Claims

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At a Glance

Piedmont WellStar HealthPlans pledges to provide accurate and efficient claims processing. To make this possible, Piedmont WellStar HealthPlans requests that providers submit claims promptly and include all necessary data elements.

A key to controlling administrative costs is reducing excess paperwork, particularly paperwork generated by improperly completed claims. The use of electronic claims submission is key to improving accuracy, timeliness, and keeping costs down.

Please follow these guidelines when submitting a claim:

1. Type claims or submit electronically. Handwritten claims may be returned.
2. Claims with eraser marks or white out corrections may be returned.
3. If a mistake is made on a claim, the provider must re-submit a new claim. Claims must be submitted by established filing deadlines or they will be denied.
4. Services for the same member with the same date of service may not be unbundled. For example, an office visit, a lab work-up and a venipuncture by the same provider on the same day must be billed on the same claim.
5. Only clean claims containing the required information will be processed within the required time limits. Rejected claims, those with missing or incorrect information, may not be resubmitted. A new claim form must be generated for resubmission.
6. Resubmit claims only if the Piedmont WellStar HealthPlans claim has not paid within 30 days.
7. Use proper place of service codes for all claims.
8. Use Modifier 25 when a provider performs a significant separately identifiable evaluation and management of a member on the same date of service as the original visit.
9. Bill anesthesia claims with the correct codes from the American Society of Anesthesiologists with the appropriate anesthesia modifiers and time units if applicable.
10. Submit only one payee address per tax identification number.

Submission Guidelines

*****Please keep in mind, the information in this section reflects common practices. For specific timelines and restrictions, please refer to your contract. For questions, email Provider Relations at ProviderRelations@pwplans.org *****

Electronic Filing
The Piedmont WellStar HealthPlans claims processing system allows provider access to submitted claims information, including the ability to view claim details such as claim status (i.e. was there an error on submission?) and the claim number to be used as a reference indicator.

Electronically filed claims may be submitted in the following ways:

- ***Electronic Data Interchange (EDI)***
  Piedmont WellStar HealthPlans accepts electronic claims in data file transmissions. Electronic claim files sent directly to Piedmont WellStar HealthPlans are permitted only in HIPAA standard formats.

  Providers who have existing relationships with clearinghouses such as Emdeon, Relay Health and others (Piedmont WellStar HealthPlans Payer ID: 251PD), can continue to transmit claims in the format produced by their billing software. These clearinghouses are then responsible for reformatting claims to meet HIPAA standards and passing the claims on to Piedmont WellStar HealthPlans.

  For all EDI submissions, the NPI (National Provider Identifier) number is required. When care is coordinated, the referring provider's name and NPI are required.

- ***Individual Claim Entry and Submission of Claims Directly to Piedmont WellStar HealthPlans***
  Individual claim entry is available to network providers with established Provider OnLine accounts. This feature allows direct submission of both professional (CMS-500) and institutional (UB-04) claims via a user-friendly interface, using the internet's highest level of security to make the process safe and easy. Providers are able to submit claims directly without incurring clearinghouse expenses. These claims are loaded into batches and immediately posted in preparation for adjudication. Via the Provider OnLine EDI tools, these batches can be viewed in several standard report formats.

  In order to submit EDI files directly, Piedmont WellStar HealthPlans providers must:
  - Have a computer with Internet access.
  - Have the ability to download and install a free Active-X secure FTP add-on.
  - Have an existing Provider OnLine account or register for a new provider or submitter account by filling out the application form at www.pwplans.org.
  - Use billing software that allows the generation of a HIPAA-compliant 837 professional or institutional file.

- Have a sample 837 file exported from their billing system containing only Piedmont WellStar HealthPlans claims.
- Complete testing with Piedmont WellStar HealthPlans.

Paper Claim Forms

- ***CMS-1500 forms***
  These forms are for professional services performed in a provider's office, hospital or ancillary facility. (Provider-specific billing forms are not accepted.)

- **UB-04 forms**
  These forms are for inpatient hospital services or ancillary services performed in the hospital. (Hospital-specific billing forms are not accepted.)

Deadlines
Unless noted otherwise in your individual provider agreement, Piedmont WellStar HealthPlans accepts new claims for services up to 90 days after the date of service for members.

