

# Horizon NJ Health - Billing Guide

This guide is intended to offer hospitals, physicians and health care professionals the information required for Horizon NJ Health to accurately and efficiently process claims prepared by or for hospitals, physicians and health care professionals for medical services provided to members of our health plan. This section contains notes of interest highlighting billing information relevant to the topic detailed above them. The notes may be titled as follows:

**IMPORTANT** – Reminds the reader of claim submission problems that can be avoided. These errors can result in rejection, inaccurate claim payments or denials, usually because required information is missing, invalid, incomplete or inconsistent with standard billing practices.

**Note:** Reviews an associated piece of information, which clarifies or explains specific details about the service, but may not directly impact reimbursement. For example, place of service is required to determine eligibility for payment, but does not necessarily affect payment amount.

In the event of additional questions about Horizon NJ Health programs or policies, please review the entire Manual or contact the Provider Services at **1-800-682-9091**.

In order to comply with contractual obligations, regulatory requirements or state and federal law, Horizon NJ Health reserves the right, at any time, to modify or update information contained in this document. Notification will be posted at least 30 days prior to the effective date unless the effective date of a law or regulation does not permit this time frame. Hospitals, physicians and health care professionals may access the For Providers section of the Horizon NJ Health website at **horizonNJhealth.com** to check for updates on billing requirements and other policies and procedures relevant to reimbursements for services.

**IMPORTANT** – Horizon NJ Health, its subcontracted vendors or the State of New Jersey are responsible for payment for all services included in the member's benefit package. Services not included in the benefit package are reimbursable by the member only if the hospital, physician or health care professional notifies the member in writing and in advance of providing the service(s) of this obligation. Members should not be billed for any service covered under their benefit package. Should Horizon NJ Health require a copayment for any service or population group, an itemization of these items will be included in the benefit listing and will be available on the website. The practice of balance billing Medicaid/NJFC and FIDE-SNP beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under both federal and State law. These prohibitions apply to both Medicaid/NJFC-only beneficiaries, as well as those eligible for Medicare coverage or other insurance. A provider enrolled

in the Medicaid/NJFC FFS program or in managed care is required to accept as **payment in full** the reimbursement rate established by the FFS program or managed care plan.

All costs related to the delivery of health care benefits to a Medicaid/NJFC eligible beneficiary, other than authorized cost sharing, are the responsibility of the FFS program, the managed care plan, Medicare (if applicable) and/or a third-party payer (if applicable). If a provider receives a Medicaid/NJFC FFS or managed care payment, the provider shall accept this payment as payment in full and shall not bill the beneficiary or anyone on the beneficiary's behalf for any additional charges.

## 9.1 Requirements for Filing Claims

### 9.1.1 General Requirements

Horizon NJ Health is a Medicaid managed care plan that is under contract with the New Jersey Department of Human Services. Horizon NJ Health will pay claims based only on eligible charges. Unless the provider contract states otherwise, claims will be paid on the lesser of billed charges or

the contracted rate (Horizon NJ Health fee schedule). Claims submitted by nonparticipating Horizon NJ Health providers will be paid on the lesser of billed charges or the Horizon NJ Health nonparticipating provider fee schedule. Consistent with CFR 42 Part § 447.45: the following definition shall apply to clean claims as used within the Horizon NJ Health Billing Guide:

“Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.”

Under the New Jersey Health Claims Authorization, Processing and Payment Act, claims must also meet the following criteria:

- (a) the health care provider is eligible at the date of service
- (b) the person who received the health care service was covered on the date of service
- (c) the claim is for a service or supply covered under the health benefits plan
- (d) the claim is submitted with all the information requested by the payor on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of section 4 of P.L.2005, c.352 (C.17B:30-51)
- (e) the payor has no reason to believe that the claim has been submitted fraudulently

Other requirements, such as timeliness of claims processing includes:

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing. Horizon NJ Health shall pay all clean claims from hospitals, physicians and other health care professionals within 30 days of the date of receipt of EDI claims and within 40 days for paper claims. MLTSS claims will be paid within 15 days of the receipt of EDI claims and within 30 days for paper claims.

The time limitation does not apply to claims from providers under investigation for fraud or abuse. The date of receipt is the date Horizon NJ Health receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Horizon NJ Health is required to report all claims to the State of New Jersey for services provided to members through electronic media. Practitioners and facilities may not use a PO Box as an acceptable billing address. A physical street address must be used. In addition, when submitting ZIP codes anywhere on a claim, practitioners and facilities must use the full nine-digit format. Therefore, all billing addresses, whether submitted on paper or electronically, must contain a physical billing address. To have payments sent to a different address or PO Box, the pay-to provider name and address field on the 837-I and 837-P transaction must be used.

## 9.1.2 National Practitioner Identifier (NPI)

Horizon NJ Health requires all practitioners use their NPI numbers for all claim submissions. To ensure our systems properly identify you as an individual, group or facility, Horizon NJ Health requires you register the NPI with your taxonomy and tax identification numbers. Another requirement that will affect both timeliness and payment is the use of name differential on your W-9. Horizon NJ Health continues to accept the use of your provider identification numbers (legacy ID). The continued use of the legacy ID is recommended, as the claims processing system uses this number for adjudication and payment activities. Please make sure your name matches the name used on your W-9. Below are some helpful hints, which will facilitate accurate and consistent management of your claims.

- Physicians, facilities, and health care professionals are required to have an NPI. Please register for one if you have not already secured your NPI.

- Groups are not technically required to have an NPI, but are encouraged to have one as long as there is a legal entity associated with the business name and tax identification number. To register the group NPI with Horizon NJ Health, we will need the W-9 for the business and all associated individual NPIs paid to that tax ID number.
- Facilities, including hospitals and groups chosen to subpart their type 2 NPI, will need to choose a master NPI if all of the registered numbers are under the same tax identification number. Designating a master NPI number will help Horizon NJ Health assign claims to the right location for payment purposes. A valid W-9 for the business and all associated individual NPIs that are paid to that tax ID number should be registered with Horizon NJ Health.
- Where an NPI number is shared among different locations using the same tax ID number, the Horizon NJ Health legacy ID is needed to distinguish where the claim payment should be sent.
- Nonparticipating practitioners and facilities are also required to adhere to the NPI requirements. To facilitate payment for claims, Horizon NJ Health encourages you to register your NPI with us in the same manner described above. To complete this task, please visit the "For Providers" section of [horizonNJhealth.com](http://horizonNJhealth.com) and download our NPI Collection Form. Once completed, fax your forms and CMS documentation to Horizon NJ Health at **1-609-583-3004**.

## 9.1.3 Procedures for Claim Submission

Horizon NJ Health is required by state and federal regulations to capture and report specific data regarding services rendered to its members. All services rendered, including capitated encounters and fee-for-service claims, must be submitted on the CMS 1500 (HCFA1500) version 02/12 or UB-04 claims form, or via electronic submission in a HIPAA — compliant 837 or NCPDP format. Horizon NJ Health does not accept handwritten or stamped claims. These claims forms and electronic submissions must be consistent with the instructions provided by CMS requirements, as stated in the CMS Claims Manual, which can be accessed at [cms.gov/Manuals/IOM/list.asp](http://cms.gov/Manuals/IOM/list.asp).

The hospital, physician and health care professional, to appropriately account for services rendered and to ensure timely processing of claims, must adhere to all billing requirements.

# Horizon NJ Health - Billing Guide

When data elements are missing, incomplete, invalid or coded incorrectly, Horizon NJ Health cannot process the claims.

- Claims for billable services provided to Horizon NJ Health members must be submitted by the hospital, physician or health care professional that performed the services.
- Professional services are not reimbursable to a hospital unless the hospital is specifically contracted for professional services. Horizon NJ Health policy is to reimburse these services only when billed on a CMS 1500.
- Claims filed with Horizon NJ Health are subject to the following procedures:
  - Verification that all required fields are completed on the claim
  - Verification that all diagnosis codes, modifiers and procedure codes are valid for the date of service
  - When appropriate, verification of the referral for specialist or non-primary care physician claims (excluding “self-referral” types of care)
  - Verification of member’s eligibility for services under Horizon NJ Health during the time period in which services were provided
  - Verification that the services were provided by a participating or nonparticipating hospital, physician or health care professional that has received authorization to provide services to the eligible member
  - Verification that the hospital, physician or health care professional has been given approval for services that require prior authorization by Horizon NJ Health
- Horizon NJ Health is the “payor of last resort” on all claims submitted for members of its health plan. Hospitals, physicians and health care professionals must verify whether the member has Medicare coverage or any other third party resources and, if so, provide documentation that the claim was first processed by this other insurer as appropriate.

**IMPORTANT** – Rejected claims are defined as claims with invalid or missing data elements, such as the tax ID number, that are returned to the submitter or EDI source without registration in the claim processing system. Since rejected claims are not registered in the claim processing system, the hospital, physician or health care professional must re-submit clean claims within 180 calendar days from the date of service. This guideline applies to claims submitted on paper or electronically. Rejected claims are different than denied claims, which are registered in the claim processing system, but do not meet requirements for payment under Horizon NJ Health guidelines.

Horizon NJ Health encourages all hospitals, physicians, and health care professionals to submit claims electronically. We utilize the TriZetto Provider Solutions (TTPS) Direct Data Entry (DDE) SimpleClaim system. All providers that previously used Emdeon to directly enter their Horizon NJ Health claims must switch to DDE SimpleClaim.

For more information on registering, please go to <https://trizettoprovidersolutions.wufoo.com/forms/horizon-nj-health-providers>. If you have any further questions about registering with TTPS for DDE claim submission, please call TriZetto at **1-800-556-2231** or email [ttpsupport@cognizant.com](mailto:ttpsupport@cognizant.com).

While Horizon NJ Health strongly encourages submitting claims via EDI, if a paper claim is necessary, please submit red and white paper claims only for all medical services to Horizon NJ Health at the following address:

**Horizon NJ Health  
Claims Processing Department  
PO Box 24078  
Newark, NJ 07101-0406**

**Note:** Out-of-state, non-Horizon NJ Health providers should send claims to their local Blue Cross Blue Shield Plan.

**IMPORTANT** – Requests for reimbursement for retail pharmacy and all outpatient drugs for persons designated as aged, blind or disabled should be submitted directly to the State of New Jersey.

**IMPORTANT** – Requests for reimbursement for mental health services for all enrollees, except the developmentally disabled, FIDE-SNP or MLTSS members, should be submitted directly to the State of New Jersey.

**Note:** Be sure to include the member’s Medicaid ID number on all claims submitted to the State of New Jersey.

**Note:** Horizon NJ Health subcontracts with Davis Vision to provide and/or coordinate vision services for eligible members. All services, except ophthalmologic procedures, are coordinated and paid by Davis Vision. Please call **1-877-226-3729** for information about submitting invoices.

**Note:** Horizon NJ Health subcontracts with Scion Dental to provide and/or coordinate dental services for eligible members. Please call the Provider Call Center at **1-855-878-5368** for routine provider questions related to eligibility, claims, authorizations, credentialing, contracting, adding/changing provider data/locations, and fee schedules.

# Horizon NJ Health - Billing Guide

**Note:** Horizon NJ Health subcontracts with Laboratory Corporation of America, Inc. (LabCorp) for most routine and specialized laboratory services. Generally, Horizon NJ Health is responsible for payment of claims for PAT/STAT laboratory service provided in hospitals and ambulatory surgical centers. Horizon NJ Health will also provide reimbursements for claims for laboratory services included on LabCorp's excluded test listing. An authorization is required for any test included on this listing; please submit claims to Horizon NJ Health as specified above. Unless otherwise specified within specific contractual arrangements, laboratory services should be referred to LabCorp.

## 9.1.4 Claim Filing Deadlines

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing. COB claims must be submitted within 60 days from the date of the primary insurer's EOB.

- Horizon NJ Health's Appeals Department utilizes specific criteria when reviewing valid proof of timely filing.
- Member's name
- Horizon NJ Health or Medicaid ID number
- Billed amount
- Date of service
- Billed/mailed date
- Address where the claim form was sent (Horizon NJ Health or insurance code)
- For EDI submissions, a 999 report indicating submission to the correct insurance code is required for consideration of timely submission.

### For claims selected electronically:

- Submit an electronic data interchange (EDI) acceptance report. This must show that Horizon NJ Health or one of its affiliates received, accepted and/or acknowledged the claim submission.

