Claim Submission

All claims for authorized, covered services provided to eligible, Kelsey-Seybold assigned HMO, POS and EPO members must be submitted on a CMS 1500 form, a UB 04, or in an electronic format, as applicable. Claims submitted with 'Unlisted Procedure Codes' must include documentation supporting the use of that code for payment consideration. If necessary to determine if the claim is payable, Kelsey-Seybold may within thirty (30) days of receipt of a clean claim, request additional information from the treating provider.

Mail Paper Claims to:
Kelsey- Seybold Clinic
Attn: Claims Department
P. O. Box 31031
Tampa, Florida 33631

Professional Electronic Claims:
Payor ID: KELSE

Institutional Electronic Claims:
Payor ID: KELSI

In order for an electronic claim to be considered a clean claim, the provider must submit the claim using the ASCX12N/005010X222 format in compliance with all applicable laws related to electronic healthcare claims including applicable implementation guides, companion guides and trading partner agreements. Kelsey-Seybold will not reject or refuse to pay an electronically submitted claim if the claim is submitted together with or in a batch with a claim that is not a clean claim as defined in this document. A batch submission is a group of electronic claims which are submitted for processing at the same time and identified by a batch control number.

The Centers for Medicare & Medicaid Services (CMS) initiated the implementation of a National Provider Identifier (NPI) for all healthcare providers effective May 23, 2007. This unique identification number should be used when submitting healthcare claims both electronically and non electronically.

The following specifications are also critical to the successful submission and adjudication of your electronically filed claims.

They are (HCFA/CMS 1500):

- The UPIN of the rendering healthcare provider must appear in at least one of these fields: FA23, FB117, or FA058.
- Effective May 23, 2007, the healthcare provider's National Provider Identification (NPI) number should be included with the submission of a claim. The NPI should be placed in fields:
  - 2030A (Referring Provider Name)
  - 2030B (Rendering Provider Name)

Please review the following Definition of a Clean Claim for non-electronic claims. Failure to submit a clean claim as defined below will result in a claim denial. If you receive a denial from K-S due to not providing all the elements of a clean claim as specified below, you must re-submit a "corrected" claim to the address indicated above with all the required data elements of a clean claim within thirty (30) days of the date on the EOB.

1. **Definition of a Clean Claim for Physicians or Non-institutional Providers.** The following is a list of essential data elements that must be on all claims filed:

(A) subscriber's/patient's plan ID number (CMS 1500, field 1a);
(B) patient's name (CMS 1500, field 2);
(C) patient's date of birth and gender (CMS 1500, field 3);
(D) subscriber's name (CMS 1500, field 4);
(E) patient's address (street or P.O. Box, city, zip) (CMS 1500, field 5);
(F) patient's relationship to subscriber (CMS 1500, field 6);
(G) subscriber's address (street or P.O. Box, zip) (CMS 1500, field 7);
(H) whether patient's condition is related to employment, auto accident, or other accident (CMS 1500, field 10);
(I) subscriber's policy number (CMS 1500, field 11);
(J) subscriber's birth date and gender (CMS 1500, field 11a);
(K) HMO or preferred provider carrier name (CMS 1500, field 11c);
(L) disclosure of any other health plans (CMS 1500, field 11d); if respond "yes", then specified in paragraph (2)(A)-(E) section are applicable; if respond "no", the data elements are not considered essential if the claim is accompanied by a copy of a document signed by the enrollee or insured that there is no other health care coverage;
M) patient's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500, field 12);
(N) subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500, field 13);
(O) date of current illness, injury, or pregnancy (CMS 1500, field 14);
(P) first date of previous same or similar illness (CMS1500, field 15);
(Q) name of referring physician or "None" if none (CMS 1500, field 17);
(R) I.D. number of referring physician if one is named (CMS 1500, field 17a);
(S) Narrative description of procedure (CMS 1500, field 19) for unclassified procedures;
(T) diagnosis codes or nature of illness or injury (CMS 1500, field 21);
U) if the claim is a duplicate claim, a "D" is required, if the claim is a corrected claim, a "C" is required (CMS 1500, field 22);
(V) prior authorization number (CMS 1500, field 23), is applicable when prior authorization is required;

