

Professional Claims Basics

Quick Reference Guide

Key Points

- TriWest does not determine what a provider should be billed.
- TriWest and our claims processor, PGBA, pay clean claims for participating providers as a third-party administrator for the Department of Veterans Affairs (VA).
- All covered entities and transmissions of claims information must comply with the Health Insurance Portability and Accountability Act (HIPAA) and other federal regulations.
- If applicable, a claim must comply with Medicare billing guidelines. This includes bundled codes and use of required modifiers or sub-set modifiers.

TriWest's Role

Many of our network's less traditional Complementary and Integrative Healthcare Services (CIHS) providers aren't familiar with the claims submission process, claims terminology or steps that are required to be properly submit claims.

As part of the Community Care Network (CCN) program, you offer Veterans the care they need. TriWest wants to educate all of our CCN providers and especially CIHS providers on how to submit clean claims for that care.

If you have not yet taken the Basics of Billing webinar, then we strongly encourage you to do this first, as that training covers these materials and more. You can sign up for a training webinar by logging into the TriWest Payer Space on Availity.com. Navigate to the TriWest Learning Center, click on Sessions, and register for a webinar.

Provider's Determine Billing

Before we look at claims in depth, we need to make very clear that TriWest does not determine what a provider should bill. The determination of a diagnosis code, the determination of the CPT or Clinic Code, the number of units, the billed amount – all of these are yours to determine and should be based on your best judgement as the provider of care. These determinations are not criteria TriWest can or should dictate to providers. However, you must ensure that you are providing care within the scope of the approved referral/authorization. TriWest will deny claims for care that does not show as authorized.

What is a Claim?

For health care you do not create an invoice, you submit a claim. A claim is a request for payment



from a third party on behalf of the patient. For CCN, the patient is usually a Veteran. In special and rare circumstances, CCN may cover a newborn or spouse. All professional claims – no matter how they are submitted or who they are submitted to – capture the same information as a CMS 1500 form.

Every provider and insurance payer in the U.S. uses this format for capturing claims information. Since the CMS 1500 is the basis for all professional claims, we are going to walk through completing one. Once you understand this, you can submit an electronic claim as well.

Common Terms used in Health Care Claims

ICD-10 Code:

- This is an acronym for International Classification of Diseases, Tenth Revision. This coding system, developed over a period of 10 years, is international. For the U.S., the Centers for Medicare and Medicaid (CMS) implemented the 10th revision in October of 2015.
- An ICD code is the diagnosis. With 68,000 codes, an ICD-10 provides a precise description of an injury, illness or condition. The first three alphanumeric characters describe a general condition, such as a fracture. The next set of numbers, which follow a decimal point, define location, severity and other details.
- When you submit a claim you must include an ICD code that matches the Veteran's diagnosis, this is the reason for the care rendered. If the diagnosis does not align with the care provided, the claim may be denied.
- If the authorization notification included any language on the underlying cause – such as stress due to PTSD – then you can look up the ICD-10 codes for PTSD, choose the one that best fits the patient and use that when you submit a claim for care.
- There are free online tools that look up the ICD codes based on a description. CMS also has tools available on [their website](#).

HCPCS & CPT Billing Codes:

- HCPCS is an acronym for Healthcare Common Procedure Coding System. Level II HCPCS are alphanumeric codes that describe billable products and supplies, such as crutches and oxygen.
- A Level I HCPCS is a CPT service code. CPT is an acronym for Current Procedural Terminology. The American Medical Association (AMA) developed these 5-digit codes to describe medical procedures or services. This listing is extensive and includes most traditional health care services covered by insurance. For professional services, such as an office visit, surgical procedure or manipulation, providers bill CPT codes.
- CMS, as the payer for Medicare and Medicaid claims, assigns remittance values to all billable codes. Under CCN, the codes billed by you or your practice determine what you get paid.
 - If a CPT is considered a timed code, then it will bill in 15-minute blocks or “units” instead of number of visits or number of procedures. So, a therapeutic service, such as a massage therapy, bills in units – it is a timed code.
 - If a physician gave three injections, these would bill as three units, since each injection is a unit. This is NOT a timed code.
- TriWest's notification of authorization will often include a description or range of billable codes as a way to define the pre-approved episode of care.
 - For CIHS claims, a descriptive CPT code may not exist. Instead, your authorization information may include a description of the services and a date range. Your information may also define the number of visits or units.
 - Care is capped at the defined limits unless you have submitted a Referral Request to the



Veteran's VA Medical Center (VAMC) and received approval for additional care.

