Claim Requirements, Coordination of Benefits and Payment Disputes

- UB-04 Claims
- CMS-1500 Claim Form
- Billing Requirements for Hospital-Owned Freestanding Facilities for UB-04 and CMS 1500 Claims

General Payment Information

Tufts Health Plan processes completed, clean claims that meet the conditions of payment and that are submitted within the time frames required. “Completed claims” 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 accurately completed (as described in this chapter).

Additional payment policies and clinical coverage criteria are available for many specific services on our provider website. To ensure accurate claims processing, providers and their office staff must follow these documented policies.

Payment of Claims

“Clean claims” must meet the following conditions of payment:

- The billed 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, or identified elsewhere in the provider’s agreement with Tufts Health Plan (if applicable), or authorized by Tufts Health Plan and in compliance with the provider agreement
  - Provided in an emergency in accordance with the member’s benefit document
  - Medically necessary as defined in the member's benefit documents
- Both paper and electronic claims must be received by Tufts Health Plan, as evidenced by a Tufts Health Plan claim number, within the 90-calendar day filing limit from the date of service (for outpatient or professional claims) or the date of discharge (for inpatient or institutional claims).
- 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 Referral, Authorization and Notification Policy.
- The services were billed using the appropriate CPT and/or HCPCS codes or other codes assigned by Tufts Health Plan.
- In the case of professional services billed by the hospital, services were billed electronically or on CMS-1500 forms with a valid CPT/HCPCS code.
- “Clean claims” do not include a claim from a provider who is under investigation for fraud or abuse.

Electronic Data Interchange

Electronic data interchange (EDI) allows providers to submit electronic transactions to Tufts Health Plan. This commonly refers to claim, referral and eligibility transactions but may 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); for additional information, refer to the HIPAA 837 Companion Guide for direct submitters
- Submissions from a variety of external clearinghouse sources

Note: Prior to submitting claims to Tufts Health Plan, providers must register their National Provider Identifier (NPI) directly with Tufts Health Plan.

Claims that Cannot Be Submitted via EDI

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), if applicable
- Pharmacy

Receipt of Claims

EDI Claims

The date of receipt is defined as the day the claim is processed at Tufts Health Plan, resulting in a Tufts Health Plan claim number being assigned to the claim. Proof of receipt is supported by the 277CA report, 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 requiring signed receipts included in each filing. Said 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. Said log or patient account ledger must be available for inspection by Tufts Health Plan upon reasonable notice to the provider.

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 standard red claim forms provided by W.B. Mason. Black and white versions of these forms, including photocopied versions, faxed versions and/or 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.

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 submitted for processing.

For all Commercial claims:

- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 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.
- Remove all staples from claims and supporting documentation.

- 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 form)
  - Provider Tax ID

Paper claims should be mailed to **P.O. Box 178, Canton, MA 02021**

If a claim is rejected, the provider must resubmit a corrected claim no later than 90 calendar 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.

Note: Unreadable claims may be returned to the submitting provider.

Billing Requirements for Hospital Outpatient Services

CMS-1500 and UB-04 forms are the acceptable standard for paper billing; the ANSI X12N 837 claim transaction is the acceptable standard for electronic billing. All providers must use the most current ICD-CM diagnosis codes and valid CPT/HCPCS procedure codes, unless otherwise specified by Tufts Health Plan.

To be appropriately compensated when a hospital bills for professional services in addition to facility and ancillary services for clinic visits, including behavioral health and/or substance use disorder (BH/SUD) services, 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 department (ED) professional services	CMS-1500	837 Professional
ED facility and ancillary services	UB-04	837 Institutional

Eligibility Inquiry

Providers and their office staff should use self-service channels to verify member effective dates and cost share. Calls from offices that elect not to use a self-service tool and continue to call Provider Services for basic eligibility inquiries will be transferred to our interactive voice response (IVR) system to complete eligibility verification. The following self-service channel options are available to providers:

- Web-based eligibility status via the secure Provider portal
- New England Healthcare EDI Network (NEHEN) and NEHENNET
- Status information via the provider's clearinghouse
- IVR — call 888-884-2404

Online Adjustment Requests

Provider Services call center staff is unable to process claim adjustment requests. Registered providers may submit claim adjustments using the secure Provider portal. Providers who are not currently registered may follow the instructions to become a registered user.