When Piedmont WellStar HealthPlans is the secondary payer, claims are accepted with the explanation of benefit (EOB) from the primary carrier. This claim must be received within 90 days of the primary EOB remittance date. Claims submitted after these deadlines will be denied for untimely filing.

Members cannot be billed for the Piedmont WellStar HealthPlans portion of the claims submitted after these deadlines; however, they may be billed for co-payments, co-insurance and/or deductibles.

Claims Address
Claim forms should be submitted to the following address:

Piedmont WellStar HealthPlans
PO Box 1039
Pittsburgh, Pennsylvania 15230-1039

Diagnosis Codes
Claims must be submitted with a diagnosis code, indicating the member's medical condition or circumstances necessitating evaluation or treatment. The diagnosis codes submitted on claim forms must correlate to the documentation contained within the member's medical record and reflect or support the reason services have been provided. Follow these guidelines to avoid the most common claims coding problems:

- New POA (Present on Admission Indicator)
- Diagnosis should be coded using ICD-10-CM. Make sure the diagnosis code is valid and complete (i.e., includes all digits).
- The primary diagnosis should describe the chief reason for the member's visit to

the provider.

- When a specific condition or multiple conditions are identified, these conditions should be coded and reported as specifically as possible.
- For coding of services provided on an outpatient basis, do not code the diagnosis as “rule out”, “suspect” or “probable” until such time as the condition is confirmed. Code the condition to the highest degree of certainty, such as symptoms, signs, or abnormal test results.
- When addressing both acute and chronic conditions, assign codes to all conditions for which the member is seeking medical care.
- When coding ongoing or chronic conditions, do not assume the code used at a previous visit is appropriate for a current visit.
- In coding diabetes, be certain to identify the current status of the member’s condition as Type I or Type II, controlled or uncontrolled, referring to the direction of ICD-10-CM.
- Use caution in coding injuries, identifying each as specifically as possible.
- Refer to guidelines throughout ICD-10-CM, for “late effect” coding and sequencing.
- “Well” vs. “sick” visits — If a preventive visit was scheduled, but symptoms of illness or injury exist at the time of the visit, code the primary diagnosis as “preventive.” The condition(s) for which the member is being treated should be coded as a secondary diagnosis.
- V-codes are used for circumstances affecting a member’s health status or involving contact with health services that are not classified under ICD-910-CM. In general, they do not represent primary disease or injury conditions and should not be used routinely. V-codes used to describe personal and/or family history of medical conditions are covered when used for a screening procedure; however, V-codes that pertain to mental health, learning disorders or social conditions are not covered.

Claims Resubmission

Claims may be resubmitted if Piedmont WellStar HealthPlans has not issued payment within 30 days. These resubmitted claims can be a photocopy or a reprinted claim.