- If your specialty falls outside of common CPT definitions, use one of the **VA's National Clinic Codes**. Do this wherever a CPT code is required.
- If CMS has codes or coding suggestions, follow those. Massage therapy, biofeedback and acupuncture are examples of CIHS services that may have traditional CPT codes.

Code Modifiers:

- Modifiers provide additional information on the CPT code. It may indicate left (LT) or right (RT) or it may indicate that a procedure or service was distinct or independent from other services. GP, GO and GN are required with therapy visits.
- The CMS National Correct Coding Initiative (NCCI) updates coding policy on a regular basis. TriWest follows current CMS policies, so claims must also follow current CMS policies.
 - Some service codes are "bundled". They do not pay independently. The codes billed with chiropractic codes are often bundled into the chiropractic payment.
 - If a service is:
 - usually bundled, and
 - performed separately, or
 - performed in addition to other care then you must add a modifier to indicate this. This allows the service line to pay as a separate service. For example on modifier "59", payment is not guaranteed if the spreadsheet indicated modifier is not allowed.
 - For some modifiers you may need a secondary or subset modifier. Using "59" as an example again, there are four additional "X" subset modifiers that indicate if the service is from a separate encounter, covering a separate structure or other.

Current NCCI information is available from CMS and groups who focus on specialty billing education. If your claims deny for incorrect modifiers or pay as "bundled" in spite of a modifier, please visit one of these resources. Providers can re-submit a claim within 90 days. With compliant modifiers and coding, TriWest can pay you for covered services.

HIPAA:

- The Health Insurance Portability and Accountability Act (HIPAA) protects patient information. Any covered entity, such as a physician, hospital, insurance payer, billing company or clearinghouse, must comply with this federal law. TriWest, our CCN providers, PGBA and VA are all considered covered entities.
- Compliance with law requires the use of a HIPAA Release Form. Getting a release signed at the start of any care permits you, as a provider, to submit a claim through PGBA without a Veteran's signature on each and every claim form. PGBA and TriWest can then process, pay and report this information to VA because the permission extends to us as additionally covered groups or entities.
- A signed release also allows you to upload supporting medical documentation or summaries to VA. Remember, without supporting medical documentation, your claims could be denied.
- If you need an example of a HIPAA-compliant request form, TriWest has a basic example included on the last page of this document.

Components of a Professional Claim

There are three main sections in a claim:

- Insured or Patient Information – about the patient



- Clinical Information – about the care provided
- Provider Information – about you as a provider

We are going to look at each section and walk through the type of information required. An example of a completed CMS 1500 is included at the end of this walk-through.

Section 1: PATIENT AND INSURED INFORMATION

FIELD 1 – Type of Insurance

| | | | | | | |
|---|--|--|--|---|---|--|
| 1. MEDICARE <input type="checkbox"/> (Medicare#) | MEDICAID <input type="checkbox"/> (Medicaid#) | TRICARE <input type="checkbox"/> (ID#/DoD#) | CHAMPVA <input type="checkbox"/> (Member ID#) | GROUP HEALTH PLAN <input type="checkbox"/> (ID#) | FECA BLK LUNG <input type="checkbox"/> (ID#) | OTHER <input checked="" type="checkbox"/> (ID#) |
|---|--|--|--|---|---|--|

For this field, you should choose “Other” as the Veteran is using his or her VA Benefits.

FIELD 1a Insured’s ID Number

| |
|---|
| 1a. INSURED’S I.D. NUMBER (For Program in Item 1) Veteran’s Full SSN or EDIPI Number |
|---|

Except in rare cases, the CCN program only covers Veteran benefits, so the Insured’s ID is the Veteran’s ID. Enter the Veteran’s SSN, MVIICN or the Veteran Unique Identification number. The full SSN is preferred for correct claim identification but you may submit the last 4 of the SSN preceded by 5 zeros.

FIELD 2 – Patient’s Name

| |
|---|
| 2. PATIENT’S NAME (Last Name, First Name, Middle Initial) Last (suffix), First, Middle Initial |
|---|

Since care is for the Veteran, enter the patient’s name.

