Reimbursement Policy

Subject: **Claims Submission – Required Information for Facilities**	
Policy Number: **G-06030**	Policy Section: **Administration**
Last Approval Date: **06/13/2023**	Effective Date: **06/13/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.simplyhealthcareplans.com.** ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Simply Healthcare Plans, Inc. (Simply) Medicare Advantage covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Simply Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Simply Medicare Advantage strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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Policy

Institutional Providers (Facilities) are required to submit the original *CMS UB-04/CMS*-1450 Medicare Uniform Institutional Provider Bill to Simply Medicare Advantage for payment of healthcare services, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Institutional Providers (Facilities) must submit a properly completed *UB-04/CMS-1450*, or its electronic equivalent, for services performed or items/devices provided. If the required information is not provided, the claim is not considered a clean claim and Simply Medicare Advantage can delay or deny payment without being liable for interest or penalties. The *UB-04/CMS-1450* claim form, or its electronic equivalent, must include the following information, if applicable:

- Billing provider information (name, address, and telephone number)
- Patient control number
- Medical record number
- Type of bill
- Federal Tax Identification Number
- Statement covers period (from-through)
- Patient information (name, member ID number, address, date of birth, and gender)
- Admission/start of care date
- Type of admission or visit
- Point of origin for admission or visit
- Patient discharge status
- Condition code(s), occurrence code(s), and date(s)
- Occurrence span code(s) and date(s) for inpatient services only
- Value codes and amounts
- Revenue code(s) and applicable corresponding CPT/HCPCS codes, if necessary; applicable claims billed only with the revenue code will be denied. Providers will be asked to resubmit with the correct CPT/HCPCS code in conjunction with the applicable revenue code.
- Date(s), unit(s), total charge(s), and noncovered charge(s) of service(s) rendered
- Clinical Laboratory Improvement Amendment (CLIA) certification number
- Insurance payer's information (name, provider number, and *Coordination of Benefits (COB)* secondary and tertiary payer information)
- Prior payments — payers insured's information (name, relationship to patient, member ID number, and insurance group name and number)
- Principal, admitting and other ICD-10 diagnosis codes and present on admission (POA) indicator, as applicable.
- Diagnosis and procedure code qualifier (all seven digits for ICD-10) and date of principal procedure for inpatient services
- Patient reason for visit code
- Attending and operating provider name and Tax ID, if applicable
- National provider identifier provider number (in accordance with CMS requirements)
- Claim reporting data elements in accordance with applicable state compliance requirements, including the following:
    - Admission source code
    - Applicable value code for billed admission type code
    - Birth weight with applicable value and admission type codes

- Facility type code
- National drug code(s) (NDC) to include the NDC number, unit price, quantity, and composite measure per drug.

Simply Medicare Advantage cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Although Simply Medicare Advantage prefers the submission of claims electronically through the Electronic Data Interchange (EDI), Simply Medicare Advantage will accept paper claims. A paper claim must be submitted on an original claim form with dropout red ink, computer-printed or typed, and in a large, dark font in order to be read by optical character reading (OCR) technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.

Providers should refer to their provider manuals and state specific guidelines for details on claims submission requirements.

Related Coding
Standard correct coding applies

Policy History	
06/13/2023	Review approved and effective: added statement referencing provider manuals and state specific guidelines; added electronic equivalentj
04/12/2021	Review approved: no updates
01/01/2021	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Claims Requiring Additional Documentation
Claims Submission – Required Information for Professional Providers
Corrected Claims
Modifier Usage
Provider Preventable Conditions
Unlisted, Unspecified, or Miscellaneous Codes
Simply Medicare Advantage Electronic Data Interchange Manual