Claims

Filing a Paper Claim

Before filing any claim, be sure to confirm the member's eligibility. It is very important to include the member's correct identification number. Do not bill with a Social Security number. (Please see Section 2 - Member Eligibility).

Non-Hospital

To be eligible for payment, all paper claims must be filed on fully and accurately completed CMS 1500 forms with the current ICD-10 diagnosis codes (at the highest level of specificity) and CPT-4 or HCPCS procedure codes (including applicable modifiers). Claims may be suspended or denied when data items on claim forms are incomplete or incorrect. Table 3 - 1 contains descriptions of field numbers and HPSM requirements corresponding to the standard CMS 1500 Claim Form.

Hospital

To be eligible for payment, inpatient and outpatient hospital paper claims must be submitted to HPSM using a fully and accurately completed UB-04 claim form. Claims may be suspended or denied when data items on claim forms are incomplete or incorrect. Table 3 - 2 contains description of field numbers and HPSM requirements corresponding to the standard UB-04 Claim Form

Long Term Care Paper Claims

To be eligible for payment, long term care paper claims must be submitted to HPSM using a fully and accurately completed 25-1 claim form. Claims may be suspended or denied when data items on claim forms are incomplete or incorrect

It is very important to include your appropriate NPI Number when submitting claims.

Paper claims should be submitted to the following address:

Health Plan of San Mateo
Attention: Claims Department
801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

Paid and denied claims are acknowledged on the remittance advice (RA) within 15 working days of receipt.

The status of all submitted claims may be checked via HPSM's website (www.hpsm.org) once a User ID and Password have been established. Please contact the HPSM Provider Services Department at **650-616-2106** for assistance.

You may also obtain Claim Status by contacting HPSM's Claims Department at **650-616-2056**, or by email at ClaimsInquiries@HPSM.org.

Table 3-1: CMS-1500 Field Descriptions and Requirements

Field #	Description	Requirement
1	Medicaid/Medicare/Other ID	Enter an "X" in the Medicaid Box (for all programs except CareAdvantage)
1A	Insured's ID	Enter Member's HPSM ID number
2	Member's Name	Entered as it appears on the HPSM ID Card
3	Member's DOB/Sex	Enter Member's DOB in 8-digit format (MMDDYYYY)
4	Insured's Name	Use if billing for a newborn using Mom’s ID
5	Member's Address and Telephone	Enter Member's Complete Address and Telephone Number
6	Patient Relationship to Insured	This field may be used when billing for an infant using the mother's ID by checking the "Child" box
7	Insured's Address	Not Required by HPSM
8	Patient Status	Not Required by HPSM
9	Other Insured's Name	”X” if applicable
9A	Other Insured's Policy/Group Number	Enter information, if applicable
9B	Other Insured's Policy/Group Number	Enter information, if applicable
9C	Employer's Name/School Name	Enter information, if applicable
9D	Insurance Plan Name/Program Name	Enter information, if applicable
10	Is Patient's Condition Related To:	Enter “X” in the appropriate box below.
10A	Employment	”X” Yes or No if applicable
10B	Auto Accident/Place	”X” Yes or No if applicable
10C	Other Accident	”X” Yes or No if applicable
10D	Reserved for Local Use	Enter the amount of patient's Share-of-Cost for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign ($) (e.g. if billing for $100, enter 10000 not 100).
11	Insured's Policy Group or FECA Number	Enter information if applicable

Field #	Description	Requirement
11A	Insured's Date of Birth/Sex	Enter information if applicable
11B	Employer's Name or School Name	Enter information if applicable
11C	Insurance Plan Name of Program Name	”X” if applicable “”
11D	Is There Another Health Benefit Plan?	Enter an "X" in the box if the recipient has other coverage.
12	Patient's or Authorized Person's Signature	Not Required by HPSM, use “Signature on File”
13	Insured's or Authorized Person's Signature	Not Required by HPSM, use “Signature on File”
14	Date of Current Illness/Injury/Pregnancy	Enter date, if applicable
15	Similar Illness	Not Required by HPSM
16	Date Unable to Work	Not Required by HPSM
17	Referring Provider	Physician name or other source
17A/B	ID Number of Referring Physician	Enter the referring or prescribing or ordering practitioner's NPI.
18	Hospitalization Dates	Enter dates of admission and discharge.
19	Reserved for Local Use	Use this area for providing additional information which may be necessary for HPSM to process your claim appropriately; such as “Baby using Mom’s ID”, anesthesia start/stop times, or proof of eligibility.
20	Outside Lab	”X” if applicable .Name of outside lab must be listed in box 32.
21.1	Diagnosis or Nature of Illness or Injury	Enter all letters and/or numbers of the ICD-10-CM at its highest specificity. Do not use decimal point.
21.2	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code at its highest specificity, if present.
21.3	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code at its highest specificity, if present.
21.4	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM code at its highest specificity, if present.

Field #	Description	Requirement
22	Medicaid Re-submission Code	Not Required by HPSM
23	Prior Authorization Number	For physician and pediatric services requiring a Prior Authorization Request (PAR). It is not necessary to attach a copy of the PAR to the claim. Recipient information and NPI on the claim must match the PAR. Only one PAR Control Number can cover the services billed on any one claim.
24A	Date(s) of Service	Enter the date or date span the service was rendered in the "From" and "To" boxes in the 6-digit, MMDDYY, format. Do not bill “future” dates – services cannot be billed until after the “from” date on the claim.
24B	Place of Service	Enter one code indicating where the service was rendered.
24C	Type of Service	Not Required by HPSM
24D	Procedures, Services, or Supplies Modifier	Enter the applicable procedure code (HCPCS or CPT-4) and modifier, if required.
24E	Diagnosis Code Pointer	Reference diagnosis code(s) from box 21 applicable to each service line.
24F	Charges	In full dollar amount, enter the usual and customary fee for service(s). Do not use the dollar sign ($). If an item is a taxable medical supply, include the applicable state and county sales tax.
24G	Days or Units	Enter the number of medical "visits", surgical lesions, hours of detention time, units of anesthesia time, etc.
24H	EPSDT Family Plan	Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are CHDP-screening related. Leave blank if not applicable.
24I	ID Qualifier	Not required by HPSM
24J	Rendering Provider NPI	Enter NPI
24.1-24.6	Claim lines	Follow instructions for each claim line.
25	Federal Tax ID Number	Enter the 9-digit provider Tax ID number.
26	Patient's Account No.	This is an optional field that will help you to easily identify a recipient on RAs.
27	Accept assignment?	“X” Yes or No
28	Total Charge	In full dollar amount, enter the total for all services. Do not enter a decimal point (.) or dollar sign ($).

Field #	Description	Requirement
29	Amount Paid	Enter the amount of payment received from the other coverage (Box 10D). Do not enter Medicare payments in this box. Medicare payment amount will be calculated from the Medicare EOMB/RA when submitted with the claim.
30	Balance Due	Enter the difference between Total Charges and Amount Paid.
31	Provider Signature/Date	Not required for CareAdvantage claims
32	Service Facility Location Information	Can include Outside Lab. List location where service was rendered.
32a	NPI of Facility	NPI of location listed in Box 32.
32b		Not Required
33	Billing Provider Info and Phone Number	Required
33a	NPI of Billing Provider	Required
33b		Not Required

TABLE 3-2: UB-04 Field Descriptions and Requirements

Field #	Description	Requirement
1	Hospital Name, Address and Zip Code	Enter the hospital name, address and 5-digit zip code.
2	Alternate Address of Facility	Not Required by HPSM
3	Patient Control Number	This is an optional field that will help you easily identify a recipient on RTDs and RAs.
3b	Medical Record Number	This is an optional field that will help you easily identify a recipient on RTDs and RAs.
4	Type of Bill	Enter the appropriate Type of Bill code as specified in the UB-04 Manual Billing Procedures.
5	Federal Tax ID Number	Enter the 9-digit Federal Tax ID number.
6	Statement Covers Period (From-Through)	In 6-digit format MMDDYY, (Month, Day, Year) enter the dates of service included in this billing.
7	Blank	Not Required by HPSM
8	Patient Name	Required