FIELD 3 – Patient’s Birthdate

| | |
|-------------------------|---|
| 3. PATIENT’S BIRTH DATE | SEX |
| MM DD YY | M F <input checked="" type="checkbox"/> |
| 00 00 00 | |

TriWest and PGBA can use the date of birth (DOB) information to identify a Veteran in our system, but with a DOB and the full SSN, we should be able to identify a Veteran. You must enter two digits for month, two digits for day and four digits for year.

FIELD 4 – Insured’s Name

| |
|---|
| 4. INSURED’S NAME (Last Name, First Name, Middle Initial) Veteran’s Name |
|---|

As in **Field 2**, please enter the patient’s name in the following order: the full last name, first name, and middle initial. Include the suffix (e.g., Jr, Sr.) after the last name and before the first name. Do not include any titles with the name.

For an electronic claim, parts of a name go into separate fields. For a paper form, use commas to separate the last name, first name and middle initial. You can use a dash for hyphenated names. **Do not use periods.**



FIELD 5 – Insured’s Address (multi-field)

| | |
|-------------------------------------|-------------------------------|
| 5. PATIENT'S ADDRESS (No., Street) | |
| Permanent Address no commas/periods | |
| CITY | STATE |
| City | ST |
| ZIP CODE | TELEPHONE (Include Area Code) |
| Zip | (123) 1234567 |

When you complete the Veteran’s address, **please do not use any commas or periods**. Be sure to use the Veteran’s permanent address, even if they are seasonal visitors in your area. This helps ensure the correct VAMC is aware of the services rendered. This is the address used to mail the Veteran’s EOB.

FIELD 6 – Patient’s Relationship to Insured

| | | | |
|------------------------------------|-------------------------------------|--------|--------------------------|
| 6. PATIENT RELATIONSHIP TO INSURED | | | |
| Self | <input checked="" type="checkbox"/> | Spouse | <input type="checkbox"/> |
| Child | <input type="checkbox"/> | Other | <input type="checkbox"/> |

This is always “Self” as the Veteran is both the insured and the patient.

FIELD 7 – This field is not required. It duplicates FIELD 5.

FIELD 8 – This information is not collected, please leave blank.

FIELD 9 a-d – Other Insured’s Name – Multi-Field

| |
|---|
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER |
| b. RESERVED FOR NUCC USE |
| c. RESERVED FOR NUCC USE |
| d. INSURANCE PLAN NAME OR PROGRAM NAME |

This series of fields capture the information if there is other commercial health insurance (OHI). These fields may not be applicable for some CIHS claims – commercial health insurance does not cover all categories of care.

If 1) health insurance typically pays for the care and 2) the Veteran has OHI, then complete these fields. If there is no OHI, ignore these fields. Approximately 10-15% of our Veterans do have OHI. Be sure to determine this when you verify benefits.

EXAMPLE: Veteran Jane is receiving VA-authorized acupuncture.

- *Her husband has Blue Cross Blue Shield (BCBS) through his workplace and carries Veteran Jane through his work insurance.*
- *BCBS will pay for acupuncture under his insurance plan.*



In this case, add the name of the husband (the Other Insured – Field 9) along with the insurance plan (9d), his policy number and group number (9a). **If the Veteran has OHI coverage, you must submit the claim to that insurance plan first.** Please review our education materials on OHI for more information.

- If it is the Veteran who has the OHI coverage, add his/her name and policy information.
- You do not need to include any TRICARE, Medicare or Medicaid information in these fields; these are not commercial OHI programs.

FIELDS 10a-10c – Is Patient’s Condition Related To:

| | | |
|--|-----------------------------|------------------------------------|
| 10. IS PATIENT'S CONDITION RELATED TO: | | |
| a. EMPLOYMENT? (Current or Previous) | | |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| b. AUTO ACCIDENT? | | |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | PLACE (State) <input type="text"/> |
| c. OTHER ACCIDENT? | | |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | |

Fields 10 a through 10c allow you to indicate if the Veteran’s condition relates to an accident – work, auto or other. With the CCN program, all care is pre-authorized with an Approved Referral. VA should already be aware of any service-related issues or issues related to accidents. This means that you, the provider do not need to coordinate or investigate any coverage liability. Leave this field blank for CIHS claims. **FIELD 10d** – Claim Code –Unless this claim relates to an appeal or duplicate submission, you do not use the NUCC Condition code. Generally, leave this field blank for CIHS claims.

