting rejected claims, and (c) discusses the process for appealing a denied claim.

Generally, there are three common types of errors that result in claim denials:

- Billing/data entry errors
- Noncompliance with coverage policy

- Billing for services that are not medically necessary
- Incorrect member ID number
- Invalid/missing diagnosis code
- Past timely filing requirements
- Incorrect provider number
- Missing, incorrect or invalid modifier
- Invalid/missing Healthcare Common Procedure Coding Systems (HCPCS) code
- Missing or incorrect quantity

In some cases, additional documentation may be required in order for the claim to complete adjudication. After Harvard Pilgrim receives the additional information, the claim is adjusted or corrected.

Compliance Issues Resulting in Claim Denials

Harvard Pilgrim may deny coverage or reject a claim for these reasons:

- The patient is not eligible for Medicare Advantage benefits.
- The provider is not qualified to furnish the Medicare services billed.
- Medicare Advantage is the secondary payer to other insurance and the primary plan has not processed the claim.
- Services are excluded by national or local coverage policy because:
  - The service is not covered.
  - A limited benefit is exhausted.
  - Claim/services do not meet technical requirements for payment, e.g., non-compliance with Correct Coding Initiative (CCI) edits (including national and local requirements).

Eliminating Procedure Code Unbundling

Unbundling occurs when a provider bills in multiple parts for a procedure that would typically be reported under a single comprehensive code. This unethical act reflects improper procedure reporting under CCI coding requirements. CMS has identified specific code pairs that Harvard Pilgrim will reject if a provider bills for them for the same patient on the same day. In most unbundling cases, providers cannot bill beneficiaries for amounts Medicare denies due to unbundling.

Harvard Pilgrim has adopted a policy of reviewing claims to ensure correct coding. The Plan utilizes a corrective coding re-bundling/unbundling software, which is integrated with our claims payment system IkaClaims. Services that should be bundled and paid under a single procedure code will be subject to review.

Special Considerations When Submitting Harvard Pilgrim Medicare Advantage Claims

Depending on the specialty of the provider, there are additional, special considerations a biller must be aware of when submitting claims. These considerations include:

- Determining whether claims should be submitted to Medicare
- Requesting prior authorization for:
  - Services that require authorization (see Medicare Advantage Provider Manual)
  - Services that are not normally covered by the plan, if medical necessity may warrant coverage
- Providing Notice of Exclusions of Medical Benefits (NEMBs)

Prompt Payment by Medicare Advantage Organization

A submitted claim will be considered a "clean claim" if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare. The following prompt payment requirements apply:

- Harvard Pilgrim shall either pay or deny clean claims **submitted by contracted providers** for covered services to Medicare Advantage Members within forty-five (45) days of receipt.
- Harvard Pilgrim will either pay or deny clean claims **submitted by non-contracted providers** within 30 calendar days of the request. All other claims submitted by non-contracted providers will be paid or denied within 60 calendar days from the date of the request.

Claims with incomplete or inaccurate data elements will be returned with written notification of how to correct and resubmit the claim. Claims that need additional information in order to be reprocessed will be suspended and a written request for the specific information will be sent to the provider. If the requested information is not received within the specified timeframe, the claim will be closed and the provider will be notified.

The MA organization may not pay, directly or indirectly, on any basis (other than emergency or urgent services) to a provider or other practitioner who has opted out of the Medicare program by filing with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

If you would like to review any of the sections referenced in their entirety, please access the CMS website at www.cms.gov. You are encouraged to review this site periodically to obtain the most current CMS policy and procedures as released.

Online Claims Information

Harvard Pilgrim encourages participating providers to check the status of their claims on the Harvard Pilgrim Stride[SM] Provider Portal of Harvard Pilgrim's website at www.harvardpilgrim.org/provider. In addition to checking claims status, you can also verify eligibility and benefit information. You will need your log in ID number and password to access this information.

Please refer to our worksheet "Getting Started with the Medicare Advantage Provider Portal" to ensure that you have the necessary information for registration.

If you need assistance with registration or have questions about the portal, please contact the Medicare Advantage Provider Service Center at 888-609-0692.

PUBLICATION HISTORY

10/15/13	original documentation
02/06/14	administrative edits for clarity
12/15/14	reviewed; no changes
07/15/17	updated ICD-9 references to ICD-10; updated "special consideration when submitting Harvard Pilgrim Medicare Advantage claims" section
11/15/17	updated "clean claim" submission by non-contacted providers information
01/02/20	updated claim submission address
01/01/22	updated document format
09/05/23	updated paper claims mailing address for Stride Medicare Advantage
09/25/23	updated EMDEON to Change Healthcare
11/22/23	added claims submission section