**Note:** A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.

- The acceptance report must:
  1. Include the actual wording that indicates the claim was either "accepted," "received" and/or "acknowledged."  
(Abbreviations of those words are also acceptable.)
  2. Show the claim was accepted, received, and/or acknowledged within the timely filing period.

### For paper claims:

1. The submission date must be within the timely filing period.
2. Certified mail receipts as valid proof of timely filing.
3. Only red and white paper claims can be processed.

### Other valid proof of timely filing documentation

Valid when incorrect insurance information was provided by the patient at the time the service was rendered:

- A denial/rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating coverage termination prior to the date of service of the claim
- Letter from another insurance carrier or employer group indicating no coverage for the patient on the date of service of the claim

All of the above must include documentation that the claim is for the correct patient and the correct date of service. The date on the other carrier's payment correspondence starts the timely filing period for submission to Horizon NJ Health. In order to be considered timely, the claim must be received by Horizon NJ Health within 60 days from the date on the other carrier's correspondence. Not including all of the information requested will result in a rejected inquiry or a delay in response. If the claim is received after the timely filing period, it will not meet timely filing criteria.

**REFER TO SECTION 10** – Section 10.0 Complaint and Appeals Process for complete instructions of the submission time frames and procedures for administrative or medical appeals.

## 9.1.5. Filing Corrected Claims

### For paper claims:

CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in Box 22 of the paper claim with the original claim number of the corrected claim and a copy of the original Explanation of Payment (EOP). With the original claim number for which the corrected claim is being submitted. Horizon NJ Health will reject any claims that are not submitted on red and white forms or that have any handwriting on them.

### For UB-04 claims:

UB-04 claims should be submitted with the appropriate resubmission code in the third digit of the bill type (for corrected claim this will be 7), the original claim number in Box 64 of the paper claim and a copy of the original EOP.

# Horizon NJ Health - Billing Guide

Send red and white paper corrected claims to:

**Horizon NJ Health**  
**Claims Processing Department**  
**PO Box 24078**  
**Newark, NJ 07101-0406**

## Correcting electronic HCFA 1500 claims:

EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF\*F8\* with the original claim number for which the corrected claim is being submitted.

## Correcting electronic UB-04 claims:

EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF \*F8\* with the original claim number for which the corrected claim is being submitted.

Both paper and electronic claims must be submitted within 365 calendar days from the initial date of service.

## 9.2 Claim Forms (Paper)

Horizon NJ Health requires that all hospitals, physicians and health care professionals use the standard CMS 1500 (HCFA 1500) or UB-04 claim forms to report services, which are reimbursable or capitated. The CMS 1500 (HCFA 1500) claim form must be completed for all professional medical services. The UB-04 claim form must be completed for all facility claims. When services are rendered by MLTSS providers, facilities should file a UB-04 form, and nonfacilities should use the CMS 1500.

**Horizon NJ Health does not accept handwritten or black and white claims.**

### 9.2.1 CMS 1500 (HCFA 1500) Claim Form

#### (Paper Submission)

The CMS 1500 (HCFA 1500) Paper Submissions claim form must be used to bill all professional services to Horizon NJ Health. Horizon NJ Health only accepts form version 02/12. The National Uniform Claim Committee (NUCC) created the CMS 1500 form (version 02/12) to accommodate coding changes for ICD-10. There are two significant changes on the revised CMS 1500, the claim form used to submit paper claims to Medicare and the required claim form to submit paper claims to Horizon NJ Health.

The CMS 1500 Form (version 02/12) gives physicians the ability to

- Identify whether they are using ICD-9-CM or ICD-10-CM codes.
- Include up to 12 codes in the diagnosis field (the limit on the 08/05 version is four codes in the diagnosis field).
- Include information that will improve the accuracy of the data reported, such as being able to identify the role of the provider and specific dates of illness.
- Align paper copy claim submissions with the ASC X12 Health Care Claim: Professional (837P) transaction.

CMS has advised providers to use the following process to assure clean claims submission. All information must be:

- Aligned within the data fields.
- On an original red ink on white paper claim 02/12 version form.
- Typed. Do not print, handwrite or stamp any extraneous data on the form.
- In black ink.
- In large, dark font, such as PICA or ARIAL 10-, 11- or 12-point type.
- In capital letters.

More information about Administrative Simplification and Compliance Act (ASCA) exceptions can be found in Chapter 24 of the "Medicare Claims Processing Manual," which is available on the CMS website at [cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf).

#### Required Fields for CMS 1500 (HCFA 1500) Claim Form

This section will provide the list of required fields for Horizon NJ Health; however, you must refer to the most current CMS coding instructions for a complete list of codes and requirements.

# Horizon NJ Health - Billing Guide

## Place of Service Codes

### Code Description

- 11 Office
- 12 Home
- 19 Off Campus - Outpatient Hospital
- 20 Urgent Care Facility
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room – Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance – Land
- 42 Ambulance – Air or Water
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Residential Treatment Center
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Use Disorder Treatment Center
- 56 Psychiatric Residential Treatment Center
- 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
- 99 Other Unlisted Facility

## Type of Service Codes

### Code Description

- 1 Medical Services
- 2 Surgery
- 3 Consultations
- 4 Radiology (total component)
- 5 Laboratory (total component)
- 6 Radiation Therapy (total component)
- 7 Anesthesia
- 8 Assistant Surgery
- 9 Other (e.g., prosthetic eyewear, contacts, ambulance)
- D DME
- F ASC

## Required and Conditional Field Indicator

**IMPORTANT** – An authorization number and/or referral number must be included in box #23 on a CMS 1500 (HCFA 1500) claim form or box #63 on a UB-04 form. The required fields that must be completed for the standard CMS 1500 (HCFA 1500) or UB-04 claim forms are in the respective claim form areas. If the field is required without exception, an “R” (required) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (conditional) and the relevant conditions are explained in the “Instructions and Comments” box.

### 9.2.2 The UB-04 (CMS 1450) Claim Form (Paper)

The UB-04 (CMS 1450) claim form must be used to bill all facility services to Horizon NJ Health. This section will provide the list of required fields for Horizon NJ Health. However, you must refer to the most current CMS coding instructions for a complete list of codes and requirements.

## Type of Bill Codes

### Code Description

- 111 Hospital/Inpatient (Part A)/Admit through Discharge

### Code Description

- 112 Hospital/Inpatient (Part A)/Interim – First Claim
- 113 Hospital/Inpatient (Part A)/Interim – Continuing Claims
- 114 Hospital/Inpatient (Part A)/Interim – Last Claim
- 115 Hospital/Inpatient (Part A)/Late Charge Only
- 117 Hospital/Inpatient (Part A)/Replacement of Prior Claim
- 121 Hospital/Hospital Based or Inpatient(Part B)/Admit Through Discharge
- 131 Hospital/Outpatient/Admit Through Discharge
- 211 Skilled Nursing/Inpatient (Part A)/Admit Through Discharge
- 212 Skilled Nursing/Inpatient (Part A)/Interim – First Claim
- 213 Skilled Nursing/Inpatient (Part A)/Interim – Continuing Claims
- 214 Skilled Nursing/Inpatient (Part A)/Interim – Last Claim
- 321 Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge
- 322 Hospice Interim – First Claim
- 323 Hospice Interim -- Continuing Claim
- 324 Hospice Interim – Final Claim
- 331 Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge

# Horizon NJ Health - Billing Guide

- 711 Clinic/Rural Health Clinic (RHC)/Admit Through Discharge
- 721 Clinic/Independent Renal Dialysis Facility/Admit through Discharge
- 731 Clinic/FQHC/Admit Through Discharge
- 831 Special Facility or Hospital ASC/ASC for Outpatients/Admit Through Discharge

## Type of Admission Codes

### Code Description

- 1 Emergency
- 2 Urgent
- 3 Elective

## Patient Status Codes

### Code Description

- 01 Discharged to Home or Self Care (routine discharge)
- 02 Discharged/Transferred to Another Short-Term General Hospital
- 03 Discharged/Transferred to SNF
- 04 Discharged/Transferred to ICF
- 05 Discharged/Transferred to Another Type of Institution (including distinct parts) or Referred for Outpatient Services to Another Institution
- 06 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
- 07 Left Against Medical Advice
- 08 Discharged/Transferred to Home Under Care of an IV Drug Therapy Provider
- 09 Admitted as an Inpatient to this Hospital
- 20 Expired (or did not recover – Christian Science Patient)
- 30 Still Patient or Expected to Return for Outpatient Services
- 40 Expired at Home (hospice claims only)
- 41 Expired in a Medical Facility, such as Hospital, SNF, ICF or Freestanding Hospice (hospice claims only)
- 42 Expired – Place Unknown (hospice claims only)
- 50 Hospice – Home
- 51 Hospice – Medical Facility

## Commonly Used Revenue Codes

### Code Description

- 100 – 129 Room and Board Charges
- 130 – 249 Semi-private; Private; Ward, Nursery, Subacute, ICU, CCU
- 250 – 259 Pharmacy
- 260 – 269 IV Therapy
- 270 – 279 Medical/Surgical Supplies & Devices
- 280 – 289 Oncology
- 290 – 299 Durable Medical Equipment (DME)
- 300 – 319 Laboratory/Laboratory Pathological
- 320 – 339 Radiology Diagnostic/Therapeutic
- 340 – 349 Nuclear Medicine
- 350 – 359 CT Scan
- 360 – 369 Operating Room Services
- 370 – 379 Anesthesia
- 410 – 449 Therapy Services
- 450 – 459 Emergency Codes
- 540 – 548 Ambulance Services
- 720 – 729 Labor and Delivery
- 730 – 750 Outpatient Surgery
- 800 – 880 Radiology
- 900 – 919 Psychiatric/Psychological
- 920 – 999 Nuclear Medicine

## Required and Conditional Field Indicator

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the services rendered to Horizon NJ Health members.

**IMPORTANT** – Referrals are valid for up to 180 days. The referral number on the claim does not generate a payment. The actual referral must be submitted with each claim to avoid claim processing delays or denials.

## 9.2.3 Taxonomy Codes

Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique ten-character alphanumeric code that enables providers to identify their specialty at the claim level.

Taxonomy codes are assigned at both the individual provider and organizational provider level. Taxonomy codes have three distinct levels: Level I is Provider Type, Level II is Classification, and Level III is the Area of Specialization. Examples and discussion of taxonomy codes can be found at <https://www.cms.gov/medicare/providerenrollment-and-certification/medicareprovidersupenroll/taxonomy.html>.

# Horizon NJ Health - Billing Guide

For paper UB04 institutional claims, the taxonomy code should be placed in box 81 and should be submitted with the "B3" qualifier. For CMS-1500 professional claims, the taxonomy code should be identified with the qualifier "ZZ" in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the "ZZ" qualifier for the billing level. Claims that do not contain these codes cannot be processed.

## CMS 1500 (08-05) Professional Claim Form (for enumerated providers)

Billing Provider NPI Field 33a  
Billing Provider TIN Field 25  
Referring Provider NPI Field 17b  
Rendering Provider NPI Field 24j  
Service Facility Location NPI Field 32a

**IMPORTANT** – Make sure that your claim software supports the revised 1500 claim form (08-05). Reference the 1500 Reference Instruction Manual at [Nucc.org](http://Nucc.org) for specific details on completing this form.

## UB-04 Paper Institutional Claim Form (for enumerated providers)

Billing Provider NPI Locator 56  
Billing Provider TIN Locator 05  
Billing Provider Taxonomy Code Locator 81  
Attending Provider NPI Locator 76  
Operating Provider NPI Locator 77  
Other Provider NPI Locator 78-79

## 9.3 Procedures for Electronic Submission – Electronic Data Interchange

**IMPORTANT** – Effective January 1, 2017, registered providers must include their taxonomy code, tax identification number, and NPI on all claims. Atypical providers, as defined by CMS, must submit their taxonomy code and their tax identification number.

**IMPORTANT** – All claims submitted electronically must be in a HIPAA compliant 837 or NCPDP format. Electronic data interchange (EDI) allows faster, more efficient and cost-effective claim submission for hospitals, physicians and health care professionals. EDI, performed in accordance with nationally recognized standards, supports the industry's efforts to reduce overhead administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

**IMPORTANT** – Referrals are valid for up to 180 days and up to 6 visits. The referral number on the claim does not generate a payment. The actual referral must be submitted with each claim to avoid claim processing delays or denials.