Field #	Description	Requirement
8a	Blank	Not Required
8b	Patient Name	Last name, first name, middle initial
9	Patient Address	
9a	Patient's Street Address	Required
9b	City	Required
9c	State	Required
9d	Zip	Required
9e	Zip + 4	Not Required
10	Birth date	8-Digit, MMDDYYYY
11	Sex	Enter M or F
12	Admission Information - Date	Enter admit date as 6 digits, MMDDYY
13	Admission Hour	Enter as 2 digit - Eliminate the minutes, convert the hour of admission/discharge to 24-hour (00-23) format (for example, 3 p.m. = 15)
14	Admission Type	Enter the numeric code indicating the necessity for admission to the hospital. Emergency = 1, Elective = 3.
15	SRC	If the patient was transferred from another facility, enter the number code indicating the source of transfer. Hospital - 4, SNF - 5, another Health Care Facility - 6.
16	DHR	Discharge Hour, 1-2 digits - Eliminate the minutes, convert the hour of admission/discharge to 24-hour (00-23) format (for example, 3 p.m. = 15)
17	Status	Enter the numeric code explaining the patient's status of the "through" date (Box 6).
18 - 28	Condition Codes	Applicable HPSM codes are: Other Coverage, Emergency Certification, Family Planning, Billing Limit Exception etc.
29	ACDT State	Not Required
30	Blank Field	Not Required
31-36	Occurrence Codes	Not Required
37	Blank Field	

Field #	Description	Requirement
38	Name/Address of Patient	Required
39-41	Value Codes	Patient's Share-of-Cost code"23" or Medicare Deductible or End Stage Renal Claims.
42	Revenue Codes	Enter the appropriate accommodation or ancillary code
43	Description	Enter the description of the accommodation or ancillary code.
44	HCPCS/Rates	Required for services other than Inpatient Hospital
45	Service Date	Required for services other than Inpatient Hospital
46	Service Units	Enter the number of days of care by accommodation code.
47	Total Charges	In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($).
48	Non-Covered Charges	Not Required by HPSM
49	Unlabeled	Not Required by HPSM
50A-C	Payer	Enter name of Coverage of Health Plan
51A-C	Member Health Plan ID	Required
52A-C	Release of Information Certification	Y or N
53A-C	Assignment of Benefits Certification Indicator	Y or N
54A-B	Prior Payment	Enter the full dollar amount of payment received from Other Coverage or Share of Cost if applicable.
55A-C	Estimated Amount Due	Enter the difference between "Total Charges" and any deduction.
56	NPI	Required
57	Unlabeled	Sometimes used for TIN
58A-C	Insured's Name	Required
59A-C	Patient's Relationship to Insured	If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's Relationship to the Medi-Cal recipient (e.g. 03 Child).
60A-C	Insured's Unique ID	Enter the Member's ID number.
61A-C	Insured Group Name	Not Required by HPSM

Field #	Description	Requirement
62A-C	Insurance Group Number	Not Required by HPSM
63A-C	Prior Authorization Codes	For services requiring a Prior Authorization Request (PAR) enter the PAR Control Number.
64A-C	Document Control Number	Not Required by HPSM
65A-C	Employer Name	Not Required by HPSM
66A-H	Diagnosis Codes	No entry can be made
67 A-Q	Diagnosis Codes	Enter all letters and/or numbers of the ICD-10-CM codes at their highest level of specificity, if present.
68	Blank	
69	Admit DX	Not Required by HPSM
70 a-c	Patient Reason DX	Not Required
71	PPS Code	Not Required
72 a-c	ECI	Not Required
73	Blank	
74	Principal Procedure Code and Date	Enter the appropriate Procedure code identifying the primary medical or surgical procedure.
75	Blank	
76	Attending Physician ID	Include physician name, NPI and qualifier
77	Operating Physician ID	Include physician name, NPI and qualifier
78-79	Other	If applicable
80	Remarks	Use this area for procedures that require additional information, e.g. enter Mother's name when the baby is using Mother's ID and the baby's birth date or proof of eligibility
81 a-d	CC	Not Required

For HOSPITAL OUTPATIENT SERVICES billed on a UB-04 form

The following fields are *NOT REQUIRED BY HPSM*: 16–22, 43, and 46. In addition, Field #44 requirement should read: Enter CPT-4 procedure code and appropriate modifiers, if needed.

TABLE 3-3: LTC 25-1 Field Description and Requirements

Field #	Description	Requirement

Field #	Description	Requirement
1	Claim Control Number	HPSM use only. DO NOT mark in this area. A unique 13-digit number, assigned by HPSM to track each claim, will be entered here when the claim is received by HPSM
1A	Provider Name, Address	Enter your name and address if this information is not pre-imprinted. Please confirm that this information is correct before submitting claims. Zip Code (Box 128). Enter the five-digit ZIP code
	Zip Code (Box 128).	Enter the five-digit ZIP code of the facility if this information is not already pre-imprinted.
2	Provider Number	Enter your Medi-Cal NPI number if it is not preprinted. Include all nine characters of the number. Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that consistently bill with other than the 10-character Medi-Cal NPI number will be denied.
3	Delete	If an error has been made for a particular patient, enter an "X" in this space to delete both the upper and lower line. Enter the correct billing information on another line. When the *Delete* box is marked "X", the information on both lines will be "ignored" by the system and will not be entered as a claim line.
4	Patient Name	Enter the patient's last name, first name and if known, middle initial. Avoid nicknames or aliases.
5	Medi-Cal Identification Number	Enter the 10-character recipient ID number as it appears on the Benefits Identification Card (BIC).
6	Year Of Birth	Enter the patient's year of birth in a two-digit format (YY) from the BIC. If the recipient is 100 years of age or older, enter the recipient's age and the full four-digit year of birth (CCYY) in the *Explanations* area (Box 126a).
7	Sex	Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the BIC.
8	ARF Reference Number	For services requiring an ARF, enter the nine-digit ARF Reference Number. It is not necessary to attach a copy of the ARF to the claim. Recipient information on the ARF must match the claim. Be sure the billed dates fall within the ARF authorized dates.

Field #	Description	Requirement
9	Medical Record Number	This is an optional field that will help you to easily identify a recipient. Enter the patient's medical record number or account number in this field (maximum of five characters – either numbers or letters may be used). Whatever you enter here will appear on the RA.
10	Attending M.D. Medi-Cal ID No.	Enter the physician's nine-character Medi-Cal Provider Number. If the physician does not have a provider number, enter his/her State license number (not always nine characters). Be sure the attending physician's ID number is entered on a(n): • Admit claim • Initial Medi-Cal claim for a Medi-Care/Medi-Cal crossover patient • Claim when there is a change in the attending physician's provider number.
11	Billing Limit Exception	If there is an exception to the six-month billing limitations from the month of service, enter the appropriate reason code number and include the required documentation. The appropriate documentation must be supplied to justify the exception to the billing limitation.
12 / 13	Date Of Service	Enter the period billed using a six-digit MMDDYY [Month, Day, Year] format for the FROM and THRU dates. Bill only one calendar month of service at a time. Be sure the authorization dates on the ARF cover the period billed. For example, September 1, 2003 is written 090103. **Note:** When a patient is discharged, the through date of service must be the discharge date. When a patient expires, the thru date of service must be the date of death.

