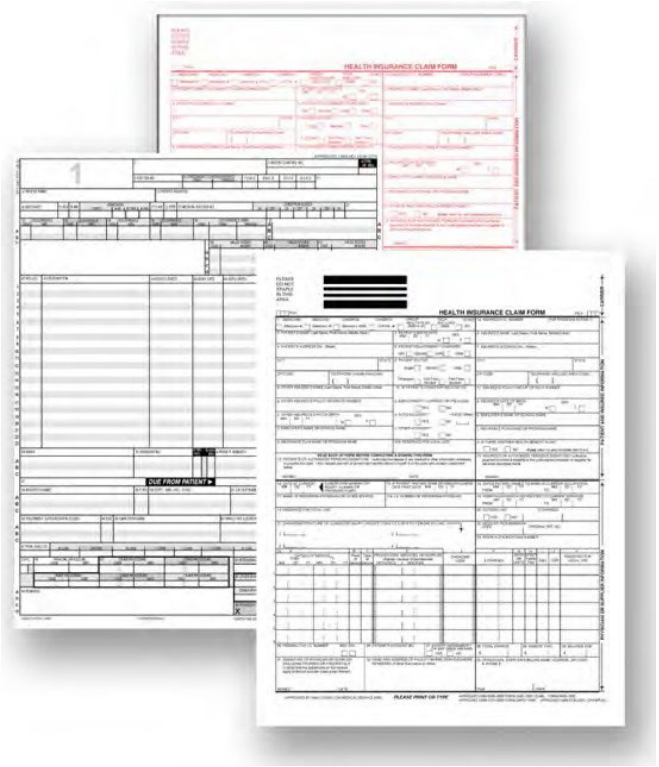
AmeriHealth Caritas Pennsylvania

Community HealthChoices | AmeriHealth Caritas Pennsylvania



Claims Filing Instructions
Medical Providers
April 2025

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AmeriHealth Caritas Pennsylvania (PA) and AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) hereafter referred to as the Plan (where appropriate), is required by state and federal regulations to capture specific data regarding services rendered to its Members/Participants. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

Section 6401 of the Affordable Care Act (ACA) requires that all providers must be enrolled in Medicaid in order to be paid by Medicaid. This means all providers must enroll and meet all requirements of the Pennsylvania Department of Human Services (DHS) which then issues a Medicaid identification number called Promise Provider Identification (PPID). The enrollment requirements include registering every service location with the state and having a different service location extension for each location.

Additionally, DHS has implemented the requirement that all providers must revalidate their Medical Assistance enrollment every five (5) years. (ACA) (§42 CFR 455.414). Claims from Providers who have not accurately updated their enrollment information cannot be paid.

Providers should log into PROMISe™ to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

Reimbursement for all rendering network providers for claims subject to the ordering/referring/prescribing (ORP) requirement is determined by validating that participating ordering/referring/prescribing practitioners have a valid PPID. Claims subject to the ORP requirement will be denied when billed with the NPI of a network ordering/referring/prescribing provider that is not enrolled in Medicaid. For more information on claims subject to ORP requirements please go to: https://www.amerihealthcaritaspa.com/pdf/provider/communications/bulletins/mab-99-17-02.pdf

Claim Filing

AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC are required by state and federal regulations to capture specific data regarding services rendered to its Members/Participants. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

Important: To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of providers (Code of Federal Regulations: 42CFR, §455.410), Providers participating with AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC must participate in the Pennsylvania Medical Assistance Program.

All providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

Important note: This applies to non-participating out-of-state providers as well. This means all providers must enroll and meet applicable Medical Assistance provider requirements of DHS and receive a Pennsylvania Promise ID (PPID). The enrollment requirements for facilities, physicians and practitioners include registering every service location with DHS and having a different service location extension for each location.

DHS fully intends to terminate Medical Assistance enrollment of all non-compliant providers.

AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC will comply with DHS's expectation that non- compliant providers will also be terminated from out network, since medical assistance enrollment is a requirement for participation with AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC. Enroll by visiting: http://provider.enrollment.dpw.state.pa.us/

The Department of Human Services (DHS) also requires that Providers obtain an NPI and share it with them. Further information on DHS's requirements can be found at https://www.dhs.pa.gov/providers/Providers/Pages/NPI.aspx.

