Administrative Simplification
Statement of Clarification

Simplification Area: Claims Processing

Topic: Splitting of Claims

Objective: Clarify reasons that health plans split claims

Expected Impact: *Hospitals & Medical Practices:* By creating claims that won't be spilt by health plans, providers can expedite the timeframe for billing any secondary payer(s) and/or the patient.

Synopsis:

There are situations when claims need to be split, either by the provider or by the health plan. If the health plan splits the claim, each of the split claims is processed separately. Providers' systems vary in their ability to reconcile claims that are split by the health plan. To assist providers whose systems present such problems, health plans have outlined the most common conditions under which claims are split. This information will allow providers (if they prefer) to generate claims that may not need to be split by the health plans.

These guidelines do not, in any way, imply that providers are required to change their practices for producing claims.

Background:

There are situations when claims need to be split, either by the provider or by the health plan. If the health plan splits the claim, each of the split claims will be processed as separate and distinct claims and they will be reported on the remittance advice as different claims.

Reconciling split claims may create extra work for providers. Providers may need to track and account for all splits before they can bill the patient for the patient responsibility portion, bill any secondary coverage, close out the account.

Providers would like to know the conditions under which a claim will be split by the health plan, so that providers can consider these conditions as part of their logic for producing claims. With this information, providers may be able to create claims that do not need to be split by the health plan.

Conditions Under Which Health Plans will Split Claims

Unless otherwise noted, these situations apply both to claims submitted on paper and claims submitted electronically. Not all health plans will split for all of these reasons.

Claim Splitting Conditions	Description of Split
1. Claim with too many line items.	Claim with more line items than can be processed by the health plan's production system. • For professional claims, how many lines will trigger the claim to be split? • For institutional claims, how many lines will trigger the claim to be split? Provider Action: Create claims with fewer lines
2. Claim with covered and non-covered dates of services for the member due to eligibility.	A submitted claim has multiple lines of service with different dates. Some lines are for dates under which the member is eligible for coverage by the health plan. Other lines are for dates that the member is not eligible for coverage by the health plan. Provider Action: Make sure the patient is eligible for coverage with the health plan for the full period of the claim.
3. Claim with line items that will be adjudicated under different pricing scenarios.	A submitted claim has multiple line items and different service pricing logic will be used to adjudicated the different line items. Possible reasons for different service pricing logic include, but may not be limited to: • Line items fall under different contracting terms between a provider and the health plan. • Line items fall under more than one authorization given by a health plan • Professional claims for capitated providers, containing 'cap' and 'non-cap' services • Professional claims containing physician charges and ASC (ambulatory surgical center) charges Provider Action: Make sure that all services on the claim do not cross different provider contract periods and are covered under the same pricing methodology.
4. Claim with line	A submitted claim has multiple line items that are the responsibility of different organizations

Conditions Under Which Health Plans will Split Claims

Claim Splitting Conditions	Description of Split
items that are delegated to different organizations	• Facility services (health plan) and professional services (delegated medical group) • Mental health service and medical services • Pharmacy and high cost injectables with medical services. Provider Action: Make sure that all services on the claim are the responsibility of the health plan.
5. Claim reflects dual coverage by the health plan.	There are two responsible parties for the claim, both of which have coverage by this health plan. The health plan will process the claims as primary payer and as secondary payer. Provider Action: There is nothing providers can do to stop these splits.
6. Claim with dates of service that cross a calendar year.	A submitted claim has lines of service that occurred in different calendar years. Provider Action: Make sure that all services on the claim do not cross different calendar years.
7. Claim with multiple lines with different primary diagnosis.	A submitted claim has multiple lines of service with different primary diagnoses, for example, the claim has accident & non-accident lines or the claims has maternity & non-maternity lines Provider Action: Make sure that all services on the claim have the same primary diagnosis.
8. Claims with a billed amount of $100,000 or more.	A submitted claim has a billed amount of $100,000 or more Provider Action: Make sure that claims are for a billed amount less than $100,000