Parkland
Community Health Plan

| PCHP Reimbursement Policy | | |
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| Topic: Professional Provider Claim Submission Requirements | Policy Number: PCHP.RI.015 | Policy Section: Administration |
| Last Modification Date: | Effective Date: 5/15/2025 | |

**Policy Disclaimer:**

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

**Policy:**

PCHP requires accurate and complete information for all claims submitted to ensure timely processing and reimbursement. The following details must be included on all claim submissions:

A) Patient Information: Including name, address (including ZIP code), date of birth, gender, relationship to insured, and pertinent medical condition related to employment or an accident, Member ID.
B) Coordination of Benefits/Other Insured's Information: Name, policy or group number, and insurance plan or program name.
C) Referring Physician or Source Name.
D) Indication of Outside Laboratory.
E) ICD-10-CM Diagnosis Code(s).

F) Clinical Laboratory Improvement Amendments (CLIA) Certification Number.
G) Date(s) of Service(s) Rendered.
H) Place of Service.
I) Procedures, Services, or Supplies: Description using CPT-4 codes/HCPCS codes and appropriate modifiers.
J) National Drug Code(s) (NDC): Including NDC number, unit price, quantity, and composite measure per drug.
K) Charges for Service(s) Rendered.
L) Day(s) or Unit(s) Related to Service(s) Rendered.
M) Total Charges and Amount Paid by Patient.
N) Federal Tax Identification Number.
O) Group or Facility Name and Address (including ZIP code) where services were rendered, along with the National Provider Identifier (NPI) of the service facility.
P) NPI Information:
   a. Individual Servicing Provider's NPI must be reported as the rendering provider ID.
   b. When billing from a group, the group's NPI must be reported as the billing provider.
   c. Referring, Ordering, or Supervising Provider's NPI and other non-NPI identifiers.
Q) Billing Provider Information: Name, address (including ZIP code), and telephone number.
R) Indication of Signature on File: Handwritten or computer-generated signature for the provider of service or representative, along with the date of signing.

PCHP will not accept claims with altered billing information. Altered claims will be returned to the provider with an explanation for the return.

While electronic submission via Electronic Data Interchange (EDI) is preferred, PCHP also accepts paper claims. Paper claims must be submitted on an original claim form with drop-out red ink, computer-printed or typed in a large, dark font suitable for Optical Character Recognition (OCR) technology. Hand-written claims are not accepted and will be rejected. All claims must be legible; illegible claims will be rejected or denied.

Providers are encouraged to consult their provider manuals and state-specific guidelines for comprehensive information on claims submission requirements.

**References:**

This policy has been developed through consideration of the following:

CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative

**Policy History:**

| Description | Date |
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| Policy Created | May 9, 2024 |
| Policy Approved | January 30, 2025 |