Adjustment requests can be made online for the following reasons:

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

Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation. If submitting supporting documentation on paper that corresponds to an online claim adjustment, include the online tracking sheet so that the claim may be properly adjudicated. **Note:** Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating this.

Providers who do not use the online claim adjustment tool must submit their adjustment requests via EDI or mail by following the appropriate process outlined in this manual.

Claim corrections submitted by EDI for late charges (frequency code 5), replacement claims (frequency code 7) and/or voided claims (frequency code 8) must include the original Tufts Health Plan claim number. The original claim number should be submitted in the 837 in the following format: **Loop 2300 Claim Information/REF – Payer Claim Control Number/REF01=F8 and REF02**. Corrections submitted by EDI that do not include the original claim number will be rejected.

Providers should follow existing submission guidelines outlined in this manual when submitting corrected claims. Corrected claims submitted by EDI will also be rejected in the following circumstances:

- If the original claim is in process and has not been adjudicated
- If an adjustment to the original claim is currently in process
- If the correction request is received after the submission deadline

Negative Balance

A negative balance is a dollar amount owed to Tufts Health Plan that is reflected on the summary page of the Explanation of Payment (EOP) and in the PLB segment of the 835 file. Negative balances are created when Tufts Health Plan determines that a claim has been overpaid and retracts/re-adjudicates that previously paid claim. When a paid service is retracted on an EOP, the amount retracted becomes a negative or “owed” dollar amount. Tufts Health will recover this negative dollar amount by using other claims payments as credits to satisfy (offset/take back) the negative balance.

When the negative balance amount exceeds the amount of credits available on the EOP, the negative value will be carried to a future EOP. Negative balance activity is reported in the summary box of the printed EOP and in the PLB segment of the 835 file.

Retraction Causes

Some situations that cause a retraction and produce a negative balance include, but are not limited to:

- Duplicate payment
- Payment to the wrong provider
- Payment for the wrong member
- Retroactive termination of a member
- Overpayment identified through internal or external audits
- Payment adjustment from rate correction (e.g., claim should have been paid at contract rate)

Balance amounts are subject to change through ongoing claims processing and review. Retractions can generate a new negative balance even after a previous negative balance is settled.

Negative Balance Recovery

Tufts Health Plan will recover negative balances by using other claims payments as credits to satisfy (offset/take back) the negative balance. If there are insufficient claims payments, a negative balance may be transferred to other claims systems within Point32Health and its affiliates to offset the amount. If a negative balance is not fully recovered through other claims payments within 90 calendar days, Tufts Health Plan issues the provider a refund request letter.

If a negative balance cannot be recovered through other claims payments or a refund check, Tufts Health Plan reserves the right to place any uncollected funds in a collection status.

Returned Funds

Providers must complete and submit a Returned Funds Form and payment EOP for claims requesting to be refunded to the Finance Services Team when returning funds to Tufts Health Plan due to incorrect payments. Submitting funds without the form and supporting documentation can delay the process of having the funds allocated back to the provider's account.

Explanation of Payment

The EOP is a weekly report of all claims that have been paid, pended or denied to that provider. This form is identified by the Tufts Health Plan logo and shading. The EOP also includes a summary of claims in process that indicates claims that Tufts Health Plan has received but may require additional review or information before being finalized in the system. EOPs may be viewed electronically by logging on to the PaySpan Health website; 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 an 835 from PaySpan Health is handled by PaySpan's Health Provider Support Team via their website or by calling 877-331-7154, option 1. Provider support team specialists are available Monday–Friday from 8 a.m.–8 p.m., EST.

Table 1: EOP 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	Member's name
Patient ID	Member's Tufts Health Plan ID number
Account	Member's account number assigned by the provider
Claim#	Tufts Health Plan assigned claim number

Field Name	Explanation
Provider name	Provider who rendered the service
NPI	Rendering provider's NPI number
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. Note: This field displays only when applicable
Member responsibility	Copayment, deductible and/or coinsurance charges
Amount paid	Amount paid by Tufts Health Plan
Pay code	Most claims will be identified by a pay code and message for paid, denied and/or pending claims Note: Not all claims will have a pay code listed if the claim is in pending status

Claims Follow-Up

Payspan Health 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 EOP reports, with the following exceptions:

- "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 report will appear on the EOP once the claim has been adjudicated. If a submitted claim does not appear on either the EOP or the Summary of Claims in Process report within 30 to 45 calendar days, verify the claim was received by logging on to the secure Provider portal or by contacting Provider Services. 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 address within the timely filing deadline.

