Reimbursement Policy

Subject: **Claims Submission – Required Information for Professional Providers**	
Policy Number: **G-06029**	Policy Section: **Administration**
Last Approval Date: **06/09/2023**	Effective Date: **06/09/2023**

**** 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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

Professional providers of healthcare services are required to submit an original *CMS-1500 Health Insurance Claim Form*, or its electronic equivalent, to Simply Medicare Advantage for payment of healthcare services unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Providers must submit a properly completed *CMS-1500 Health Insurance Claim Form*, or its electronic equivalent, for services performed or items/devices provided. If the required information is not submitted, the claim is not considered a clean claim, and Simply Medicare Advantage will deny payment without being liable for interest or penalties. The *CMS-1500 Health Insurance Claim Form*, or its electronic equivalent, must include the following information, if applicable:

- Patient information (name, address including ZIP code, date of birth, gender, relationship to insured, and medical condition as related to employment or an accident)
- Insured's information (member ID number, name, address including ZIP code, policy, group or *Federal Employees' Compensation Act* number, name of insurance plan or program, and name of other health benefit plan)
- Coordination of benefits/other insured's information (name, policy or group number, and name of insurance plan or program)
- Name of referring physician or source
- Indication of outside laboratory
- ICD-10-CM diagnosis code(s)
- *Clinical Laboratory Improvement Act* certification number
- Date(s) of service(s) rendered
- Place of service
- Procedures, services, or supplies (description of services rendered using CPT-4 codes/HCPCS codes and appropriate modifiers)
- Charge(s) for service(s) rendered
- Day(s) or unit(s) related to service(s) rendered
- Total charges and amount paid by patient
- Federal TIN
- Name and address of facility where services were rendered and the NPI of the service facility
- NPI:
  - Individual servicing provider's NPI must be reported as the rendering provider ID
  - When billing is from a group, the group's NPI must be reported as the billing provider
- NPI or other non-NPI ID number of the referring, ordering or supervising provider
- Billing provider information (name, address including ZIP code, telephone number)
- Indication of signature on file — a handwritten or computer generated signature for the provider of service or their representative — and date the form was signed
- 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. Altered claims 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 drop out red ink, computer-printed or typed, and in a large, dark font in order to be read by optical character reading 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	
06/09/2023	Review approved and effective: added policy statement; added statement referencing provider manuals and state specific guidelines; added or electronic equivalent
04/12/2021	Review approved: minor administrative 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 Facilities
Corrected Claims
Modifier Usage
Provider Preventable Conditions
Unlisted, Unspecified, or Miscellaneous Codes
Electronic Data Interchange Manual