(W) date(s) of service (CMS 1500, field 24A);
(X) place of service codes (CMS 1500,field 24B);
(Y) type of service code (CMS 1500, field 24C);
(Z) procedure/modifier code (CMS 1500,field 24D);
(AA) diagnosis code by specific service (CMS 1500, field 24E);
(BB) charge for each listed service (CMS 1500,field 24F);
(CC) number of days or units (CMS 1500,field 24G);
(DD) physician's or provider's federal tax ID number (CMS 1500, field 25);
(EE) total charge (CMS 1500, field 28);
(FF) signature of physician or provider or notation that the signature is on file with the HMO or preferred provider carrier (CMS 1500, field 31);
(GG) name and address of facility where services rendered (if other than home or office) (CMS 1500, field 32);
(HH) physician's or provider's billing name and address (CMS 1500, field 33); and
(II) operative report, when more than one procedure is performed during a single operative session.

2. **Data elements contained in this section are necessary for claims filed if circumstances exist which render the data elements applicable to the specific claim being filed. The applicability of any given data element contained in this paragraph is determined by the situation from which the claim arose.**

(A) other insured's or enrollee's name (CMS 1500, field 9), is applicable if patient is covered by more than one health benefit plan, such as situations described in paragraph (3). If data specified in paragraph (1)(L),"disclosure of any other health benefit plans", is answered yes, this is applicable;
(B) other insured's or enrollee's policy/group number (CMS 1500,field 9a), is applicable if patient is covered by more than one health plan, such as situations described in paragraph (3), this is applicable;
(C) other insured's or enrollee's date of birth (CMS 1500, field 9b), is applicable if patient is covered by more than one health plan, generally in situations described in paragraph (3), this is applicable;
(D) other insured's or enrollee's plan name (employer, school, etc.) (CMS 1500, field 9c), is applicable if patient is covered by more than one health benefit plan, generally in situations described in paragraph (3), this is applicable;
(E) other insured's or enrollee's HMO or insurer name (CMS 1500, field 9d), is applicable if patient is covered by more than one health plan, generally in situations described in paragraph (3), this is applicable;
(F) subscriber's plan name (employer, school, etc.) (CMS 1500, field 11b) is applicable if the health plan is a group plan;
(G) Whether assignment was accepted (CMS 1500, field 27), is applicable when assignment under Medicare has been accepted;

(H) Amount paid (CMS 1500,field 29), is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber;
(I) Balance due (CMS 1500, field 30), is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber; and
(J) a copy of the Explanation of Benefits (EOB) provided by the primary carrier.

(3) Coordination of benefits or non-duplication of benefits. If a claim is submitted for covered services for benefits in which coordination of benefits is necessary, the amount paid by the primary plan is considered to be an element of a clean claim for purposes of the secondary plan's processing of the claim. The Explanation of Benefits from the primary payor must be submitted to the secondary payor for payment to be considered. If a claim is submitted for covered services or benefits in which non-duplication of benefits is an issue, the amounts paid by all other valid coverage is considered to be an element of a clean claim. If a claim is submitted for covered services or benefits and the policy contains a variable deductible the amount paid by all other health insurance coverage, except for amounts paid by individually underwritten and issued hospital confinement indemnity, specified disease, or limited benefit plans of coverage, is considered to be an element of a clean claim.

(4) Definition of a Clean Claim for Institutional Providers. The following is a list of essential data elements that must be on all claims filed:
(A) Provider's name, address and telephone number (UB-04, field 1);
(B) Patient control number (UB-04, field 3);
(C) Type of bill code (UB-04, field 4) and shall include a "7" in the third position if the claim is a duplicate and an "8" in the third position if the claim is a corrected claim;
(D) Provider's federal tax ID number (UB-04, field 5);
(E) Statement period (beginning and ending date of claim period)(UB-04, field 6);
(F) Patient's name (UB-04, field 12);
(G) Patient's address (UB-04, field 13);
(H) Patient's date of birth (UB-04, field 14);
(I) Patient's gender (UB-04, field 15);
(J) Patient's marital status (UB-04, field 16);
K) Date of admission (UB-04, field 17);
(L) Admission hour (UB-04, field 18);
(M) Type of admission (e.g. emergency, urgent, elective, newborn) (UB-04, field 19);
(N) Source of admission code (UB-04, field 20);
(O) Patient-status-at-discharge code (UB-04, field 22);
(P) Value code and amounts (UB-04, fields 39-41);
(Q) Revenue code (UB-04, field 42);

