CHAPTER 7:

General Billing Rules

Reviewed/Revised: 1/24, 9/24, 5/25, 12/25

7.0 GENERAL INFORMATION

This chapter contains general information related to ACA StandardHealth with Health Choice billing rules and requirements.

ACA StandardHealth with Health Choice follows the HIPAA Compliant 837 transaction guidelines and the coding standards described in the current editions of the Uniform Billing (UB-04) Manual; the 1500 Manual; the ADA Manual; International Classification of Diseases (ICD) Clinical Modification (CM) and Procedure Classification System (PCS) Manuals; Physicians' Current Procedural Terminology (CPT Manual; Healthcare Common Procedure Coding System (HCPCS) Guidelines; Centers for Medicaid and Medicare Services (CMS), and the Current Dental Terminology (CDT) Manual.

ACA StandardHealth with Health Choice Provider Notices can be found on our website at: https://www.azblue.com/aca-standardhealth-health-choice - 'For Providers' -> 'Provider Notices'.

7.1 NATIONAL PRACTITIONER IDENTIFICATION (NPI)

ACA StandardHealth with Health Choice requires each provider to be registered with an active National Provider Identification (NPI) number. The NPI number is to be used as the healthcare provider identifier for all claim/encounter submissions.

Contracted providers can submit their NPI number to the ACA StandardHealth with Health Choice Network Services Department using the appropriate AzAHP credentialing form found on the website: Forms | ACA StandardHealth Health Choice.

All claims/encounters must be submitted with the NPI as applicable. All rendering providers must bill under their own NPI number. As a result, incident-to billing is not permissible for advance practitioners. (A rendering provider is defined as the individual who provided care to the client and needs to be reported as such in box 24J of the CMS 1500 claim form.)

7.2 MEMBER ID NUMBER AND PROVIDER CLAIM SUBMISSION

As a Blue Cross Blue Shield of Arizona (BCBSAZ) plan, this is a key element used to identify which Blue Plan the member belongs. This change only affects billing for services rendered to a Health Choice member outside of Arizona. Providers rendering services outside of Arizona will submit claims directly to the Blue plan within that state.

EXCEPTION: *Blue Cross Blue Shield of Arizona Health Choice contracted providers located in contiguous (bordering) counties to Arizona will submit claims directly to Health Choice.* Below is a current listing of contiguous counties (subject to change upon county boundary changes by each state).

- **California:** San Bernardino County
- **Nevada:** Clark County and Lincoln County
- **Utah:** Kane County and Washington County
- **Colorado:** Montezuma County
- **New Mexico:** San Juan County, McKinley County, Cibola County, Catron County, Grant County, and Hidalgo County

As a reminder, Arizona providers and contracted providers located in contiguous counties to Arizona will submit claims to *Blue Cross Blue Shield of Arizona Health Choice* for all administered Health Plans.

Below is an example of what the ACA StandardHealth with Health Choice ID format looks like:

Health Plan	**ID #**
ACA StandardHealth with Health Choice (ACA/IU65)	**IAZ**12345678

If you do not use the correct ACA StandardHealth with Health Choice ID number when submitting claims or requesting prior authorization, claims will be rejected, and we will not be able to process your request(s).

7.3 ELECTRONIC SUBMISSIONS

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors. ACA StandardHealth with Health Choice offers the ability to submit claims/encounters electronically through our clearinghouse

All electronic submissions shall be submitted in compliance with applicable law including HIPAA regulations, and BCBSAZ Health Choice policies and procedures. For contracted providers, please contact your software vendor, or your BCBSAZ Health Choice Provider Performance Representative can provide more information about electronic billing. For non-contracted providers, please contact your software vendor for more information about electronic billing.

EDI Claim/Encounter Submission

Electronic Clearinghouse Submission*	
ACA StandardHealth with Health Choice	**Payer ID RP105**

In some instances (described throughout this manual), medical records may be required to support payment. If medical records are required to support electronic claim/encounter submissions, records may be mailed to the Health Choice Claims Department. Refer to Section 7.14 *Documentation Requirements* for additional guidance.

7.4 PAPER CLAIM SUBMISSION REQUIREMENTS

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors.

We understand that at times you may need to submit a claim through the mail, here's some reminders:

- When a claim is submitted, please ensure that the printed information is aligned correctly with the appropriate section/box on the form.
- Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or not submitted on the correct form will be returned to the provider without processing.
- Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.
- Do not submit double-sided, multiple-page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.). To ensure that all pages of a multiple-page, UB-04 claim are processed as a single claim the pages **must** be numbered. Totals should not be carried forward onto each page, and each page can be treated as a single page. **The total should be entered on the last page only.**
- Please do not staple documents or claims. If there is a document being submitted with the claim, the document should lay directly behind the claim and can be paper-clipped or rubber-banded together.