FIELD 11 a-d – Insured’s Policy or Group Multi-Field

FIELD 11 – For the Veteran’s policy number, you should again enter the Veteran’s EDIPI number or the social security number.

FIELD 11a – Insured’s Date of Birth and Sex information was completed in FIELD 3, you do not need to complete it here.

FIELD 11b – Other Claim ID applies for Worker’s Comp or Casualty – it does not apply for Veteran benefits. Please leave this field blank.

FIELD 11c – Insurance Plan or Program Name is “CCN Veteran Benefits Program”.

FIELD 11d – Is there another Health Benefit Plan?

When you verified benefits through TriWest’s Payer Space on Availity, you should have determined if there is OHI for this Veteran. If there is, you should check “YES” and then include this information in FIELD 9, 9a and 9d. If there is no OHI, check “No”. Most claims will be “No”.

FIELD 12 and FIELD 13 - Patient’s or Authorized Person’s Signature and Insured’s Signature

| | | |
|---|---|--|
| <small>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</small> <small>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</small> | | <small>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</small> |
| SIGNED <input type="text" value="Signature or 'Signature On File'"/> | DATE <input type="text" value="NA if on file"/> | SIGNED <input type="text" value="Signature or 'Signature On File'"/> |



- Most providers have a HIPAA Release form signed by patients at time of initial service. That allows you, the provider of services, to submit claims after the fact.
- With a signed form on file, you do not need to capture a patient’s signature in either field. Instead, insert “Signature On File” or “SOF” to indicate signed permission was provided by via a HIPAA form. No date is required when you indicate “SOF”.

Section Two: CLINICAL INFORMATION

FIELD 14 – Date of Current Illness, Injury or Pregnancy (LMP)

| | | | |
|---|----|------|------|
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) | | | |
| MM | DD | YY | QUAL |
| 00 | 00 | 0000 | |

Enter the first date of the present episode of care for which you are submitting this claim. The area to the right of the vertical dotted line is for pregnancy related care only.

Fields 15, 16 and 18 are dates for care that may have previously related episodes. These would apply for Worker’s Compensation and hospitalization. This care is not typically part of a CIHS claim; leave the field blank for most claims.

FIELD 15 – Other Date related to the patient’s condition or treatment. If any, that date goes here. For most CIHS therapy claims, FIELD 15 is not applicable.

FIELD 16 – Dates Patient Unable to Work in Current Occupation is for Worker’s Compensation or injury cases. It is completed by a clinician who can assess functional status.

FIELD 17, 17b – Name of Referring Provider or Other Source and NPI

| | | | |
|--|--|-----|----------------|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | 17a | |
| Name of Referring Provider | | 17b | NPI |
| | | | Provider's NPI |

If the approved referral to you was initiated by another clinician in the community, and you know who this is, add that information here. However, since all referrals must be pre-approved by VA and can be tracked in TriWest’s system, this field is not required.

FIELD 18 – Hospitalization Dates Related to Current Services captures information related to an inpatient stay. For most CIHS therapy claims, FIELD 18 is not applicable.

FIELD 19 – Additional Claim Information is not used. Leave this field blank.

FIELD 20 – Outside Lab? \$ Charges

| | | | |
|------------------------------|--|------------|--|
| 20. OUTSIDE LAB? | | \$ CHARGES | |
| <input type="checkbox"/> YES | <input checked="" type="checkbox"/> NO | | |

If you are billing for services you purchased, such as for an outside lab, then mark “YES” and insert the charges. For most CIHS therapy claims, FIELD 20 is not applicable. Leave this field blank.

FIELD 21 – Diagnosis or Nature of Illness or Injury

| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) | | | | ICD Ind. |
|---|---------|----|----|----------|
| A. F4312 | B. R457 | C. | D. | |
| E. | F. | G. | H. | |
| I. | J. | K. | L. | |

Field 21 lists, in order of priority, all ICD-10 diagnosis codes.

- Field 21 A contains the primary diagnosis and is the main reason the Veteran is seeking care.
- Fields 21 B through L contain any additional diagnosis codes (secondary, tertiary, etc.).
- Do not include any narrative, just codes.
- Do **not** include the decimal point in the diagnosis code. This creates a rejection.
- Only use ICD-10 codes. ICD-9 codes, which may still be listed in some tools, are obsolete.
- Use of an ICD-9 code creates a rejection.

