Priority Health	BILLING POLICY No. 081
CLAIM SUBMISSION GUIDELINES	
Effective date: May 19, 2025 **Date of origin: Mar. 18, 2025**	**Review dates: 03/2025**

APPLIES TO
All plans

DEFINITION
Claim submission guidelines. Electronic claims are preferred, but claims can also be mailed to our claims address:

Priority Health Claims
P.O. Box 232
Grand Rapids, MI 49501

To set up electronic claim or RA file sharing, see instructions in our Provider Manual.

REQUIREMENTS FOR ALL CLAIM SUBMISSIONS

- Use standard CMS 1500 form (02-12 version or later) or UB-04 facility form
- Handwritten claims won't be accepted
- Faxed claims won't be accepted
- Don't use red ink, highlighters, neon stickers, labels or rubber stamps
- Fill out original claim form in its entirety
- Don't use copies of claim forms.
- Print claims data within the boxes
- Don't put notes at the top or bottom of claims
- Use a laser printer
- Don't print slashed zeros
- A POS indicator is required on all inpatient claims
- Itemization is required when billing for rehabilitation services

TAXONOMY CODES
Taxonomy Codes are used to classify the type, classification and specialization of health care providers. To ensure accurate and timely claims processing and payment, Priority Health requires all claims, whether paper or electronic, to include the taxonomy code of the rendering provider. This is consistent with National Uniform Billing Guidelines.

Taxonomy codes should be submitted as follows:

On a CMS 1500:

- Box 24i should contain the qualifier ZZ
- Box 24j should contain the taxonomy code

On a UB-04 / CMS 1450:

- Box 81 should contain taxonomy code and submitted with the "B3" qualifier

The Health Care Provider Taxonomy Code - HPTC set is maintained by the National Uniform Claim Committee (NUCC). Get more information about taxonomy codes from CMS.

CMS 1500 REQUIRED FIELD INFORMATION

Item 1	Indicate all types of insurance coverage applicable
Item 1a	Contract number plus two-digit suffix. Medicaid – patient recipient ID number
Item 2	Patient's name
Item 3	Patient's date of birth & gender
Item 4	Insured's name
Item 5	Patient's address
Item 6	Patient's relationship to insured
Item 7	Insured's address
Item 9a & 9d	Other insurance information
Item 10	Patient's condition related to:
Item 10a-c	Employment, auto, or other accident is applicable*
Item 11	Insured's group number
Item 12	Patient's signature on file
Item 13	Insured's signature on file
Item 14	Date of current illness, injury, or pregnancy
Item 15	Indicate if patient has had same or similar illness; other date
Item 17	Qualifier and name of referring physician
Item 17b	NPI of referring physician; required unless patient is self-referring
Item 18	Hospitalization dates related to current service, if applicable
Item 19	Additional claim information, use for prenatal dates of service, description of unlisted codes, or reason for corrected claim
Item 21	Diagnosis using standard ICD-10 diagnosis code; use primary diagnosis code and indicator first
Item 22	Corrected claim code, if applicable
Item 23	Prior authorization number, if applicable
Iten 24a	Date the service was provided
Item 24b	Place of service – all standard Medicare place of service codes are accepted
Item 24d	CPT and/or HCPCS codes, modifiers when necessary. For unlisted codes, specify what service is being provided.
Item 24e	Link service to any diagnosis listed in Item 21, as applicable
Item 24f	Charges
Item 24g	Days or units
Item 24i	ID qualifier, for taxonomy codes
Item 24j	Rendering provider NPI
Item 25	Federal tax ID number
Item 26	Patient's account number
Item 27	Accept assignment
Item 28	Total charges

Item 31	Typed first name then last name pf physician or supplier, including degrees or credentials (no handwritten signatures are accepted)
Item 32	Name and address of facility where services were rendered
Item 32a	NPI of service facility
Item 32b	Taxonomy codes
Item 33	Physician's or supplier's billing name and address (Social Security number or owner of tax ID number)
Item 33a	NPI of billing provider
Item 33b	Taxonomy codes

*Failure to populate this information may result in claim denials for prior authorization requirements or other claim denials.