Field #	Description	Requirement
14	Patient Status	Enter the appropriate patient status code from the list below. The patient status code must agree with the accommodation code (that is, if the status code indicates leave days, the accommodation code must also indicate leave days). **Code Patient Status** 00 Still under care 01 Admitted 02 Expired 03 Discharged to acute hospital 04 Discharged to home 05 Discharged to another LTC facility 06 Leave of absence to acute hospital (bed hold) 07 Leave of absence to home 08 Leave of absence to acute hospital /discharged 09 Leave of absence to home/discharged 10 Admitted/expired 11 Admitted/discharged to acute hospital 12 Admitted/discharged to home 13 Admitted/discharged to another LTC facility 32 Transferred to TC status in same facility
15	Accommodation Code	Enter the appropriate accommodation code for the type of care billed, as listed in *the Long Term Care* Accommodation *Codes* **Note:** HPSM does not require that a copy of Form LTC 231 (*Certification for Special Program Services*) be attached to the *Payment Request for Long Term Care* (25-1).
16	Primary DX (Diagnosis) Code	Enter the Primary ICD-10-CM diagnosis Code (International Classification of Diseases 9th Revision, Clinical Modification) for the following: • Admit claim • Initial Medi-Cal claim for a Medi-Care/Medi-Cal crossover patient • Change in diagnosis **Note**: ICD-10-CM coding must be three, four or five digits with the fourth and fifth digits included if present. The vertical line serves as the decimal point. Do not enter decimal point when entering this code. Current copies of the ICD-10-CM codes may be ordered from: PMIC 4727 Wilshire Blvd., Suite 300 Los Angeles, CA 90010 **1-800-633-7467**

Field #	Description	Requirement
17	Gross Amount	When billing for full Medi-Cal coverage, compute the gross amount by multiplying the number of days times the appropriate Medi-Cal daily rate for the accommodation code listed. When entering the gross amount, do not use symbols ($) or (.). The pre-imprinted vertical line serves as the decimal point. Use this method in entering all dollar amounts on the *Payment Request* form
18	Patient Liability / Medicare Deductible	Enter the recipient's net Share of Cost (SOC) liability. The recipient's net liability is determined by subtracting from the recipient's original SOC shown on the Medi-Cal card, the amount expended by the recipient that qualifies under Medi-Cal rules as expenditures which may be used to reduce the patient's SOC liability. For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items "not covered" by Medi- Cal. The recipient's net SOC liability is the amount billed to the recipient. This SOC is deducted from the Medi-Cal allowed amount. The PATIENT LIABILITY entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the *DHS 6114* form, *Item 15*. When billing the recipient for less than the SOC amount indicated by the Host, enter an explanation in the *Explanations* area on the claim form
19	Other Coverage	Enter the amount paid by other insurance carrier(s) for the period billed, if applicable. Other Coverage includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. **Note:** If the Host indicates a coverage code "L" for the recipient, providers must bill Other insurance carriers prior to billing Medi-Cal.
20	Net Amount Billed	Enter the amount requested for this billing. To compute the net amount, subtract patient liability and Other Coverage (if any) from the gross amount billed. If the net amount billed computes to $00.00, enter the amount as "0000". Do not leave blank.
21	M.D. Certification	Not required.
22	Additional Claim Lines	
116		The *Payment Request* form may be used to bill services for as many as six patients. Bill only one month's services on each line.

Field #	Description	Requirement
117	Attachments	Enter an "X" if attachments are included with the claim. Leave blank if not applicable. **Note:** If this box is not marked, attachments may not be seen by the examiner, which may cause the claim to be denied.
118	Provider Reference No.	Enter any number up to seven digits to identify this claim form in your filing system. Any combination of alpha or numeric characters may be used. This number will be referenced by HPSM on any forms sent to you that pertain to the billing data on the form. It will not be included on the *Remittance Advice*.
119	Date Billed	In six-digit format, enter the date the claim is submitted for HPSM payment.
120	FI USE ONLY	Leave blank.
126		Not applicable
126A	Explanations	Use this area for procedures that require additional information or justification. It is essential to clearly indicate the billing line number in this area.
127	Signature of Provider Or Person Authorized by Provider (Representative)	The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ball-point pen only. An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable. The signature does not have to be on file at HPSM.
127A	Affix Label Here	BIC cards do not have labels. Leave these boxes blank.

Timelines for Claims Submission

Medi-Cal Claims

Claims Submission from Date of Service	Reimbursement Policy
0-6 months	100% of approved payment
7-9 months	75% of approved payment

Claims Submission from Date of Service	Reimbursement Policy
10-12 months	50% of approved payment
> 1 year	0% of approved payment (without written justification)

Your claims must be submitted within 180 days from the date of service in order to qualify for the full approved payment amount.

Claims received beyond 180 days from the date of service will be pro-rated according to the guidelines listed in the table above and the member may not be balance billed.

CareAdvantage and HealthWorx Claims

Your claims must be submitted within 1 calendar year from the date of service.

Additional documentation needed

The following are common circumstances that will require additional documentation to be submitted with the claim:

- **Non-specific injection codes (i.e., 90782)**
  Indicate the name, NDC number and dose of medication administered.
- **Multiple procedures that are performed at the same session**
  Indicate the number of procedures performed in the narrative and in the Units section of the form.
- **Unlisted codes or codes that are “Not otherwise classified” usually ending in "99"**
  Submit procedure, office or operative notes describing the procedure performed.
- **Multiple surgical procedures**
  Submit an operative report with the claim.
- **Special supplies**
  Submit description (e.g., 99070). AIl special supplies should be coded utilizing their HCPC Level II codes. Special supplies coded 99070 will require adequate documentation to ensure that usual and customary supplies over and above the general and accepted practice were used. These claims may be pended for reimbursement consideration.
- **High level (99285) Emergency Room claims**

Billing Tips for Claims Submission

HPSM uses optical character recognition (OCR) technology to facilitate expedited turnaround time of your paper claims submission.

- Verify member eligibility prior to submission of a claim. Use only the member’s HPSM ID number, not Social Security or other numbers.
- Be sure to indicate the National Practitioner Identifier (NPI) on your claim form under PIN # in Box 33 (CMS-1500).

- Service dates cannot be in the future even when part of a date span
- If you are billing claims for a physician in a group practice, use the group NPI in the PIN # section in Box 33 (CMS-1500) and not the rendering physician's individual NPI number.
- Remember to include RAF and TAR numbers when needed. The NPI on the claim form should match the one used on the TAR
- For CMS-1500 paper claims, remember to sign and date each claim legibly – no signature stamps. Please use blue or black ink only. Signatures are not required on UB-04 claims, all lines of business. Signatures are not required for CareAdvantage claims.
- For paper claims, place any attachments that are smaller than 8½ x 11 on a piece of 8½ x 11 blank paper.
- Remember procedure codes 1000-8000 require modifiers.
- Vision claims require Modifiers. (Qualifying Codes not used after 07/06)
- When billing more than one of the same procedures for Lab or X-Rays, enter on one line with the appropriate count and documentation.
- "On-Call Providers" need to contact Provider Services so that their services/claims will be paid.
- Submit claims electronically.
- Do not submit paper claims with:
    - Changes made with dry line or correction fluid.
    - Data touching the box edges or data running outside of the numbered boxes.
    - Handwritten descriptions.
    - Super-bills that are photo copied

Important Billing Guidelines

It is very important that your billing staff check their error reports to guarantee timely claims submission. **A rejected claim will not be considered to have been submitted to HPSM.**

Claims for services provided to members who are later determined to be retroactively eligible with HPSM must be submitted **within 60 days of determination of eligibility** with the corresponding Medi-Cal Delay Reason Code

Note: In order to avoid a denied claim for late submission, please note in the remarks section the date that Proof of Eligibility (POE) was received by the Provider.

Claims for services provided to members who have Medicare and Other health insurance as primary coverage and HPSM as secondary coverage, claim and primary insurance remittance advice must be submitted to HPSM within one year of the month of service with the corresponding Medi-Cal Delay Reason Code to meet timeliness requirements.