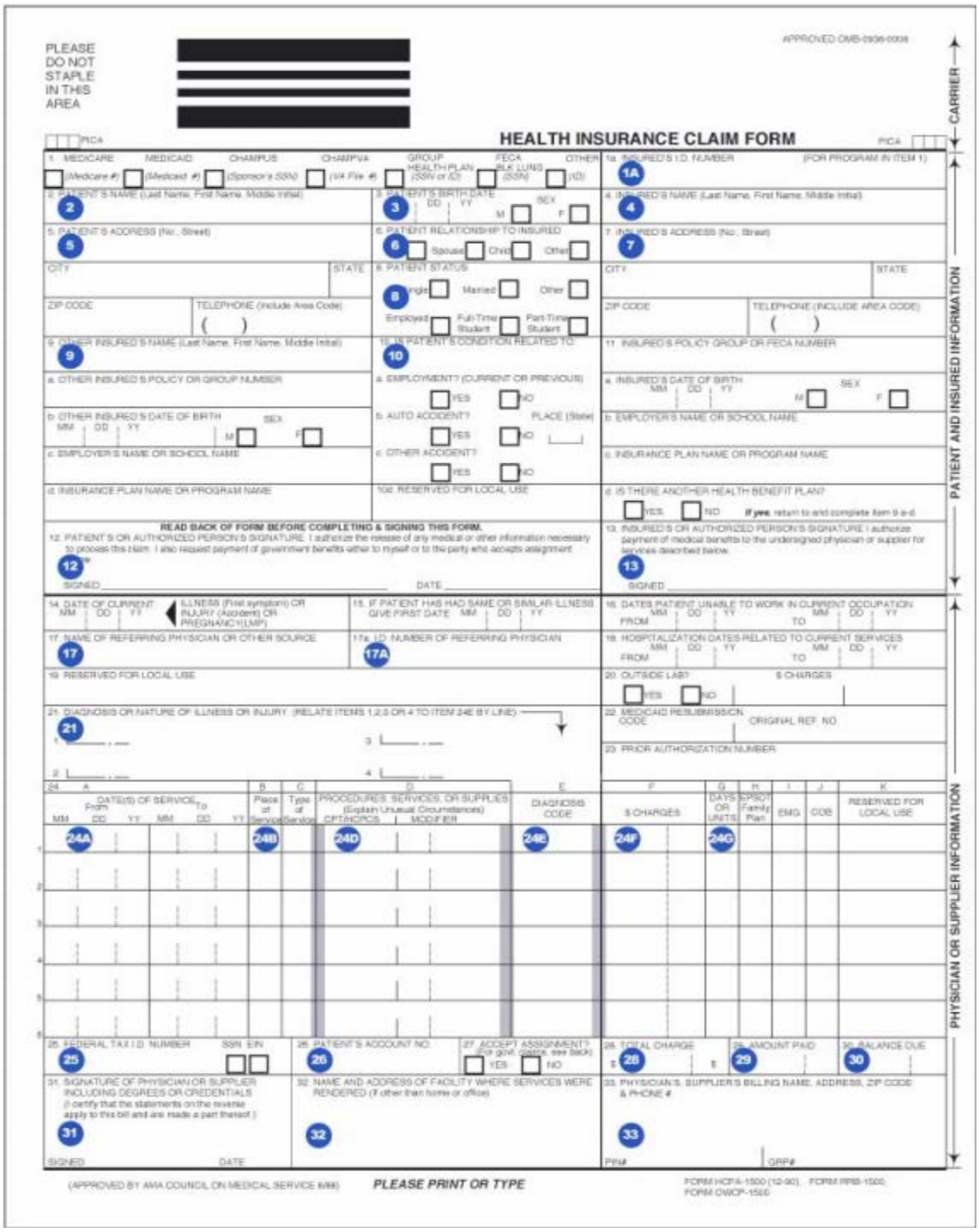
Claims Documentation

Clean vs. Unclean Claims
A clean claim refers to a claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. This term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim. A defect or impropriety may include, but is not limited to, the following:

- Lack of required substantiating documentation
- A particular circumstance requiring special treatment that prevents timely payment from being made on the claim
- Any required fields where information is missing or incomplete
- Invalid, incorrect or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes)
- A missing explanation of benefits (EOB) for a member with other coverage
- Claims requiring medical review before payment
- Claims requiring authorization that was not obtained

Required Fields on a CMS-1500 Claim Form
The following CMS-1500 claim form is standard in the insurance industry; however, Piedmont WellStar HealthPlans requires providers to complete only those fields noted in the figure below. Each field is explained in the numbered key that follows this illustration.

CMS-1500 Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) — 1A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — 2

3. PATIENT'S BIRTH DATE MM DD YY SEX M F — 3

4. INSURED'S NAME (Last Name, First Name, Middle Initial) — 4

5. PATIENT'S ADDRESS (No., Street) — 5

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other — 6

7. INSURED'S ADDRESS (No., Street) — 7

CITY | STATE

8. PATIENT STATUS Single Married Other — 8
Employed Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) — 9

10. IS PATIENT'S CONDITION RELATED TO: — 10

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment — 12

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. — 13

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE — 17

17a. I.D. NUMBER OF REFERRING PHYSICIAN — 17A

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) — 21

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY — 24A	B Place of Service — 24B	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS — 24D	MODIFIER	E DIAGNOSIS CODE — 24E	F $ CHARGES — 24F	G DAYS OR UNITS — 24G	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN — 25

26. PATIENT'S ACCOUNT NO. — 26

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ — 28

29. AMOUNT PAID $ — 29

30. BALANCE DUE — 30

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) — 31

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) — 32

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # — 33

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90) FORM PRB-1500
FORM OWCP-1500

Explanation of Required Fields on a CMS-1500 Claim Form
If a numbered field is not included, it is not required by Piedmont WellStar HealthPlans in order to process a claim.