**Note:** Hospitals, physicians and health care professionals submitting claims electronically should make sure the referral number is present on the claim.

**Note:** EDI Technical Support Team is available during regular business hours, 8 a.m. through 5 p.m., Monday through Friday, and can be reached at **1-800-556-2231**.

### 9.3.1 Hardware/Software Requirements

There are many different products that can be used to bill electronically. Hospitals, physicians and health care professionals should send EDI claims to TriZetto TTPS whether through direct submission or through another clearinghouse/vendor using payor number 22326. Only TriZetto TTPS can submit claims electronically to Horizon NJ Health.

### Contracting with TriZetto and Other Electronic Vendors

If you are a hospital, physician or health care professional interested in submitting claims electronically to Horizon NJ Health but do not have TriZetto EDI services, contact TriZetto at **1-800-556-2231**. You may also choose to contract with another EDI clearinghouse or vendor who already has access to TriZetto EDI services.



## Contacting the EDI Technical Support Group

Hospitals, physicians and health care professionals interested in sending claims to Horizon NJ Health electronically may contact the EDI Technical Support Group for information and assistance.

Once Horizon NJ Health is notified of the intent to submit claims through EDI, the organization's contact will receive a complete list of ID numbers for Horizon NJ Health hospitals, physicians and health care professionals, the electronic payor number, TriZetto-specific edits, and any other information needed to initiate electronic billing with Horizon NJ Health.

**Note:** Physicians can contact the EDI Technical Support Group to obtain names of other EDI clearinghouses and vendors.

## Transmission Requirements

Once the material is received, proceed as follows:

- Read over the materials carefully
- Transmission can begin upon receipt of ID numbers for Horizon NJ Health individual hospitals, physicians and health care professionals

Contact the EDI Technical Support Group to answer any questions you may have. If you wish to receive confirmation to begin electronic submission, the EDI Technical Support Group will contact you via fax, mail or email on the effective day for EDI claim submission.

No approval is necessary. Contact your system vendor and/or TriZetto to inform them that you are now going to submit production claims electronically to Horizon NJ Health. You will be asked for the electronic payor address and the TriZetto-specific edits included in your Horizon NJ Health documentation.

**Note:** Contact EDI Technical Support at **1-800-556-2231** to notify them of your intention to begin EDI transmissions.

## 9.3.2 Specific Data Record Requirements

EDI claims should be submitted according to HIPAA standards. These standards can be found in the Implementation Guides written by the Designated Standard Maintenance Organizations (DSMOs) responsible for each transaction. Additional information can be found at [hipaa-dsmo.org](http://hipaa-dsmo.org).

## 9.3.3 Electronic Claim Flow Description

In order to send claims electronically to Horizon NJ Health, all EDI claims must first be forwarded to TriZetto using payor number **22326**. This can be completed via a direct submission or through another EDI clearinghouse or vendor. Once TriZetto receives the transmitted claims, they are validated against TriZetto's proprietary specifications and Horizon NJ Health-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a TriZetto error report. The name of this report can vary, based on the physician's contract with their intermediate EDI vendor or TriZetto. Claims are then passed to Horizon NJ Health, and TriZetto returns a conditional acceptance report to the sender immediately.

Claims forwarded to Horizon NJ Health by TriZetto are immediately validated against physician and member eligibility records. Claims that do not meet this requirement are rejected and sent back to TriZetto, which also forwards this rejection to its trading partner – the intermediate EDI vendor or directly to the hospital, physician or health care professional. Claims passing eligibility requirements are then passed to the claim processing queues. Claims are not considered received under timely filing guidelines if rejected for missing or invalid provider or member data.

Hospitals, physicians and health care professionals are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from TriZetto or other contracted vendors must be reviewed and validated against transmittal records daily.

**Note:** For a detailed list of TriZetto data requirements, contact EDI Technical Support at **1-800-556-2231**.

## 9.3.4 Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Horizon NJ Health must first pass TriZetto's proprietary edits and Horizon NJ Health-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at Horizon NJ Health. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the rejection notices (the functional acknowledgements to each transaction set and the unprocessed claim report) received from TriZetto or your vendor in order to identify and resubmit these claims accurately.

## Common Rejections

- Missing or invalid member ID
- Claims with missing or invalid batch level records
- Claim records with missing or invalid required fields
- Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
- Claims without or that have invalid hospital, physician or health care professional National Provider Identifier (NPI) numbers whenever applicable. Per federal requirements, atypical providers are excluded
- No physical billing address on file
- No taxonomy code

**Note:** Hospital, physician or health care professional identification number validation is not performed at the clearinghouse. Claims will be rejected if the hospital, physician or healthcare professional number fields are empty.

## 9.3.5 Submitting Corrected Claims with EDI

Providers using electronic data interchange (EDI) can submit corrected claims electronically rather than via paper to Horizon NJ Health.

**Note:** A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. The electronic corrected claim submission capability allows for faster processing, increased claims accuracy and a streamlined submission process. For your EDI clearinghouse or vendor to start using this new feature they need to:

- Use "6" for adjustment of prior claims "7" for replacement of a prior claim or "8" for a voided claim utilizing bill type in loop 2300, CLM05-03 (837P).
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- Include the Horizon NJ Health claim number in order to submit your claim with the 6, 7 or 8.
- Bill all services, not just the services that need corrections.
- Do use this indicator for claims that were previously processed (approved or denied).
- Do not use this indicator for claims that contained errors and were not processed (such as claims that did not appear on a remittance advice; i.e., rejected up front).

- Do not submit corrected claims electronically and via paper at the same time.
- Please note that either a written or stamped note stating that any claim is a corrected claim will result in that claim being returned for correction.

## 9.3.6 Electronic Billing Inquiries

Please direct inquiries as follows:

### Action

- If you would like to be authorized to transmit electronic claims
- If you have specific EDI technical questions
- If you have general EDI questions or questions on where to enter required data

### Contact

- TriZetto Technical Support at **1-800-556-2231**

### Action

- If you have questions about your claims transmissions or status reports
- Contact your System Vendor or call TriZetto at **1-800-556-2231**

### Action

- If you have questions about your claim status (receipt or completion dates)
- If you have questions about claims that are reported on the Remittance Advice
- If you need to know a provider ID number

### Contact

- **NaviNet.net.** If the required information is not found, call Provider Services at **1-800-682-9091**.

### Action

- If you would like to update provider, payee, UPIN, tax ID number, physical billing address or payment address information
- For questions about changing or verifying provider information

### Contact

**Email:** [providerfileops2@HorizonBlue.com](mailto:providerfileops2@HorizonBlue.com)  
**fax:** 1-973-274-4126  
**Provider Services at 1-800-682- 9091**

# Horizon NJ Health - Billing Guide

This guide is intended to offer hospitals, physicians and health care professionals the information required for Horizon NJ Health to accurately and efficiently process claims prepared by or for hospitals, physicians and health care professionals for medical services provided to members of our health plan. This section contains notes of interest highlighting billing information relevant to the topic detailed above them. The notes may be titled as follows:

**IMPORTANT** – Reminds the reader of claim submission problems that can be avoided. These errors can result in rejection, inaccurate claim payments or denials, usually because required information is missing, invalid, incomplete or inconsistent with standard billing practices.

**Note:** Reviews an associated piece of information, which clarifies or explains specific details about the service, but may not directly impact reimbursement. For example, place of service is required to determine eligibility for payment, but does not necessarily affect payment amount.

In the event of additional questions about Horizon NJ Health programs or policies, please review the entire Manual or contact the Provider Services at **1-800-682-9091**.

In order to comply with contractual obligations, regulatory requirements or state and federal law, Horizon NJ Health reserves the right, at any time, to modify or update information contained in this document. Notification will be posted at least 30 days prior to the effective date unless the effective date of a law or regulation does not permit this time frame. Hospitals, physicians and health care professionals may access the For Providers section of the Horizon NJ Health website at **horizonNJhealth.com** to check for updates on billing requirements and other policies and procedures relevant to reimbursements for services.

**IMPORTANT** – Horizon NJ Health, its subcontracted vendors or the State of New Jersey are responsible for payment for all services included in the member's benefit package. Services not included in the benefit package are reimbursable by the member only if the hospital, physician or health care professional notifies the member in writing and in advance of providing the service(s) of this obligation. Members should not be billed for any service covered under their benefit package. Should Horizon NJ Health require a copayment for any service or population group, an itemization of these items will be included in the benefit listing and will be available on the website. The practice of balance billing Medicaid/NJFC and FIDE-SNP beneficiaries, whether eligible for FFS benefits or enrolled in managed care, is prohibited under both federal and State law. These prohibitions apply to both Medicaid/NJFC-only beneficiaries, as well as those eligible for Medicare coverage or other insurance. A provider enrolled

in the Medicaid/NJFC FFS program or in managed care is required to accept as **payment in full** the reimbursement rate established by the FFS program or managed care plan.

All costs related to the delivery of health care benefits to a Medicaid/NJFC eligible beneficiary, other than authorized cost sharing, are the responsibility of the FFS program, the managed care plan, Medicare (if applicable) and/or a third-party payer (if applicable). If a provider receives a Medicaid/NJFC FFS or managed care payment, the provider shall accept this payment as payment in full and shall not bill the beneficiary or anyone on the beneficiary's behalf for any additional charges.

## 9.1 Requirements for Filing Claims

### 9.1.1 General Requirements

Horizon NJ Health is a Medicaid managed care plan that is under contract with the New Jersey Department of Human Services. Horizon NJ Health will pay claims based only on eligible charges. Unless the provider contract states otherwise, claims will be paid on the lesser of billed charges or

the contracted rate (Horizon NJ Health fee schedule). Claims submitted by nonparticipating Horizon NJ Health providers will be paid on the lesser of billed charges or the Horizon NJ Health nonparticipating provider fee schedule. Consistent with CFR 42 Part § 447.45: the following definition shall apply to clean claims as used within the Horizon NJ Health Billing Guide:

“Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.”

Under the New Jersey Health Claims Authorization, Processing and Payment Act, claims must also meet the following criteria:

- (a) the health care provider is eligible at the date of service
- (b) the person who received the health care service was covered on the date of service
- (c) the claim is for a service or supply covered under the health benefits plan
- (d) the claim is submitted with all the information requested by the payor on the claim form or in other instructions that were distributed in advance to the health care provider or covered person in accordance with the provisions of section 4 of P.L.2005, c.352 (C.17B:30-51)
- (e) the payor has no reason to believe that the claim has been submitted fraudulently

Other requirements, such as timeliness of claims processing includes:

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing. Horizon NJ Health shall pay all clean claims from hospitals, physicians and other health care professionals within 30 days of the date of receipt of EDI claims and within 40 days for paper claims. MLTSS claims will be paid within 15 days of the receipt of EDI claims and within 30 days for paper claims.

The time limitation does not apply to claims from providers under investigation for fraud or abuse. The date of receipt is the date Horizon NJ Health receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Horizon NJ Health is required to report all claims to the State of New Jersey for services provided to members through electronic media. Practitioners and facilities may not use a PO Box as an acceptable billing address. A physical street address must be used. In addition, when submitting ZIP codes anywhere on a claim, practitioners and facilities must use the full nine-digit format. Therefore, all billing addresses, whether submitted on paper or electronically, must contain a physical billing address. To have payments sent to a different address or PO Box, the pay-to provider name and address field on the 837-I and 837-P transaction must be used.

## 9.1.2 National Practitioner Identifier (NPI)

Horizon NJ Health requires all practitioners use their NPI numbers for all claim submissions. To ensure our systems properly identify you as an individual, group or facility, Horizon NJ Health requires you register the NPI with your taxonomy and tax identification numbers. Another requirement that will affect both timeliness and payment is the use of name differential on your W-9. Horizon NJ Health continues to accept the use of your provider identification numbers (legacy ID). The continued use of the legacy ID is recommended, as the claims processing system uses this number for adjudication and payment activities. Please make sure your name matches the name used on your W-9. Below are some helpful hints, which will facilitate accurate and consistent management of your claims.

- Physicians, facilities, and health care professionals are required to have an NPI. Please register for one if you have not already secured your NPI.