Primary and Secondary Should be Diagnosis ICD-10

In our example, the Veteran is receiving care because of PTSD. You look up the codes that best describe the Veteran's condition through an online tool and determine that PTSD has four ICD-10 codes: F43.1 – F43.12. Each has a different description. Choose the code that best fits the conditions described by VA and add this to 21A as the **primary** diagnosis.

A secondary diagnosis code may apply if your services are driven by more than one condition.

Recent trauma created a state of emotional shock and stress, which made the Veteran's PTSD worse. The shock is not the primary reason for care, but it is a secondary factor for some or all of the care.

As with a primary diagnosis, you should research the ICD-10 code that applies. Enter this secondary diagnosis code into Field 21B.

Most CIHS claims use just the primary diagnosis code, but if the services you provide specifically address a secondary condition, you should add these to support the services you bill.

FIELD 22 – Resubmission and/or Original Reference Number

| 22. RESUBMISSION CODE | ORIGINAL REF. NO. |
|-----------------------|-------------------|
| | |

If you are resubmitting the claim, you should add the Claim Number associated with the initial claim in FIELD 22. In general, along with the appropriate Resubmission code, such as 7 for correction

FIELD 23 – Prior Authorization Number

| 23. PRIOR AUTHORIZATION NUMBER |
|------------------------------------|
| Referral Number from Authorization |

This field is VERY important. TriWest will only pay for pre-authorized care with an Approved Referral. Always include the VA Referral Number in this field.



FIELD 24 A-J – Claims Codes Multi-field

| 24. A. DATE(S) OF SERVICE | | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---------------------------|----|----|----|----|----|----|---------------------|--------|---|----------|--|----|----------------------|---------------|------------------|----------------------|--------------|-----------------------------|
| MM | DD | YY | MM | DD | YY | | | | CPT/HCPCS | MODIFIER | | | | | | | | |
| 10 | 25 | 18 | 10 | 25 | 18 | 99 | | | TAIC | | | AB | 10.00 | 2 | | NPI | 1234567890 | |
| 10 | 28 | 18 | 10 | 28 | 18 | 99 | | | TAIC | | | AB | 10.00 | 2 | | NPI | 1234567890 | |
| | | | | | | | | | | | | | | | | NPI | | |
| | | | | | | | | | | | | | | | | NPI | | |

Field 24 is the Billed Services section. A paper CMS 1500 form has room for a maximum of six specific codes (six rows). Electronic claims are not limited to six. If you have supplemental information to support the billed service, you can include this in the shaded area or in a defined field if billing electronically. This is NOT typically used, but it is an option.

- **Section 24A** – add the Date of Service (DOS). For most CIHS claims, services do not extend across multiple days – so the “from” and “to” dates are for the same date. For multiple sessions or appointments, note each one with a separate DOS. You can combine several dates of service (DOS) in one claim, as in our example.
- **Section 24B** – add the Service Location Code. This is where you actually provided the service. CMS publishes a Place of Service Code Set that you can use. If you cannot find a location that fits where you are providing therapy/services, use the appropriate place of service and guide to review the CMS place of service listing.
- **Section 24C** – most CIHS claims will not be considered an emergency. Leave this field blank.
- **Section 24D** – add the CPT service code (Massage Therapy, Acupuncture) or the VA National Clinic Code. If you need to apply a modifier for this code – such as “LT”, “RT” or “59”, please include those in the modifier columns. You can include up to four modifiers and subset modifiers.
- **Section 24E** – add the appropriate “Diagnosis Pointer” to indicate the applicable ICD-10 code. If only one ICD-10 code applies, list only the one code. If multiple codes apply, list the multiple fields. In our example both the A and B codes apply, so “AB” was inserted.
- **Section 24F** – enter your billed charge for this line of service in 24F. Add “00” to indicate whole dollar amounts.
- **Section 24G** – enter the number of units your billed amount includes.

In the example, a practitioner charges \$5 for every 15 minutes of therapy. The Veteran received 30 minutes of care on 10/25/18 and another 30 minutes on 10/28/18. So the practitioner billed for \$10.00 and two units on two different days.

If you are billing a defined CPT code for your services, please familiarize yourself with the CMS rates and rules.