If your claim is not accepted, this submission does not count as a clean claim submission. If you receive a returned claim, the provider must re-file a legible copy of the claim on the correct claim form type, and it must be refilled within the appropriate time frame detailed in an upcoming section. ***Please note**: *Faxed claims are not accepted for processing*.

MAILING ADDRESS FOR PAPER CLAIMS:
ACA StandardHealth with Health Choice
P.O. BOX 52033

PHOENIX, AZ 85072-2033

7.5 CLAIM SUBMISSION TIME FRAMES

We ask providers to submit complete and accurate claims within 30 days of service. Generally, we deny payment of any claims received more than one year after the date of service. Members are not liable for payment of a claim denied for untimely filing.

Timeliness	NON-CONTRACTED (NSA Applicable Claims only)	CONTRACTED
Claim Submissions	12 Months from the DOS	6 Months from DOS
Claim Re-submission	12 Months from the processing date of the original claim Submission	12 Months from DOS
Dispute	30 Business days to ask for open negotiation	**Disputes related to coverage, benefit book exclusions, medical necessity, non-contracted claim denials** Within 2 years from date of denial (there is only one level of internal appeal) **Payment disputes (Services are covered, provider believes the services weren't reimbursed correctly/underpaid)** One year after denial or other notification, or date of the occurrence if the provider did not receive notification (level one, internal appeal)
Second Level Dispute	After open negotiation, 4 business days to seek Federal IDR	**Disputes related to coverage, benefit book exclusions, medical necessity, non-contracted claim denials** Up to 4 months from date of final internal adverse determination (external) **Payment disputes (Services are covered, provider believes the services weren't reimbursed correctly/underpaid)** Within 60 days of Provider's receipt of Level 1 decision (level two, internal appeal)

Proof of timely filing

Proof of timely filing must be submitted with grievances related to timely filing denials. For more information about provider grievances, see Chapter *Claim Disputes, Member Appeals and Member Grievances.*

7.6 BILLING MEMBERS FOR SERVICES

Generally speaking, BCBSAZ network providers are contractually prohibited from balance billing a member for amounts in excess of the applicable cost-share amounts for covered services. This includes:

- **Billing for denied claims**

BCBSAZ network providers may not bill members for claims for covered services that are denied because the provider failed to:
− Adhere to timely claim filing requirements
− Adhere to billing policies and procedures
− Submit requested medical records needed to adjudicate a claim.

- **Billing for services considered investigational or not medically necessary**

7.7 GENERAL BILLING RULES

Most of the rules for billing Blue Cross Blue Shield of Arizona Health Choice follow those observed by Medicare and other third-party payers. However, the following requirements are emphasized:

Billing must follow completion of service delivery

- A claim/encounter may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

Referring/Ordering provider information

- Referring/ordering provider information is a claim submission requirement for all services rendered as a result of a referral/order. The claim must contain the name and individual NPI of the provider who referred/ordered the service(s)/item(s). If the referring provider information is not reported on the claim or if the provider is not enrolled in BCBSAZ Health Choice, the claim cannot be paid. On the CMS-1500 form, referring/ordering physician information is required in box 17a when ordering provider is any of the following:

o Laboratory o Radiology o Medical and Surgical Supplies o Respiratory DME	o Enteral and Parenteral Therapy o Durable medical Equipment o Drugs (J-Codes) o Temporary K and Q codes	o Orthotics o Prosthetics o "V"codes – (including, but not limited to codes pertaining to vision and hearing) o 97001-97150 or 97159-97546

For Electronic claim/encounter submissions, please refer to the ASCX12 HIPAA Guidelines for the appropriate loop/segment to utilize for reporting the referring/ordering physician information. A copy of the HIPAA Guidelines can be purchased from the Washington Publishing Company at http://www.wpc-edi.com/.

If applicable, enter the Qualifier:

- **DN** Referring Provider
- **DK** Ordering Provider*

- **DQ** Supervising Provider

National Drug Code (NDC) Requirements

- These requirements are in accordance with and support of the Federal Deficit Reduction Act of 2005, which mandates that all providers submit National Drug Codes (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. These services are currently represented on submitted claims by use of the Healthcare Common Procedure Coding System (HCPCS) codes.

NDC Definition

- The NDC is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the FDA. The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer.