Electronic Claims Follow-Up — 999 and 277CA Reports

- **Direct Submission —** Reports are posted online within 72 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 within the 90-calendar day filing limit.
- If the claim has not appeared on your EOP or electronic remittance, review the original transmission report.
- **ABILITY —** Claims accepted or rejected by ABILITY can be reviewed in the provider's LinkMail Box.
  - For more information, refer to the user manual on the ABILITY 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. This report 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

The filing deadline is 90 calendar days from the date of service (for professional or outpatient claims) and 90 calendar days from the date of hospital discharge (for inpatient or institutional claims). To be considered for review, payment disputes received after the filing deadline must be submitted within 90 calendar days of the EOP on which the claim originally denied. A request for reconsideration received more than 90 calendar days past the deadline will not be considered.

Professional or Outpatient Services

The filing deadline for claims submission for all Commercial products is 90 calendar days from the date of service. This includes the following products:

- Health Maintenance Organization (HMO)
- Exclusive Provider Options (EPO)
- Point of Service (POS)
- Preferred Provider Organization (PPO)

Inpatient/Institutional Services

The filing deadline for institutional claims submission for all Commercial products is 90 calendar 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 from the date of the primary insurer's explanation of payment (EOP). The EOP 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.

Refer to the Coordination of Benefits Payment Policy for more information.

Funds Retracted by another Carrier

To ensure timely payment, submit the claim with the other carrier's retraction statement within 90 calendar days of date on retraction statement.

Filing Deadline Adjustments

Documented proof of timely submission must be submitted with the Request for Claim Review Form and payment of a claim that was previously denied due to the filing deadline. Requests for filing deadline adjustments for claims should be sent to the following address for Tufts Health Plan Commercial. (Commercial products include HMO, POS, and PPO):

Tufts Health Plan
Provider Payment Disputes
P.O. Box 251
Canton, MA 02021

Requests for filing deadline adjustments for claims should be sent to the following address for US Family Health Plan: Tufts Health Plan

Provider Payment Disputes
P.O. Box 495
Canton, MA 02021

Submitting Proof of Timely Filing for a Paper Submission

Attach documented proof of timely submission to the EOP and circle the claim to be adjusted.

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

- Copy of 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, if insurance information is not made available by the member
- Copy of EOP from another carrier if the member did not identify themselves 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 calendar days of the date on the letter
- Copy of a Worker's Compensation denial received by Tufts Health Plan within 90 calendar days of the date of the denial
- Copy of claim form returned by Tufts Health Plan with imprinted 12-digit number at the bottom of the claim form. The first five digits indicate the date (Y/MM/DD)[1]. Refer to this Provider Manual for information on the paper claim submission requirements.

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 documentation since each denial is based on the current message code on the claim.

Submitting Proof of Timely Filing for an EDI Submission

Providers who submit their claims electronically through a clearinghouse, MD On-Line or directly to Tufts Health Plan must send their EDI acceptance report, which indicates proof of timely submission. Acceptance of an EDI claim as evidenced by a Tufts Health Plan claim number will be required as proof of timely submission.

Circle the claim that is disputed on both the report(s) and the EOP. Details on the report requirements are listed below:

EDI Through	Reports Required for Proof of Timely Submission	Report Detail
Direct to Tufts Health Plan One or the other required	Claims acceptance summary report **or** Claims acceptance detail report	Claims accepted at Tufts Health Plan by claim number
Change Healthcare™/ WebMD/Envoy One or the other required	Provider claim status report (RPT-10) **or** Special handling/unprocessed claims report (RPT-11)	Claims accepted at Tufts Health Plan by claim number
Change Healthcare™/ WebMD/Healthwire One or the other required	Provider claim status report (RPT-10) **or** Special handling/unprocessed claims report (RPT-11)	Claims accepted at Tufts Health Plan by claim number
Capario	INS (insurance) response report	Claims accepted at Tufts Health Plan by claim number
MD On-line	Acceptance report in your **LinkMail Box**	Claims accepted at Tufts Health Plan by claim number

Reports must show receipt at Tufts Health Plan, either through direct submission, MD On-Line or a clearinghouse. If a report indicates a rejection at the clearinghouse, the claim will not be considered for reprocessing. It is the provider's

[1] Applies to Commercial members only

responsibility to review all reports from the clearinghouse and/or Tufts Health Plan and review any rejected claims at that time. Rejections must be corrected and received by Tufts Health Plan within 90 calendar days of the date of service (for outpatient claims) or date of discharge (for inpatient or institutional claims) in order to be considered for payment.