CMS-1500 Claim form fields

Field #	Required Field Explanation
1A	Insured's ID number—11-digit member ID number (combination of the 9-digit member number and the 2-digit relationship code on the front of the member ID card)
2	Member's name—member's last name, first name, and middle initial
3	Member's birth date—Member's date of birth in month/day/year format; also, member's gender
4	Insured's name—last name, first name, and middle initial of policy-holder
5	Member's address—member's current address, including city, state, and zip code; also member's telephone number
6	Member's relationship to the insured—applicable relationship box marked
7	Insured's address—insured's current address, including city/state/zip code; also insured's telephone number
8	Member's status—applicable box(es) marked
9	Other insured's name—if the member is covered by another health insurance plan, please list the insured's last name, first name, and middle initial here; also list the insured's policy or group number, date of birth, gender, employer's name or school name, and insurance plan name or program name
10	Member's condition related to— check boxes if condition is related to employment, auto accident or other accident.
12	Member's release—indicates if member has signed release of information from provider
13	Authorized signature—indicates if member's signature authorizing payment to provider is on file
17	Referring provider's name—first, and last name of referring provider; if member is self-directed, please print "NONE"

CMS-1500 Claim form fields (continued).

Field #	Required Field Explanation
17A	Referring provider's ID number—Universal Physician Identification Number (UPIN)
17B	Provider's NPI
21	Diagnosis or nature of illness or injury—minimum of one diagnosis code (ICD-9 coding)
24A	Date(s) of service (from/to) in month/day/year format
24B	Place of service—2-digit CMS standard code indicating where services were rendered
24D	Procedures, services, and modifier—CPT or HCPCS code and modifier (if applicable)
24E	Diagnosis Pointer—indicates diagnosis code or diagnoses that apply to service on a given line
24F	Charges—amount charged for service
24G	Days or units—number of times service was rendered
25	Federal tax ID number— tax ID number of provider rendering service
26	Member's account number—provider-specific ID number for member (up to 12 digits)
28	Total charge—total of all charges on bill
29	Amount paid—amount paid by member and third-party payers

CMS-1500 Claim form fields (continued).

30	Balance due—current balance due from insured
31	Signature of provider/supplier— should include degree or credentials (Please make sure the signature is legible.)
32	Name and address of facility—name of facility where services were rendered (if other than home or provider's office)
33	Provider's billing information—billing provider's name, address, and telephone number; also list the PIN number (6-digit ID number assigned to the provider by Piedmont WellStar HealthPlans)

Required Fields on a UB-04 Claim Form

The following UB-04 claim form is standard in the insurance industry. Each field is explained in the numbered key that follows this illustration.

UB-04 Claim Form

UB-04 Data Elements					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
1	Required by Medicare	Billing Provider Name	1	AN	25
	Required by Medicare	Billing Provider Street Address	2	AN	25
	Required by Medicare	Billing Provider City, State, Zip	3	AN	25
	Required by Medicare	Billing Provider Telephone, Fax, Country Code	4	AN	25
2	May be required by another payer when applicable / not required by Medicare	Billing Provider's Designated Pay-to Name	1	AN	25
	May be required by another payer when applicable / not required by Medicare	Billing Provider's Designated Pay-to Address	2	AN	25
	May be required by another payer when applicable / not required by Medicare	Billing provider's Designated Pay-to City, State	3	AN	25
	May be required by another payer when applicable / not required by Medicare	Billing provider's Designated Pay-to ID	4	AN	25
3a	Required by Medicare	Patient Control Number	1	AN	24
3b	May be required by another payer when applicable / not required by Medicare	Medical/Health Record Number	2	AN	24
4	Required by Medicare	Type of Bill (TOB)	1	AN	4
5	Required by Medicare	Federal Tax Number	1	AN	4
	Required by Medicare	Federal Tax Number	2	AN	10
6	Required by Medicare	Statement Covers Period - From/Through	1	N/N	6/6
7	Field not used	Unlabeled	1	AN	7
	Field not used	Unlabeled	2	AN	8
8a	Required by Medicare	Patient Name/ID	1	AN	19
8b	Required by Medicare	Patient Name	2	AN	29
9a	Required by Medicare	Patient Address - Street	1	AN	40
9b	Required by Medicare	Patient Address - City	2	AN	30
9c	Required by Medicare	Patient Address - State	2	AN	2
9d	Required by Medicare	Patient Address - Zip	2	AN	9
9e	May be required by another payer when applicable / not required by Medicare	Patient Address - Country Code	2	AN	3
10	Required by Medicare	Patient Birthdate	1	N	8
11	Required by Medicare	Patient Sex	1	AN	1
12	Required for Types of Bill 011X, 012X, 018X, 021X, 022X, 032X, 033X, 041X, 081X, or 082X	Admission/Start of Care Date	1	N	6