UB-04 REQUIRED FIELD INFORMATION

Field 1	Provider name and address
Field 2	Pay-to location
Field 3A	Patient control number
Field 3B	Medical health record number
Field 4	Type of bill
Field 5	Federal tax identification number
Field 6	Statement covers period
Field 8	Patient name-ID number
Field 9	Patient address
Field 10	Patient birthdate
Filed 11	Patient sex
Field 12	Admission date
Field 13	Admission hour
Field 14	Type of admission
Field 15	Source of admission
Field 17	Patient Status
Field 18-28	Condition codes
Field 31-36	Occurrence codes
Field 38	Responsible party name and address
Field 39-41	Value codes (if applicable)
Field 42	Revenue code
Field 43	Description of revenue code
Field 44	HCPCS rates (CPT codes required if billing for lab, diagnostic, or therapeutic procedures)
Field 45	Service date
Field 46	Service units (if applicable)
Field 47	Total charges (by revenue code category)
Field 48	Non-covered charges – primary payer (if applicable)
Field 50	Payer name
Field 51	Health Plan ID

Field 52	Release of Information
Field 53	Assignment of benefits
Field 54	Prior payments (if applicable)
Field 55	Estimated amount due
Field 56	National provider identification (NPI)
Field 57	Other/payer identification
Field 58	Insured's name
Field 59	Patient's relationship to insured
Field 60	Policy holder's contract number
Field 61	Group name
Field 62	Group number
Field 66	Internal classification of disease (ICD) version qualifier
Field 67A-Q	Principal diagnosis; also see POA indicators
Field 69	Admitting diagnosis
Field 70	Patient reason for visit (DX)
Field 71	Prospective payment system (PPS) code
Field 72	External cause of injury
Field 73	DRG (inpatient only)
Field 76	NPI for attending physician
Field 77	NPI for operating physician
Field 78	NPI for the other physician

DRG AND OUTLIER PAYMENTS

Services considered part of DRG

The following services provided by facilities within 3 days of admission are part of DRG payments and aren't separately reimbursable:

- Outpatient services followed by admission before midnight of the following day
- Diagnostic services (including clinical diagnostic laboratory tests) provided by the admitting hospital or an entity of that hospital within 3 days prior to admission
- Preadmission services provided within 3 days of admission
- Emergency room services within 24 hours of admission

Excluded from DRG

- Within a **Critical Access Hospital (CAH) only**: Diagnostic services rendered during ER visits 48 to 72 hours prior to admission are considered part of the ER visit and are excluded from DRG.
- Ambulance services

Outlier claims and payments

Outlier payments partially offset the financial burden of claims with a significantly higher than normal operating cost. Costs must be above a fixed-loss cost threshold specified in the provider's contract to qualify.

Priority Health will determine whether to reimburse above the usual DRG based on terms of the facility contract. Any additional payment will be subject to medical utilization and quality review procedures.

HMO / POS / PPO and MyPriority outlier claims
If your provider contract requires contacting Priority Health to ask for an outlier payment, contact our Provider Helpline at 800.942.4765 to determine whether admission meets outlier criteria.

The facility will be informed if the case doesn't meet criteria to be reviewed for outlier payment. A letter will be sent to the facility instructing on the appeals process.

Medicaid / Healthy Michigan outlier claims
When specified in contracts the State of Michigan Medicaid Low Day/Low Cost and High Day/High Cost Outlier Payment Methodology will be followed.

Medicare outlier claims
In-network outliers follow same process as Medicaid. Out-of-network claims will use the CMS pricer. Any additional payments are subject to medical and quality review procedures.

To request review
Submit documentation that services were above and beyond those included in the fixed rate. Documentation should be attached to the dispute (appeal).

Present-on-admission (POA) indicators

Per CMS standards, facilities are required to report present-on-admission indicators for principal and secondary diagnoses. This includes external causes of injuries present at the time of admission for members of all plans. POA conditions also include those that develop during an outpatient encounter. Reimbursement may be reduced for services that include a diagnosis not present on admission.

POA indicators

- **Y**: Diagnosis was present at the time of inpatient admission
- **N**: Diagnosis was not present at the time of inpatient admission
- **U**: Documentation is insufficient to determine if condition was present at the time of admission
- **W**: Unable to determine clinically if the condition was present at the time of admission
- **Blank**: Only use is the diagnosis is exempt from POA

Get more information on POA from CMS.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Mar. 18, 2025	Most of this policy compiles guidelines already present in our online Provider Manual and is already in effect. With the publishing of this policy, we added guidelines for **taxonomy codes** that will go into effect on May 19, 2025.