- Groups are not technically required to have an NPI, but are encouraged to have one as long as there is a legal entity associated with the business name and tax identification number. To register the group NPI with Horizon NJ Health, we will need the W-9 for the business and all associated individual NPIs paid to that tax ID number.
- Facilities, including hospitals and groups chosen to subpart their type 2 NPI, will need to choose a master NPI if all of the registered numbers are under the same tax identification number. Designating a master NPI number will help Horizon NJ Health assign claims to the right location for payment purposes. A valid W-9 for the business and all associated individual NPIs that are paid to that tax ID number should be registered with Horizon NJ Health.
- Where an NPI number is shared among different locations using the same tax ID number, the Horizon NJ Health legacy ID is needed to distinguish where the claim payment should be sent.
- Nonparticipating practitioners and facilities are also required to adhere to the NPI requirements. To facilitate payment for claims, Horizon NJ Health encourages you to register your NPI with us in the same manner described above. To complete this task, please visit the "For Providers" section of [horizonNJhealth.com](http://horizonNJhealth.com) and download our NPI Collection Form. Once completed, fax your forms and CMS documentation to Horizon NJ Health at **1-609-583-3004**.

## 9.1.3 Procedures for Claim Submission

Horizon NJ Health is required by state and federal regulations to capture and report specific data regarding services rendered to its members. All services rendered, including capitated encounters and fee-for-service claims, must be submitted on the CMS 1500 (HCFA1500) version 02/12 or UB-04 claims form, or via electronic submission in a HIPAA — compliant 837 or NCPDP format. Horizon NJ Health does not accept handwritten or stamped claims. These claims forms and electronic submissions must be consistent with the instructions provided by CMS requirements, as stated in the CMS Claims Manual, which can be accessed at [cms.gov/Manuals/IOM/list.asp](http://cms.gov/Manuals/IOM/list.asp).

The hospital, physician and health care professional, to appropriately account for services rendered and to ensure timely processing of claims, must adhere to all billing requirements.

# Horizon NJ Health - Billing Guide

When data elements are missing, incomplete, invalid or coded incorrectly, Horizon NJ Health cannot process the claims.

- Claims for billable services provided to Horizon NJ Health members must be submitted by the hospital, physician or health care professional that performed the services.
- Professional services are not reimbursable to a hospital unless the hospital is specifically contracted for professional services. Horizon NJ Health policy is to reimburse these services only when billed on a CMS 1500.
- Claims filed with Horizon NJ Health are subject to the following procedures:
  - Verification that all required fields are completed on the claim
  - Verification that all diagnosis codes, modifiers and procedure codes are valid for the date of service
  - When appropriate, verification of the referral for specialist or non-primary care physician claims (excluding “self-referral” types of care)
  - Verification of member’s eligibility for services under Horizon NJ Health during the time period in which services were provided
  - Verification that the services were provided by a participating or nonparticipating hospital, physician or health care professional that has received authorization to provide services to the eligible member
  - Verification that the hospital, physician or health care professional has been given approval for services that require prior authorization by Horizon NJ Health
- Horizon NJ Health is the “payor of last resort” on all claims submitted for members of its health plan. Hospitals, physicians and health care professionals must verify whether the member has Medicare coverage or any other third party resources and, if so, provide documentation that the claim was first processed by this other insurer as appropriate.

**IMPORTANT** – Rejected claims are defined as claims with invalid or missing data elements, such as the tax ID number, that are returned to the submitter or EDI source without registration in the claim processing system. Since rejected claims are not registered in the claim processing system, the hospital, physician or health care professional must re-submit clean claims within 180 calendar days from the date of service. This guideline applies to claims submitted on paper or electronically. Rejected claims are different than denied claims, which are registered in the claim processing system, but do not meet requirements for payment under Horizon NJ Health guidelines.

Horizon NJ Health encourages all hospitals, physicians, and health care professionals to submit claims electronically. We utilize the TriZetto Provider Solutions (TTPS) Direct Data Entry (DDE) SimpleClaim system. All providers that previously used Emdeon to directly enter their Horizon NJ Health claims must switch to DDE SimpleClaim.

For more information on registering, please go to <https://trizettoprovidersolutions.wufoo.com/forms/horizon-nj-health-providers>. If you have any further questions about registering with TTPS for DDE claim submission, please call TriZetto at **1-800-556-2231** or email [ttpsupport@cognizant.com](mailto:ttpsupport@cognizant.com).

While Horizon NJ Health strongly encourages submitting claims via EDI, if a paper claim is necessary, please submit red and white paper claims only for all medical services to Horizon NJ Health at the following address:

**Horizon NJ Health  
Claims Processing Department  
PO Box 24078  
Newark, NJ 07101-0406**

**Note:** Out-of-state, non-Horizon NJ Health providers should send claims to their local Blue Cross Blue Shield Plan.

**IMPORTANT** – Requests for reimbursement for retail pharmacy and all outpatient drugs for persons designated as aged, blind or disabled should be submitted directly to the State of New Jersey.

**IMPORTANT** – Requests for reimbursement for mental health services for all enrollees, except the developmentally disabled, FIDE-SNP or MLTSS members, should be submitted directly to the State of New Jersey.

**Note:** Be sure to include the member’s Medicaid ID number on all claims submitted to the State of New Jersey.

**Note:** Horizon NJ Health subcontracts with Davis Vision to provide and/or coordinate vision services for eligible members. All services, except ophthalmologic procedures, are coordinated and paid by Davis Vision. Please call **1-877-226-3729** for information about submitting invoices.

**Note:** Horizon NJ Health subcontracts with Scion Dental to provide and/or coordinate dental services for eligible members. Please call the Provider Call Center at **1-855-878-5368** for routine provider questions related to eligibility, claims, authorizations, credentialing, contracting, adding/changing provider data/locations, and fee schedules.

# Horizon NJ Health - Billing Guide

**Note:** Horizon NJ Health subcontracts with Laboratory Corporation of America, Inc. (LabCorp) for most routine and specialized laboratory services. Generally, Horizon NJ Health is responsible for payment of claims for PAT/STAT laboratory service provided in hospitals and ambulatory surgical centers. Horizon NJ Health will also provide reimbursements for claims for laboratory services included on LabCorp's excluded test listing. An authorization is required for any test included on this listing; please submit claims to Horizon NJ Health as specified above. Unless otherwise specified within specific contractual arrangements, laboratory services should be referred to LabCorp.

## 9.1.4 Claim Filing Deadlines

Horizon NJ Health must receive all claims within 180 calendar days from the initial date when services were rendered. If claims are not received within 180 calendar days from the initial date of service, claims will be denied for untimely filing. COB claims must be submitted within 60 days from the date of the primary insurer's EOB.

- Horizon NJ Health's Appeals Department utilizes specific criteria when reviewing valid proof of timely filing.
- Member's name
- Horizon NJ Health or Medicaid ID number
- Billed amount
- Date of service
- Billed/mailed date
- Address where the claim form was sent (Horizon NJ Health or insurance code)
- For EDI submissions, a 999 report indicating submission to the correct insurance code is required for consideration of timely submission.

### For claims selected electronically:

- Submit an electronic data interchange (EDI) acceptance report. This must show that Horizon NJ Health or one of its affiliates received, accepted and/or acknowledged the claim submission.

**Note:** A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.

- The acceptance report must:
  1. Include the actual wording that indicates the claim was either "accepted," "received" and/or "acknowledged."  
(Abbreviations of those words are also acceptable.)
  2. Show the claim was accepted, received, and/or acknowledged within the timely filing period.

### For paper claims:

1. The submission date must be within the timely filing period.
2. Certified mail receipts as valid proof of timely filing.
3. Only red and white paper claims can be processed.

### Other valid proof of timely filing documentation

Valid when incorrect insurance information was provided by the patient at the time the service was rendered:

- A denial/rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating coverage termination prior to the date of service of the claim
- Letter from another insurance carrier or employer group indicating no coverage for the patient on the date of service of the claim

All of the above must include documentation that the claim is for the correct patient and the correct date of service. The date on the other carrier's payment correspondence starts the timely filing period for submission to Horizon NJ Health. In order to be considered timely, the claim must be received by Horizon NJ Health within 60 days from the date on the other carrier's correspondence. Not including all of the information requested will result in a rejected inquiry or a delay in response. If the claim is received after the timely filing period, it will not meet timely filing criteria.

**REFER TO SECTION 10** – Section 10.0 Complaint and Appeals Process for complete instructions of the submission time frames and procedures for administrative or medical appeals.

## 9.1.5. Filing Corrected Claims

### For paper claims:

CMS-1500 should be submitted with the appropriate resubmission code (value of 7) in Box 22 of the paper claim with the original claim number of the corrected claim and a copy of the original Explanation of Payment (EOP). With the original claim number for which the corrected claim is being submitted. Horizon NJ Health will reject any claims that are not submitted on red and white forms or that have any handwriting on them.

### For UB-04 claims:

UB-04 claims should be submitted with the appropriate resubmission code in the third digit of the bill type (for corrected claim this will be 7), the original claim number in Box 64 of the paper claim and a copy of the original EOP.

# Horizon NJ Health - Billing Guide

Send red and white paper corrected claims to:

**Horizon NJ Health**  
**Claims Processing Department**  
**PO Box 24078**  
**Newark, NJ 07101-0406**

## Correcting electronic HCFA 1500 claims:

EDI 837P data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF\*F8\* with the original claim number for which the corrected claim is being submitted.

## Correcting electronic UB-04 claims:

EDI 837I data should be sent in the 2300 Loop, segment CLM05 (with value of 7) along with an addition loop in the 2300 loop, segment REF \*F8\* with the original claim number for which the corrected claim is being submitted.

Both paper and electronic claims must be submitted within 365 calendar days from the initial date of service.

## 9.2 Claim Forms (Paper)

Horizon NJ Health requires that all hospitals, physicians and health care professionals use the standard CMS 1500 (HCFA 1500) or UB-04 claim forms to report services, which are reimbursable or capitated. The CMS 1500 (HCFA 1500) claim form must be completed for all professional medical services. The UB-04 claim form must be completed for all facility claims. When services are rendered by MLTSS providers, facilities should file a UB-04 form, and nonfacilities should use the CMS 1500.

**Horizon NJ Health does not accept handwritten or black and white claims.**

### 9.2.1 CMS 1500 (HCFA 1500) Claim Form

#### (Paper Submission)

The CMS 1500 (HCFA 1500) Paper Submissions claim form must be used to bill all professional services to Horizon NJ Health. Horizon NJ Health only accepts form version 02/12. The National Uniform Claim Committee (NUCC) created the CMS 1500 form (version 02/12) to accommodate coding changes for ICD-10. There are two significant changes on the revised CMS 1500, the claim form used to submit paper claims to Medicare and the required claim form to submit paper claims to Horizon NJ Health.

The CMS 1500 Form (version 02/12) gives physicians the ability to

- Identify whether they are using ICD-9-CM or ICD-10-CM codes.
- Include up to 12 codes in the diagnosis field (the limit on the 08/05 version is four codes in the diagnosis field).
- Include information that will improve the accuracy of the data reported, such as being able to identify the role of the provider and specific dates of illness.
- Align paper copy claim submissions with the ASC X12 Health Care Claim: Professional (837P) transaction.

CMS has advised providers to use the following process to assure clean claims submission. All information must be:

- Aligned within the data fields.
- On an original red ink on white paper claim 02/12 version form.
- Typed. Do not print, handwrite or stamp any extraneous data on the form.
- In black ink.
- In large, dark font, such as PICA or ARIAL 10-, 11- or 12-point type.
- In capital letters.

More information about Administrative Simplification and Compliance Act (ASCA) exceptions can be found in Chapter 24 of the "Medicare Claims Processing Manual," which is available on the CMS website at [cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf).

#### Required Fields for CMS 1500 (HCFA 1500) Claim Form

This section will provide the list of required fields for Horizon NJ Health; however, you must refer to the most current CMS coding instructions for a complete list of codes and requirements.

