

**Administrative Simplification**  
**Policy Guidelines**

**Simplification Area:** Claims Processing

**Topic:** Processing Possible Injury Claims

**Objective:** Reduce Administrative Overhead and Expedite Claims Processing

When providers follow these guidelines, a health plan will be able to determine, in a timely manner, whether it (the health plan) is financially responsible. If the total amount of all claims for the injury is less than \$300, the health plan will pay the claim without further investigation, *in most cases*.

**Expected Impact:** *Hospitals & Practitioners* – 25 hours per month of staff time is typically required for researching and tracking down information about who is financially responsible for paying a patient's injury claim. Payment turnaround for these claims is 17-45 days longer than non-injury claims, depending upon whether the patient needs to be contacted and how easy it is to get the information from them.

*Health Plans* – Working with providers to get sufficient information to determine whether or not they are financially responsible for a patient's injury claims typically requires 100-200 hours/month.

**Background:**

When a patient receives care for injuries sustained during an accident, health plans need information about the injury in order to determine who is financially responsible, e.g. themselves, Labor & Industries, an Automobile Insurer, some other third party, etc. Some of this information may come from the care provider, and some of it **MUST** come from the patient, based upon subrogation provisions within the member's contract.

Care providers can incorporate their information on the claim form. The patient must submit a signed incident/injury report containing his/her information. (In some cases, the patient can provide the information to the health plan over the phone. The patient should check with the health plan with any questions.) If the patient completes AND signs the incident/injury report in the care provider's office, the care provider can submit it with the claim. Otherwise patients must submit it on their own. If the patient does not submit their incident/injury report, the health plan may deny the care provider's claim. In this situation, **the care provider can bill the patient directly to collect fees for services provided.**

To expedite the processing of accident claims, accident information from the care provider should be included on the claim form, whether it is a paper claim or an electronic claim. The following guidelines describe how accident information from the care provider should be incorporated onto the claim forms, thereby eliminating the need to routinely send visit notes, or any additional paperwork from the provider. (There may be circumstances when a health plan requests additional information from the provider. These cases should be the exception and not the rule.) The patient must still submit his/her accident information.

#### Health Plan specific considerations:

- Molina Healthcare will pay claims for covered services when probable TPL/COB has not been established or third party benefits are not available to pay a claim. Molina Healthcare will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL/COB collections on behalf of Members for audit and review.

#### **Guidelines:**

These guidelines address the following types of claims

- UB-04 (typically hospital claims) – paper
- HIPAA 837 Institutional - electronic
- CMS 1500 (typically physician claims) – paper
- HIPAA 837 Professional - electronic

#### *Why does accident description information need to be included on the claim?*

When a person is injured in an accident, the members' health plan may not be financially responsible for covering the cost of the required care. This is called Other Party Liability (OPL), i.e. when financial responsibility for coverage shifts from a patient's health plan to a third party. For example, if a person is injured in a car accident, the automobile insurance company may be financially responsible. If a person is injured at work, L&I may be financially responsible.

In most accident cases, the patient's health plan will not pay a claim for service until they confirm that they are responsible. Some health plans make exceptions. When coverage responsibility is unclear, health plans may pay the claim if the cumulative total of *all claims relating to the accident* is below a threshold level. This is called the OPL threshold. Most participating health plans have agreed to a minimum OPL threshold of \$300, for most injury claims. Health plans may have higher thresholds depending upon the type of accident. These higher thresholds are listed in the table below. These OPL thresholds only apply when a) financial responsibility for a patient's health care resulting from an accident is not clear, (work and automobile injuries typically do not apply to OPL thresholds) and b) the cumulative total of all claims related to the accident, from all providers, is less than the threshold amount.

In order to determine whether they are financially responsible, health plans may investigate accident-related claims. If accident description information is not on the claim or has not been received from the patient, the claim will be pended until responsibility can be determined. The health plan will send the patient an incident/injury report to; a) obtain clarification of the nature of the accident and, b) determine whether any other party is responsible. If a patient's health plan determines that it is not responsible, it is incumbent upon the patient to work with the responsible third party to pay the provider's claim.

If the health plan does not receive the information about the accident, it may deny the claim. The care provider has the option of billing the patient directly to collect fees for services related to the accident/injury.

If the provider supplies specific information about the accident (i.e. the type of accident, when it occurred and who is responsible) on the claim form, the health plan can quickly determine if it is responsible. The health plan can then either pay the claim or let the provider know to bill the responsible party.

***When must accident description information be included on the claim?***

1. The Diagnosis Code table posted at [www.wahealthcareforum.org/adminsimp/claims\\_process/diagnosis-report.asp](http://www.wahealthcareforum.org/adminsimp/claims_process/diagnosis-report.asp) identifies when accident description information from a care provider should be included on a UB-04, CMS 1500 or HIPAA 837 claim. It also identifies the Other Party Liability (OPL) threshold.

If one of these diagnoses is used **and the visit is not accident related**, ‘ACC- No Known Injury’ or ‘ACC- NKI’ should be recorded in the Remarks section of the claim. This will help streamline the claims processing.