UB-04 Data Elements, continued.					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
13	May be required by another payer when applicable / not required by Medicare	Admission Hour	1	AN	2
14	Required for Types of Bill 011X, 012X, 018X, 021X, and 041X	Priority (Type) of Admission or Visit	1	AN	1
15	Required by Medicare	Point of Origin for Admission or Visit	1	AN	1
16	May be required by another payer when applicable / not required by Medicare	Discharge Hour	1	AN	2
17	Required for Types of Bill 011X, 012X, 013X, 014X, 018X, 021X, 022X, 023X, 032X, 033X, 034X, 041X, 071X, 073X, 074X, 075X, 076X, 081X, 082X, 085X	Patient Discharge Status	1	AN	2
18-28	Required if applicable	Condition Codes		AN	2
29	May be required by another payer when applicable / not required by Medicare	Accident State		AN	2
30	Field not used	Unlabeled	1	AN	12
	Field not used	Unlabeled	2	AN	13
31-34	Required if applicable	Occurrence Code/Date	a	AN/N	2/6
	Required if applicable	Occurrence Code/Date	b	AN/N	2/6
35-36	Required if applicable	Occurrence Span Code/From/Through	a	AN/N/N	2/6/6
	Required if applicable	Occurrence Span Code/From/Through	b	AN/N/N	2/6/6
37	Field not used	Unlabeled	a	AN	8
	Field not used	Unlabeled	b	AN	8
38	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	1	AN	40
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	2	AN	40
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	3	AN	40
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	4	AN	40
	May be required by another payer when applicable / not required by Medicare	Responsible Party Name/Address	5	AN	40
39-41	Required if applicable	Value Code	a-d	AN	2
	Required if applicable	Value Code Amount	a-d	N	9

UB-04 Data Elements, continued.					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
42	Required by Medicare	Revenue Codes	1-23	N	4
43	May be required by another payer when applicable / not required by Medicare	Revenue Code Description/Investigational Device Exemption (IDE) Number/Medicaid Drug Rebate	1-23	AN	24
44	Required if applicable	Healthcare Common Procedure Coding System (HCPCS)/Accommodation Rates/Health Insurance Prospective Payment System (HIPPS) Rate Codes	1-23	AN	14
45	Required if applicable	Service Dates	1-23	N	6
46	Required if applicable	Service Units	1-23	N	7
47	Required by Medicare	Total Charges	1-23	N	9
48	Required if applicable	Non-Covered Charges	1-23	N	9
49	Field not used	Unlabeled	1-23	AN	2
		Page _ of Creation Date _	23	N/N	3/3
50	Required by Medicare	Payer Identification - Primary	A	AN	23
	Required by Medicare	Payer Identification - Secondary	B	AN	23
	Required by Medicare	Payer Identification - Tertiary	C	AN	23
51	Required by Medicare	Health Plan ID	A	AN	15
	Required if applicable	Health Plan ID	B	AN	15
	Required if applicable	Health Plan ID	C	AN	15
52	Required by Medicare	Release of Information	A	AN	1
	Required by Medicare	Release of Information - Secondary	B	AN	1
	Required by Medicare	Release of Information - Tertiary	C	AN	1
53	May be required by another payer when applicable / not required by Medicare	Assignment of Benefits - Primary	A	AN	1
	May be required by another payer when applicable / not required by Medicare	Assignment of Benefits - Secondary	B	AN	1
	May be required by another payer when applicable / not required by Medicare	Assignment of Benefits - Tertiary	C	AN	1
54	Required if applicable	Prior Payments - Primary	A	N	10
	Required if applicable	Prior Payments - Secondary	B	N	10
	Required if applicable	Prior Payments - Tertiary	C	N	10
55	May be required by another payer when applicable / not required by Medicare	Estimated Amount Due - Primary	A	N	10