- **Section 24H** – this refers to Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) and Family Planning services. Leave this column blank.
- **Section 24I** – if you are using an alternate identifier, other than an NPI, please insert the code for that here. Otherwise, leave this field blank.
- **Section 24J** – enter your NPI or the NPI of the provider that rendered services. If you have several instructors or therapists providing services, please submit a separate claim for each provider. Do not combine these into a single claim. If you are a solo practitioner, do **NOT** put Type 1 in Box 24J.



National Drug Code (NDC) Billing Guidelines

When billing claims with drug codes on a CMS 1500 form (professional), electronic 837P, UB-04 (institution) and/or electronic 837I it is necessary to bill the NDC number, units and quantity correctly.

Professional Paper Claim Guidelines (CMS-1500)

In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left-justified), immediately followed by the NDC. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of measure (UN, ML, GR, or F2), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.

| 24 | A. DATES OF SERVICE | | | | | | B. PLACE OF SERVICE | C. PROCEDURE, SERVICE, OR SUPPLIES (EMG) | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. SPLIT (SPLIT) (SPLIT) | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|----|-------------------------|---------|---------|-------|-------|-------|---------------------|--|--|-------|----------|----------------------|---------------|------------------|--------------------------|--------------|-----------------------------|
| | From MM | From CC | From YY | To MM | To CC | To YY | | | OPT | HCPCS | MODIFIER | | | | | | |
| 1 | N400409477702 ML600.000 | | | | | | | | | | | 17.94 | 6 | N | | 12345678901 | |
| | 01 | 01 | 18 | 01 | 01 | 18 | 11 | | J0744 | | | | | N | NPI | 123456789 | |

| | | | |
|---------------|--------------|-----------------|----------|
| N4 | 00409477702 | ML | 600.000 |
| NDC Qualifier | 11-digit NDC | Unit of Measure | Quantity |

Institutional Paper Claim Guidelines (UB-04)

In the line-item field 42-46, enter the appropriate drug-related revenue code in field 42. In field 43, report the NDC qualifier N4 (left-justified), immediately followed by the 11-character NDC in the 5-4-2 format (no hyphens). Immediately after the last digit of the NDC, enter the appropriate qualifier for the correct package size, NDC unit of measure (UN, ML, GR, or F2), followed by the quantity (number of NDC units up to three decimal places), as indicated in the example below.

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE |
|-------------|------------------------|------------------------------|
| 1 636 | N400409477702ML600.000 | J0744 |
| 2 | | |
| 3 | | |

| | | | |
|---------------|--------------|-----------------|----------|
| N4 | 00409477702 | ML | 600.000 |
| NDC Qualifier | 11-digit NDC | Unit of Measure | Quantity |

It is important to include the N4 before the 11-digit NDC number and to not include drug name on the claim form. Including the drug name on the claim form may result in the claim being denied.

Note: For more detailed information regarding claims submission, please refer to the [Claims Submission Quick Reference Guide](#).



Section Three: PHYSICIAN OR SUPPLIER INFORMATION

FIELD 25 – Federal Tax ID Number

| | | |
|-----------------------------|--------------------------|--------------------------|
| 25. FEDERAL TAX I.D. NUMBER | SSN | EIN |
| TIN # Here | <input type="checkbox"/> | <input type="checkbox"/> |

Enter your tax identification number (TIN) in this field. Do not include any hyphens. Check the “EIN” field to indicate that this is a business-tax-identification number.

Please be aware, if you choose to use a Social Security number (SSN) instead of a TIN, your number will display with the claims information. Using a separate TIN is an easy step that offers **significant** protection for providers.

FIELD 26 – Insert patient number in this field for providers tracking purposes.

FIELD 27 – Accepts Assignment?

| |
|---|
| 27. ACCEPT ASSIGNMENT? (For govt claims, see back) |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |

This field indicates that you agree to *accept assignment* under the terms of the payer’s program. Accepting assignment means you are participating as part of TriWest’s contracted CCN network and TriWest will pay for clean claims.

You should check “YES” if you are in our CCN network. If you are not in network, you must submit your claims to VA directly. TriWest cannot pay out-of-network claims.

FIELD 28 – Total Charge

| | |
|------------------|--------------------------|
| 28. TOTAL CHARGE | <input type="checkbox"/> |
| \$ 20.00 | |

Add all of the charges in column F and insert that total in Field 28. This is the total amount of billed charges for this claim.

