Summit COMMUNITY CARE

Arkansas | Medicaid

Reimbursement Policy

Claims Submission — Required Information for Facilities

Policy Number: **G-06030**
Policy Section: **Administration**
Last Approval Date: **5/6/2025**
Effective Date: **5/6/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.summitcommunitycare.com**.

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The health plan requires institutional providers (facilities) to submit the original UB-04/CMS-1450 Medicare Uniform Institutional Provider Bill for payment of healthcare services, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Institutional providers (facilities) must submit a properly completed UB-04/CMS-1450, or its electronic equivalent, for services performed or items/devices provided. If the required information is not provided, we can delay or deny payment without being liable for interest or penalties. The UB-04/CMS-1450 claim form, or its electronic equivalent, must include the following information, if applicable:

- Billing provider information (name, address, and telephone number)
- Patient control number
- Medical record number
- Type of bill
- Federal tax identification number
- Statement covers period (from-through)
- Patient information (name, member ID number, address, date of birth, and gender)
- Admission/start of care date
- Type of admission or visit
- Point of origin for admission or visit
- Patient discharge status
- Condition code(s), occurrence code(s), and date(s)
- Occurrence span code(s) and date(s) for inpatient services only
- Value codes and amounts
- Revenue code(s) and applicable corresponding CPT/HCPCS codes, if necessary. Applicable claims billed only with the revenue code will be denied. Providers will be asked to resubmit with the correct CPT/HCPCS code in conjunction with the applicable revenue code
- Date(s), unit(s), total charge(s), and noncovered charge(s) of service(s) rendered
- CLIA certification number
- Insurance payer's information (name, provider number, and Coordination of Benefits (COB) secondary and tertiary payer information)
- Prior payments — payers' insureds' information (name, relationship to patient, member ID number, and insurance group name and number)
- Principal, admitting, and other ICD-10 diagnosis codes and Present on Admission (POA) indicator, as applicable
- Diagnosis and procedure code qualifier (all seven digits for ICD-10) and date of principal procedure for inpatient services
- Patient reason for visit code
- Attending and operating provider name and tax ID, if applicable
- NPI number (in accordance with CMS requirements)
- Claim reporting data elements in accordance with applicable state compliance requirements, including the following:
  - Admission source code
  - Applicable value code for the billed admission type code
  - Birth weight with applicable value and admission type codes

- Facility type code
- National Drug Code(s) (NDC) to include the NDC number, unit price, quantity, and composite measure per drug

The health plan cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

The health plan prefers the submission of claims electronically through the Electronic Data Interchange (EDI). The health plan will accept paper claims. A paper claim must be submitted on an original claim form with dropout red ink, computer-printed or typed, and in a large, dark font in order to be read by optical character reading (OCR) technology. All claims must be legible. If any field on the claim is illegible, the claim will be rejected or denied.

Providers should refer to their provider manuals and state-specific guidelines for details on claims submission requirements.

Related Coding
Standard correct coding applies.

Policy History
- **05/06/2025 -** Review approved: no changes
- **06/13/2023 -** Review approved: added policy statement and last sentence to policy; Providers should refer to their provider manuals and state-specific guidelines for details on claims submission requirements
- **04/12/2021 -** Review approved: no changes
- **04/30/2019 -** Review approved: no changes
- **03/01/2019 -** Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following:
- CMS
- State contract
- State Medicaid

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
- Claims Requiring Additional Documentation
- Claims Submission – Required Information for Professional Providers
- Corrected Claims
- Modifier Usage
- Provider Preventable Conditions
- Unlisted, Unspecified, or Miscellaneous Codes