UB-04 Data Elements, continued.					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
	May be required by another payer when applicable / not required by Medicare	Estimated Amount Due - Secondary	B	N	10
	May be required by another payer when applicable / not required by Medicare	Estimated Amount Due - Tertiary	C	N	10
56	Required by Medicare	National Provider Identifier (NPI) - Billing Provider	1	AN	15
57	Required if applicable	Other Provider ID	A	AN	15
	Required if applicable	Other Provider ID	B	AN	15
	Required if applicable	Other Provider ID	C	AN	15
58	Required by Medicare	Insured's Name - Primary	A	AN	25
	Required by Medicare	insured's Name - Secondary	B	AN	25
	Required by Medicare	insured's Name - Tertiary	C	AN	25
59	Required if applicable	Patient's Relationship - Primary	A	AN	2
	Required if applicable	Patient's Relationship - Secondary	B	AN	2
	Required if applicable	Patient's Relationship - Tertiary	C	AN	2
60	Required by Medicare	Insured's Unique ID - Primary	A	AN	20
	Required by Medicare	Insured's Unique ID - Secondary	B	AN	20
	Required by Medicare	Insured's Unique ID - Tertiary	C	AN	20
61	Required if applicable	Insurance Group Name - Primary	A	AN	14
	Required if applicable	Insurance Group Name - Secondary	B	AN	14
	Required if applicable	Insurance Group Name - Tertiary	C	AN	14
62	Required if applicable	Insurance Group No. - Primary	A	AN	17
	Required if applicable	Insurance Group No. - Secondary	B	AN	17
	Required if applicable	Insurance Group No. - Tertiary	C	AN	17
63	Required if applicable	Treatment Authorization - Primary	A	AN	30
	Required if applicable	Treatment Authorization - Secondary	B	AN	30
	Required if applicable	Treatment Authorization - Tertiary	C	AN	30
64	Required if applicable	Document Control Number (DCN)	A	AN	26
	Required if applicable	Document Control Number (DCN)	B	AN	26
	Required if applicable	Document Control Number (DCN)	C	AN	26
65	Required if applicable	Employer Name (of the insured) - Primary	A	AN	25
	Required if applicable	Employer Name (of the insured) - Secondary	B	AN	25
	Required if applicable	Employer Name (of the insured) - Tertiary	C	AN	25

UB-04 Data Elements, continued.					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
66	Required by Medicare	Diagnosis and Procedure Code Qualifier (International Classification of Diseases [ICD] Version Indicator)	1	AN	1
67	Required for Types of Bill 011X. 012X, 013X, 014X, and 021X	Principal Diagnosis Code and Present on Admission (POA) Indicator	1	AN	8
67A-Q	Required if applicable	Other Diagnosis and POA Indicator	A-O	AN	8
68	Field not used	Unlabeled	1	AN	8
	Field not used	Unlabeled	2	AN	9
69	Required for Types of Bill 011X, 012X, 021X, and 022X	Admitting Diagnosis Code	1	AN	7
70a	Required if applicable	Patient Reason for Visit Code	1	AN	7
70b	Required if applicable	Patient Reason for Visit Code	1	AN	7
70c	Required if applicable	Patient Reason for Visit Code	1	AN	7
71	May be required by another payer when applicable / not required by Medicare	Prospective Payment System (PPS) Code	1	AN	3
72a	May be required by another payer when applicable / not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
72b	May be required by another payer when applicable / not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
72c	May be required by another payer when applicable / not required by Medicare	External Cause of Injury Code and POA Indicator	1	AN	8
73	Field not used	Unlabeled	1	AN	9
74	Required if applicable	Principal Procedure Code/Date	1	N/N	7/6
74a	Required if applicable	Other Procedure Code/Date	1	N/N	7/6
74b	Required if applicable	Other Procedure Code/Date	1	N/N	7/6
74c	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
74d	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
74e	Required if applicable	Other Procedure Code/Date	2	N/N	7/6
75	Field not used	Unlabeled	1	AN	3
	Field not used	Unlabeled	2	AN	4
	Field not used	Unlabeled	3	AN	4
	Field not used	Unlabeled	4	AN	4
76	Required if applicable	Attending Provider - NPI/QUAL/ID	1	AN	11/2/9
	Required if applicable	Attending Provider - Last/First	2	AN	16/12
77	Required if applicable	Operating Physician - NPI/QUAL/ID	1	AN	11/2/9
	Required if applicable	Operating Physician - Last/First	2	AN	16/12

