

## Section 6 Billing Guidelines

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## Section 6 Billing Guidelines

### Billing, Reimbursement, and Claims Submission

#### Submitting a Claim

NHP is committed to processing clean claims within at least 45 days of receipt. The claim receipt’s Julian date is embedded in the NHP claim number as shown on the Explanation of Payment (EOP).

A clean claim is defined as one that includes at least the following information:

- Full member name
- Member’s date of birth
- Full NHP member identification number
- Date of service
- Valid diagnosis code(s)
- Valid procedure code(s)
- Valid place of service code(s)
- Charge information and units
- National provider identifier (NPI) group number
- NPI rendering provider number, when applicable
- Vendor name and address
- Provider’s federal tax identification number

#### Claim Submission Guidelines

When using a billing agent or clearinghouse, providers are responsible for meeting all NHP claim submission requirements.

NHP requires the submission of all paper and electronic claims within 90 days of the date of service unless otherwise contractually agreed.

NHP’s claim submission guidelines are as follows:

Claim Type	Submission Format
Professional Charges	CMS- 1500
Durable Medical Equipment (DME)	CMS- 1500
DME Supplies, Home Infusion Services, etc.	CMS- 1500
Institutional/Facility Charges	UB-04

NHP does not accept any other claim submission forms.

#### EDI (Electronic) Claims

Claims submitted electronically are subject to the claim edits established by NHP.

- Companion Guides are available to help providers set up EDI submissions.
- NHP’s payer ID number is 04293.

For questions regarding electronic claims submissions, please contact NHP’s e-Commerce Department at 617-772-5550.

#### Paper Claims

Paper claims must be submitted on the proper forms, within the aforementioned time frames or per specific contract arrangements. NHP’s front edits apply to both EDI and paper claim submissions.

Submit *new* claims only to:

*Mail*      Neighborhood Health Plan  
 P.O. Box 10  
 Nutting Lake, MA 01865-0010

Please do not send any correspondence to this address. (See “Appendix A” for correspondence addresses.)

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#### Behavioral Health Services Claims

NHP’s Behavioral Health benefit is administered through NHP’s delegated partner [Beacon Health Strategies](#).

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## Billing for Professional Services, Durable Medical Equipment, and Supplies

Professional charges, as well as DME and supplies must be billed on a CMS-1500 claim form and include all pertinent and/or required information. Please refer to NHP's CMS-1500 Claim Form Completion Guidelines for additional information on required fields. Missing, incomplete or invalid information can result in claim denials.

When billing for DME items, include an invoice which includes any applicable acquisition costs.

In addition, the group and the rendering clinician's NPI numbers are required on most professional claim submissions. Claims submitted without a valid number are subject to rejection by NHP's Claims system. For any questions, contact the NHP Customer Care Center.

## Billing for Inpatient and Outpatient Facility Services

Institutional charges must be billed on a UB-04 claim form and include all pertinent and/or required information. Please refer to NHP's UB-04 Claim Form Completion Guidelines for additional information on required fields.

NHP requires the facility's NPI on all institutional claim submissions. Claims submitted without valid numbers are subject to rejection by NHP's Claims system. Please contact NHP's Customer Care Center with questions regarding provider number submission requirements.

Where appropriate, valid ICD-9, revenue (REV), CPT-4 and/or HCPCS, and standard three-digit type of bill codes are required on institutional claims.

### Room Charges

NHP covers only the semi-private room rate unless a private room is pre-authorized. When not pre-authorized, the semi-private room rate will be applied to all private room charges.

### Itemization

The itemization of inpatient charges is required upon request with each day of service separately reported.

## Coordination of Benefits (COB) Guidelines

Coordination of Benefits (COB) is the process to determine how medical, dental and other health care services will be paid when a person is covered under more than one insurer. Providers are required to notify NHP when other coverage is identified.

The order of benefit determination is the term used for establishing the primary versus secondary insurer or plan. The primary carrier must pay its portion of the claim first, then the secondary carrier could be responsible for the balance up to its benefit or policy limits.

When a member enrolls with NHP through MassHealth, NHP is always the payer of last resort. When a member enrolls with NHP through an employer plan, NHP would coordinate benefits as applicable to determine primary or secondary coverage. All payments for covered NHP services rendered are considered as payment in full.

Services and charges must be billed on an appropriate claim form and submitted to NHP within 90 days of receipt of the Explanation of Payment (EOP) or remittance advice from the primary insurance carrier.