When required data elements are missing or are invalid, claims will be rejected by the Plan for correction and re-submission.

Claims for billable and capitated services provided to Plan Members/Participants must be submitted by the provider who performed the services.

Claims filed with the Plan are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification for electronic claims against 837 edits at Optum/Change Healthcare™, Availity, or other clearinghouse.
- Verification of Member/Participant eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible Member/Participant.
- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- Verification of whether there is Medicare coverage or any other third-party resources and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to the Plan.

- **All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN, and Location Numbers).**
- **All 837 claims with Claim Attachments should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field # 80 for UB-04 Claim Form.**

Important: **Rejected claims** are defined as claims with invalid or required missing data elements, such as the provider tax identification number, Provider PPID number, Member/Participant ID number, that are returned to the provider or EDI* source without registration in the claim processing system.

- **Rejected claims** are not registered in the claim processing system and can be resubmitted as a new claim.
- **Rejected claims are considered original claims and timely filing limits must be followed**.

Important: **Denied claims** are registered in the claim processing system but do not meet requirements for payment under Plan guidelines. They should be resubmitted as a corrected claim.

- Denied claims must be re-submitted as corrected claims within 365 calendar days from the date of service.
- Set claim frequency code correctly and send the original claim number.

Note: These requirements apply to claims submitted on paper or electronically.

* For more information on EDI, review the section titled Electronic Data Interchange (EDI) for Medical and Hospital claims in this guide.

Claim Mailing Instructions
Submit claims to the Plan at the following address:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC w/o Medicare**	**AmeriHealth Caritas PA CHC w/ Medicare**
Claims Processing Department	Claims Processing Department	Claims Processing Department
P.O. Box 7118	**P.O. Box 7110**	**P.O. Box 7143**
London, KY 40742	London, KY 40742	London, KY 40742

The Plan encourages all providers to submit claims electronically. Providers may submit electronic claims via Optum/Change Healthcare or Availity clearinghouses. Hereafter throughout this document we will use "Clearinghouse" to mean either Optum/Change Healthcare or Availity. For those interested in electronic claim filing, contact your EDI software vendor or **Optum/Change Healthcare's Provider Support Line at 1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 AM to 8 PM ET.

Any additional questions may be directed to the EDI Technical Support Hotline at **1-866-695-1330** or by email at: edi.support@amerihealthcaritas.com

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or Member/Participant data.

Note: Claims must be received by the EDI vendor by 9:00 p.m. in order to be transmitted to the Plan the next business day.

Exceptions

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB (claim adjudication).

Important: Claims originally rejected for missing or invalid data elements must be corrected and re-submitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system.

Important: Requests for adjustments may be submitted by telephone to Provider Claims Services at **1-800-521-6007**.

(Select the prompts for the correct Plan, and then, select the prompt for claim issues.) If submitting via paper or EDI, please include the original claim number.

If you prefer to resubmit claims by mail or by EDI, please refer to instructions under "Resubmitted Professional Corrected Claims."

If you prefer to write, please be sure to stamp each claim submitted "**corrected**" or "**resubmission**" and address the letter to:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC w/o Medicare**	**AmeriHealth Caritas PA CHC w/ Medicare**

Claims Processing Department	Claims Processing Department	Claims Processing Department
P.O. Box 7118	**P.O. Box 7110**	**P.O. Box 7143**
London, KY 40742	London, KY 40742	London, KY 40742

Adjusted Claims

Claims with issues where resolution does not require complete re-submission of a Claim can often be easily adjusted. Adjusted Claims cannot involve changing any fields on a Claim (for example an incorrect code) and can often be corrected over the phone or through NaviNet. Adjusted Claims usually involve a dispute about amount/ level of payment or could be a denial for no authorization when the Network Provider has an authorization number. If a Network Provider has Claims needing adjustment and there is a manageable volume of Claims (five or less), the Network Provider can call AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC Provider Claim Services Unit (PCSU) at **1-800-521-6007**.

Electronically:
Mark claim frequency code "7" and use CLM05-3 to report claims adjustments electronically. Include the original claim number.