The Advantages of Submitting Claims Electronically

Reduces your administrative costs

- ✔ Handling of paper claims is eliminated.

Accurate claims data

- ✔ Your claims are formatted and submitted directly into our host system. This prevents the original claim data from having to be re-keyed.

Faster claims submission

- ✔ Claims enter our system faster and, in turn, claims are processed quicker.

Electronic Claims Requirements

- ✔ All existing claims data is still required
- ✔ All information that is currently submitted on your paper claims must also be included on all electronic claims (see Filing a Paper Claim).

Filing Electronic Claims

Getting Started

To get started, please contact HPSM's Provider Services Department at **650-616-2106**.

HPSM supports the following batch claim file formats:

- CMC (Inpatient, Outpatient, Professional)
- UB-04 Version 4 of 6 Flat file (Inpatient, Outpatient)
- NSF 3.01
- ANSI X.12 EDI (3921) 837
- HIPAA 837 4010 (Professional and Institutional)

HPSM also has the ability to receive claims information over the web using our eHEALTHsuite portal.

Delivery Method	Directions
FTP (File Transfer Protocol)	FTP to www.hpsm.org. Dial-in number is **650-616-8062**. Plain text only, migrating to 128-bit SSL encryption. Please contact the HPSM MIS Department at **650-616-2025** to set up your User ID and Password and receive more detailed instructions.
E-mail	E-mail ec@hpsm.org PGP encryption preferred.

eHEALTHsuite	CMS-1500 professional claims can be completed and submitted via HPSM's website at www.hpsm.org. Please contact the HPSM Provider Services Department at **650-616-2106** to set up your User ID and Password and receive more detailed instructions.
Clearinghouses	Emdeon (WebMd): HPSM Payer ID code is: SX174**.** Call Emdeon Business Services Support at **877-469-3263**. Office Ally: Call Office Ally at **949-464-9129** to obtain an ID and password or visit www.officeally.com.

The status of all submitted claims, regardless of submission method, can be checked via HPSM's website (www.hpsm.org) once a User ID and Password have been established. Please contact the HPSM Provider Services Department at **650-616-2106** for assistance.

Important Reminders

Be sure that you have a valid NPI number.

- This is very critical in the electronic process. It is imperative that your NPI number be included on all electronic claims. Please check with HPSM's Provider Services Department before initiating submission to verify your Medi-Cal or Medicare Provider ID.

Confirmation that HPSM received your claim

- Electronic claims are acknowledged via e-mail within 2 working days.
- Additionally, HPSM will **reject** claims with the following common errors:
    - Invalid Medi-Cal Provider ID Number
    - No NPI number

It is very important that your billing staff check their error reports to guarantee timely claims submission. **A rejected claim will not be considered to have been submitted to HPSM.**

If you are not currently filing claims electronically and wish to do so, please call the HPSM EC Coordinator at **650-616-2017** or send an email to: ec@hpsm.org.

All electronic claims must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The deadline for HIPPA compliance for electronic transactions and code sets for all covered entities was October 16, 2003.

For questions regarding electronic claim submission and testing, please call the HPSM EC Coordinator at **650-616-2017**.

Methods of Reimbursement

Fee-for-Service

Providers contracted under the fee-for-service reimbursement arrangement are paid for approved services based on the applicable HPSM fee schedule. All payments generated to fee-for-service providers are a direct result of claims submitted to HPSM. All claims must be submitted to HPSM within three hundred and sixty-five (365) days of the date of service in order to qualify for the payment. A pro-rated amount will be paid by the Medi-Cal plan if the claim is submitted more than one hundred eighty (180) days to three hundred and sixty five (365) from the date of service, without a valid Medi-Cal delay reason code, as per contract provisions.

Capitation

Providers contracted under a capitation payment arrangement are paid a monthly per member per month (PMPM) for each HPSM Medi-Cal member, including CareAdvantage members, on the monthly PCP Case Management List. This payment covers the cost of all capitated procedures performed. (See Primary Care Capitation Code List in the end of this section.)

The monthly payment is received whether or not the patient is seen by the provider in any given month. Capitated providers are reimbursed on a fee-for-service basis for approved covered services not included in the capitation arrangement. Claims for all services must be submitted to HPSM within three hundred sixty five (365) days of the date of service without a valid Medi-Cal delay reason code, as per contract provisions. This claims data is then used to determine among other things, encounter rates and utilization of preventive services and is the basis of our reporting of the Health Plan Employer Data Information Set (HEDIS) to the California Department of Health Care Services and other state and Federal regulatory agencies. (For more information on HEDIS see Section 8). Proper submission of claims data will significantly reduce the need for on-site Medical Record review or requests for chart copies to be mailed to HPSM.

Please note: All practitioners should ensure that claim forms are submitted with appropriate CPT-4 procedure codes and/or Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes for each service rendered at the time of the visit regardless of payment methodology (i.e. monthly capitation payment or fee-for-service).

HPSM Fee Schedule

For most services, HPSM reimburses providers the lesser of the billed amount or the maximum allowable fee based on the California Department of Health Care Services (DHCS) Medi-Cal rates. Reimbursement rates may change during the year. Any code listed may have a service limitation associated with it or need prior authorization.

To review current Medi-Cal rates, please see the Medi-Cal website at www.medi-cal.ca.gov. The HPSM Fee Schedule for PCPs, Specialists a.k.a. Referral Providers (non-OB), OB Specialists, Other Service Providers,

Hospitals, and Pharmacies are described below.

For HealthWorx, HPSM uses the Medi-Cal Fee Schedule as the base. The main differences are that PCPs are paid Fee-For Service under these programs, not at a capitated rate, and these programs have higher co-pays as well. Co-pay amounts are subtracted from the total Fee schedule amounts due before payment is released by HPSM.

For CareAdvantage, HPSM uses the Medicare Participating Fee schedule. To review current rates, please see the Noridian website at https://med.noridianmedicare.com/web/jeb/fees-news/fee-schedules/mpfs

Contracted PCPs

Primary Care Physicians are paid a capitation amount each month for each Medi-Cal member (including CareAdvantage) on their Case Management list. For HPSM, PCPs are Family Practice, General Practice, Internal Medicine, and Pediatric providers. OB/GYN providers are eligible to serve as PCPs should they enter into a contract with HPSM to serve as such.

Supplemental Notes for Payment to Primary Care Providers

- Capitation rates are based on a defined Scope of Services that includes office visits, inpatient services, preventative services, minor surgical procedures, and some laboratory services. The Scope of Services can be found later in this Section.
- Capitation rates may be adjusted for age/sex cost differences where deemed appropriate.
- PCPs may receive an "Extended Hours" capitation rate which is 10% higher than the base capitation rate, if the PCP maintains eight (8) additional office hours per week, in any combination of weekday evenings after 6:00 p.m. and weekends.
- PCPs may receive a 20% supplemental capitation payment quarterly if they are open to new members and accept new members who are automatically assigned to them.
- If the PCP has joined the IZ Registry, they can receive extra payment for each member under 18.
- For services provided to Medi-Cal members outside of the Capitation Scope of Services, PCPs are paid 123% State Medi-Cal rates for covered services.

PCP Fee Schedule for Other Programs

For the HealthWorx program, PCPs are paid at 133% State Medi-Cal rates for covered services.

Contracted Specialists (non-OB) a.k.a. "Referral Providers"

Contracted Specialists (a.k.a. "Referral Providers") are reimbursed at 123% of

State Medi-Cal rates for covered services for Medi-Cal and 133% for HealthWorx. CareAdvantage contracted specialists are paid at 90% of the Medicare Participating Fee Schedule.