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.

Limitation of Dispute Process

Tufts Health Plan will consider payment disputes and adjustment requests for Commercial claims with dates of service within the current year, and the two previous calendar years, for the following disputes:

- The level of compensation
- Claims denied for no referral when a referral was obtained
- Claims denied for lack of prior authorization or inpatient notification

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 calendar 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 received by Tufts Health Plan within 90 calendar days of the date of service (for professional or outpatient claims) or date of discharge (for inpatient or institutional claims).

Retroactive Denials

Tufts Health Plan may reprocess claims in accordance with our adjudication guidelines to ensure appropriate payment for services rendered. In accordance with state law governing Massachusetts-based fully insured plans and the Group Insurance Commission (GIC), Tufts Health Plan sends notification to behavioral health providers in Massachusetts and allows 30 calendar days for a response prior to retroactively denying or adjusting claims to reduce payment for behavioral health services. If communication is not received from the provider within 30 calendar days (15 calendar days for coordination of benefits or worker's compensation claims), the claim will be readjusted and processed.

Provider Compensation/Reimbursement Disputes

Provider Payment Disputes

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 described in the Online Adjustment Requests section. If submitting a paper request for reconsideration of a denied claim, include a completed Request for Claim Review Form and follow the process outlined below. Please provide one claim number, per form. Multiple claim numbers on one form are not accepted.

Submitting a Payment Dispute

Online Claim Adjustments

Registered providers may submit claim adjustments using the secure Provider website. Providers who are not registered users of the website may register via the Provider login page.

Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation. Providers submitting paper documentation that corresponds to an online claim adjustment must submit the online tracking sheet so that the claim is processed accurately.

Note: Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating the claim is not adjustable. Refer to the section below regarding submitting claim adjustments via mail.

Claim Adjustments Submitted via Mail

Paper claim payment disputes should be submitted to the following address for Tufts Health Plan Commercial:

Tufts Health Plan
Provider Payment Disputes
P.O. Box 251
Canton, MA 02021

Paper claim payment disputes should be submitted to the following address for US Family Health Plan:
Tufts Health Plan

Provider Payment Disputes
P.O. Box 495
Canton, MA 02021

Tufts Health Plan requires the Request for Claim Review Form for Commercial provider payment disputes submitted by mail.

- Forms must be submitted with all required information, as denoted by asterisks (*). Incomplete forms will be returned to the submitting provider for completion and resubmission.
- If the original claim was denied, enter the Tufts Health Plan denial code in the 'Denial Code' field (do not use HIPPA message codes)
- Supporting documentation must be single-sided
- Disputes submitted without the Request for Claim Review Form will be rejected and returned to the submitter.
- Do not highlight, as it may appear blacked out when scanned and may delay the processing of the dispute(s). A separate dispute form must be submitted for each adjustment along with any supporting documentation.
  Note: Cloned documentation (i.e., information that is duplicated across patient documentation that is not specific to the encounter and/or member) does not meet medical necessity requirements and will not be accepted as evidence of the service billed

Adjustments can be requested when submitting a dispute by mail for the following reasons:

- **Corrected Claim Adjustments**
  When submitting a corrected claim adjustment via mail, attach a written explanation (single sided only) of the requested changes or a corrected claim to the Explanation of Payment (EOP) and the Request for Claim Review Form). The claim number to be adjusted should be circled and sent to the correct address.
- **Claims Denied for No Referral**
  For all HMO and POS claims paid at the unauthorized benefit level or denied for no referral, attach a copy of the referral or the referral number to the EOP and circle the claim number to be adjusted.

Process for Submitting Corrected Claims via EDI

Claim corrections submitted by electronic data interchange (EDI) for late charges (Frequency Code 5), replacement claims (Frequency Code 7) and voided claims (Frequency Code 8) must include the original Tufts Health Plan claim number submitted in the 837 in the following format: **Loop 2300 Claim Information/REF – Payer Claim Control Number/REF01=F8 and REF02.** Corrections submitted by EDI that do not include the original claim number will be rejected.