UB-04 Data Elements, continued.					
FL	**Requirement**	**Description**	**Line**	**Type**	**Size**
78	Required if applicable	Other Provider - QUAL/NPI/QUAL/ID	1	AN	2/11/2/9
	Required if applicable	Other Provider - Last/First	2	AN	16/12
79	Required if applicable	Other Provider - QUAL/NPI/QUAL/ID	1	AN	2/11/2/9
	Required if applicable	Other Provider - Last/First	2	AN	16/12
80	Required if applicable	Remarks	1	AN	21
	Required if applicable	Remarks	2	AN	26
	Required if applicable	Remarks	3	AN	26
	Required if applicable	Remarks	4	AN	26
81	Required if applicable	Code-Code - QUAL/CODE/VALUE	a	AN/AN/AN	2/10/12
	Required if applicable	Code-Code - QUAL/CODE/VALUE	b	AN/AN/AN	2/10/12
	Required if applicable	Code-Code - QUAL/CODE/VALUE	c	AN/AN/AN	2/10/12
	Required if applicable	Code-Code - QUAL/CODE/VALUE	d	AN/AN/AN	2/10/12

Place-of-Service Codes

All providers are required to submit CMS-1500 claim forms with CMS standard two-digit place-of-service codes entered in Box 24B. Forms submitted without these codes will be rejected with no adjudication and returned to the provider for resubmission. This policy applies to all Piedmont WellStar HealthPlans products.

Commonly Used Place-of-Service Codes

Code	Description
11	Office
12	Home
15	Mobile
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Chemical Dependency Treatment Facility
56	Psychiatric Residential Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory

Codes and Modifiers

Claims Coding
Providers who are reimbursed for professional and ancillary services on a fee-for-service basis agree to accept the network reimbursement, less deductibles, coinsurance, and copayments as payment in full for covered services provided to Piedmont WellStar HealthPlans members.

Unlisted Codes

- **Procedures**
  When necessary and appropriate, a provider may bill for a procedure that does not have an existing CPT/HCPCS code. The provider should use the "miscellaneous" or "not otherwise classified" code that most closely relates to the service provided. When using "unlisted" or "not otherwise classified" codes for billing, providers may be asked to supply supporting documentation.

- **Medications**
  "Unlisted" or "not otherwise classified" drugs must be submitted with applicable HCPCS codes. The claim must include a description of the item/drug supplied, the correct dosage, and the National Drug Classification Code number (NDC#).

- **Modifiers**
  Frequently used provider modifiers are listed in the following table. For a complete list of modifiers, refer to the CPT manual and the HCPCS Level II manual.

Provider Modifiers

Modifier	Description
24	Unrelated Evaluation and Management service by the same provider during a postoperative period
25	Significant, separately identifiable evaluation and management service by the same provider on the same day of the procedure or other service
33	Preventive Services
50	Bilateral procedure
57	Decision for Surgery
59	Distinct procedural service
62	Two surgeons

Physician Modifiers, continued.

76	Repeat procedure by same provider or other qualified health care professional
77	Repeat procedure by another provider or other health care professional
80	Assistant surgeon
82	Assistant surgeon (when qualified resident and surgeon not available)
91	Repeat Clinical Diagnostic Laboratory Test
LT	Left Side
RT	Right Side

- **Anesthesia Modifiers**
  Anesthesia claims for all members should be billed with the correct codes from the American Society of Anesthesiologists (ASA) — 00100–01999 — which are included in the CPT manual.

  Services performed for Piedmont WellStar HealthPlans members by a Certified Registered Nurse Anesthetist (CRNA) are eligible for reimbursement and can be billed in conjunction with the anesthesiologist's charges, provided the appropriate modifier is used.

  Appropriate anesthesia modifiers also should be billed, including, but not limited to the following:

Anesthesia Modifiers

Modifier	Description
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a provider; more than four concurrent anesthesia procedures
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	Certified Registered Nurse Anesthetist (CRNA) service with medical direction by a provider
QY	Medical direction of one CRNA by an anesthesiologist

QZ	CRNA service without medical direction by a provider

- **Home Medical Equipment Modifiers**
  Home medical equipment (HME) modifiers include, but are not limited to, the following:

Home Medical Equipment Modifiers

Modifier	Description
RR	Rental
NU	New Purchase
UE	Used durable medical equipment

Code-Specific Policies

- **Blood Draw/Venipuncture**
  Piedmont WellStar HealthPlans does not reimburse for blood draw/venipuncture when that service is provided in conjunction with any other laboratory or evaluation and management service on the same date of service.