A **Dispute** is a verbal or written expression of dissatisfaction by a Network Provider regarding a Plan decision that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity. Disputes may focus on issues concerning the Plan services processes, other Health Care Provider, Members/Participants or claims.

An **appeal** is a written request from a Health Care Provider for the reversal of a denial by the Plan, through its Formal Provider Appeals Process, with regard to two (2) major types of issues. The two (2) types of issues that may be addressed through the Plan's Formal Provider Appeals Process are:

- Disputes not resolved to the Network Provider's satisfaction through the Plan's Informal Provider Dispute Process
- Denials for services already rendered by the Health Care Provider to a Member/Participant including, denials that do not clearly state the Health Care Provider is filing a Member/Participant Complaint or Grievance on behalf of a Member/Participant (even if the materials submitted with the Appeal contain a Member/Participant consent).

<u>Clinical provider</u> medical appeals must be submitted in writing to:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC**
Clinical Provider Appeals Department	Clinical Provider Appeals Department
P.O. Box 7307	**P.O. Box 8011**
London, KY 40742	London, KY 40742

<u>Written</u> Disputes should be mailed to:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC**
Informal Provider Disputes	Informal Provider Disputes
P.O. Box 7316	**P.O. Box 7316**
London, KY 40742	London, KY 40742

Refer to the Provider Manual for complete instructions on submitting appeals.

Note: AmeriHealth Caritas PA EDI Payer ID# 22248
AmeriHealth Caritas PA CHC EDI Payer ID # 77062

Refunds for Claims Overpayments or Errors

The Plan and the Pennsylvania Department of Human Services encourage providers to conduct regular self-audits to ensure accurate payment.

Medicaid program funds that were improperly paid or overpaid must be returned. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make immediate arrangements to return the funds to the Plan or follow the DHS protocols for returning improper payments or overpayment.

1. Contact Provider Claim Services at **1-800-521-6007** to arrange the repayment. There are two ways to return overpayments to the Plan:
    - Have the Plan deduct the overpayment/improper payment amount from future claims payments.
    - Submit a check for the overpayment/improper amount directly to:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC without Medicare**	**AmeriHealth Caritas PA CHC w/ Medicare**
ATTN: Provider Refunds	ATTN: Provider Refunds	ATTN: Provider Refunds
P.O. Box 7118	**P.O. Box 7110**	**P.O. Box 7143**
London, KY 40742-7118	London, KY 40742-7110	London, KY 40742-7143

Note: Please include the Member/Participant's name and ID, date of service, and Claim ID.

2. Providers may follow the "Pennsylvania Medical Assistance (MA) Provider Self-audit Protocol" to return improper payments or overpayments. Access the DHS voluntary protocol process via the following link: https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx.

Submit a 275 claim attachment transaction

AmeriHealth Caritas Pennsylvania CHC is accepting ANSI 5010 ASC X12 275 unsolicited attachments via Optum/Change Healthcare, Availity, or other clearinghouse. Please contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic 275 attachment submissions via AmeriHealth Caritas Pennsylvania EDI payer ID: 22248 or the AmeriHealth Caritas Pennsylvania CHC EDI payer ID: 77062.

There are three ways that 275 attachments can be submitted.

- Batch : you may either connect to Optum/Change Healthcare or Availity directly or submit via your EDI clearinghouse.
- API via JSON: you may use Optum/Change Healthcare to submit an attachment for a single claim.
- Portal : individual providers can register at Optum/Change Healthcare or Availity https://www.availity.com/documents/learning/LP_AP_GetStarted_Atypical/index.html#/ to submit attachments.

The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, xml, doc, and txt.

In addition, the following 275 claims attachment report codes have been added effective August 1, 2023. When submitting an attachment, use the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04, as documented in the Claims Filing Instructions.