  Providers of "physician-administered" drugs include any provider whose license and scope of practice permits the administration of drugs, such as a medical doctor (MD), Doctor of Osteopathic Medicine (DO), nurse practitioner (NP), physician assistant (PA), ambulatory surgery centers (ASCs), hospital outpatient clinic/services and skilled nursing facilities (SNFs).

In order to ensure compliance with guidelines for NDC codes, BCBSAZ Health Choice has adopted the Noridian NDC crosswalk for reference. The NDC/HCPCS crosswalk provides a listing of each National Drug Code that is assigned to a HCPCS. Please refer to the NDC crosswalk as applicable for your Jurisdiction located at https://med.noridianmedicare.com/ .

***HCPCS codes that will require the NDC information on the claim submission*

Drugs billed using HCPCS codes include:

- A, C, J, Q and S codes as applicable.
- "Not otherwise classified" (NOC) and "Not otherwise specified" (NOS) drug codes (e.g., J3490, J9999, and C9399)
- CPT codes, 90281-90399 for immune globulins
- CPT Codes 90476-90749 for vaccines and toxoids
- Providers **must** submit a valid 11-digit NDC when billing a HCPCS drug or CPT procedure code as defined above.
- The qualifier "N4" must be entered in front of the 11-digit NDC. The NDC will be submitted on the same detail line as the CPT/HCPCS drug procedure code in the pink shaded area for Electronic claims/encounters, the drug information is reported in Loop 2410

Billing multiple units

- If the same service is provided multiple times on the same date, and the service is not

required to be reported with a modifier to indicate an additional procedure was performed, then services for the same provider/member/location/modifier(s), are required to have the service code entered once on the claim form with the appropriate units rolled up.

- The unit field is used to specify the number of times the procedure was performed on the date of service.
    - For time/unit-based services, units should first be calculated for each instance of the service; then the total units reported should be a combination of all units for that particular service/day/provider/member/location/modifiers(s) added together.
        - For example: for a 97110 the unit duration is 15min so for a service that lasted an hour, the units would be 4 (60/15). If an additional 97110 for the same day/provider/ member/location/modifier(s) was provided for 30 minutes, the units for that instance would be 2 (30/15), the total units reported on the one 97110 claim line would be 6.
- The total billed charge is the unit charge multiplied by the number of units.

Age, gender, and frequency-based service limitations.

BCBSAZ Health Choice uses the limitations on services based on recipient age and/or gender as set forth by standard coding guidance.

- Some procedures have a limit on the number of units that can be provided during a given time span.

Medicare and Third-Party Payments

- BCBSAZ individual/family (non-group) policies do not coordinate benefits with other commercial carriers. These policies coordinate only with another BCBSAZ policy or Medicare.
- BCBSAZ individual/family (non-group) policies do not coordinate benefits with other commercial carriers. These policies coordinate only with another BCBSAZ policy or Medicare.

If a BCBSAZ individual/family member also has coverage through the Arizona Health Care Cost Containment System (AHCCCS) or another state Medicaid agency, our coverage is primary. If a BCBSAZ member has AHCCCS/Medicaid coverage, submit the claim to us for adjudication as the primary payer.

Correct Coding Initiative

BCBSAZ Health Choice follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on Fee-For-Service claims for the same provider, same member, and same date of service.

Correct coding means billing procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code. Some examples of **incorrect** coding include:

- Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service and clinically justified as demonstrated in the medical record. Claims submitted to BCBSAZ Health Choice utilizing modifier 59 will be subject to Medical Review. **Documentation in the medical record must satisfy the criteria required for appropriate use of the modifier.** Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

To align with Medicare billing rule, bilateral procedures are to be billed on one line with the "50" modifier and the appropriate number of units.

Separate services during the post-operative period may be billed with modifier 58 or 78.

Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

Emergency services claims

- All claims are considered non-emergent and subject to applicable prior authorization unless the provider clearly identifies the service billed on the claim form as an emergency.
- On the UB claim form, the Admit Type must be "1" (emergency), "5" (trauma) or "4" (newborn) on all emergency inpatient and outpatient claims.
- All other Admit Types, including "2" for urgent, designate the claim as non-emergent.
- On the CMS 1500 claim form, Field 24C must be marked to indicate that the service billed on a particular claim line was an emergency or the place of service that the procedure was billed with must be "23" for emergency room or "20" for urgent care facility.
- For electronic Professional claims/encounters, loop 2400 segment SV109 must indicate a 'Y'

for emergency services. For electronic Institutional claims/encounters, the admit type reported in loop 2300 segment CL101 must be included as indicated above.