2. In addition to diagnosis, there are other indications that the visit may be accident related.

For **UB-04 & HIPAA 837-Institutional** claims with a diagnosis other than one of the above, accident information must be included if one of the following code values are on the claim.

Condition Code: On UB-04: Boxes 18-28 On HIPAA 837I: Loop 2300 Segment HI

Health Plans	If Condition Codes =					
	01	02	03	05	28	29
Aetna	Yes	Yes	Yes	Yes	Yes	Yes
Asuris Northwest Health *2	-	-	-	-	-	-
First Choice Administrators	-	Yes	-	Yes	-	-
Group Health	Yes	Yes	Yes	Yes	Yes	Yes
Labor & Industries *1	Pref	Pref	Pref	Pref	Pref	Pref
Health and Recovery Services Administration	-	-	-	-	-	-
Molina	Pref	Pref	Pref	Pref	Pref	Pref
PacifiCare	Yes	Yes	Yes	Yes	Yes	Yes
Premera	Yes	Yes	Yes	Yes	Yes	Yes
Regence *2	-	-	-	-	-	-
Uniform Medical Plan *1	Pref	Pref	Pref	Pref	Pref	Pref

\*1 - Providers are encouraged to supply this information, but it is not required

\*2 - Condition Codes will not be used to determine if accident information is required.

Occurrence Code & Date: On UB-04: Boxes 31-36 On HIPAA 837I: Loop 2300 Segment HI

Health Plans	If Occurrence Code =													
	01		02		03		04		05		06		11	
	Acc Info Req?	Occur Date Req?	Acc Info Req?	Occur Date Req?	Acc Info Req?	Occur Date Req?	Acc Info Req?	Occur Date Req?	Acc Info Req?	Occur Date Req?	Acc Info Req?	Occur Date Req?	Acc Info Req?	Occur Date Req?
Aetna *1	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref
Asuris	Yes	Yes	-	-	-	-	-	-	Yes	Yes	-	-	Yes	Yes
First Choice	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	-	-
GHC	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	-	-	-	-
L&I *1	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref
HRSA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Molina	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref
PacifiCare	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-
Premera	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Regence	Yes	Yes	-	-	-	-	-	-	Yes	Yes	-	-	Yes	Yes
UMP *1	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref

\*1 - Providers are encouraged to supply this information, but it is not required

Value Code & Amount: On UB-04: Boxes 39-41 On HIPAA 837I: Loop 2300 Segment HI

Health Plans	If Value Code =													
	14		15		41		42		43		44		45	
	Acc Info Req?	Value Amnt Req?	Acc Info Req?	Value Amnt Req?	Acc Info Req?	Value Amnt Req?	Acc Info Req?	Value Amnt Req?	Acc Info Req?	Value Amnt Req?	Acc Info Req?	Value Amnt Req?	Acc Info Req?	Value Amnt Req?
Aetna	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Asuris *2	-	-	-	-	-	-	-	-	-	-	-	-	-	-
First Choice	Yes	-	Yes	-	-	-	-	-	-	-	-	-	Yes	-
GHC	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	-	-
L&I *1	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref
HRSA	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Molina *2	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref
PacifiCare	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-	Yes	-
Premera *2	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Regence *2	-	-	-	-	-	-	-	-	-	-	-	-	-	-
UMP *1	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref	Pref

\*1 - Providers are encouraged to supply this information, but it is not required

\*2 - Value Codes are not used to determine if accident information is required

For **CMS 1500 & HIPAA-Professional** claims with a diagnosis other than one of the above, accident information must be included if one of the following is checked

On CMS 1500: Box 10 'Is Patient Condition Related To:'

On HIPAA 837P: Loop 2300 Segment CLM (CLM 11-1, 11-2, 11-3)

Health Plans	If Condition Related to . . .		
	Employment	Auto Accident	Other Accident
Aetna	Yes	Yes	Perf
Asuris Northwest Health	Yes	Yes	Yes
First Choice Administrators	Yes	Yes	Yes
Group Health	Yes	Yes	Yes
Labor & Industries <sup>*1</sup>	Pref	Pref	Pref
Health and Recovery Services Administration	Yes	Yes	Yes
Molina	Pref	Pref	Pref
PacifiCare	Yes	Yes	Yes
Premera	Yes	Yes	Yes
Regence	Yes	Yes	Yes
Uniform Medical Plan <sup>*1</sup>	Pref	Pref	Pref

<sup>\*1</sup> - Providers are encouraged to supply this information, but it is not required

**What** accident description information should be included on the claim?

Health plans need to know enough information about the accident to determine if they are responsible or whether a third party is responsible. Health plans need to know **how** the accident happened and **when** it happened.

