"Complete Claims" Processing Guidelines for California

Title 28 California Code of Regulations (CCR)	Federal Code of Regulations – Title 42	2003 Practice Management Info Corp. Book
Claim Document Completion and Submission		
Section 1300.71 (a)(2)(B)(i)(ii) *AB1455 Page 2 Lines 12-18* For institutional providers: the completed UB92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC; entries stated as mandatory by NUBC and required by federal statute and regulations; and any state-designated data requirements included in statutes or regulations. *Section 1300.71 (a)(2)(D)(i)* *AB1455 Page 2 Line 23; Page 3 Lines 1-3* For physicians and other professional providers: the Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format;	*Part 424 Subpart C Section 424.30 through 424.40* • Institutional Providers • Must be on UB92 claim form. • Professional Providers • Must be on CMS 1500 claim form • Can't submit more than six lines of service on one claim • For referred and/or ordered Services the name of the referring or ordering physician and the NPI or UPIN numbers must be present in box 17 and 17A	*Pages 278-310* Includes item by item instructions for completion of CMS-1500 claim form.

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Coding Requirements		
Section 1300.71 (a)(2)(D)(ii) *AB 1455 Page 3 Lines 4-5* Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes; *Section 1300.71(a)(2)(D)(iii)* *AB 1455 Page 3 Lines 6-8* entries stated as mandatory by NUCC and required by federal statute and regulations; and any state-designated data requirements included in statutes or regulations	*Part 424 Subpart C Section 424.32 (1), Section 424.32 (2), and Section 424.34 (4)* • Must have appropriate coding • CPT Level I codes • Appropriate CPT and/or HCPCS modifiers • HCPCS National Level II Codes • HCPCS Local Level III Codes • ICD-9-CM	*Pages 120-131, 291 and 298-299* "Medicare requires that all claims contain codes for patient diagnoses and for procedures provided. The coding systems used for these purposes are…" • CPT Level I Codes (ref. Pp. 120 and 298-299) • HCPCS Codes (ref. Pp. 120-124 and 298-299) • ICD-9-CM Codes (ref. Pp. 124-131 and 291)

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Clean/Contested Claims		
Section 1300.71 (a)(11) *AB 1455 Page 2 Lines 3-6: Page 9 Lines11-23* "Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" as defined by section (a)(10) " information necessary to determine payor liability" as defined in section (a)(11). "Reasonably relevant information" means the minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any government information requirements. (11) "Information necessary to determine payer liability" means the minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's or the plan's capitated provider's liability, if any, and to comply with any governmental information requirements.	*Part 447 Subpart A Section 447.45 (2)(b)* • Develops parameters for a clean claim • Develops parameters for what constitutes a contested claim.	*Pages 261-277 and 305* • Claims returned as unprocessable (ref. Pp. 261-276) • Most Common Reasons for Claim Rejection (ref. P. 277) • Other Tips for Filing Claims (ref. P. 305)

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Payment		
Section 1300.71 (g)(4) *AB 1455 Page 18 Lines 13-16* Every plan contract with a provider shall include a provision stating that except for applicable co-payments and deductibles, a provider shall not invoice or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan or the plan's capitated provider for any covered benefit. *AB 1455 Page 18 Lines 7 – 12* If a non-contracted provider disputes the appropriateness of a plan's or a plan's capitated provider's computation of the reasonable and customary value, determined in accordance with section (a)(3)(B), for the health care services rendered by the non-contracted provider, the plan or the plan's capitated provider shall receive and process the non-contracted provider's dispute as a provider dispute in accordance with section 1300.71.38.	*Part 414 Subpart B Section 414.48 (a)(b)* • Non-contracted Physicians must accept payment in full less any copayments or deductibles. • Non-contracted physician may no longer balance bill a member. • To dispute the reasonable and customary fee received, the Non-contracted provider must submit an appeal through the health plan's provider dispute resolution process	PMIC doesn't address this.

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Surgical Guidelines		
AB 1455 Page 2 Lines 22- describes what constitutes a 'complete' claim which states that the information required on the CMS1500 or the NUBC is a requirement. On the CMS1500 form, the requirements in box 24 (d) requires the use of CPT/HPCS numbers and box 23 requires the use of ICD-9 codes. This pertains to all of the procedures that would have any of the billing code numbers.	Part 414 Subpart B Section 414.40 (1)(3) **Global Major Surgery** • Includes preoperative, intraoperative, and postoperative care of 90 days **Global Minor Surgery** • Includes visit, surgery, and postoperative care of 10 days • Includes minor surgeries, nonincisional procedures, and endoscopy procedures **Multiple Procedures Reduction Rule** *Part 414 Subpart B Section 414.40 (3)* • Multiple surgery performed by the same physician on the same patient during the same operative session • Highest valued procedure allowed at 100% second highest through the fifth highest valued procedure allowed at 50% • Operative report required when more than five procedures are performed at once, payment decision at the carrier's discretion	*Pages 131-138* CPT specifically defines the Surgical Package to include: • Local or topical anesthesia (including digital blocks, etc) • One Evaluation and Management code on date immediately prior to or on date of procedure • Immediate post-op care • Writing orders • Evaluation of patient post-anesthesia • Typical post-op follow up care Reference Surgery Guidelines at front of Surgery section of current CPT published by AMA) *Page 138* "Payment is made at 100% of the fee schedule amount for the highest valued procedure and 50% … for the 2nd through 5th procedures… Use the multiple procedures modifier, '-51' on the secondary and tertiary procedures."

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Surgical Guidelines (Con't)		
	Multiple Endoscopies • Major endoscopic procedure allowed at 100% • Family Base code allowable amount is deducted from the fee schedule amount for each additional covered endoscopic procedure from that family **Bilateral Procedures** *42 Part 414 Subpart B Section 414.40 (3)* • Defined as performed on the same anatomic site on opposite sides of the body through separate incision **Professional & Technical Components** *Part 414 Subpart B Section 414.40 (2)* **Unbundling** • Unbundling activities may be considered potentially fraudulent as they inflate costs **Up coding** • Charging a higher level of service than was actually rendered may be considered potentially fraudulent	*Page 139-140* "When more than one endoscopic procedure from the same family is billed, special endoscopic pricing rules apply" This section specifies endoscopic pricing rules. *Page 177* "Bilateral procedures are identical procedures…performed on the same anatomic site but on opposite sides of the body…Each procedure should be performed through its own separate incision… Medicare will pay 150% of the amount allowed for a unilateral procedure." *Pages 169-172 and 416-418* • Use of CCI and CCI edits (ref. Pp. 169-172) • Unbundling (ref. Pp. 416-417) • Upcoding (ref. Pp. 416-418)