Medical review is a function of BCBSAZ Health Choice and is performed to determine medical necessity and coding appropriateness.
BCBSAZ Health Choice reserves the right to review claims for emergency services to determine medical necessity and appropriate billing and coding. Physicians and facilities must bill the level of service as documented in medical records and as identified in the CPT coding descriptions to ensure proper reimbursement.

7.8 EVALUATION AND MANAGEMENT SERVICES (E&M)

When determining the level of "established patient" Evaluation and Management (E&M) services (i.e., 99211-99215), code selection is based on Medical Decision Making (MDM) or total time, including face-to-face and non-face-to-face time spent on the date of the encounter. History and physical examination elements are not required for code level selection for office and other outpatient services. However, a medically appropriate history and/or physical examination should still be documented. *Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.*

It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. *The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported*. [CMS 100-04, Chapter 12, Section 30.6.1]

Medical Decision Making (MDM) is defined by the complexity of a physician's work that is necessary to establish a diagnosis and/or to select a healthcare management option.

Evaluation and Management services are assigned based on the medical appropriateness and/or necessity of the physician patient encounter. E&M services must meet the specific requirements of the Current Procedural Terminology (CPT) code billed on the claim with the caveat that 1 of the determining components must include medical decision making. A physician should not submit a CPT code for a high-level E&M service (i.e., 99214 or 99215), when the circumstances surrounding the physician patient encounter do not **support medical decision making of moderate to high complexity**.

7.9 RECOUPMENT

ACA StandardHealth with Health Choice will conduct post-payment review of all claims and recoup any monies erroneously paid.

- Under certain circumstances, BCBSAZ Health Choice may find it necessary to recoup or take back money previously paid to a provider.
- Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

- Upon completion of the recoupment, BCBSAZ Health Choice will send a remittance advice explaining the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the recoupment.

In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter. In the case of recoupments, the time span allowed for resubmission of a clean claim will be the *greatest* of:

- Twelve months from the date of service, or
- Sixty days from the date of the adverse action.

7.10 RESUBMISSIONS, ADJUSTMENTS, AND VOIDS

When **resubmitting a denied claim or adjusting (correcting) a previously paid claim,** you must submit a new claim form containing all previously submitted lines. If any previously paid lines are blanked out, the system will assume that those lines should not be considered for reimbursement, and payment will be recouped. When replacing a claim, you must resubmit any documentation that was sent with the denied or previously paid claim.

Resubmitting a denied CMS 1500 claim or requesting adjustment to a previously adjudicated claim:

Enter an "A" or "7" in Field 22 (Medicaid Resubmission Code) and the CRN (claim reference number which is found on the remittance advice) of the claim in the field labeled "Original Ref. No." *Failure to replace a 1500 claim without Field 22 completed can cause the claim to be considered a "new" claim and then not link to the original denial/paid claim. The "new" claim may be denied for timely filing limits exceeded.*

- **Resubmit the claim in its entirety,** including all original lines if the claim contained more than one line. Handwritten information or corrections on 1500 forms are not accepted and will be denied. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Resubmitting a denied UB claim or requesting adjustment to a previously adjudicated claim:

- Replace UB with the appropriate Bill Type and **resubmit the claim in its entirety**, including all original lines.
    - Bill type - xx7 for a replacement and corrected claim

  Failure to replace a UB-04 without the appropriate Bill Type can cause the claim to be considered a "new" claim, and it will not link to the original denial. The "new" claim may be denied as timely filing exceeded.
- Enter the CRN of the denied claim in the "Document Control Number" (Field 64) and/ "Remarks" field (Field 84).
- Handwritten information or corrections on the UB form is not accepted and will be denied.

Resubmitting a denied ADA dental claim or requesting adjustment to a previously paid claim:

- Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number) on the ADA form.
    - Enter a note in Box 35 ("Remarks") indicating the claim as "resubmission" or "corrected claim" and provide an explanation. Refer to Chapter 10 *Billing on the ADA Claim Form*, for instruction on completing Box 35.
- **Resubmit the claim in its entirety,** including all original lines if the claim contained more than one line. Handwritten information or corrections on ADA forms are not accepted and will be denied. Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

The *original CRN must be included on the claim to identify the claim being adjusted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

Claim/Encounter voids and replacements can be submitted electronically; however, we are unable to accept electronic attachments at this time. To include required or requested supporting documentation, such as members' medical records, clearly label, **include the corrected paper claim**, and send to the Claims department at the correct address.