Form	Information	Location
UB-04 (Paper)	<ul style="list-style-type: none"> <li>• 'Condition Code'</li> <li>• 'Occurrence Code &amp; Date'</li> <li>• 'Value Code and Amount'</li> <li>• 'Diagnosis'</li> <li>• Accident Description (see below) <sup>*1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Boxes 18-28</li> <li>• Boxes 31-36</li> <li>• Boxes 39-41</li> <li>• Boxes 66-72</li> <li>• Box 80 'Remarks'</li> </ul>
HIPAA 837 Institutional (Electronic)	<ul style="list-style-type: none"> <li>• Condition Code</li> <li>• Occurrence Code &amp; Date</li> <li>• Value Code and Amount</li> <li>• Diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• Loop 2300 Segment HI</li> <li>• Loop 2300 Segment HI</li> <li>• Loop 2300 Segment HI</li> <li>• Loop 2300 Segment HI</li> <li>• Loop 2300 Segment NTE (Billing Note) NTE01='ADD',NTE02 for the Accident Description</li> </ul>

Form	Information	Location
CMS 1500 (Paper)	<ul style="list-style-type: none"> <li>• ‘Is Patient’s Condition Related To:’</li> <li>• ‘Diagnosis or Nature of Illness or Injury’.</li> <li>• ‘Date of Current Injury’</li> <li>• Accident Description (see below) *<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Box 10</li> <li>• Box 21</li> <li>• Box 14</li> <li>• Box 19 ‘Reserved for Local Use’. *<sup>2</sup></li> </ul>
HIPAA 837 Professional (Electronic)	<ul style="list-style-type: none"> <li>• Accident Indicator</li> <li>• Accident Date</li> <li>• Accident Description (see below) *<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Loop 2300 Segment CLM (11-1,2,3)</li> <li>• Loop 2300 Segment DTP (01 = ‘439’ &amp; 03 = Accident Date)</li> <li>• Loop 2300 Segment NTE (Note Reference Code) NTE01= ‘ADD’, NTE02 for the Accident Description</li> </ul>

\*<sup>1</sup> *Accident Description* - Unfortunately, due to the shortage of room on the claim form, the accident description information needs to be abbreviated and condensed. Be sure to *clearly specify* a) whether the accident was related to *work, auto, sports, school, home or other*, and b) *the date* the accident occurred (see examples).

The following are examples of short descriptors that can be included on a claim that will assist the health plan in making a decision whether an incident report needs to be sent to the member for additional information.

- Dx 845 ACC- Fell at home this a.m.
- Dx 813 ACC- Fell playing hockey at school today
- Dx 873.64 ACC- Cut tongue on dental bridge today
- Dx 873.43 ACC- Struck face by racquetball on 1-10-02
- Dx 882.0 ACC- Injured hand while gardening approx 1 week ago
- Dx 719.16 ACC- Hit lt knee while playing football at school today.
- Dx 836.50 ACC- States rt knee gave out skiing today

The ‘ACC-’ prefix highlights that the description information related to an accident.

\*<sup>2</sup> Ideally, accident information will go in Box 19 ‘Reserved for Local Use’. As described in the table below, some health plans may allow providers to put accident information anywhere on the form where there is space.

Health Plan	Instruction for Accident Description on CMS 1500
Aetna	Prefer in Box 14, but will accept anywhere on the form.
Asuris Northwest Health	Anywhere on the form -- using the ‘ACC-’ prefix
First Choice	Prefer in Box 19, but will accept anywhere on the form. Use the ‘ACC-’ prefix
Group Health	Only in box 19 form -- using the ‘ACC-’ prefix
Labor & Industries * <sup>1</sup>	Pref - Anywhere on the form -- using the ‘ACC-’ prefix
Health and Recovery	Prefer in Box 19, but will accept anywhere on the form. Use ‘ACC’

Services Administration	prefix
Molina	Anywhere on the form – using the ‘ACC-’ prefix.
PacifiCare	Anywhere on the form – using the ‘ACC-’ prefix.
Premera	Anywhere on the form – using the ‘ACC-’ prefix.
Regence	Anywhere on the form -- using the ‘ACC-’ prefix
Uniform Medical Plan <sup>*1</sup>	Pref - Anywhere on the form -- using the ‘ACC-’ prefix

\*1 – Providers are encouraged to supply this information, but it is not required

What are other processing considerations?

If accident description information is included on the claim form, the provider does not need to send any additional paperwork to the health plan, unless it is requested. In fact, submitting paperwork that is not requested may only delay the processing of the claim.

For most injuries, the patient must complete and sign an incident/injury report for the health plan. (In some cases, the patient can provide the information to the health plan over the phone. The patient should check with the health plan with any questions.) If the patient does not submit accident information to the health plan, the provider’s claim may be denied. Depending upon the health plan, claims may be pended for up to 14-50 days waiting for accident information from the patient. If information from the patient is still not received, the claim will be denied. The provider can then bill the patient directly to collect fees for services.

Providers are encouraged to inform the patient of the patient’s responsibility to complete an incident/injury report form. They may even have the patient fill out the form while in the office.

There may be circumstances when a health plan pays an accident claim and it is later determined that a third party has also made payment on the claim. In these situations, the provider will be expected to refund the health plan’s payment amount.