Providers should follow existing submission guidelines when submitting corrected claims. Corrected claims submitted by EDI will also be rejected in the following circumstances:

- If the original claim is in process and has not been adjudicated
- If an adjustment to the original claim is currently in process
- If the correction request is received after the submission deadline.

Claims Denied for Lack of Prior Authorization or Inpatient Notification

- Submit a typed, case-specific letter of appeal with the necessary supporting clinical documentation.
- Attach a copy of the claim and the EOP.
- Include pertinent information in your appeal: an explanation as to why the proper procedure to obtain inpatient notification or prior authorization was not followed or an explanation and evidence of how the proper procedure was followed. Tufts Health Plan considers relevant supporting documentation to be a copy of the provider's original information faxed/submitted to Tufts Health Plan and relevant medical records. If authorization is applicable, please include the authorization number received verbally or in writing from Tufts Health Plan.

Compensation/Reimbursement Appeals

- Submit a typed letter of medical necessity (LOMN) explaining why the service was necessary.
- Attach the EOP and circle the claim to be reviewed.
- Submit all supporting documentation in the form of invoices, operative notes, office notes, radiology/pathology report(s) or any necessary medical record information for a fee adjustment request.

Appeals for Unlisted Procedure Code Denials

- Appeals for denials resulting from the billing of an unlisted procedure code must include operative notes that identify the service(s) performed associated with the unlisted code.
- The portion of the operative notes that identifies the unlisted service must be underlined (do not highlight). If operative notes are not underlined to indicate the services performed, the submitter will be notified by letter that the appeal will not be reviewed.
- Providers submitting unlisted or miscellaneous drug codes not currently covered by a HCPCS code must include an invoice with the claim that includes the drug name, appropriate National Drug Code (NDC) number and dosage. For more information, refer to the FDA National Drug Code Directory

Refer to the Unlisted and Not Otherwise Classified Codes Payment Policy on the Payment Policy page for more information on unlisted procedure codes.

Correct Coding

Tufts Health Plan follows industry-standard coding guidelines. Providers should refer to current industry standard coding guidelines for a complete list of ICD, CPCT/HCPCS, revenue codes, modifiers and their usage. In the event a provider believes Tufts Health Plan has not complied with required uniform standards for billing and coding, per M.G.L. c 176O, Section 5A, providers may dispute the coding compliance by completing the Chapter 305 Compliance Form. All fields on the form must be completed and supporting documentation must be sent as attachments via email to the Medical Policy Department as instructed on the form.

Required documentation

Letters requesting reconsideration must include or be accompanied by the following or the request will be returned to the provider 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 Claims Denied for Lack of Prior Authorization or Inpatient Notification section.

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. To expedite the review process, when submitting hospital records, please include the page numbers for the history, physical and discharge summaries. If authorization is applicable, include the authorization number received verbally or in writing from Tufts Health Plan.

Within 10 business days of receipt of all required documentation, a letter is sent to the provider acknowledging receipt and explaining that a written response will be forthcoming that explains the decision.

A written response outlining the decision typically is sent to the provider within 45 business days of the receipt of all documentation. In certain situations, this time frame may be extended by Tufts Health Plan to allow for information gathering, chart review and/or claims adjudication.

Coordination of Benefits

Regardless of whether Tufts Health Plan is the primary or secondary insurer, members must follow plan procedures to receive benefits. For additional information, refer to the Coordination of Benefits Policy.

Motor Vehicle Accidents

Tufts Health Plan coordinates with auto insurance coverage, including personal injury protection (PIP) and/or Medical Payment (MedPay) on claims for services rendered as a result of a motor vehicle accident (MVA).

Members living in Massachusetts: Motor vehicle insurance is the primary insurance until all benefits are exhausted:

- Up to $2,000 PIP for members covered under an insured plan; or
- Up to $8,000 PIP and MedPay for members covered under a self-insured ERISA-qualified plan
- MedPay is primary for members covered under a self-insured ERISA plan and secondary for Commercially insured plans.

Members living in New Hampshire: Tufts Health Plan is the primary insurance for Commercially insured plans and secondary for members covered under a self-insured ERISA-qualified plan.

Members living in Rhode Island/covered by Rhode Island group coverage: Motor vehicle insurance (i.e., no-fault coverage) is the primary.

If providers choose to obtain payment from the motor vehicle insurer, they should bill the insurer directly. If further payment is requested after receiving the insurer’s statement or check, providers must submit a copy of the auto carrier’s documents (i.e., PIP exhaust or benefit denial letter) along with the claim(s) to Tufts Health Plan within the 90-calendar day filing deadline date from the date the statement or check was issued.