## Third-Party Liability Claims

When a NHP member is involved in an automobile accident, providers should notify NHP directly by calling the Third Party Liability Department at 617-772-5685 and making the proper notation on submitted claims. An NHP representative can assist with the process of determining which carrier should be billed for services. Providers should use MassHealth's TPL Indicator Form for reporting other insurance information discovered during patient encounters for all NHP members. These forms are available to providers by calling their Provider

Relations representative or emailing Provider Relations at [prweb@nhp.org](mailto:prweb@nhp.org).

When NHP is the secondary carrier, all claims must be submitted with a copy of the primary carrier’s EOP, remittance advice, or denial letter.

### Workers Compensation (WC) Claims

When an NHP member is injured on the job, the employer’s workers compensation carrier should be billed directly for the services. Only upon denial from the workers compensation carrier will NHP consider additional claims.

### Reconciling Your Explanation of Payment (EOP)

Each claim line on your EOP has a specific line that indicates the service codes billed to NHP. Any claim that has been denied will have a “Remark” to explain why the claim was denied.

A claim line can be denied for many reasons, including these examples:

- The payment submitted is included in the allowance for another service/procedure.
- The service code submitted is not within the NHP contract.
- The member is/was not effective for the dates of service (i.e., NHP was billed for five days but the member was effective for only three of those days).
- The time limit for filing the claim may have expired.
- An authorization is required and not on file.

A claim can also be denied for multiple reasons. (For example, first reason: The member identification number submitted was invalid.

Second reason: The procedure submitted for the same claim was not covered under the contract).

If you believe a denied claim is wrong, and wish to re-submit the claim for payment, please ensure that all reasons for the claim denial have been addressed. Not addressing all the reasons a claim has been denied will only delay the claim being resolved.

As stated on each EOP, providers are strongly encouraged to reconcile the EOP within 90 days of receipt. Requests for adjustments received beyond the 90 day adjustment request filing limit cannot be considered for reprocessing.

The following is an example of an EOP highlighting where claim lines and service codes can be found. A small sample of service codes is also given. On this example EOP, one particular claim line has been highlighted because the claim was denied. A remark is also highlighted on the EOP as an explanation of why the claim was denied.

Line #	Date of Service From	Date of Service To	Service Code	Units	\$ Billed	\$ Allowed	\$ COB	Deductible	\$ Coins	\$ Copay	Paid	Results
<b>Prov Name</b> ABC MEDICAL CENTER INC. <b>Prov NHP #</b> 2343678912 <b>Prov NHP #</b> 06112234 <b>Patient Account #</b> 1234567890 <b>Member Number / Name</b> NHP0110223 / SMITH, JOHN A. <b>Claim Number</b> 987654321 <b>DRG</b>												
1	12/30/2008	12/30/2008	74160	1	\$2,541.00	\$457.28	\$0.00	\$0.00	\$0.00	\$0.00	\$487.58	PAID
2	12/30/2008	12/30/2008	72151	1	\$2,201.00	\$457.28	\$0.00	\$0.00	\$0.00	\$0.00	\$487.28	PAID
3	12/30/2008	12/30/2008	03967	70	\$84.00	\$42.59	\$0.00	\$0.00	\$0.00	\$0.00	\$42.59	PAID
<b>Totals:</b>					\$4,826.00	\$957.15	\$0.00	\$0.00	\$0.00	\$0.00	\$977.45	
<b>Prov Name</b> ABC MEDICAL CENTER INC. <b>Prov NHP #</b> 2343678912 <b>Prov NHP #</b> 06112234 <b>Patient Account #</b> 9876543210 <b>Member Number / Name</b> NHP027054 / JONES, JANE A. <b>Claim Number</b> 1472536911 <b>DRG</b>												
1	12/12/2008	12/12/2008	82565	1	\$11.00	\$10.78	\$0.00	\$0.00	\$0.00	\$0.00	\$10.78	PAID
2	12/12/2008	12/12/2008	84132	1	\$38.00	\$9.88	\$0.00	\$0.00	\$0.00	\$0.00	\$9.88	PAID
3	12/12/2008	12/12/2008	84520	1	\$21.00	\$8.31	\$0.00	\$0.00	\$0.00	\$0.00	\$8.31	PAID
4	1/21/2009	12/12/2008	36413	0	\$16.00	\$8.11	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	DENIED
5	12/12/2008	12/12/2008	87070	1	\$51.00	\$18.14	\$0.00	\$0.00	\$0.00	\$0.00	\$18.14	PAID
<b>Totals:</b>					\$157.00	\$66.82	\$0.00	\$0.00	\$0.00	\$0.00	\$46.91	
<b>Remarks:</b> Line 04 - Payment is included in the allowance for another service/procedure. Payment is included in the allowance for another service/procedure.												
<b>Examples of Service Codes:</b> 0302 = CT Scan - Body 0636 = Drugs requiring detail codes 0300 = Laboratory 0306 = Laboratory - Bacteriology / Microbiology												