Contracted Specialists (OB)

Contracted Obstetricians are paid a global fee for prenatal care, currently $1,600. Global Services include antepartum care, delivery, and postpartum care, including:

- Hospitalized admission
- Patient history
- Vaginal or Caesarean section delivery
- Physical examination after previous Caesarean section delivery
- Labor management
- Hospital discharge
- All applicable postoperative care

The postpartum office visit is reimbursed at $50.00

Global billing requires 13 OB visits

In order to bill for global obstetrical care, providers must render services for at least thirteen (13) OB visits, and submit claim with from - through billing format. Otherwise, services are paid for on a fee-for-service basis. Document services for global obstetrical care in the Reserved for Local Use field (Box 19) on the CMS-1500 claim form, or on an attachment, for reimbursement.

- If you are billing electronically, provide at least 13 visit dates in the Remarks field. The initial pregnancy-related office visit may be counted as one of the 13 visits.
- If fewer than 13 visits are rendered, providers must bill services on a per-visit basis. In the event you do not indicate the 13 visit dates, your claim will be denied.
- In the event a provider plans to bill a global fee but then does not perform the delivery, each antepartum visit (HCPCS code Z1034) must be billed separately.

Contracted other service providers

Contracted Other Service Providers are reimbursed at 100% of State Medi-Cal rates for covered services for Medi-Cal and HealthWorx. CareAdvantage contracted Other Service Providers are reimbursed at 90% of the Medicare Participating Fee Schedule.

Contracted hospitals

Contracted Hospitals are reimbursed on a per-diem basis for Medi-Cal, and HealthWorx. Contracted Hospitals are paid the current DRG rate for CareAdvantage members.

Contracted pharmacies

HPSM contracts with a pharmacy benefit manager, Argus, for pharmacy services. Contracted pharmacies bill Argus for drugs and HPSM for medical supplies.

Payment Policies, Rules, & Non-Standard Coding Methodologies

HPSM follows the payment policies and rules outlined in the Medi-Cal Provider Manuals for Medi-Cal and HealthWorx. HPSM follows Medi-Cal modifier requirements for these lines of business. HPSM follows the current Medicare guidelines for the CareAdvantage line of business.

The Center for Medicare and Medicaid Services (CMS) oversees Medicare and Medicaid plans on a national level. CMS requires health plan compliance programs to identify health care fraud, abuse, and waste. The goal of HPSM's compliance program is to focus on areas of government concern, such as unbundling, up-coding, medically unnecessary services, duplicate billing, and billing for services not rendered.

HPSM has implemented *Cotiviti*® as a technologically advanced tool for reviewing billing practices. Using nationally recognized payment and coding guidelines, *Cotiviti*® allows HPSM's claims system to pend, edit, or deny claim entries based on CMS and AMA guidelines.

Your HPSM RAs outline the nature of the coding and edits that have been identified by HPSM's Claims Department. Please use this information as an instrument to review and improve your billing practices.

HPSM's policy regarding consolidation of multiple services or charges, and payment adjustments due to coding changes:

- In cases where a provider submits a claim to HPSM for "unbundled" services, HPSM reimburse according to the bundled payment schedule.

HPSM's policy regarding multiple procedures:

- HPSM will reimburse the allowable amount for multiple procedures with appropriate documentation.

HPSM's policy regarding reimbursement for assistant surgeons:

- HPSM reimburses 20% of the Medi-Cal allowable amount for the procedure code. See the Medi-Cal rates schedule under procedure type "O".

HPSM's policy regarding reimbursement for the administration of immunizations and injectable medications:

- **For Medi-Cal**
  You must be a VFC provider to be reimbursed through VFC. The VFC program, operated by the California Department of Health Care Services, furnishes federally purchased pediatric vaccines to health care providers at no cost to serve children birth-18 years whose parents cannot pay out of pocket for vaccines. Vaccines are used for children covered by Medi-Cal, children without health insurance or whose insurance does not cover vaccine, and American Indian or Alaskan native children. For more information, contact the State toll free at 877-2 GET VFC (877-243-8832).
  Use SL modifiers to get reimbursed for the administrative fee from HPSM. For high-risk adults, use the SK modifier.
- **For HealthWorx and CareAdvantage**
  Vaccines should be billed directly to HPSM.

HPSM'S Long Term Care Billing and Procedure Codes

Claims shall be submitted according to established protocols as set forth in the EDS Medi-Cal Manual, in reference materials from PLAN, and/or as set forth in the Provider Manual. If the Member has other health insurance the other insurance must be billed prior to billing PLAN in accordance with §§ 4.5 and 4.8 of the Agreement.

Nursing Facility Provider shall bill using its National Provider Identifier (NPI) on and after May 23, 2007 and should include the ICD-10-CM diagnosis code(s) of the Member's condition on any Claim. An approved modifier must be included, wherever applicable.

Nursing Facility Provider who has rendered Covered Services to eligible Members shall submit Claim forms within three hundred and sixty five (365) days of the date of service, in accordance with the provisions of § 4.4(a) of the Agreement. Claims submitted for Medi-Cal members after six (6) months will be reduced to 75% of the allowable, and those submitted after nine (9) months from the date of service will be reduced to 50% of the allowable, claims submitted 1 year from the date of service, will be denied.

Reimbursement Guidelines

Claims are required to have accurate and specific ICD-10 diagnosis codes and CPT-4 procedure codes and/or HCPCS codes. Claims are reviewed for the following items and reimbursement for covered services will be based on the most appropriate coding:

Evaluation and management services

Office visit codes for initial or new patients will be allowed for separate reimbursement, according to the CPT guideline, when billed in conjunction with a reimbursable procedure (see CPT-4 starred procedures).

Reimbursement will not be made when the services are considered part of the pre-operative and/or post-operative care provided as part of evaluation and management services of a major surgical procedure (global billing). Claims will be reviewed for claim history to determine appropriate Evaluation and Management visit codes in relation to initial versus established patient. In addition, reimbursement will not be made when the services provided are covered under a capitation arrangement.

Medical services after hours

After hours codes are not reimbursable when billed in conjunction with an Evaluation and Management Service.

Hospital discharge day

Visit is not separately reimbursable when billed in conjunction with a reimbursable procedure and/or an Evaluation and Management Service performed on that same discharge date.

Incidental procedures

Incidental procedures will not be separately reimbursed when billed separately on a claim for the same date of service as a primary procedure.

Unbundling

When submitting surgical or laboratory claims, use the single most comprehensive CPT -4 Procedure Code that accurately describes the entire service. When two or more procedure codes are used where a single code (or primary code) includes those codes billed, all codes will automatically be re-bundled and payment will be made for the primary code only.

Mutually exclusive procedures

When two or more codes appear on a claim for procedures that are usually not performed at the same operative session on the same patient on the same date of service, or when two or more codes describing the same type of procedure are submitted on the same claim, they are considered mutually exclusive and only one code will be reimbursed.

Unlisted procedures

Unlisted procedures should not be billed unless a more specific and current CPT-4 procedure code is unavailable in the current CPT-4 reference for the year the procedure was performed. When billing with an unlisted code, a written description of the procedure must be submitted for consideration. Unlisted procedures may not be eligible for coverage under the Plan contract, and reimbursement will be based on the terms, limitations, and policies of the Plan.

Lack of documentation will result in denial for any unlisted procedure.

Cosmetic procedures

Cosmetic surgery can be described as any procedure performed to improve the general physical appearance, where a physical functional deficit is not documented and medical necessity is not substantiated. Cosmetic surgery is not a covered benefit. In following CMS guidelines and CPT-4 coding rationale, clinical indication for possible cosmetic surgery must be substantiated with a detailed history and physical findings, previous unsuccessful medical treatment, functional impairment or limitations following disease, infection, trauma or previous surgery. Psychological stress does not constitute medical necessity.

Special supplies

All special supplies should be coded utilizing the HCPCS Level II codes. Special supplies coded 99070 will require adequate documentation to ensure that usual and customary supplies over and above the general and accepted practice were used. These claims may be pended for reimbursement consideration.