Members cannot be required to pay up front; however, if it is a motor vehicle claim, providers may bill the member's motor

vehicle insurer under PIP and/or Medpay benefits.

Under the provider's Tufts Health Plan contract, providers may not balance-bill the member or file a lien against the member's third-party settlement or judgment.

Note: Do not bill the member or the member's attorney directly even if requested by either of them. If a provider chooses to bill the member or attorney directly, it is done so at the provider's own risk.

The following applies to claims for services rendered as a result of a motor vehicle accident:

- Claims should not be submitted beyond the filing deadline from the date on the auto insurer's notification of benefit payment, denial, or exhaustion
- Claims should be submitted with dated notification from the auto insurer that benefits have been paid, denied or exhausted
- Inpatient notification procedures for any inpatient admissions resulting from an MVA, regardless of whether or not Tufts Health Plan is the primary or secondary insurer. Refer to the Referrals, Authorizations and Notifications chapter for additional information.

Note: Tufts Health Plan does not routinely compensate conditional bills.

Subrogation

Subrogation is a 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 their insurer).

Tufts Health Plan has outsourced subrogation recovery services to The Rawlings Company in Louisville, Kentucky. As a result, providers could receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries related to such claims should be directed to the Rawlings Company representative at the number indicated on the correspondence. All other subrogation questions must be directed to Provider Services at 888-884-2404.

Workers' Compensation

Members who require services due to an employment-related injury or illness should have bills directed to the member'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 their 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 member 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 calendar days from the date of the denial from the worker's compensation carrier.

Miscellaneous Billing Tips and Guidelines

- All paper CMS-1500 and UB-04 claims must be submitted on official red claim forms provided by W.B. Mason. Black and white versions of these claim forms (including photocopied versions, faxed versions, and/or 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.
- 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.
- Remove all staples from claims and supporting documentation.
- 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 "online." 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 8.5 by 11 inches.

Claim Specifications

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, and the Type column, which indicates whether a particular field is mandatory (M), optional (O) or not applicable (N/A).

Note: Claims that do not have all mandatory fields completed will be rejected and returned to the submitter.

UB-04 Claim Form Field Specifications

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 member 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 this field is not completed
5	Federal tax number	M	Enter the hospital/provider federal tax ID. Note: Claim will be returned if this field is not completed

Box	Field Name	Type	Instructions
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 Name and ID	M	8a: Enter member ID number 8b: Enter the member's last name, first name and middle initial, if any, as shown on the Tufts Health Plan member ID card
9a–e	Patient address	M	Enter the member's mailing address from the member record
10	Birthdate	M	Enter the member'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	Admission source (SRC)	M	Enter the code indicating the source of this admission/visit
16	Discharge hour	M	Enter the time (hour: 00–23) the member was discharged
17	STAT (Patient discharge status)	M	Enter the code to indicate the status of the member as of the through date on this billing
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 ("from" and "through") that identify an event that relates to the payment of the claim
37	Untitled	N/A	Not applicable
38	Untitled	N/A	Not applicable
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.

Box	Field Name	Type	Instructions
44	HCPCS/Rate/HIPPS code	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, supporting documentation must accompany the claim • Do not indicate rates
45	Service date	M	Enter the date the indicated service was provided
46	Service Units	M	Enter the units of service rendered per procedure
47	Total charges	M	Enter the charge amount for each reported line item (negative amounts will not be accepted)
48	Noncovered charges	O	Enter any noncovered charges for the primary payer pertaining to the revenue code
49	Untitled	N/A	Not applicable
50 A–C	Payer Name	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 member)	M	Report all prior payment for claim (negative amounts will not be accepted). Attach EOB from other carrier, if applicable.
55	Est. amount due	N/A	Not applicable
56	NPI	M	Enter valid NPI number of the servicing provider
57 a-c	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 member to the identified insured/subscriber.
60 a-c	Insured's unique ID	M	Enter the member's Tufts Health Plan ID number (including suffix), as shown on the member's ID 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 ID 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 codes	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
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

Box	Field Name	Type	Instructions
67 a-q	Principal diagnosis code	M	Enter the most current ICD-CM code describing the principal diagnosis chiefly responsible for causing the 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 are 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; Other 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	O	Examples: "COB-related" or "billing for denial purposes only"
81CCa–d	Code to code	O	Optional