Attachment Type	**Claim assignment attachment report code**
Itemized Bill	03
Medical Records for HAC review	M1
Single Case Agreement (SCA)/LOA	04
Advanced Beneficiary Notice (ABN)	05
Consent Form	CK
Manufacturer Suggested Retail Price /Invoice	06
Electric Breast Pump Request Form	07
CME Checklist consent forms (Child Medical Eval)	08
EOBs — for 275 attachments should only be used for non-covered or exhausted benefit letter	EB
Certification of the Decision to Terminate Pregnancy	CT
Ambulance Trip Notes/Run Sheet	AM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Claim Form Field Requirements

The following charts describe the required fields that must be completed for the standard Centers for Medicare & Medicaid Services (CMS) CMS 1500 or UB-04 claim forms. If the field is required without exception, an "R" (Required) is noted in the "Required or Conditional" box. If completing the field is dependent upon certain circumstances, the requirement is listed as "C" (Conditional) and the relevant conditions are explained in the "Instructions and Comments" box.

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. All claims must be submitted within the required filing deadline of 180 days from the date of service.

Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

Required Fields (CMS 1500 Claim Form):

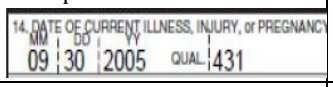
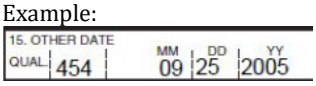
*Required [R] fields must be completed on all claims. Conditional [C] fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
N/A	**Carrier Block**			2010BB	NM103 N301 N302 N401 N402 N403	
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R	2000B	SBR09	Titled Claim Filing Indicator code in 837P.
1a	**Insured Medicaid I.D. Number**	Health Plan's Member identification number. If submitting a claim for a newborn that does not have an identification number, enter the mother's Medicaid ID number. Enter the Member's Medicaid ID number exactly the way it appears on their Plan-issued ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P.
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the Member's Health Plan ID card. If submitting a claim for a	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name.				
3	**Patient's Birth Date / Sex**	MMDDYY / M or F If submitting a claim for a newborn, enter "newborn" and DOB/Sex.	R	2010CA or 2010BA	DMG02 DMG03	Titled Gender in 837P.
4	**Insured's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the Member's Health Plan ID card or enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in 837P.
5	**Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	
6	**Patient Relationship to Insured**	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01	Titled Individual Relationship code in 837P.
7	**Insured's Address (Number, Street, City, State, Zip+4 Code) Telephone (Include Area Code)**	If same as the patient, enter "Same". Otherwise, enter insured's information.	C	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in 837P.
8	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	N/A
9	**Other Insured's Name (Last, First, Middle Initial)**	Refers to someone other than the patient. **Completion of fields 9a through 9d is required** if patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique Member ID, then the patient is the subscriber and identified in this loop. Titled Other Subscriber Name in 837P.
9a	**Other Insured's**	**Required** if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
	Policy or Group #					
9b	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	Does not exist in 837P.
9c	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	Does not exist in 837P.
9d	**Insurance Plan Name or Program Name**	**Required** if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other insurance group in 837P.
10a, b, c	**Is Patient's Condition Related to**	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident Other Accident	R	2300	CLM11	Titled related causes code in 873P.
10d	**Claim Codes (Designated by NUCC)**	Enter new Condition Codes as appropriate. Available 2-digit Condition Codes includes nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include: • AD – Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or exacerbated by the Pregnancy itself • W3- Level 1 Appeal	C	2300	NTE	NTE 01 position – input "ADD" Upper case/capital format. NTE 02 position – first six- character input "EPSDT=" (upper case/capital format where the sixth character will be the = sign. Input applicable referral directly after "=" For multiple code entries: Use "_" underscore to separate as follors: NTE*ADD*EPSDT*=YD_YM_YO~
11	**Insured's Policy Group or FECA #**	Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
11a	**Insured's Birth Date/Sex**	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P.
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line, identifier to the right of the vertical, dotted line.	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P.
11c	**Insurance Plan Name or Program Name**	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.
11c	**Insurance Plan Name or Program Name**	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.
12	**Patient's Or Authorized Person's Signature**	On the 837, the following values are addressed as follows at Optum/Change Healthcare, Availity or other clearinghouse: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	R	2300	CLM09	Titled Release of Information code in 837P.
13	**Insured's Or Authorized Person's Signature**		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P.
14	**Date Of Current Illness Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: • 431 – Onset of Current Symptoms or Illness • 439 – Accident Date	C	2300	DTP01 DTP03	Titled in the 837P: Date – Onset of Current Illness or Symptom Date – Last Menstrual Period`