Modifiers

Listed services may be modified under certain circumstances. When applicable, the modifying circumstance against general guidelines should be identified by the addition of the appropriate modifier code. Note that the utilization of modifiers will be reviewed, and supporting documentation may be requested. Inappropriate use of a modifier or using a modifier when it is not necessary will result in denial or a delay in claim payment. Some CPT-4 codes, by nature of their description, are for the professional or technical component only. In these cases, a modifier will make the claim suspend unnecessarily.

Additional items

Claims will also be screened for the following: duplicate procedures, obsolete procedures, experimental procedures, age and sex discrepancies, and questionable necessity of an assistant surgeon.

Coverage groups

It is required by HPSM that all contracted practitioners, both Primary Care Physicians (PCPs) and specialists, have seven days a week, 365 days a year call coverage for his/her practice.

All practitioners must provide HPSM with a list of the covering physicians as part of their credentialing or re-credentialing application. All practitioners must also notify HPSM if the list of covering physicians changes. Only one visit will be approved for the covering physician services, unless the office is closed for an extended period of time. Patients should be instructed to follow up with their PCP.

NOTE: If a practice is closed for more than 24 hours, the practice must notify the Provider Services Department (see Section 1 - Who to Call).

If there are members of your coverage group that do not participate with HPSM, your practice must inform them of the HPSM policies and procedures (i.e., billing procedures, address, prior approval) and the non-participating provider must agree in advance to accept the applicable HPSM reimbursement, as payment in full, for any covered services rendered. In addition, when billing for services, the non-participating practice-practitioner must clearly identify the name of the HPSM practice/practitioner for whom they are covering in Box 19 of the CMS 1500 claim form.

Surgical reimbursements

The surgical fee for all therapeutic surgical procedures covers:

- The pre-operative evaluation and care beginning with the decision to perform surgery;
- The surgical procedure and intra-operative care;
- Anesthesia, if used, whether it is local infiltration, digital or regional block and/or topical;
- Normal uncomplicated follow-up care, including the routine post-operative hospital care and routine office visits within the post-operative period. Supplies that are considered usual and customary to the surgical procedure are not separately reimbursable.

Assistant surgeons

When an assistant surgeon is used for a procedure, it should be noted on the claim by adding an assistant surgeon modifier (80) to the procedure code. All claims are subject to review pursuant to any applicable state or federal laws or regulation or any requirements of California Department of Health Care Services, Department of Managed Health Care or CMS. The claim will then be reviewed to determine if there was a medical necessity for an assistant surgeon, consistent with Milliman Care Guidelines. A procedure which always requires the use of an assistant surgeon according to the Milliman Care Guidelines will automatically be approved for payment at a reduced rate. This is currently set at 20% of the fee payable to the primary surgeon.

Assistant surgeon fee may be payable for procedures which are not on the list of assistant surgeon allowed procedures. For these exceptions, a TAR will be required and documentation supporting the medical justification for an assistant surgeon must be submitted for pre-authorization. The list of procedures for which an assistant surgeon is allowed is downloadable from the HPSM website or you may contact your Provider Services Representative for a hard copy.

Hospital discharge day

If the day of discharge or death occurs with an emergency or regular admission, it is **not reimbursable** except when the discharge/death occurs on the day of admission – even though the day may be covered by the accommodation quantity authorized on the Treatment Authorization Request (TAR).

LTC reimbursement

Payment to Nursing Facility for Skilled Nursing Facility Services provided in accordance with 22 CCR § 51123 shall be as set forth below:

(a) Provider shall furnish all equipment, drugs, supplies, and services necessary to provide nursing facility services except as provided in subsection (c) below. Such equipment supplies and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations and State licensing regulations.

(b) Services included but not limited to the following are those which are not included in the payment rate and which are to be billed separately by the Nursing Facility thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies:

> (i) Allied health services ordered by the Attending Physician; (ii) Physician services; (iii) legend drugs and Insulin; (iv) laboratory services; (v) alternating pressure mattresses/pads with motor and therapeutic air/fluid support systems/beds; (vi) atmospheric oxygen concentrators and enrichers and accessories, oxygen (except emergency), liquid oxygen system, and portable gas oxygen system and accessories; (vii) blood, plasma and substitutes; (viii) dental services; (ix) durable medical equipment as specified in 22 CCR § 51321(g) and medical supplies as specified in 22 CCR § 59998 and parts and labor for repairs of durable medical equipment if originally separately payable or owned by the Member; (x) prescribed prosthetic and orthotic devices for exclusive use by Member; and (xi) X-rays.

(c) Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental. The Member shall be responsible for reimbursement for any such personal items.

(d) Payment to nursing facilities for inpatient services shall be the State's prevailing allowable rate for the Nursing Facility as may be set forth in 22 CCR § 51511.

If Provider also renders intermediate care services, Provider shall be reimbursed as set forth in Attachment A.

Full Payment. The rates agreed to in this Exhibit 1, are to be the only payments made by PLAN to Nursing Facility for inpatient services provided to Members except where otherwise may be provided hereunder in the Agreement on in this Exhibit 1.

(e) Not withstanding (e) above, should the State, through an Operating Instruction Letter (OIL) or some other instrument, require PLAN to implement benefit changes that would result in reimbursement to Nursing Facility at a rate different than the rates set forth in (e) (ii) of this Exhibit 1 or, PLAN reserves the right, but does not have the obligation, to make said adjustments. In the event PLAN does elect to make such an adjustment, PLAN shall be obliged only to do so back to the beginning of the current fiscal year.

(f) Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved inpatient Days by the applicable rates, set out above, to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Accommodation Codes and Reimbursement

Facility should submit UB 04 Claim forms and include accommodation codes as follows:

- 21 Nursing Facilities Level A Regular Services
- 22 Nursing Facilities Level A Leave Days (non developmentally disabled patient)

The parties to this Agreement agree that Nursing Facility shall be reimbursed by PLAN when it receives Clean Claims for intermediate care services billed with accommodation codes 21 or 22 at the per diem rate of the ICF's daily State Medi-Cal rate.

Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved ICF Days at the rate set forth above to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Intermediate Care Services

Developmentally Disabled and Nursing Level-A Facilities

(a) Intermediate Care Facilities providing intermediate care services for the developmentally disabled shall furnish all equipment, drugs, services and supplies necessary to provide intermediate care services for the developmentally disabled except as provided in subsection (b) below. Such equipment, drugs, supplies, and services are, at a minimum, those which are required by law, including those required by federal Medicaid

regulations and State licensing regulations.

(b) Not included in the payment rate and to be billed separately by the ICF thereof, subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are as follows:

(i) Allied health services ordered by the attending physician; (ii) physician services; (iii) legend drugs and Insulin; (iv) laboratory services; (v) alternating pressure mattresses/pads with motor and therapeutic air/fluid support systems/beds; (vi) atmospheric oxygen concentrators and enrichers and accessories, oxygen (except emergency), liquid oxygen system, and portable gas oxygen system and accessories; (vii) blood, plasma and substitutes; (viii) dental services; (ix) durable medical equipment as specified in 22 CCR § 51321(g) and medical supplies as specified in 22 CCR § 59998 and parts and labor for repairs of durable medical equipment if originally separately payable or owned by the Member; (x) prescribed prosthetic and orthotic devices for exclusive use of patient; and (xi) X-rays.

(c) Not included in the payment rate nor in the Medi-Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental. The Member shall be responsible for reimbursement for any such personal items.

(d) Payment to ICF facilities for *inpatient services for Developmentally Disabled* shall be: (i) the State's allowable rate for the ICF; or (ii) the rate charged to the general public, whichever is lowest. ICF must complete the information set forth in Attachment A, attached hereto, and submit it to the PLAN at the time the Agreement is signed.