- To submit an electronic void, the *original claim/encounter with a frequency type code of 8 should be sent in Loop 2300 CLM05-03 and the original CRN included in Loop 2300 REF02.
- To submit an electronic replacement, the corrected claim/encounter with a frequency type code of 7 should be sent in Loop 2300 CLM05-03 and the original CRN included in Loop 2300 REF02.
- Please note: When reporting the Loop 2300 REF*F8, Payer Claim Control Number for Replacement/Reversal claims (Frequency type 7 or 8). **All claims** billed require the most recently processed claim number in the claim series to be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

Voids

When **voiding a claim**, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payments are recouped. This process should only be used when there is no other alternative.

To **void** a paid CMS 1500 claim

- Enter "V" or "8" in Field 22 (Medicaid Resubmission Code) and the *CRN of the claim to be voided in the "Original Ref. No." field.

To **void** a paid UB-04 claim:

- Use bill type xx8
- Enter the CRN of the claim to be voided in the "Remarks" field (Field 80).

- If Field 80 is used for other purposes, type the CRN at the top of the claim form.

To **void** a paid ADA claim

- Enter "VOID" and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

7.11 OVERPAYMENTS

To improve our overpayment and refund process, we have a lockbox for providers to submit overpayment/refund payments.

It is important that you use this new address to avoid delays in processing your payments.

We will accept checks with remittance documentation at our lockbox facility:

ACA StandardHealth with Health Choice
ATTN: Overpayment/Refund
PO Box 743242
Los Angeles, CA 90074-3242

A provider must notify BCBSAZ Health Choice of an overpayment. Providers can notify by submitting an overpayment/refund to the lockbox as indicated above or on a claim by requesting an adjustment to the paid claim. The provider can notify by submitting a replacement claim, which will allow recoupment of the overpayment to occur. In the event that an adjustment is needed, then providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third-party payer.

7.12 DOCUMENTATION REQUIREMENTS (Medical Record Submission)

BCBSAZ Health Choice reviews all submitted claims to ensure billed services are medically necessary, appropriate, and performed within BCBSAZ Health Choice guidelines. This review may require review of medical records, which can be conducted during the initial claim submission, or may be required in order to proceed with processing/adjudication. Medical records are required for BCBSAZ Health Choice to process level 4 and 5 emergency department claims as well as Level 4 APR-DRG and/or outlier claims. Additionally, itemized statements are required for Level 4 APR-DRG or outlier claims.

Medical records and itemized statements to support electronic claim submissions may be mailed to the following address:

ACA Standard Health with Health Choice
Attn: Claims - Medical Record Submission
P.O. Box 52033
Phoenix, AZ 85072-2033

If records or itemized statements are not submitted with a claim for a service that requires supporting documentation to establish medical necessity or appropriateness of services, the claim will be denied with all applicable denial reason/codes reflected on the claim's remittance advice, indicating what supporting documentation needs to be submitted.

For Claim Reconsiderations: If you are sending medical records in response to a claim denial, please resubmit the claim in its entirety, including the original claim number on the claim resubmission along with the medical records.

Providers must include the name and/or department of the requestor in order to ensure the records are routed appropriately. Providers should include the member's name, the member ID, the line-of-business, and reason for submission and claim number (if applicable). Records submitted without specifying the reason for submission along with the member ID information may not be routed to the intended recipient. Faxed records must be faxed directly to a specific person or department only after providers have verified the fax number and recipient.

Providers may also request a Medical Review which would require the submission of medical records when there are questions regarding coding, authorization, leveling of care, risk issues, etc. Contact us at (800) 322-8670.

7.13 INTEREST PAYMENTS

Interest Payments:
Interest payments are subject to contract terms; however, in general interest terms follow state statutes; ARS 44-1201 and ARS 20-3102. Which state interest, all Form Types, should be applied at 10% per annum (Days of interest owed * 0.000273973 * Payment owed) for any clean claims not paid within 30 days of receipt. Interest calculation begins on day 31 from the date of clean claim receipt.

7.14 SOCIAL DETERMINANTS

Social determinants of health are the conditions in which a person is born, grows, lives, works, and ages. ICD-10 codes have been created to correspond with these social determinants. Social determinants of health take into account factors like the member's education, employment, physical environment, socioeconomic status, and social support network.

The use of social determinants allows a provider to identify things such as illiteracy, unemployment, a lack of adequate food and safe drinking water, social exclusion and rejection, homelessness, alcoholism, and many other factors that could affect a member's overall health and wellbeing.
As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about the social determinant should be included in the members' chart.

Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims. Note: Social determinants are ***not*** the primary ICD-10 code. They are secondary ICD-10 codes. Dental providers will be **exempt** from the use of social determinants.