# Horizon NJ Health - Billing Guide

## Place of Service Codes

### Code Description

- 11 Office
- 12 Home
- 19 Off Campus - Outpatient Hospital
- 20 Urgent Care Facility
- 21 Inpatient Hospital
- 22 Outpatient Hospital
- 23 Emergency Room – Hospital
- 24 Ambulatory Surgical Center
- 25 Birthing Center
- 26 Military Treatment Facility
- 31 Skilled Nursing Facility
- 32 Nursing Facility
- 33 Custodial Care Facility
- 34 Hospice
- 41 Ambulance – Land
- 42 Ambulance – Air or Water
- 50 Federally Qualified Health Center
- 51 Inpatient Psychiatric Facility
- 52 Psychiatric Residential Treatment Center
- 53 Community Mental Health Center
- 54 Intermediate Care Facility/Mentally Retarded
- 55 Residential Substance Use Disorder Treatment Center
- 56 Psychiatric Residential Treatment Center
- 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
- 99 Other Unlisted Facility

## Type of Service Codes

### Code Description

- 1 Medical Services
- 2 Surgery
- 3 Consultations
- 4 Radiology (total component)
- 5 Laboratory (total component)
- 6 Radiation Therapy (total component)
- 7 Anesthesia
- 8 Assistant Surgery
- 9 Other (e.g., prosthetic eyewear, contacts, ambulance)
- D DME
- F ASC

## Required and Conditional Field Indicator

**IMPORTANT** – An authorization number and/or referral number must be included in box #23 on a CMS 1500 (HCFA 1500) claim form or box #63 on a UB-04 form. The required fields that must be completed for the standard CMS 1500 (HCFA 1500) or UB-04 claim forms are in the respective claim form areas. If the field is required without exception, an “R” (required) is noted in the “Required or Conditional” box. If completing the field is dependent upon certain circumstances, the requirement is listed as “C” (conditional) and the relevant conditions are explained in the “Instructions and Comments” box.

### 9.2.2 The UB-04 (CMS 1450) Claim Form (Paper)

The UB-04 (CMS 1450) claim form must be used to bill all facility services to Horizon NJ Health. This section will provide the list of required fields for Horizon NJ Health. However, you must refer to the most current CMS coding instructions for a complete list of codes and requirements.

## Type of Bill Codes

### Code Description

- 111 Hospital/Inpatient (Part A)/Admit through Discharge

### Code Description

- 112 Hospital/Inpatient (Part A)/Interim – First Claim
- 113 Hospital/Inpatient (Part A)/Interim – Continuing Claims
- 114 Hospital/Inpatient (Part A)/Interim – Last Claim
- 115 Hospital/Inpatient (Part A)/Late Charge Only
- 117 Hospital/Inpatient (Part A)/Replacement of Prior Claim
- 121 Hospital/Hospital Based or Inpatient(Part B)/Admit Through Discharge
- 131 Hospital/Outpatient/Admit Through Discharge
- 211 Skilled Nursing/Inpatient (Part A)/Admit Through Discharge
- 212 Skilled Nursing/Inpatient (Part A)/Interim – First Claim
- 213 Skilled Nursing/Inpatient (Part A)/Interim – Continuing Claims
- 214 Skilled Nursing/Inpatient (Part A)/Interim – Last Claim
- 321 Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge
- 322 Hospice Interim – First Claim
- 323 Hospice Interim -- Continuing Claim
- 324 Hospice Interim – Final Claim
- 331 Home Health/Hospital Based or Inpatient (Part B)/Admit Through Discharge



# Horizon NJ Health - Billing Guide

- 711 Clinic/Rural Health Clinic (RHC)/Admit Through Discharge
- 721 Clinic/Independent Renal Dialysis Facility/Admit through Discharge
- 731 Clinic/FQHC/Admit Through Discharge
- 831 Special Facility or Hospital ASC/ASC for Outpatients/Admit Through Discharge

## Type of Admission Codes

### Code Description

- 1 Emergency
- 2 Urgent
- 3 Elective

## Patient Status Codes

### Code Description

- 01 Discharged to Home or Self Care (routine discharge)
- 02 Discharged/Transferred to Another Short-Term General Hospital
- 03 Discharged/Transferred to SNF
- 04 Discharged/Transferred to ICF
- 05 Discharged/Transferred to Another Type of Institution (including distinct parts) or Referred for Outpatient Services to Another Institution
- 06 Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
- 07 Left Against Medical Advice
- 08 Discharged/Transferred to Home Under Care of an IV Drug Therapy Provider
- 09 Admitted as an Inpatient to this Hospital
- 20 Expired (or did not recover – Christian Science Patient)
- 30 Still Patient or Expected to Return for Outpatient Services
- 40 Expired at Home (hospice claims only)
- 41 Expired in a Medical Facility, such as Hospital, SNF, ICF or Freestanding Hospice (hospice claims only)
- 42 Expired – Place Unknown (hospice claims only)
- 50 Hospice – Home
- 51 Hospice – Medical Facility

## Commonly Used Revenue Codes

### Code Description

- 100 – 129 Room and Board Charges
- 130 – 249 Semi-private; Private; Ward, Nursery, Subacute, ICU, CCU
- 250 – 259 Pharmacy
- 260 – 269 IV Therapy
- 270 – 279 Medical/Surgical Supplies & Devices
- 280 – 289 Oncology
- 290 – 299 Durable Medical Equipment (DME)
- 300 – 319 Laboratory/Laboratory Pathological
- 320 – 339 Radiology Diagnostic/Therapeutic
- 340 – 349 Nuclear Medicine
- 350 – 359 CT Scan
- 360 – 369 Operating Room Services
- 370 – 379 Anesthesia
- 410 – 449 Therapy Services
- 450 – 459 Emergency Codes
- 540 – 548 Ambulance Services
- 720 – 729 Labor and Delivery
- 730 – 750 Outpatient Surgery
- 800 – 880 Radiology
- 900 – 919 Psychiatric/Psychological
- 920 – 999 Nuclear Medicine

## Required and Conditional Field Indicator

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the services rendered to Horizon NJ Health members.

**IMPORTANT** – Referrals are valid for up to 180 days. The referral number on the claim does not generate a payment. The actual referral must be submitted with each claim to avoid claim processing delays or denials.

## 9.2.3 Taxonomy Codes

Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers. Each taxonomy code is a unique ten-character alphanumeric code that enables providers to identify their specialty at the claim level.

Taxonomy codes are assigned at both the individual provider and organizational provider level. Taxonomy codes have three distinct levels: Level I is Provider Type, Level II is Classification, and Level III is the Area of Specialization. Examples and discussion of taxonomy codes can be found at <https://www.cms.gov/medicare/providerenrollment-and-certification/medicareprovidersupenroll/taxonomy.html>.

# Horizon NJ Health - Billing Guide

For paper UB04 institutional claims, the taxonomy code should be placed in box 81 and should be submitted with the "B3" qualifier. For CMS-1500 professional claims, the taxonomy code should be identified with the qualifier "ZZ" in the shaded portion of box 24i. The taxonomy code should be placed in the shaded portion of box 24j for the rendering level and in box 33b preceded with the "ZZ" qualifier for the billing level. Claims that do not contain these codes cannot be processed.

## CMS 1500 (08-05) Professional Claim Form (for enumerated providers)

Billing Provider NPI Field 33a  
Billing Provider TIN Field 25  
Referring Provider NPI Field 17b  
Rendering Provider NPI Field 24j  
Service Facility Location NPI Field 32a

**IMPORTANT** – Make sure that your claim software supports the revised 1500 claim form (08-05). Reference the 1500 Reference Instruction Manual at [Nucc.org](http://Nucc.org) for specific details on completing this form.

## UB-04 Paper Institutional Claim Form (for enumerated providers)

Billing Provider NPI Locator 56  
Billing Provider TIN Locator 05  
Billing Provider Taxonomy Code Locator 81  
Attending Provider NPI Locator 76  
Operating Provider NPI Locator 77  
Other Provider NPI Locator 78-79

## 9.3 Procedures for Electronic Submission – Electronic Data Interchange

**IMPORTANT** – Effective January 1, 2017, registered providers must include their taxonomy code, tax identification number, and NPI on all claims. Atypical providers, as defined by CMS, must submit their taxonomy code and their tax identification number.

**IMPORTANT** – All claims submitted electronically must be in a HIPAA compliant 837 or NCPDP format. Electronic data interchange (EDI) allows faster, more efficient and cost-effective claim submission for hospitals, physicians and health care professionals. EDI, performed in accordance with nationally recognized standards, supports the industry's efforts to reduce overhead administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

**IMPORTANT** – Referrals are valid for up to 180 days and up to 6 visits. The referral number on the claim does not generate a payment. The actual referral must be submitted with each claim to avoid claim processing delays or denials.

**Note:** Hospitals, physicians and health care professionals submitting claims electronically should make sure the referral number is present on the claim.

**Note:** EDI Technical Support Team is available during regular business hours, 8 a.m. through 5 p.m., Monday through Friday, and can be reached at **1-800-556-2231**.

### 9.3.1 Hardware/Software Requirements

There are many different products that can be used to bill electronically. Hospitals, physicians and health care professionals should send EDI claims to TriZetto TTPS whether through direct submission or through another clearinghouse/vendor using payor number 22326. Only TriZetto TTPS can submit claims electronically to Horizon NJ Health.

### Contracting with TriZetto and Other Electronic Vendors

If you are a hospital, physician or health care professional interested in submitting claims electronically to Horizon NJ Health but do not have TriZetto EDI services, contact TriZetto at **1-800-556-2231**. You may also choose to contract with another EDI clearinghouse or vendor who already has access to TriZetto EDI services.

## Contacting the EDI Technical Support Group

Hospitals, physicians and health care professionals interested in sending claims to Horizon NJ Health electronically may contact the EDI Technical Support Group for information and assistance.

Once Horizon NJ Health is notified of the intent to submit claims through EDI, the organization's contact will receive a complete list of ID numbers for Horizon NJ Health hospitals, physicians and health care professionals, the electronic payor number, TriZetto-specific edits, and any other information needed to initiate electronic billing with Horizon NJ Health.

**Note:** Physicians can contact the EDI Technical Support Group to obtain names of other EDI clearinghouses and vendors.

## Transmission Requirements

Once the material is received, proceed as follows:

- Read over the materials carefully
- Transmission can begin upon receipt of ID numbers for Horizon NJ Health individual hospitals, physicians and health care professionals

Contact the EDI Technical Support Group to answer any questions you may have. If you wish to receive confirmation to begin electronic submission, the EDI Technical Support Group will contact you via fax, mail or email on the effective day for EDI claim submission.

No approval is necessary. Contact your system vendor and/or TriZetto to inform them that you are now going to submit production claims electronically to Horizon NJ Health. You will be asked for the electronic payor address and the TriZetto-specific edits included in your Horizon NJ Health documentation.

**Note:** Contact EDI Technical Support at **1-800-556-2231** to notify them of your intention to begin EDI transmissions.

## 9.3.2 Specific Data Record Requirements

EDI claims should be submitted according to HIPAA standards. These standards can be found in the Implementation Guides written by the Designated Standard Maintenance Organizations (DSMOs) responsible for each transaction. Additional information can be found at [hipaa-dsmo.org](http://hipaa-dsmo.org).

## 9.3.3 Electronic Claim Flow Description

In order to send claims electronically to Horizon NJ Health, all EDI claims must first be forwarded to TriZetto using payor number **22326**. This can be completed via a direct submission or through another EDI clearinghouse or vendor. Once TriZetto receives the transmitted claims, they are validated against TriZetto's proprietary specifications and Horizon NJ Health-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a TriZetto error report. The name of this report can vary, based on the physician's contract with their intermediate EDI vendor or TriZetto. Claims are then passed to Horizon NJ Health, and TriZetto returns a conditional acceptance report to the sender immediately.

Claims forwarded to Horizon NJ Health by TriZetto are immediately validated against physician and member eligibility records. Claims that do not meet this requirement are rejected and sent back to TriZetto, which also forwards this rejection to its trading partner – the intermediate EDI vendor or directly to the hospital, physician or health care professional. Claims passing eligibility requirements are then passed to the claim processing queues. Claims are not considered received under timely filing guidelines if rejected for missing or invalid provider or member data.

Hospitals, physicians and health care professionals are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from TriZetto or other contracted vendors must be reviewed and validated against transmittal records daily.

**Note:** For a detailed list of TriZetto data requirements, contact EDI Technical Support at **1-800-556-2231**.

## 9.3.4 Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Horizon NJ Health must first pass TriZetto's proprietary edits and Horizon NJ Health-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at Horizon NJ Health. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the rejection notices (the functional acknowledgements to each transaction set and the unprocessed claim report) received from TriZetto or your vendor in order to identify and resubmit these claims accurately.