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		• 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy. Example: 				
15	**Other Date**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • 454- Initial Treatment • 304 Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End • (Relinquished Care Date) • 444 – First Visit or Consultation Example: 	C	2300	DTP01 DTP03	Titled in the 837P: Date – Initial Treatment Date Date – Last Seen Date Date – Acute Manifestation Date – Accident Date – Last X-ray Date Date – Hearing and Vision Prescription Date Date – Assumed and Relinquished Care Dates Date – Property and Casualty Date of First Contact
16	**Dates Patient Unable to Work in Current Occupation**		C	2300	DTP03	Titled Disability from Date and Work Return Date in 837P.
17	**Name Of Referring Physician or Other Source**	**Required** if a provider other than the Member/ Participant's primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to the left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM 101 NM103 NM104 NM105 NM107	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		3. Supervising Provider Qualifiers include: • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider Example: 				
17a	**Other I.D. Number of referring physician**	Enter the Health Plan provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The NUCC defines the following qualifiers: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) Required if # 17 is completed.	C	2310A (referring) 2010D (supervising) 2420E (ordering	REF01 REF02	Titled Referring Provider, Secondary Identified, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P.
17b	**National Provider Identifier (NPI)**	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310D	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P.
18	**Hospitalization Dates Related to Current Services**	**Required** when place of service is inpatient. **MMDDYY** (indicate **from** and **to** date.)	C	2300	DPT01 DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P
19	**Additional Claim Information (Designated by NUCC)**	Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and data combination.	Required	2300	NTE PWK	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		The NUCC defines the following qualifiers: • **1G** Provider UPIN Number • **G2** Provider Commercial Number • **LU** Location Number *(This qualifier is used for Supervising Provider only.)* • **N5** Provider Plan Network Identification Number • **SY** Social Security Number • **X5** State Industrial Accident Provider Number • **ZZ** Provider Taxonomy		2310B	PRV03 PRV01=PE	Titled Provider Taxonomy code 837P. Provider Additional Identifier in 837P
	Additional Claim Information	**Claim Attachment Report Type codes in 837P defines the following qualifiers** **03 - Itemized Bill** **M1 - Medical Records for HAC review** **04 - Single Case Agreement (SCA)/ LOA** **05 - Advanced Beneficiary Notice (ABN)** **CK - Consent Form** **06 - Manufacturer Suggested Retail Price /Invoice** **07 - Electric Breast Pump Request Form** **08 - CME Checklist consent forms (Child Medical Eval)** **EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter** **CT - Certification of the Decision to Terminate Pregnancy** **AM - Ambulance Trip Notes/ Run Sheet**	Required	2300	PWK01	Claim Attachment Report Type codes in 837P
20	**Outside Lab**	If applicable, indicate, Yes. (If patient had outside lab work	C	2400	PS102	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		completed). Otherwise, leave blank.				
21	**Diagnosis Or Nature of Illness or Injury. (Relate To 24E)**	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims with invalid diagnosis codes will be denied for payment. External diagnosis or "E" codes are not acceptable as a primary diagnosis.	R	2300	HIXX-02 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	
22	**Resubmission Code and/or Original Ref. No**	This field is required for resubmissions or adjustments /corrected claims. Enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field. 7 – Replacement of Prior Claim 8 – Void/cancel of Prior Claim	C **Required** for resubmitted or adjusted claims.	2300 2300	CLM05- 3 REF02 Where REF01 = F8	Titled Claim Frequency Code in the 837P. Titled Payer Claim Control Number in the 837P. Send the original claim number if this field is used.
23	**Prior Authorization Number** **CLIA Number Locations**	Enter the referral or authorization number. Refer to the Provider Manual to determine if services rendered require an authorization. Laboratory Service Providers must enter CLIA number here for the location. EDI claims: CLIA must be represented in the 2300 loop, REF02 element.	C	2300	REF02 Where REF01 – G1 REF02 Where REF01 = 9F REF02 Where REF01 = X4	Titled Prior Authorization Number in 837P. Titled Referral Number in 837P. Titled CLIA Number in 837P.
24A	**Date(s) Of Service**	"From" date: MMDDYY. If the service was performed on one day leave "To" blank or	R	2400	DTP01 DTP03	Titled Service Date in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		re-enter "From" Date. See below for Important Note (instructions) for completing the shaded portion of field 24.				
24B	**Place Of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	2300 2400	CLM05- 1 SV105	Titled Facility Code Value in 837P. Titled Place of Service Code in 837P.
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	C	2400	SV109	Titled Emergency Indicator in 837P.
24D	**Procedures, Services or Supplies CPT/HCPCS Modifier**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. **Note:** Modifiers affecting reimbursement must be placed in the 1st modifier position.	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P.
24E	**Diagnosis Pointer**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service and must be entered in field 21. Do not enter diagnosis codes in 24E. **Note:** The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107 (1-4)	Titled Diagnostic Code Pointer in 837P.
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount. (This includes capitated services.)	R	2400	SV102	Titled Line-Item Charge Amount in 837P.
24G	**Days Or Units**	Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable. (Field allows up to 3 digits)	R	2400	SV104	Titled Service Unit Count in 837P
24H	**Family Plan**	**In Shaded area of field:** AV - Patient refused referral. S2 - Patient is currently under treatment for referred diagnostic or corrective health problems. NU - No referral given; or	C	2300 2400	CRC SV111 SV112	