Description	Accommodation Code
• ICF Developmental Disability Program	41
• ICF/DD-H 4-6 beds	61
• ICF/DD-H 7-15 beds	65
• ICF/DD-N 4-6 beds	62
• ICF/DD-N 7-15 beds	66

Payment for inpatient services for Nursing Facility Level A as follows:

Description	Accommodation Code
• Nursing Facilities Level A - Regular Services	21
• Nursing Facilities Level A - Leave Days- (non developmentally disabled patient)	22

Nursing Facility shall be reimbursed by PLAN when it receives Clean Claims for intermediate care services billed with accommodation codes 21 or 22 at the ICF's daily State Medi-Cal rate.

Based on valid Claims submitted by Nursing Facility, PLAN shall multiply the number of approved ICF Days at the rate set forth above to determine the amount due. PLAN shall pay the amount due within thirty (30)

Days of receipt of valid Claims.

Full Payment: The rates as set forth above for both Developmental Disabled and Nursing Facility Level A services are to be the only payments made by PLAN to ICF for inpatient services provided to Members except where otherwise may be provided hereunder in this Exhibit 1 or any attachment thereto.

(e) Not withstanding (d) above, should the State, through an Operating Instruction Letter (OIL) or some other instrument, require PLAN to implement benefit changes that would result in reimbursement to ICF at a rate different than the rates set forth in (d) of this Exhibit 1, PLAN reserves the right, but does not have the obligation, to make said adjustments. In the event PLAN does elect to make such an adjustment, PLAN shall be obliged only to do so back to the beginning of the current fiscal year.

(f) Based on valid Claims submitted by ICF, if PLAN reimburses ICF at the Per Diem Rate, PLAN shall multiply the number of approved inpatient Days by the applicable rates, set out above, to determine the amount due. PLAN shall pay the amount due within thirty (30) Days of receipt of valid Claims.

Coordination of Benefits Billing Instructions

How to Submit Claims When HPSM is the Secondary Plan

All claims must be submitted within ninety (90) days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB should be attached to the claim.

Medicare Part A and B member claims must be submitted with the Explanation of Medicare Benefits (EOMB) form attached to the claim.

If the primary plan denies services asking for additional information, that information must be submitted to that carrier prior to submitting to HPSM.

How to Define the Primary and Secondary Plans

Once it has been determined that coordination of benefits applies, the following rules are used to define the primary and secondary plans.

- Subscriber or dependent
- Active or retired
- Effective date
- Dependent children of non-divorced parents (gender rule and birthday rule)
- Children of divorced parents (parents who have remarried and parents who have not)
- Medicare (Primary and Secondary payer)

Subscriber or Dependent

The plan that covers the member as a subscriber pays before the plan that covers the member as a dependent.

Active or Retired

If one of the family members is retired and continues to hold group coverage through his or her previous employer, the subscriber vs. dependent rule holds true. The active plan is primary for all family members.

Medicare

Medicare is primary payer when:

- Patient is 65 or older, retired, and/or disabled with no group health coverage from former employer or employer of family;
- Patient is 65 or older, retired, and has health plan from former employer;
- Patient is 65 or older, retired, and spouse is employed but doesn't have an employer group health plan;
- Patient is eligible for Medicare solely because of end stage renal disease (ESRD) and health plan of the current or former employer of patient or family has been billed for the first 30 months of Medicare eligibility. This applies regardless of whether the patient is under or over 65;
- Patient works for the military and is covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS will pay as secondary plan; or
- Patient is a veteran who rejects VA benefits.

Medicare is secondary payer when:

- Patient is 65 or older, is actively employed and has coverage under an employer group health plan;
- Patient is 65 or older and is covered under an actively employed spouse;
- Patient is disabled, under the age of 65 and is covered with 100 or more employees;
- Patient is under 65 and eligible for Medicare solely because of end stage renal disease and the health plan of the current or former employer of the patient or family member has not yet been billed for the first 30 months of Medicare eligibility;
- Patient is "Working Aged". Retired patient who is Medicare eligible returns to work, even temporarily, and receives employee health benefits;
- Patient who is eligible for Medicare and has a retired spouse returns to work, even temporarily, and gets employee benefits that covers the patient services; or
- Patient who is eligible for Medicare has VA benefits that cover the services.

Effective Date

The effective date rule applies when one member has two active group coverages. This often occurs when a member has more than one job and has elected coverage through both employers or was offered two coverages from the same employer and elected to have both. When this happens, the plan with the earliest effective date is primary.

Dependent Children of Non-Divorced Parents

This rule states that the plan of the parent with the earlier birthday is primary and the plan of the parent with the later birthday is secondary. This applies only to the month and day of birth, not the year. The birthday rule is the most common rule that is used by health insurance plans today.

Children of Divorced Parents

When children of divorced parents are covered under both parents' plan, and there is a custody/divorce decree that states one parent has primary responsibility for medical expenses, the plan of the parent with the primary responsibility is primary.

If there is no court decree assigning medical expenses responsibility, or parents hold joint medical expense responsibility, the plan of the parent with custody of the children is primary and the plan of the parent without custody is secondary.

If the children are covered under the plans of their natural parents and stepparents, the order of benefits is as follows:

1. Plan of the parent with custody pays first.
2. Plan of stepparent with custody pays secondary.
3. Plan of parent without custody pays third.
4. Plan of stepparent without custody pays last.

Medi-Cal is not liable for the cost of HMO-covered services if the recipient elects to seek services from a provider not authorized by the HMO. To establish Medi-Cal's liability, the provider must obtain an acceptable denial letter from the HMO. For additional information, refer to "HMO Denial Letters" in the Other Health Coverage (OHC).

Please remember, Medi-Cal is the payer of last resort in all cases.

Balance Billing

As a contracted provider with HPSM, there are circumstances in which you must not bill a HPSM member. You are generally prohibited by the terms of your contract and by California State Law from billing HPSM members for any costs related to services you provide, other than any applicable deductible, co-pay or co-insurance amount.

You Must Not Balance Bill A Member:

- For the difference between the charge amount and the HPSM fee schedule
- When a claim has been denied for late submission, unauthorized service, or as not medically necessary
- When claims are pending review by HPSM

Please remember to obtain the member co-pays indicated on the HPSM member ID card or co-insurance at the time of service.

Should you have any questions regarding billing HPSM members, please contact HPSM Member Services at **650-616-2133**.

Office Visits

99201- 99205	Office/outpatient visit, new, 10-40 minutes
99211- 99215	Office/outpatient visit, established, 10-40 minutes

Preventative Services (Capitated unless associated with P4P)

99381	Preventative Visit, new, infant
99382	Preventative Visit, new, age 1-4
99383	Preventative Visit, new, age 5-11
99384	Preventative Visit, new, age 12-17
99385	Preventative Visit, new, age 18-39
99386	Preventative Visit, new, age 40-64
99387	Preventative Visit, new, age 65-over
99391	Preventative Visit, est, infant
99392	Preventative Visit, est, age 1-4
99393	Preventative Visit, est, age 5-11
99394	Preventative Visit, est, age 12-17
99395	Preventative Visit, est, age 18-39
99396	Preventative Visit, est, age 40-64
99397	Preventative Visit, est, age 65-over
99401	Preventative Counseling, indiv
99402	Preventative Counseling, indiv
99403	Preventative Counseling, indiv
99404	Preventative Counseling, indiv
99432	Newborn care not in hospital

Immunization Administration

90465	IZ administration under 8 years of age (including subcutaneous and intramuscular routes) when physician counsels the patient/family; first injection, per day
90466	Each additional administration

90467	IZ administration under 8 years of age (including intranasal and oral routes) when physician counsels the patient/family; first administration, per day
90468	Each additional administration
90471	IZ administration, (including subcutaneous and intramuscular routes) one vaccine, single or combo
90472	Each additional administration
90473	IZ administration, (including intranasal and oral routes) one vaccine, single or combo
90474	Each additional vaccine, single or combo