CMS-1500 Claim Form

The CMS-1500 form can be used by:

- Independent providers, nonphysician practitioners, and other suppliers (e.g., laboratories, physical therapists, chiropractors, behavioral health providers, and durable medical equipment (DME) suppliers)
- Hospital outpatient/emergency departments

The professional component of services may only be billed on a CMS-1500 form for MDs, DOs, and podiatrists (with the exception of clinical services). Services performed by nonphysician practitioners (e.g., nurse practitioners, physician assistants, or certified registered nurse anesthetists) who participate in a professional group for whom the hospital does billing) should also be billed on a CMS-1500 form.

Use a UB-04 claim form if only billing the technical component of any of the services mentioned above.

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 Range[2]	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 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, 24f, 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 may be prepared according to Medicare guidelines provided all mandatory fields

Completion Instructions

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

- A copy of the CMS-1500 form
- Specifications for each field of the CMS-1500 form
- Specifications for hospital-owned freestanding facilities are identified in Table 3. If you do not have a provider identification number specific to the freestanding site, contact Allied Health Services at 888.880.8699, ext. 43145.
- The Type column indicates whether a particular field is M (mandatory), O (optional) or N/A (not applicable)

CMS-1500 Claim Form Field 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 member’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 member’s last name, first name, and middle initial, if any, as shown on the member’s Tufts Health Plan ID card.
3	Patient’s date of birth	M	Enter the member’s date of birth and sex.
4	Insured’s name	M	Enter the name of the insured except when the insured and the member are the same. In those cases, enter the word SAME.

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

Box	Field Name	Type	Instructions
5	Patient's address	M	Enter the member's permanent mailing address and telephone number as follows: • Street address • City, state • Zip code and phone number
6	Patient relationship to insured	M	Check the appropriate box for member'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 member's, enter 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 member 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 or program name. Attach primary insurer's EOB to the claim.
10a–10c	Is member'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 member 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
11b	Other claim ID	O	• Enter 2-character qualifier found in 837 electronic claims 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 member could be covered under insurance held by a spouse, parent, or some other person.

Box	Field Name	Type	Instructions
12	Patient's or authorized person's signature	M	• If the signature is not on file, the member or authorized representative must sign and date this box. • If the member's representative signs, the relationship to the member 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 member 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 claims to the left of the dotted line. • Enter the name of the referring and/or ordering physician or other source if the member: • 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 ID number of the referring or ordering physician. • Referring physician information is required if another physician referred the member to the performing physician for consultation or treatment. • Ordering physician information is required if a physician ordered the diagnostic services, tests, or equipment. • Inclusion of the NPI number will expedite claims processing.
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 member indicated by ICD-CM code number. Enter up to 12 codes in priority order (primary, secondary condition). Codes are arrayed across the box.

Box	Field Name	Type	Instructions
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 freestanding facilities, always enter 11 for the place of service[3]. • Anesthesia providers should enter anesthesia duration in minutes with start and end times in the shaded area. Claims missing dates of service will be returned.
24b	Place of service	M	Enter the appropriate HIPAA standard place of service code only. 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 freestanding 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 freestanding 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.
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 member's account number that the physician's/supplier's accounting system assigned. This is an optional field to enhance member identification by the physician or supplier.

[3] All freestanding facilities require a separate Tufts Health Plan-assigned, freestanding provider ID number in addition to an NPI number. Providers who do not have an ID number specific to the freestanding site should contact the Allied Health Contracting Department at 888-880-8699, ext. 43145.

Box	Field Name	Type	Instructions
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. Enter the NPI of the entity (payee) associated with the TIN. 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 Freestanding Facilities for UB-04 and CMS 1500 Claims

Any inpatient or outpatient service associated with a hospital that meets either one of the following criteria is subject to freestanding 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 freestanding

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

PUBLICATION HISTORY
07/01/24 Added Negative Balance section
10/01/24 Administrative edit

11/13/24	Added mailing addresses in the Filing Deadline Adjustments section and the Provider Payment Disputes section; administrative edits.
11/14/24	Updated links
02/01/25	Updated the following sections with information from the archived Provider Payment Dispute Policy: "Filing Deadline Policy" and "Provider Compensation/Reimbursement Disputes"; administrative edits
03/28/25	Updated "Filing Deadline Policy" section; administrative edits
04/02/25	Administrative edits