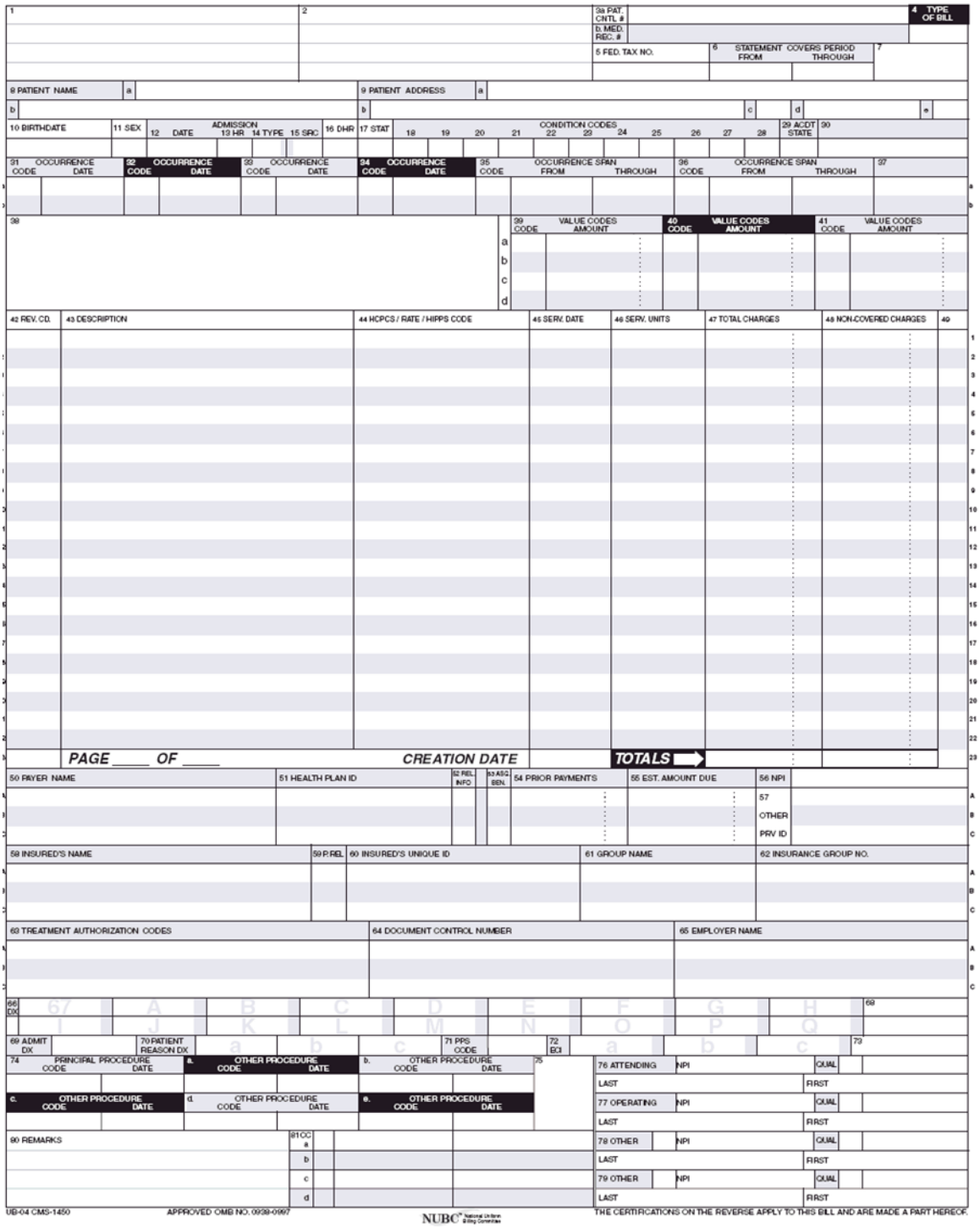
CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		ST - Referral to another provider for diagnostic or corrective treatment. **In unshaded area of field:** "Y" for Yes – if service relates to a pregnancy or family planning "N" for No – if service does not relate to pregnancy or family planning				
24I	**ID Qualifier**	If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I. • **0B** State License Number • **1G** Provider UPIN Number • **G2** Provider Commercial Number • **LU** Location Number If the rendering provider does have an NPI see field 24J below. If the Other ID number is the Health Plan ID number, enter G2.	R	2310B	REF (01) NM108	Titled Reference Identification Qualifier in 837P XX Required for NPA in NM109
24J	**Rendering Provider ID**	The individual rendering the service is reported in 24J. Enter the Provider Health Plan legacy ID number in the shaded area of the field. Use Qualifier G2 for Provider Health Plan legacy ID. Enter the NPI number in the unshaded area of the field. Use qualifier. Enter Taxonomy in shaded area ZZ Provider Taxonomy Box 19 can also be used for sending Rendering Provider taxonomy	R	2310B	REF02 NM109 PRV03	Optum/Change HealthCare, Availity, or other clearinghouse will pass this ID on the claim when present. NPI **Rendering provider taxonomy**
25	**Federal Tax ID Number SSN/EIN**	Physician or Supplier's Federal Tax ID numbers.	R	2010AA	REF01 REF02	Titled Reference Identification Qualifier and Billing Provider Tax Identification Number in the 837P. Where REF01 Qualifier EI=Tax ID Where REF01 Qualifier SY=SSN