## Provider Reimbursement

Reimbursement for services rendered must be treated as payment in full. With the exception of an applicable copayment, coinsurance or deductible, providers may not seek or accept payment from an NHP member for any covered service rendered. In addition, providers may not have any claim against or seek payment from MassHealth for any NHP covered service rendered to a MassHealth enrollee. Providers should look solely to NHP for payment with respect to NHP covered services rendered. Furthermore, a provider may not maintain any action at law or in equity against any member or MassHealth to collect any sums that are owed to the provider by NHP for any reason, up to and including NHP's failure to pay, insolvency, or otherwise breach of the terms and conditions of the NHP Provider Agreement.

In the event that a non-medically necessary or non-NHP covered service is provided in place of a covered service (either an NHP-covered service or MassHealth-covered service), the provider may not seek reimbursement from the member unless documentation is provided indicating the provider explained the liability of payment for the non-medically necessary or non-NHP covered service to the member prior to services being rendered. Documentation must indicate that the member both understood and agreed to accept liability for payment at the time of service.

### ***Serious Reportable Events/Occurrences***

A serious reportable event (SRE) is an event that occurs on the premises of a provider's site that results in an adverse patient outcome, is identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Potential SREs or quality of care (QOC) occurrences may be identified by members, providers, or NHP staff and may come into NHP through the Customer Care Center or any other department. The duty to report a SRE is the responsibility of the individual facility or provider. The facility or provider must document their findings; and provide a copy of the report to both DPH and to the NHP Director of

Quality Management and Improvement within the required time frame.

Issues of concern may also be found through claims data or when medical record audits are performed by NHP. Claims data are reviewed on a quarterly basis to identify possible SREs. Any problems identified include both acts of commission and omission, deficiencies in the clinical quality of care, inappropriate behavior during the utilization management process, and any instances of provider impairment documented to be a result of substance abuse or behavioral health issues. All contracted providers must participate in and comply with programs implemented by the Commonwealth of Massachusetts through its agencies, such as, but not limited to the Executive Office of Health and Human Services (EOHHS), to identify, report, analyze and prevent SREs, and to notify NHP of any SRE.

NHP reviews and promptly responds within 30 days to actual or potential QOC occurrences. The provider will have within seven days to report SREs. NHP utilizes the National Quality Forum's (NQF) definition of SREs (referred to as "never events") and the NQF's current listing of "never events."

NHP does not reimburse services associated with SREs and/or "never events."

To administer this policy, NHP recognizes but is not limited to the SREs identified by the National Quality Forum, HealthyMass and the CMS Medicare Hospital Acquired Conditions and Present on Admission indicator reporting.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and providers performing the billable procedure(s) during which an "event" occurred.

NHP will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another provider.

### ***Billing for Missed Appointments***

NHP considers a missed appointment as factored into the overhead cost of providing services and not a distinct reimbursable service. In recognition

of this, provider fee schedules are designed to cover this cost, keeping the member from incurring additional costs.

The practice and its providers will cooperate and participate with NHP in programs focused on improving member appointment attendance. They will not:

- Bill members for missed appointments.
- Refuse to provide services to members due to missed appointments.
- Refuse to provide services to members because the member has an outstanding balance owed to the practice from a time prior to the patient becoming an NHP member.

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## Audits

NHP's audit process ensures accuracy of charges and consistency with plan policies, provider agreements, and applicable nationally recognized medical claims reimbursement and administration policies. NHP auditing specialists, possessing thorough knowledge of medical procedures, terminology and procedural coding, will perform the audits, review findings and respond to provider questions or concerns.

Audits may be conducted on claims paid during the current year or two prior NHP fiscal (calendar) years and up to six years when investigating possible cases of fraud or abuse. NHP policies, including but not limited to medical policies, claims administration policies, and provider payment guidelines, will apply to all reimbursement and claims matters. In any matter where NHP does not maintain a specific policy or guideline, NHP adopts and follows the national standards and policies relating to procedural coding, medical claims administration and reimbursement, which are recognized by government payers such as the Centers for Medicare and Medicaid Services (CMS), MassHealth, national health insurance carrier organizations, and the American Medical Association (AMA).