- **Immunizations**
  The injection is included with the office evaluation and management code (EM) if billed together or on the same date of service.

- **Surgical Procedures**
  Providers must note surgical procedures performed during the same operative session by the same provider on a single claim form or electronic equivalent. Billing on separate claim forms may result in delayed payments, incorrect payments, or payment denial.

Reimbursement

Once all information needed to process the claim has been received, Piedmont WellStar HealthPlans will process the claim and issue either payment for the claim or a notice denying the claim in whole or in part. Payment or notice will be issued within 15 working days for electronic claims or 30 calendar days for paper claims.

Multiple Payee Addresses

Piedmont WellStar HealthPlans does not honor multiple payee addresses. Providers are required to submit a single payee address per tax ID number.

Explanation of Payment (Remittance Advice)

The Explanation of Payment (EOP), referred on the statement as a "remittance advice", is a summary of claims submitted by a provider. It shows the date of service, diagnosis and procedure performed as well as all payment information (i.e., money applied to the member's deductible or copayment, and denied services.)

For additional questions pertaining to the EOP, contact Provider Services at **855-869-7225.**

#	Description	#	Description	#	Description
1	Run date – date printed	**9**	Member number	**17**	Copayment applied (member liability)
2	Page number	**10**	Form number – claim ID number assigned by Piedmont WellStar HealthPlans	**18**	Deductible applied (member liability)
3	Provider vendor number	**11**	Date of service	**19**	Amount not covered

4	Provider name and address	**12**	Procedure code	**20**	Interest applied
5	Federal tax ID number – Provider tax ID number	**13**	Number of units billed	**21**	Net explanation – amount paid
6	Servicing provider number and name	**14**	Billed amount	**22**	Claim subtotal line – subtotal for fields 14-21
7	Member account number	**15**	Piedmont WellStar HealthPlans' allowed amount	**23**	Member subtotal line
8	Member name – last name, first name	**16**	Discount applied (not member liability)	**24**	Explanation codes

Process for Refunds
Piedmont WellStar HealthPlans accepts overpayments by taking deductions from future claims.

Overpayment
If Piedmont WellStar HealthPlans has paid in error and the provider has not sent a refund or returned the check, money will be deducted from future claims paid. The related claim information will be shown on the remittance advice as a negative amount.

Claim Follow-Up
To view claim status online go to www.pwplans.org. Existing users can log in through Provider OnLine. New users will be asked to register. For log-in information, contact Provider Services at **855-869-7225**.

To check the status of a claim without going online, call Provider Services at **855-869-7225** from 8 a.m. to 5 p.m., Monday through Friday.

Denials & Appeals

All denied claims are reported on the EOP, referred to on the statement as a “remittance advice”. This indicates whether the provider has the right to bill the member for the denied services and/or if the member is financially responsible for payment.

More detailed information on this subject can be found in the Provider Standards & Procedures section of this manual.

All appeals undergo Piedmont WellStar HealthPlans’ internal review process, which meets all applicable state and federal regulatory requirements.

False Claims

The False Claims Act (31 U.S.C. § 3729) makes it illegal to present or cause to be presented to the federal or state government a false or fraudulent claim for payment. This would apply to U.S. government programs such as Medicaid, Medicare and Medicare Part D, and the Federal Employees Health Benefit Plan (FEHBP). Any person in violation of this act could be liable to the U.S. government for not less than $5,000 and not more than $10,000 per false claim, plus three times the amount of any other damages the U.S. government sustains because of the fraudulent claims.

- **Qui tam** law suits can be filed by private citizens referred to as whistle-blowers against any health care provider allegedly violating the federal and state False Claims Act.
- **Whistle-blowers** are protected if they are discharged because of their involvement with a suit; they are entitled to reinstatement and damages double the amount of their lost wages.

Best Practices

Best practices to help prevent fraud and abuse include:

- Develop and follow the elements of a compliance program.
- Audit claims for accuracy.
- Review medical records for accurate documentation of services rendered.
- Take action if you identify a problem (i.e., contact Fraud, Waste, and Abuse at **855-222-1046).**
- Ask for photo identification when registering members at the point of service.