Reimbursement Policy

General Facility Billing

REIMBURSEMENT POLICY NUMBER: 22

Effective Date: 2/15/2026

Last Review Date: 1/2026

Next Annual Review: 7/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

☒ All health care services billed on UB04 forms (CMS 1450)
Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

☐ DRG

☐ Modified DRG

☐ Percentage of billed charges/per diem

Plan Product:

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

POLICY STATEMENT

NOTES:

- This policy is intended to provide a **general** overview of basic facility billing guidelines used and applied by the Plan. It is **not** intended to be a complete or all-inclusive summary of every facility billing guideline or regulation. Some of topics may have a separate reimbursement or coding policy document to address a subject in greater detail.
- Provider contract language applies and may vary.

I. In order to be processed correctly and promptly, claim forms must be completed accurately, as applicable to the services rendered. Claims missing required elements may be denied. Required fields to be completed include, but may not be limited to, the following:

A. Patient information (name, date of birth, Plan identification number, address, etc.)
B. Valid type of bill (TOB) for the facility type and service provided.
C. Admission date, as well as "From" and "Through" dates
D. Revenue codes (when applicable)
E. CPT/HCPCS codes (when applicable)
F. Discharge status
G. Principal diagnosis and any additional diagnosis codes
H. Source of admission
I. Condition code
J. Type of admission
K. Provider identification (national provider identification or NPI, etc.)
L. Taxonomy ID

II. Missing, incomplete, or invalid information may result in a **claim denial**. Examples that could cause claim denials if incorrect or incomplete includes, but is not limited to, the following:

A. Age to procedure and/or diagnosis conflict.
B. Diagnosis code requires additional digit(s).
C. Services provided after the discharge date.
D. Claims submitted without a taxonomy ID number.

POLICY GUIDELINES

BACKGROUND

Many facility services are submitted to payers using the claim form known as the UB-04 (also known as the CMS-1450. The format and required information to be included on these forms are determined by the National Uniform Billing Committee (NUBC). Changes to fields may be requested by CMS, the state uniform billing committees (SUBC), as well as provider and payer associations.

Most of the UB-04 Form Locators (FLs) are required data elements for Medicare billing.

This form is able to accommodate most third-party payers and hospitals and to promote consistent use of the claim form.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

The following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses general facility billing requirements:

- Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, §80.3.2.2 - Consistency Edits for Institutional Claims

CROSS REFERENCES

None

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. National Uniform Billing Committee (NUBC) CMS.
2. Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, § 80.3.2.2 - Consistency Edits for Institutional Claims. Updated 1/2/2024. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf. Accessed 6/6/2025.

POLICY REVISION HISTORY

Date	Revision Summary
8/4/2025	New Reimbursement policy
2/15/2026	Updated requirements, including taxonomy ID