Pursuant to the NHP Provider Agreement, NHP has the right to inspect, review and make copies of medical records. All requests for medical record

review are made in writing. The inspection of medical records is conducted in compliance with the provider's standard policies governing such processes and that are applied uniformly to all payers.

Provider notification includes the audit parameters and corresponding medical records. The number of selected medical records is determined based on generally accepted statistical sampling methodology, rules and techniques recognized in the field of statistical probability. Should additional areas of questions be identified, NHP reserves the right, at its election, to expand the scope of any audit, and perform extrapolation of audit results to the defined audit population. If extrapolation methodology is selected, the process shall be performed in accordance with generally accepted sampling principles as outlined above. NHP strictly adheres to state and federal requirements regarding confidentiality of patient medical records. A separate consent form will be provided when required by law.

When an initial review of a provider's medical records is required, NHP's provider audit process includes written 30 days' prior notification. For on-site audits, the provider must arrange a suitable work area, and make available to the auditor the medical records, including but not limited to pharmacy profile and corresponding fee book when applicable. The fee book should be an electronic file, such as Excel or similar program, unless another format has been agreed upon.

When additional records or documentation are necessary to complete the audit, the auditor will submit a written request for information to the provider's representative identifying the necessary documents to complete the audit, specifying a reasonable time period within which the provider will supply the requested documents.

NHP does not reimburse for audit and administrative fees incurred by a provider.

### **General Claims Audits**

General post payment claims audits are conducted to identify the accuracy of charges and the consistency of claims reimbursement with NHP's policies, Provider Agreements, Payment Guidelines,

and applicable nationally recognized medical claims reimbursement and administration policies, including but not limited to: CPT, Mass-Health, and CMS guidelines. Audits include, but are not limited to:

- Billing for services at a higher level than provided
- Billing for services not documented and not provided
- Incorrect coding, including unbundling component service codes, modifier usage, units of service, duplicate payments
- Historical claim audits to include the global surgical period for codes submitted on the current claim
- Medical necessity based on NHP, MassHealth, and/or CMS guidelines as applicable to the member benefit plan

The provider is notified by letter from NHP 30 or more days prior to retraction of any monies identifying claim discrepancies totaling over \$500 per vendor that have been identified by NHP's post-payment audit resulting in claim adjustments.

If the provider disagrees with the adjustments, a letter of appeal or a completed NHP Provider Audit Appeal Form may be submitted to NHP's Appeals department within 90 days of the EOP along with an attachment, detailing justification to support the relevant charges. NHP will review the appeal and, when appropriate, consult with NHP clinicians or subject matter experts in the areas under consideration.

The appeal determination will be final. If the determination is favorable to the provider, NHP will adjust the claims in question within 10 calendar days of the final determination notification.

### ***External Hospital Audits***

Audits are conducted at a mutually convenient time and cancellations by either party require written 15 days advance notice. NHP's audits involving inpatient and outpatient claims also include an exit interview to review and discuss the findings.

Documented unbilled services are charges for documented services that were detailed and billed for on the original audited claim but not billed to the full extent of the actual services provided. These charges will be considered for payment only when an accounting of the services is presented at the time of the on-site audit review for verification and acceptance during the on-site audit review. In addition, the charges must be submitted on an NHP accepted claim form. The accepted charges will be adjusted (netted out) against the unsupported charges at the conclusion of the audit.

If there is a question of medical necessity or level of care, the hospital designee will coordinate dissemination and review of the findings with hospital staff and present a rebuttal position prior to the exit interview or within the 30-day appeal period.

At the conclusion of the audit, if the hospital designee agrees with the findings, the auditor will provide a dated copy of the signed and final Discrepancy Report. Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and will reflect accordingly in subsequent NHP EOPs. Alternative arrangements for payment to NHP must be made in writing and signed by all parties.

### ***Physician and Ancillary Audits***

Physician and ancillary provider audits may consist of both off-site and on-site audits, with the audit of designated medical records conducted at either NHP or the vendor's office, when applicable. The determination of an off-site and/or on-site audit will be made by NHP.

Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and will reflect accordingly in subsequent NHP EOPs. Alternative arrangements for payment to NHP must be made in writing and signed by all parties.

### ***Payment Guidelines***

NHP's payment guidelines are designed to help with claim submissions by promoting accurate coding and by clarifying coverage. NHP's payment guidelines are found at [www.nhp.org](http://www.nhp.org).