Minor Surgical and Other Miscellaneous Procedures

10060	Drainage of boil
10080	Drainage of pilonidal cyst
10120	Removal, foreign body
10140	Drainage of hematoma
10160	Puncture drainage of lesion
11055	Trim skin lesion, two to four lesions
11056	Trim skin lesion, more than four lesions
11057	Puncture drainage of lesion
11100	Biopsy of lesion
11101	Biopsy, each additional lesion
11200	Removal of skin tags
11400 -11441	Removal of skin lesions: 0.05 cm to 1.0 cm
11719	Trimming of non-dystrophic nails
11720	Debridement of nails, one to five
11721	Debridement of nails, six or more
11732	Avulsion of nail plate, each addtional
11740	Drain blood from under nail
11900	Injection into skin lesion
16000	Initial treatment of burns
20612	Aspiration and/or injection of ganglion cysts
26720	Treatment of finger fracture: each
28490	Treatment of big toe fracture
30300	Removal of foreign body, intranasal (office procedure)
46600	Diagnostic anoscopy

46608	Anoscopy with removal of foreign body
46900	Destruction of of lesion(s), anus (e.g. condyloma, molluscum, etc.) simple, chemical
51100	Aspiration of bladder by needle
51701	Insertion of non-indwelling bladder catheter
51702	Insertion of temporary indwelling bladder catheter
51705	Change of cystotomy tube, simple
54050	Destruction of lesion(s), penis (e.g. condyloma, molluscum, etc.) simple, chemical
56501	Destruction of lesion(s), vulva, simple
57170	Diaphragm or cerval cap fitting with instructions
65205	Removal of foreign body, eye
69200	Clear outer ear canal
69210	Remove impacted ear wax
69400	Eustacian tube inflation, transnasal

Laboratory Services

36400	MD, Venipuncture, less than 3 years
36405	MD, Scalp Vein, less than 3 years
36406	MD, Other Vein, less than 3 years
36410	Venipuncture, adult
36415	Collection of venous blood by Venipuncture
36416	Collection of Capillary blood specimen
81000	Urinalysis, with microscopy
81001	Urinalysis, automated with microscopy
81002	Urinalysis: without microscopy
81003	Urinalysis: automated without microscopy
81005	Urinalysis: chemical, qualitative
81007	Urinalysis: bacteria screen, except culture or dipstick
81015	Urinalysis: microscopic only
81020	Urinalysis: two ir three glass test
82270	Blood: Occult, feces: consecutive collected specimens
82272	Blood: Occult, feces, single specimen (e.g. from rectal exam)
82948	Stick Assay Blood Glucose

85004	Blood count, automated differential WBC count
85013	Blood count, spun microhematocrit
85014	Hematocrit
85018	Hemoglobin, Colorimetric
85025	Blood count, complete, automated or automated differential WBC count
85027	Blood count, completem automated
85041	Blood count, RBC count, automated
85048	Blood count, leukocyte (WBC), automated
85049	Blood count, platelet, automated
85650	RBC sedimentation rate: Wintrobe
86580	TB intradermal test
87081	Bacterial culture, screening only for single organism
87084	Culture with colony estimation from destiny chart
87086	Urine culture, colony count
87168	Macroscopic examination, artropod
87172	Pinworm exam (e.g. cellophane tape prep)
87205	Smear, stain and interpretation: Routine stain
87210	Smear, stain and interpretation: Wet mount
87220	Tissue examination for fungi (KOH Slide)
99000	Specimen handling, from physician’s office to laboratory
99001	Specimen handling, other
36400	MD, Venipuncture, less than 3 years
36405	MD, Scalp Vein, less than 3 years
36406	MD, Other Vein, less than 3 years
36410	Venipuncture, adult
36415	Collection of venous blood by Venipuncture
36416	Collection of Capillary blood specimen
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81002	Urinalysis: without microscopy
81003	Urinalysis: automated without microscopy
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81015	Urinalysis: microscopic only
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82270	Blood: Occult, feces: consecutive collected specimens
82272	Blood: Occult, feces, single specimen (e.g. from rectal exam)
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85013	Blood count, spun microhematocrit
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85027	Blood count, completem automated
85041	Blood count, RBC count, automated
85048	Blood count, leukocyte (WBC), automated
85049	Blood count, platelet, automated
85650	RBC sedimentation rate: Wintrobe
86580	TB intradermal test
87081	Bacterial culture, screening only for single organism
87084	Culture with colony estimation from destiny chart
87086	Urine culture, colony count
87168	Macroscopic examination, artropod
87172	Pinworm exam (e.g. cellophane tape prep)
87205	Smear, stain and interpretation: Routine stain
87210	Smear, stain and interpretation: Wet mount
87220	Tissue examination for fungi (KOH Slide)
99000	Specimen handling, from physician’s office to laboratory
99001	Specimen handling, other

ECG, Hearing Tests and Supplies

92551	Pure Tone Hearing Test: Air Only
92552	Pure Tone Audiometry: Air Only
92553	Audiometry, Air and Bone
92555	Speech Threshold Audiometry

92556	Speech Audiometry, Complete
93000	Electrocardiogram, Complete
93005	Electrocardiogram, Tracing
93010	Electrocardiogram Report
93040	Rhythm ECG with Report
93041	Rhythm ECG, tracing only
93042	Rhythm ECG, report only
99070	Special Supplies covered for any of the above CPT codes covered by capitation

Mental Health Services

90801	Psychiatric diagnostic interview
90802	Interactive psychiatric diagnostic interview
90804	Individual psychotherapy 20-30 minutes
90806	Individual psychotherapy 45-50 minutes
90810	Interactive individual psychotherapy 20-30 minutes
90812	Interactive individual psychotherapy 45-50 minutes
90805	Individual psychotherapy with E/M 20-30 minutes
90807	Individual psychotherapy with E/M 45-50 minutes
90808	Individual psychotherapy 75-80 minutes
90809	Individual psychotherapy with E/M 75-80 minutes
90811	Individual psychotherapy with E/M 75-80 minutes
90814	Interactive psychotherapy 75-80 minutes
90815	Interactive psychotherapy with E/M 75-80 minutes
90813	Interactive individual psychotherapy
90846	Family psychotherapy without patient present
90847	Family psychotherapy without patient present
90849	Multiple family group psychotherapy
90853	Group psychotherapy
90857	Interactive group psychotherapy
90862	Pharmacologic management and review
90875	Psychotherapy with biofeedback 20-30 minutes
90876	Psychotherapy with biofeedback 45-50 minutes
90880	Hypnotherapy

90885	Evaluation of records
90887	Consultation with family
90889	Preparation of psychiatric report
90901	Biofeedback training, any modality
90911	Biofeedback training perineal muscles, anal or urethral sphincter
96101	Psychological testing by PhD or MD, per hour
96102	Psychological testing by technician, per hour
96103	Psychological testing by computer, with qualified healthcare professional interpretation
96105	Assessment of aphasia, with interpretation and report, by hour
96116	Neuropsychological status exam
96118	Neuropsychological testing by PhD or MD per hour
96119	Neuropsychological testing by technician, per hour
96118	Neuropsychological testing by computer, with qualified healthcare professional interpretation

Contacting the Claims Department

Providers should check HPSM's website for member eligibility and claims status. Providers are encouraged to direct questions to the Claims Department via e-mail at claimsinquiries@hpsm.org. The Claims Department is available by phone **650-616-2056** Monday, Tuesday, Thursday and Friday from 8:00 a.m. to 5:00 p.m. (closed from 12-1:30), and Wednesdays from 8:00 a.m. to 12:00 p.m.

Claims Disputes

Please refer to **Section 5 - Provider Disputes Resolution** for information.

Claims Status Inquiries via HPSM's Web Claims System

Providers who are registered with HPSM's Web Claims System may review the status of their claims by logging on with their user ID and password.

Providers who are interested in using the Web Claims System should contact the HPSM Provider Services Department at **650-616-2106** for assistance.