FIELD 29 – Amount Paid

| |
|-----------------|
| 29. AMOUNT PAID |
| \$ 0.00 |

CIHS claims may not have payments from other insurance payers. Leave this field blank if you have not received any payments from other payers. If you received payment from OHI payers or from the Veteran, enter that amount here.

- If you submitted a claim to an OHI plan and received partial payment, enter that amount here.
- If you collected a co-pay, co-insurance or deductible from a Veteran as part a requirement for submitting a claim to another commercial insurance payer, you will need to remit this amount back to the Veteran once TriWest has paid you the balance of the allowed amount.
- Generally, providers should not collect out-of-pocket costs from Veterans. If Veterans owe any co-pay or co-insurance, VA will determine this after care has been rendered and submit the claim to the Veteran directly.

FIELD 30 – Leave this field blank.



FIELD 31 – Signature

| | |
|---|------|
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | |
| SOF | |
| SIGNED | DATE |

If you are completing this claim as a paper submission, please sign and date this form. If you are submitting electronically, indicate the name of the provider

FIELD 32, 32a, AND 32b – Service Facility Location

| | |
|--|----|
| 32. SERVICE FACILITY LOCATION INFORMATION | |
| 1234 W Provider Blvd Provider City TX 00000 | |
| a. | b. |

Enter location of your practice/business or the location where the services were provided. This information should align with “24B” Place of Service Code. Please do not use commas or periods.

FIELD 32a –NPI number of the servicing location

If the services were in the office, indicate the group NPI. If the services were in the facility indicate the facility NPI.

FIELD 32b – Other Facility identification number can be inserted, if applicable. A CIHS claim does not typically use an alternate location identifier. This field is not required.

FIELD 33, 33a, AND 33b – Billing Provider Information

| | |
|--|----|
| 33. BILLING PROVIDER INFO & PH # (000) 0000000 | |
| 1234 W Provider Blvd Provider City TX 0000 | |
| a. 1234567890 | b. |

This is the SERVICING and BILLING provider’s information. Enter the billing name, address, ZIP code and phone number. This information may also be your billing office contact information if you use a third party billing service.

TITLE 33a – this section is for the servicing provider’s NPI number.

TITLE 33b – This section is for Other ID numbers – please indicate if this is a State License number (0B code), a commercial provider number (G2 Code) or if there is an applicable taxonomy code (ZZ code). A CIHS claim does not typically use an “Other” identifier.

Most Common Errors

- The most common error with claims is duplication.
 - All providers may create a free account on Availity (www.availity.com) which allows access to reporting tools and the ability to submit claims electronically at no additional charge. As a registered provider, you can check claim status individually or in a report format. Availity tools



allow real-time tracking and eliminate needless re-submission.

2. You submitted a handwritten CMS 1500 and the system scan could not decipher the form. Handwritten claims may reject out of the system as non-compliant. Please submit typed or electronic claims. Use the Courier or Courier New font 10. Be sure to mono-space front work best with the scanner technology. Do not mix fonts or use italics, scripts, percent signs, question marks, or parenthesis.
3. The claim went to the wrong insurance payer. Confusion on who is responsible for paying the claim is common. When we investigate missing claims, we often find that providers submitted claims to TRICARE, Medicare, or VA in error. If your claims are completely missing, you may want to ensure there is no confusion on the part of your billing team.
4. Errors with Coding Modifiers – Modifier 59
 - a) If a therapist/practitioner is providing care which is typically bundled, but needs to indicate that a particular service was performed on the same day, and is considered distinct or independent of the bundled codes, then a “59” modifier code is used. However, if you simply provide a “59” code, TriWest will deny this as non-compliant. This modifier requires an X-subset modifier.