(R) Revenue description (UB-04, field 43);
(S) Service date (UB-04, field 45) is the claim is for outpatient services;
(T) Units of service (UB-04, field 46);
(U) Total charge (UB-04, field 47);
(V) HMO or preferred provider carrier name (UB-04, field 50);
(W) Provider number (UB-04, field 51) if the HMO or preferred provider carrier, prior to June 17, 2003, required provider numbers and gave notice of that requirement to physicians and providers;
(X) Subscriber's name (UB-04, field 58);
(Y) Patient's relationship to subscriber (UB-04, field 59);
(Z) Patient's/subscriber's certificate number, health claim number, ID number (UB-04, field 60);
(AA) Insurance group number (UB-04, field 62);
(BB) Treatment authorization codes (UB-04, field 63) when authorization is required;
(CC) Principal diagnosis code (UB-04, field 67);
(DD) Admitting diagnosis code (UB-04, field 76);
(EE) Attending physician ID (UB-04, field 82);
(FF) Signature of provider representative or notation that the signature is on file with the HMO or preferred provider carrier (UB-04, field 85);
(GG) Date bill submitted (UB-04, field 86);
(HH) Covered days (UB-04, field 7), is applicable if Medicare is a primary or secondary payer;
(II) Non-covered days (UB-04, field 8), is applicable if Medicare is a primary or secondary payer;
(JJ) Coinsurance days (UB-04, field 9), is applicable if Medicare is a primary or secondary payer; Lifetime reserve days (UB-04, field 10), is applicable if Medicare is a primary or secondary payer
(KK) Lifetime reserve days (UB-04, field 10), is applicable if Medicare is a primary or secondary payer;
(LL) Discharge hour (UB-04, field 21), is applicable if the patient was an inpatient, or was admitted for outpatient observation;
MM) Condition codes (UB-04, field 24-30), are applicable if the CMS UB-04 manual contains a condition code appropriate to the patient's condition;
(NN) Occurrence codes and dates (UB-04, fields 31-36), are applicable if the CMS UB-04 manual contains an occurrence code appropriate to the patient's condition;
(OO) Occurrence span code, from and through dates (UB-04, field 36), is applicable if the CMS UB-04 manual contains an occurrence span code appropriate to the patient's condition;
(PP) HCPCS/Rates (UB-04, field 44), is applicable if Medicare is a primary or secondary payer;
(QQ) Prior payments – payer and patient (UB-04, field 54), is applicable if payments have been made to the physician or provider by the patient or another payer;
(RR) Diagnosis codes other than principle diagnosis code (UB-04, fields 68-75), is applicable if there are diagnoses other than the principle diagnosis;
(SS) Procedure coding methods used (UB-04, field 79), is applicable if the CMS UB-04 manual indicates a procedural coding method appropriate to the patient's condition;
(TT) Principal procedure code (UB-04, field 80), is applicable if the patient has undergone an inpatient or outpatient surgical procedure; and
(UU) Other procedure codes (UB-04, field 81), is applicable as an extension of sub-paragraph (QQ) of this paragraph if additional surgical procedures were performed

Claim Appeals

If a claim you submit is denied and additional information is not requested as part of the denial, you may appeal the decision. All appeals must be accompanied by a completed Claims Payment Appeals Request form and an explanation as to why the payment decision should be reviewed. (Claims Payment Appeals Request form can be found on the Kelsey-Seybold Clinic website at www.kelsey-seybold.com) under the Affiliate Doctors link. Written claim appeals must be submitted to Kelsey-Seybold within the appeals deadline specified in your Agreement.

In order for the appeal to be considered, appeals should be directed to:

Kelsey-Seybold Clinic
Attn: Appeals Department
P.O. Box 841209
Pearland, TX 77584

You may inquire about claims appeals status by calling Provider Services at (713) 442-5440.