## Common Rejections

- Missing or invalid member ID
- Claims with missing or invalid batch level records
- Claim records with missing or invalid required fields
- Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
- Claims without or that have invalid hospital, physician or health care professional National Provider Identifier (NPI) numbers whenever applicable. Per federal requirements, atypical providers are excluded
- No physical billing address on file
- No taxonomy code

**Note:** Hospital, physician or health care professional identification number validation is not performed at the clearinghouse. Claims will be rejected if the hospital, physician or healthcare professional number fields are empty.

## 9.3.5 Submitting Corrected Claims with EDI

Providers using electronic data interchange (EDI) can submit corrected claims electronically rather than via paper to Horizon NJ Health.

**Note:** A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. The electronic corrected claim submission capability allows for faster processing, increased claims accuracy and a streamlined submission process. For your EDI clearinghouse or vendor to start using this new feature they need to:

- Use "6" for adjustment of prior claims "7" for replacement of a prior claim or "8" for a voided claim utilizing bill type in loop 2300, CLM05-03 (837P).
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- Include the Horizon NJ Health claim number in order to submit your claim with the 6, 7 or 8.
- Bill all services, not just the services that need corrections.
- Do use this indicator for claims that were previously processed (approved or denied).
- Do not use this indicator for claims that contained errors and were not processed (such as claims that did not appear on a remittance advice; i.e., rejected up front).

- Do not submit corrected claims electronically and via paper at the same time.
- Please note that either a written or stamped note stating that any claim is a corrected claim will result in that claim being returned for correction.

## 9.3.6 Electronic Billing Inquiries

Please direct inquiries as follows:

### Action

- If you would like to be authorized to transmit electronic claims
- If you have specific EDI technical questions
- If you have general EDI questions or questions on where to enter required data

### Contact

- TriZetto Technical Support at **1-800-556-2231**

### Action

- If you have questions about your claims transmissions or status reports
- Contact your System Vendor or call TriZetto at **1-800-556-2231**

### Action

- If you have questions about your claim status (receipt or completion dates)
- If you have questions about claims that are reported on the Remittance Advice
- If you need to know a provider ID number

### Contact

- **NaviNet.net.** If the required information is not found, call Provider Services at **1-800-682-9091**.

### Action

- If you would like to update provider, payee, UPIN, tax ID number, physical billing address or payment address information
- For questions about changing or verifying provider information

### Contact

**Email:** [providerfileops2@HorizonBlue.com](mailto:providerfileops2@HorizonBlue.com)  
**fax:** 1-973-274-4126  
**Provider Services at 1-800-682- 9091**

## 9.4 Common Coding Requirements

### 9.4.1 Diagnosis Codes

All claims must include the proper ICD-10-CM diagnostic code.

The Centers for Medicare and Medicaid Services (CMS) provides specific guidelines to aid in standardizing U.S. coding practices. The guidelines for outpatient facilities, physician offices and ancillary care are summarized below:

- Identify each service, procedure or supply with an ICD-10-CM code to describe the diagnosis, symptom, complaint, condition or problem.
- Identify services or visits for circumstances other than disease or injury, such as follow-up care after chemotherapy, with V codes provided for this purpose.
- Code the primary diagnosis first, followed by the secondary, tertiary and so on. Code any coexisting conditions that affect the treatment of the patient. Do not code a diagnosis that is no longer applicable.
- Code to the highest degree of specificity. Carry the numerical code to the fourth or fifth digit when available. Remember, there are only approximately 100 valid three-digit codes; all other ICD-10-CM codes require additional digits.
- Code a chronic diagnosis, when it is applicable to the patient's treatment.
- When only ancillary services are provided, list the appropriate V code first and the problem second. For example, if a patient is receiving only ancillary therapeutic services, such as physical therapy, use the V code first, followed by the code for the condition.
- For surgical procedures, code the diagnosis applicable to the procedure. If, after the procedure has been done, the condition necessitating the surgery is more specifically identified, or even determined to be different than the preoperative diagnosis, code the most specific diagnosis determined to be the reason for the surgery.

Horizon NJ Health has adopted these diagnosis guidelines for its health plan and recommends that hospitals, physicians and health care professionals remain informed about these requirements through updated ICD-10-CM coding manuals. Both the State of New Jersey and the HIPAA transaction code sets require the use of a diagnosis code on all claims. To ensure that diagnosis codes are accurate, use the appropriate codes from the most recent ICD-10-CM coding manuals. Using deleted or incorrect codes will result in inability to process your claim or payment delays.

### 9.4.2 Procedure Codes

#### Common Procedure Terminology

CPT is a standardized system of five-digit codes and descriptive terms used to report the medical services and procedures performed by physicians or health care professionals. It was developed and is updated and published annually by the American Medical Association (AMA). CPT codes communicate to physicians, health care professionals, patients and payors the procedures performed during a medical encounter. Accurate coding is crucial for proper reimbursement from payors and compliance with government regulations.

The AMA revises and publishes the CPT Book on an annual basis. Appendix B of CPT always consists of a summary of additions, deletions and revisions to the current edition. Of these three types of changes, only the descriptions of revised codes appear in Appendix B, so you must refer to the manual itself to look at the descriptors of the new codes.

All physicians and health care professionals must use the appropriate procedure codes from the most recent HCPCS and CPT coding manuals or quarterly updates. Claim processing cannot be completed without accurate procedure codes, which reflect the services provided to enrollees.

### 9.4.3 Modifiers

Modifiers are used to report that the procedure has been altered by a specific circumstance. Modifiers provide valuable information about the actual services rendered, reimbursement and payment data. Modifiers also provide for coding consistency and editing for Level I (Common Procedure Terminology Codes) and Level II (Healthcare Common Procedure Coding System).

Sometimes, CPT codes require the addition of two-digit modifiers. CPT modifiers allow you to show that a service was altered in some way from the stated CPT Book description. Because the use of modifiers is frequently the only way to alter the meaning of a CPT code, it is very important to know how to use modifiers correctly.

## Modifiers can indicate:

- A service or procedure has both a professional and a technical component
- A service or procedure was performed by more than one physician
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred

Use the appropriate modifier from the most recent HCPCS and CPT coding manuals. Using deleted or incorrect codes and failing to use a modifier can result in denials, incorrect payments or claim payment delays.

**IMPORTANT** – Modifiers should not be used for multiple evaluation and management events unless the activity occurs at separate times on the same day. The Evaluation and Management Services Guide from CMS will be used by Horizon NJ Health to determine the appropriateness of coding submitted by physicians and health care professions, including the use of modifiers.

For more information on the Evaluation and Management Services Guide, please visit the Medicare Learning Network (MLN) at [cms.gov/MLNGenInfo](https://cms.gov/MLNGenInfo).

**Note:** These modifiers are subject to change. Consult the current CPT or HCPCS publications for the most up-to-date modifier list.

## 9.4.4 Units

The number of units or times a particular service is performed must be accurately indicated on all claims. When spanning dates of services, the number of units must match the count of the actual days within the spanned dates. If services were performed intermittently throughout the spanned dates of services, each date must be listed separately on the bill or an itemized statement must be submitted along with the claim.

When billing for loaded mileage, exact mileage must be identified on the claim. When billing for observation, units are equivalent to hours. All anesthesia providers are required to indicate the true amount of minutes in the days/units field of the claim form when billing for services.

**IMPORTANT** – The number of units and the service dates must be coordinated in order to obtain the most accurate reimbursement for the services billed. Services performed once (one date of service) must be indicated with a “1” in the unit’s field.

## 9.4.5 Other Coding

Use the appropriate coding as indicated in the official guides for the CMS 1500 and UB-04 claim forms or HIPAA-compliant electronic transaction sets when completing additional fields such as bill type, place of service and type of service. Incorrect coding can cause under- or over-payments or claim payment delays.

## 9.4.6 Taxonomy Codes

Taxonomy codes on electronic claim submissions with the ASC X12N 837P and 837I format are placed in segment PRV03 and loop 2000A for the billing level and segment PRV03 and loop 2420A for the rendering level.

## 9.4.7 Pharmacy (HCPC Codes)

When billing for all “J” and “Q” codes via revenue codes, the appropriate National Drug Codes (NDC) number, metric units, unit of measure, and revenue code must be submitted as well. Failure to submit the NDC number, metric units, unit of measure, and revenue code along with the “J” or “Q” code will result in the claim being rejected. This guideline applies to all claims.

## 9.4.8 Vaccine Administration Services

When billing for the administration of vaccines, only one initial administration code can be reported per day, regardless of vaccine administration method. For example: CPT codes 90460 (18 years and younger), 90471 and 90473 are initial administration codes and cannot be billed on the same date. When billing multiple vaccine administration codes, please report as multiple units on one line. For example, if you have 3 units of one vaccine administration code, please bill the code on one line with 3 units.

## 9.5 Common Causes of Claim Processing Delays, Rejections or Denials

- Authorization or referral number invalid or missing
- Billed charges missing or incomplete
- Claim information does not match authorization
- Coordination of benefits (COB) information missing or incomplete
- Diagnosis code missing 4th or 5th digit
- Diagnosis, procedure or modifier codes invalid or missing
- DRG codes missing or invalid
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) information missing or incomplete

# Horizon NJ Health - Billing Guide

- Eligibility/enrollment is not valid on DOS
- Employer identification number (EIN) missing or invalid
- Explanation of benefits (EOB) missing or incomplete
- Hospital, physician or health care professional identification number missing or invalid
- Illegible claim information
- Incomplete forms
- Payor or other insurer information missing or incomplete
- Place of service code missing or invalid
- Procedure/service code does not match authorization
- Physician name missing or invalid
- Revenue codes missing or invalid
- Spanning dates of service do not match the listed days/units
- Signature missing
- Third-party liability (TPL) information missing or incomplete
- Type of service code missing or invalid
- When billing urgent care center claims, Horizon NJ Health reimburses facilities only and not the individual providers. Urgent care centers are reimbursed at an all-inclusive case rate.

## 9.5.1 Newborn Claim Information Missing or Invalid

All newborns receive an individual member number. Please check the Electronic Medicaid Eligibility Verification System (EMEVS) for the Medicaid number and include it when the claim is billed. Always include the first and last name of the mother and baby on the claim. If the baby has not been named, insert "Girl" or "Boy" in front of the mother's last name as the baby's first name. Verify that the appropriate last name is recorded for the mother and baby.

**IMPORTANT** – The claim for baby must include the baby's date of birth.

**IMPORTANT** – On claims for twins or other multiple births, indicate the birth order in the patient name field, e.g., Baby Girl Smith A, Baby Girl Smith B, etc.

## 9.5.2 Attachments Missing from Original Claim

Hospitals, physicians and health care professionals are required to submit an invoice for implantable and other insurance EOBs if they are denied. If these items are not submitted with the claim or are submitted separately (EDI and paper), incorrect payment or denials may occur.

Adjustments to these payments or denials should be submitted as corrected claims not as a resubmission of the original claim. Please submit to the correspondence address below:

**Horizon NJ Health**  
**Claims Processing Department**  
**PO Box 24078**  
**Newark, NJ 07101-0406**

Signed consent forms for sterilization are required for payment under federal requirements. (See Section 3.3 Family Planning.) These forms should be submitted to the address below:

**Horizon NJ Health**  
**PO Box 24078**  
**Newark, NJ 07101-0406**

Signed receipt of information form, FD-189 must be submitted during the request for prior authorization for hysterectomies.

## 9.5.3 Claims and Clinical Editing

The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) have spearheaded a correct coding initiative that intends to establish norms for coding medical services. Medicaid programs are required to apply National Correct Coding Institute (NCCI) edits to physician and outpatient hospital claims. Services deemed to be a part of a more complex service as defined by the NCCI will be re-bundled or denied as established by current criteria set by CMS in its claims processing manual. Horizon NJ Health also uses the CMS Claims Processing Manual as a guide to managing payments for services provided to its members, including the medically unlikely edits (MUE) subset and redundant edits. CMS publishes the majority of existing MUEs on the CMS website at [cms.gov/nationalCorrectCodInitEd/](https://cms.gov/nationalCorrectCodInitEd/).