Example of a CMS 1500 Form

TriWest VA CCN Claims
 P.O. Box 108851
 Florence, SC 29502-8851

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

FICA

| | | | |
|--|--|---|--|
| <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER | | 1a. INSURED'S ID, NUMBER Veteran's Full SSN or EDIPI Number | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Last (Suffix), First, Middle Initial | | 3. PATIENT'S BIRTH DATE MM DD YY 00 00 00 M <input type="checkbox"/> F <input type="checkbox"/> | |
| 5. PATIENT'S ADDRESS (No. Street) Permanent Address (no punctuation) CITY: City STATE: ST ZIP CODE: Zip TELEPHONE (Include Area Code): (123) 1234567 | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Veteran's Name 7. INSURED'S ADDRESS (No., Street) CITY: STATE: ZIP CODE: TELEPHONE (Include Area Code): | |
| 8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9. OTHER INSURED'S POLICY OR GROUP NUMBER 10. RESERVED FOR NUCC USE 11. RESERVED FOR NUCC USE 12. INSURANCE PLAN NAME OR PROGRAM NAME | | 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State): c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC) 11. INSURED'S POLICY GROUP OR FECA NUMBER Veteran's Full SSN or EDIPI Number 11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> 11. OTHER CLAIM ID (Designated by NUCC) 11. INSURANCE PLAN NAME OR PROGRAM NAME CCN Veteran Benefits Program 11. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i> | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: Signature or "Signature on File" DATE: NA if on file | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: Signature or "Signature on File" | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: | | 15. OTHER DATE MM DD YY QUAL: | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Name of Referring Provider | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 17a. NPI Provider's NPI | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES: | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to A-L to service line below (24E) | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | |
| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER 10 25 22 10 25 22 22 99244 AB | | 23. PRIOR AUTHORIZATION NUMBER VA Referral Number | |
| 25. FEDERAL TAX ID NUMBER SSN TIN TIN # Here | | 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 28. TOTAL CHARGE \$ 100 00 | | 29. AMOUNT PAID \$ | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SIGNED: DATE: | | 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # () | |

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)



Example of a HIPAA Release Form

HIPAA Privacy Authorization Form

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to

_____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

OR

b. all past, present, and future periods.

3. Extent of Authorization

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse treatment
- Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date, event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

Date

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)



Claims Submission Requirements

- Providers should submit claims within 30 days after rendering services. There is a 180day timely filing limit.
- Providers are required to include the Department of Veterans Affairs (VA) referral/authorization number with all VA Community Care Network (CCN) and Patient Centered Community Care (PC3) claims submissions.
- Providers are required to share the VA referral/authorization number with the ancillary providers included in a Veteran's episode of care. The ancillary provider is also required to use this same VA referral/authorization number when submitting their claim for the specific episode of care.
- Providers should not collect copays, cost-shares or deductibles. CCN reimburses up to 100% of the allowed amount, including any patient obligation.
- Payments made by VA shall be considered payment in full under CCN. Providers may not impose additional charges to TriWest or the Veteran for covered services.
- TriWest can process claims for out-of-network providers if the service is ancillary to the care associated with an Approved Referral/Authorization, – for example, radiology, pathology, and anesthesiology.
- Emergent (ER) services are reimbursable if ER department is a network facility. ER services require notification to VA.
- Network Urgent Care does not require pre-authorization, however an eligibility check is highly recommended prior to rendering of care, to avoid possible claim denials.
- For CCN, TriWest follows Medicare Fee-for-Service billing guidelines, fee schedules and payment methodology when applicable.

Clean Claim Requirements

- In order for a claim to process and pay, TriWest must have visibility to the appointment in our systems.
 - With an Approved Referral/Authorization and appointment confirmation, TriWest's system generates an authorization for the primary provider.
- The VA referral/authorization number is the unique identifier assigned for each Approved Referral/Authorization's episode of care. All claims submitted without a VA referral/authorization number will be denied. The only exception is urgent care.
- It is important that you properly submit claims to PGBA with the following documentation, and in the correct format:
 - VA referral number AND one of the following:
 - 10-digit Electronic Data Interchange Personal Identifier (EDIPI)
 - 17-digit Master Veteran Index (MVI) ICN
 - Social Security number (SSN)
 - Last 4 digits for SSN with preceding 5 zeros i.e., 00000XXXX

It is extremely important that you do not use any extra characters, spaces, or words with the referral/authorization number or the claim will deny.

- For example, if the referral/authorization number is VA0012345, referral numbers included in the following format would be denied:
 - Auth. VA0012345
 - Auth.# VA0012345
 - Ref .VA0012345
 - Ref. # VA0012345



- VA 0012345
- VA012345
- Please include a Type 2 (organization) NPI on all claims in box 33 as the billing party with the Type 1 Rendering provider in box 24J. If you are a solo practitioner without an organizational NPI, please use your individual NPI in box 33a only.
- Ensure all coding aligns with Medicare criteria, if applicable. When Medicare policy does not apply, please follow language in your authorization information, VA consult notes, the Provider Handbook or other training materials provided by TriWest and VA.