Horizon NJ Health continues to enhance its software used to adjudicate medical, professional and hospital outpatient claims. Horizon NJ Health uses McKesson ClaimsXten software. This is a clinically-based editing solution, that helps ensure that our code and claim editing rules are accurate and consistent with standard business practices and ensures that the claim editing system is transparent to all participating providers, and that claim payments are accurate and consistent with standard business practices and medical policies. ClaimsXten edits are applied to all claims submitted to Horizon NJ Health by physicians, health care professionals and hospitals.

## 9.6 Coordination of Benefits

Any services provided to a Horizon NJ Health member are reviewed against benefits provided for that same individual under other insurance carriers with whom the member has coverage. Horizon NJ Health, as a managed care program for Medicaid and NJ FamilyCare members in New Jersey, is the “**payor of last resort**” on claims for services provided to members also covered by Medicare, employee health plans or other third-party medical insurance. Payors, which are primary to Horizon NJ Health, include (but are not limited to):

- Private health insurance, including assignable indemnity contracts
- Health maintenance organizations (HMOs)
- Public health programs, such as Medicare
- Profit and nonprofit health plans
- Self-insured plans
- No-fault automobile medical insurance
- Liability insurance
- Workers’ compensation
- Long-term care insurance
- Other liable third parties

In cases where another insurer, including Medicare fee for service, is deemed responsible for payment, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier’s explanation of benefits or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and will not exceed the normal Horizon NJ Health benefits, which would have been payable had no other insurance existed. Hospitals, physicians and health care professionals should not file a claim with Horizon NJ Health until they receive the EOB from the member’s other insurance carrier(s). Make sure you follow that insurer’s administrative requirements, standard claim submission policies and forms.

Upon receipt of payment, submit applicable claims to Horizon NJ Health for payment of deductibles and coinsurance amounts. Horizon NJ Health reimburses after coordination of benefits and only up to the primary contracted rate for the service. The claim, PCP referral and primary insurer’s explanation of benefits (EOBs) must be submitted within 60 days of the date of the other carrier’s correspondence or 180 days from the date of service, whichever is later. When preparing the claim, include a complete record of the original charges and primary (or additional) payor’s payment as well as the amount due

from the secondary or subsequent payor.

Submit all pages of the primary (or additional) insurer’s EOB to avoid delays in completing claims due to missing information or coding and message descriptions. This information ensures accurate coordination of benefits. With the exception of Medicare, Horizon NJ Health’s same notification policies that are routinely applied and required must be followed for any claims to be considered for payment. In the case of Medicare as the primary insurer, practitioners and facilities are advised to follow Horizon NJ Health’s procedures, as some services may be exhausted or not covered by Medicare.

**IMPORTANT** – All coordination of benefit (COB) claims must be submitted with a copy of the EOB from the primary insurer. If the primary insurance claim has been paid, the COB claim can be submitted through EDI transmission. If the primary insurance claim has been denied, a paper copy of the primary explanation of payment should be sent. Submit paper claims for all medical services to Horizon NJ Health at the following address:

**Horizon NJ Health  
Claims Processing Department  
PO Box 24078  
Newark, NJ 07101-0406**

When seeking reimbursement from Horizon NJ Health as secondary insurer where Medicare is an enrollee’s primary source of insurance, you must use one of the following processes. When you provide services to a member who has other coverage, you must bill the member’s primary insurer directly. Be sure to follow that insurer’s claims submission policies. You must then submit a claim and the primary insurer’s explanation of benefits (EOB) to Horizon NJ Health within 60 days of the date of the EOB or within 180 days of the date of service, whichever is later. Alternatively, secondary/coordination of benefits (COB) claims may be submitted electronically, utilizing the following COB loops:

Loop	Description	Reported Data
2320	Other Subscriber Information	Name of Primary Insurance
2330A	Other Subscriber Name	Name of Subscriber*
2330B	Other Payer Name	Payment Date from Other Insurance
2340	Line Adjudication Information	Other Insurance Payment

**Note:** Although a primary insurer may have unique coding specific to their business, providers must bill with valid ICD-10-CM, CPT-4 and HCPCS codes. Unique or invalid codes specific to other insurers will cause claim processing delays or denials.



# Horizon NJ Health - Billing Guide

**IMPORTANT** – The hospital, physician or health care professional may not submit billed charges to Horizon NJ Health that are different than charges submitted to other insurers for the same services. The submitted bill must contain the exact billed amounts by procedure line as is reflected on the primary or additional insurer's EOB.

**IMPORTANT** – The primary or additional insurer's EOB must include member name, billed amounts, paid amounts, adjustments, coinsurance amounts, deductibles, copayments and all associated messages and notes. Incomplete information may result in a claim processing delay or denial.

## 9.6.1 Medicare

When both Medicare and Medicaid cover a member and the service is a benefit of both programs, the claim must first be filed with Medicare. Hospitals, physicians and health care professionals should not file a claim with Horizon NJ Health until they receive the Medicare EOB. Upon receipt of payment, submit the claim along with a copy of the Medicare EOB to Horizon NJ Health within 60 days of the date of the Medicare EOB or 180 days from the date of service, whichever is later.

Medicare primary members have no prior authorization requirements and are not required to be seen by a participating Horizon NJ Health hospital, physician or health care professional, unless Medicare does not cover the service. When Horizon NJ Health, by default, becomes the primary payor, the hospital, physician or health care professional must comply with all coverage requirements indicated by Horizon NJ Health to be considered for payment. Horizon NJ Health advises that services to members covered by Medicare and Medicaid be reported despite the fact that authorization is not required. This will avoid delays in claims payment for services that Horizon NJ Health must cover.

Medicare-eligible services denied by Medicare due to failure to comply with medical, administrative or filing requirements will not be covered by Horizon NJ Health.

**Note:** When Medicare is primary and the procedure...

- is covered by Medicare, an authorization or referral is not required by Horizon NJ Health, even if one is normally required by Horizon NJ Health. Reporting these services to Horizon NJ Health is advised.
- is not covered by Medicare, an authorization or referral is required by Horizon NJ Health if one is normally required by Horizon NJ Health.

**IMPORTANT** – The hospital, physician or health care professional may re-bill for services originally denied by Medicare when Medicare overturns the denial. The

hospital, physician or health care professional must submit the re-bill within 60 days of the date of Medicare's EOB or 180 days from the date of service, whichever is later.

## 9.6.2 Other Third-Party Medical Insurance

Members covered by a primary insurer including Medicare should be instructed to notify Horizon NJ Health of their primary coverage. Claims submitted to Horizon NJ Health as the secondary or tertiary insurer are subject to eligibility and benefit coverage. To receive payment for a claim submitted to Horizon NJ Health as the secondary or tertiary insurer, the hospital, physician or health care professional must submit a copy of the primary insurer's EOB or denial letter along with the claim to Horizon NJ Health.

**NOTE** – Submit claims to Horizon NJ Health within 60 days of the date of the primary insurer's remittance and/or EOB or 180 days from the date of service, whichever is later. Participating hospitals, physicians or health care professionals may not bill Horizon NJ Health members for deductibles and coinsurance or balances above our allowable fees. Medicaid is the "payor of last resort;" therefore, the payments received from the primary insurer and/or Horizon NJ Health must be considered payment in full. Members are not to be billed for any Horizon NJ Health covered service. If the service is not covered by the other insurer or Horizon NJ Health, there must be prior written agreement to bill the member for these non-covered services.

**REFER TO** – Section 10.0 Grievances and Appeals Process, for complete instructions of the submission time frames and procedures for administrative or medical appeals.

**IMPORTANT** – If there is any possibility that the services provided will not be covered by the primary insurer, the hospitals, physicians or health care professionals should obtain the appropriate referrals or prior authorizations needed to obtain coverage under Horizon NJ Health. Failure to do so may result in denial for payment.

**IMPORTANT** – If you provide services to a member who is ill or injured as the result of a third party action, you must notify Horizon NJ Health of this information. In the event that this information is determined after the claim is submitted and/or resolved, you are still required to inform Horizon NJ Health. This includes recording the information about the injury or condition on the claim and notifying Horizon NJ Health of any lawsuits or legal action in relation to the injury or condition.

**IMPORTANT** – When completing the CMS 1500 (HCFA 1500) claim form, be sure to complete #7 on the form.

## Motor Vehicle Accidents

Motor vehicle accident-related claims should be submitted to the primary carrier prior to being submitted to Horizon NJ Health. If benefits exhaust or are unavailable, the claim may be submitted to Horizon NJ Health along with an explanation of benefits or a denial letter in order to be considered for payment. In all cases, Horizon NJ Health's referral, prior authorization and notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the hospital, physician or health care professional will have 60 days from the date of the letter to submit the claim or 180 days from the date of service, whichever is later. Upon receipt of an EOB from the primary carrier, Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier's EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer.

Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

In all cases, Horizon NJ Health's referral, prior authorization and notification policies that are routinely applied and required must be followed for any claims to be considered for payment.

**IMPORTANT** – When preparing the claim, all information relating to the accident must be included on the claim. This includes diagnosis codes, accident indicators and occurrence codes (UB-04 claim forms) where appropriate. Additionally, if a primary insurer has made payment for services, the insurer's EOB must be included when submitting the claim for payment.

## Workers' Compensation

Workers' compensation covers any injury that is the result of a work-related accident. If Horizon NJ Health is aware of a workers' compensation carrier, Horizon NJ Health will reject the hospital, physician or health care professional's claim and direct that the claim be submitted first to the primary workers' compensation carrier. If insurance coverage is not available at the time the claim is submitted or the workers' compensation carrier ceases to provide coverage, the claim will be considered for payment.

Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the hospital, physician or health care professional will have 60 days from the date of the letter to submit the claim.

## 9.6.3 Reimbursement

### Medicare

If a member has Medicaid and Medicare coverage, the hospital, physician or health care professional may bill for charges Medicare applied to the deductible or coinsurance, or both. Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier's EOB or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

**Note:** Horizon NJ Health considers the deductible, coinsurance and copayments a component of the total primary care capitation for primary care reimbursement for services, which are capitated. If your primary care contact is for fee-for-service reimbursement, please first bill the primary carrier and then bill Horizon NJ Health with the carrier(s) EOB.

**IMPORTANT** – Bills submitted to the secondary insurer must exactly match the services and amount billed to the primary insurer. This information, along with the primary insurer's EOB, is necessary to complete an accurate COB. Incomplete information could result in processing delays or denials.

### Other Third-Party Medical Insurance

Horizon NJ Health will pay the lesser of the patient responsibility as indicated on the primary carrier's explanation of benefits or the difference between our maximum allowable expense and the amount paid by the primary insurer. Please note, the total amount reimbursed by all parties will not exceed the lowest contractually agreed upon amount and normal Horizon NJ Health benefits, which would have been payable had no other insurance existed.

### Guidelines on Billing Mileage for Member Transportation Services

Horizon NJ Health members shall be transported to and from medical appointments in a manner that results in the accrual of the least number of miles. Mileage is measured by odometer from the place of departure or the point at which the member enters the vehicle to the destination or point at which the member exits the vehicle. At no time shall the transportation provider's base location be used when calculating mileage.

## 9.6.4 Services That Do Not Require a Primary Insurer EOB

### Services Not Covered by Traditional Medicare

- Hearing aids
- Diapers/Under-pads/Incontinence items
- EPSDT
- Personal care assistants (Medicare FFS only)
- Medical day care (Medicare FFS only)
- Private Duty Nursing

Physician and health care professionals may bill Horizon NJ Health for these services without submission of a primary insurer's EOB.

**Note:** If a service is covered by Medicare Advantage, please supply the resulting EOB.

**IMPORTANT** – If billing for room and board only at a skilled nursing facility, reimbursement will be considered without submission of Medicare EOB.

### Other Third-Party Medical Insurance

An EOB or notice of refusal must be submitted with all commercial and Medicare Advantage insurers' claims. Claims with primary payment can be submitted via EDI.

## 9.6.5 Denials from Primary Insurers

If the primary insurer denies payment to the hospital, physician or health care professional based on coverage exclusion, non-coverage, benefit exhaustion or non-compliance with administrative guidelines, the physician must submit a copy of the EOB or notice of refusal. The EOB or notice of refusal must include an explanation of the reason for the denial. Services denied by the primary insurer and billed to Horizon NJ Health without an explanation of the denial from the primary insurer will be denied payment.

Services denied by the primary insurer for non-compliance with medical or administrative guidelines may be submitted to the secondary with a copy of the EOB or notice of refusal and a copy of the final appeal denial letter or notice of refusal. Medical and/or administrative denials will not be considered without receipt of the final appeal denial letter.

**IMPORTANT** – Horizon NJ Health will document receipt of notices that the member's primary carrier does not cover a service or that the service is exhausted. No additional notices will be required until the anniversary date of the member's policy with that other insurer. Annually, on or after the anniversary date, the hospital, physician or health care professional must provide notice again that the service is exhausted or not covered by the primary carrier.

**Note:** The hospital, physician or health care professional must file a claim with the primary insurer within the appropriate timely filing deadlines and according to appropriate filing requirements. Failure to submit medical and administrative denial information from a primary insurer could result in processing delays or denials.

**IMPORTANT** – Upon receipt of a letter of exhaustion or denial letter from the primary carrier, the hospital, physician or health care professional will have 60 days from the date of the letter to submit the claim.

## 9.7 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT claims are paid based on the periodicity schedule. The biological component of immunizations is only paid where the Vaccines for Children (VFC) program does not offer the biological or the supply is not available. Administration of VFC-sponsored immunizations is paid on a per-visit basis; therefore, multiple shots given in a single visit will result in a per-vaccine administration payment. Physicians and health care professionals are encouraged to use combination immunizations when available.

The following CPT codes and modifiers should be used when conducting lead screening:

36405 59 Venipuncture for lead screening for children under three years of age, scalp vein

36406 59 Venipuncture for lead screening for children under three years of age, other vein

36410 59 Venipuncture for lead screening for children three years of age or older

36415 59 Collection of venous blood by Venipuncture for lead screening for children 3 years and older

36416 59 Collection of capillary blood specimen for lead screening (finger, heel, and ear stick)

83655 52 Lead test (diagnosis code required)

Horizon NJ Health sends quarterly EPSDT underutilization reports to physicians, identifying members whose EPSDT services are overdue. Compliance with using the EP modifier will increase the accuracy of these reports.

## 9.8 Risk Assessment Program

Horizon NJ Health is required by the State of New Jersey to report encounter data for all services rendered to our members, including capitated and fee-for-service activities. All physicians, hospitals and health care professionals are required to submit timely, accurate and complete encounter data. This is required even when the member is covered by another insurer.

Health care resource consumption in chronic disease can be very high. The State of New Jersey is using a

# Horizon NJ Health - Billing Guide

risk adjustment payment model in an attempt to fairly distribute Medicaid funds in proportion to the severity of illness. Horizon NJ Health is required to submit encounter data to the State of New Jersey as an estimate of the prevalence of disease in the population we serve.

It is paramount that accurate data be gathered on the prevalence of illness of Horizon NJ Health members. This leads to accurate, severity-adjusted payment from the State to the health plan and, ultimately, the provider.

For example: Not only should members seek medical care for acute conditions, they should also visit their provider for chronic conditions, such as diabetes or hypertension. Moreover, if a member visits for an acute issue and a chronic issue is relevant or discussed, we ask that this is documented in both the records and the encounter claim form.

For further information, please call Horizon NJ Health's Risk Adjustment nurse at **1-800-682-9094, x89625**.

All services must be submitted on the CMS 1500 (HCFA 1500) or the UB-04 claim form, or via electronic submission in a HIPAA-compliant 837I, 837P or NCPDP format. Horizon NJ Health is required to submit this data in a HIPAA standard file format to the State. Any coded field or data element contained in a HIPAA transaction must adhere to the national set of codes, including medical services and diagnosis. Due to the requirement to submit all services to the State, all requirements for EDI transactions are also applied to paper claims.

The State of New Jersey will reject encounter data if it does not meet their processing criteria. In some instances, Horizon NJ Health will be required to reverse payment already made to the provider if the encounter does not meet the State's criteria. A complete list of all possible encounter rejections can be obtained by going to [njmmis.com](http://njmmis.com). Under the Information section, select Edit Codes, then Encounter Edits. The following are some causes for rejections:

## Facility Services

- **NPI** – Any practitioner who is required to have an NPI must report that number in the Billing Provider, Rendering Provider, Attending Provider, Operating Provider and Other Provider fields, if applicable. The NPI is required by the State of New Jersey's Division of Medical Assistance and Health Services for both electronic and paper claims submissions. Horizon NJ Health and all practitioners of facilities serving members are required to comply with this requirement.
- **Type of Bill** – The bill type must be consistent with the type of service rendered with applicable revenue codes and corresponding HCPCS. Common bill types are listed in Section 9.2.2 of this manual.
- **Statement Covers Period** – Any practitioner billing for services must ensure that the dates of service are within the time period indicated in the Statement Covers Period stated on the claim. If a date of service is outside the dates placed in the From/Through field, the encounter will be rejected.
- **Principle Procedure Date** – Any practitioner billing for surgical services must ensure that the dates of service are within the time period indicated in the Statement Covers Period indicated on the claim. If the Principle Procedure date or Other Procedure date field is outside the dates reported in the Statement Covers Period, the encounter will be rejected.
- **Revenue Codes** – All revenue codes billed must be valid for the type of claim being billed.
- **Laboratory Services** – When billing revenue codes 300-319, the corresponding HCPCS or CPT codes must be billed.
- **Physician Administered Drug** – All services are required to report units of measure for all drugs, including their corresponding NDC code when billing with "J" or "Q" codes. The corresponding 11 digit NDC code must be reported along with the correct unit of measure:

# Horizon NJ Health - Billing Guide

A. NDC units are based upon the numeric quantity administered to the patient and the unit of measure.

UOM	Description	Guidelines
F2	International unit	International units will mainly be used when billing for Factor VIII-Antihemophilic Factors
GR	Gram	Grams are usually used when an ointment, cream, inhaler, or bulk powder in a jar are dispensed. This unit of measure will primarily be used in the retail pharmacy setting and not for physician-administered drug billing.
ML	Milliliter	If a drug is supplied in a vial in liquid form, bill in millimeters.
UN	Unit	If a drug is supplied in a vial in powder form, and must be reconstituted before administration, bill each vial (unit/each) used.

## NDC Units

Submit the decimal quantity administered and the units of measurement on the claim. If reporting a partial unit, use a decimal point.

- GR0.025
- ML2.5
- UN3.0

The quantity should be eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas. Do not zero fill, leave remaining positions blank. The following are some examples:

- 1234.56
- 2
- 12345678.123

## Paper Claim Requirements

CMS 1500 form:

- Enter the NDC in the shaded area of the service lines in Field 24
- The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information.

- Submit the NDC code in the red-shaded portion of the detail line item starting in positions 01.
- The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N412345678901).

UB-04 form:

- Field 42: Revenue code
- Field 43: NDC 11 digit number, Unit of Measurement Qualifier and Unit Quantity
- Field 44: HCPCS code

For EDI claims

LOOP	Segment	Element Name	Information
2410	LIN	02	Product or Service ID Qualifier If billing for a national drug code (NDC), enter N4.
2410	LIN	03	If billing for drugs, include the NDC. LIN**N4*1234567890
2410	CTP	04	Quantity If an NDC was submitted in LIN03, include the quantity for the NDC billed.
2410	CTP	05-1	Unit or Basis for Measurement Code If an NDC was submitted in LIN03, include the unit or basis for measurement code for the NDC billed. F2 - International unit GR - Gram ML - Milliliter UN - Unit Sample - CTP****3*UN
2410	REF	01	VY: Link Sequence Number, XZ : Prescription Number Link Sequence # (to report components for compound drug)
2410	REF	02	Link Sequence Number or Prescription Number Sample - REF01*VY*123456

Claims cannot be paid by Horizon NJ Health without this information.

For additional information on the valid NDC codes, unit and units of measure, please refer to the NJ Medicaid website. <https://www.njmmis.com/ndcLookup.aspx>

### Professional Services

- NPI – Any practitioner who is required to have an NPI must report that number in the Billing Provider, Rendering Provider and Service Facility Location if applicable. The NPI is required by the State of New Jersey’s Division of Medical Assistance and Health Services for both electronic and paper claims submissions. Horizon NJ Health and all practitioners of facilities serving members are required to comply with this requirement. Providers are prohibited from billing under the NPI number of a different provider.
- Transportation Services – When billing for transportation services, a valid origin and destination modifier are required. Horizon NJ Health members shall be transported to and from medical appointments in a manner that results in the accrual of the least number of miles. Mileage is measured by odometer from the place of departure or the point at which the member enters the vehicle to the destination or point at which the member exits the vehicle. At no time shall the transportation provider’s base location be used when calculating mileage. The CMS-1500 claim form should be completed by choosing modifiers that appropriately support the member’s place of departure and destination locations.
- Procedure Codes – All codes are to be in HIPAA-compliant format. The use of CPT Level III codes (local codes) is no longer valid.
- Diagnosis Codes – All diagnosis codes must be reported and coded to the 7th digit, if available.
- Retroactive Terminations – Horizon NJ Health participates in the Medicaid and NJ FamilyCare programs. Our members must maintain eligibility in order to receive services. There may be times when a member’s eligibility is retroactively terminated, as determined by the Medicaid/NJ FamilyCare program. This retroactivity will result in an encounter rejection. Horizon NJ Health is required to reverse payment already made to the physician, hospital and health care professional.
- Medical Claims for Fluoride Varnish – Providers should use the following procedure and diagnosis codes when submitting medical claims for fluoride varnish applications:
  - 99188
  - Z41.8 (ICD-10)

January 2019

## 9.9 Remittance Advice Documentation

### Overview of Payment Summary Page

Horizon NJ Health provides a comprehensive summary of financial information and activity on the Remittance Advice (RA).

The body of the RA contains claim detail and the Payment Summary page indicates whether the physician/payee has a positive (+) or negative (-) balance.

Many hospitals, physicians or health care professionals have requested ongoing notification of overpayments and negative payee balances in relation to claim adjudication activities, capitation payments, or accounts payable adjustments. The Payment Summary page displays this information as “rolling balances” of overpaid amounts that are owed to Horizon NJ Health. The “rolling balance” is updated on each RA after current claim payments and other adjustments have been applied.

If, after reviewing the RA, you have questions or want to request a reconsideration, go to **NaviNet.net**. If your concerns are still not resolved, contact Provider Services at **1-800-682-9091** for assistance.

These explanation codes represent the current set of codes that are returned to the hospital, physician or health care professional on the RA. Please review the following list before calling the Physician & Health Care Hotline for questions about RA codes. If an electronic RA is requested, it will be submitted in the HIPAA-compliant 835 format. The explanation codes do not apply to an electronic RA transaction.

### 9.10 LabCorp Testing/Professional Relations Representatives Billing

Some tests are not available via LabCorp and must be completed at a hospital or clinical setting and billed accordingly. Some of these tests cannot be performed in hospitals and will require prior authorization. Please contact LabCorp Customer Service for more information on tests that are not available via LabCorp.

**LabCorp Customer Service**  
**1-800-631-5250**

Information about testing not available through LabCorp is also available at **genetests.org**.

## 9.11 Out-of-State Medicaid Claims for Blue Cross and Blue Shield Association Plans

State Medicaid agencies contract with Blue Cross and/or Blue Shield Plans as Managed Care Organizations (MCOs) to provide comprehensive Medicaid benefits on a risk basis. Both federal and state regulations guide these relationships, but the eligible population, covered benefits and specific rules regarding each state's Medicaid program may differ from state to state. Many state Medicaid programs require providers to enroll as Medicaid providers with that state's Medicaid agency before payment can be issued. In other cases, a state Medicaid program will accept a provider's Medicaid enrollment in the state where the provider practices.

### Medicaid Reimbursement and Billing

Claims for all Horizon NJ Health Medicaid members should be submitted to your local BCBS Plan. If you are contracted with Horizon NJ Health, your Medicaid rates will only apply for services provided to Horizon NJ Health members. These rates do not apply to services provided to out-of-state Medicaid members. When you provide services to a Medicaid member from another state, you must accept that state's Medicaid allowance (less any member responsibility such as copayments) as payment in full. Please note that billing out-of-state Medicaid members for any amounts in excess of the Medicaid-allowed amount for Medicaid-covered services is specifically prohibited by federal regulations (42 CFR 447.15).

### Medicaid Billing Data Requirements

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements. Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims. As a reminder, applicable Medicaid claims submitted without these data elements will be denied.

### Provider Enrollment Requirements

As indicated above, some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement. If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from your local BCBS plan regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.