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
26	**Patient's Account No.**	The provider's billing account number.	R	2300	CLM01	Titled Patient Control Number in 837P.
27	**Accept Assignment**	Always indicate **Yes**. Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P.
28	**Total Charge**	Enter charges. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated Services). Blank is not acceptable.	R	2300	CLM02	Titled Total Claim Charge Amount in the 837P May be $0.
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	**Reserved for NUCC Use**		Not Required			
31	**Signature Of Physician or Supplier Including Degrees or Credentials / Date**	Actual signature is required.	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P.
32	**Name and Address of Facility Where Services Were Rendered (If other than Home or Office)**	**Required** unless #33 is the same information. Enter the physical location. **(P.O. Box #'s are not acceptable here)**	R	2310C	NM103 N301 N401 N402 N403	
32a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P.
32b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID #	C Recommended	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		The NUCC defines the following qualifiers used in 5010A1: • **0B** State License Number • **G2** Provider Commercial Number • **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two- digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.				secondary Identifier in 837P.
33	**Billing Provider Info & Ph. #**	**Required** – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location; P.O. Boxes are not acceptable	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	
33a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number. Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers: **0B** State License Number **G2** Provider Commercial Number **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two- digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space,	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Loop ID**	**Segment**	**Notes**
		hyphen, or other separator between the qualifier and number.				
33b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers: **G2** Provider Commercial Number **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two- digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	R Required Health Plan ID (Recommended)	2010A 2010AA	PRV03 PRV01=" BI" REF02 where REF01 = G2	Titled Provider Taxonomy Code in 837P. Titled Reference Identification Qualifier and Billing Provider Additional Identifier in 837P.

Required Fields (UB-04 Claim Form)



UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
1	**Unlabeled Field NUBC – Billing Provider Name, Address and Telephone Number**	**Service Location, no PO Boxes (Required)** Left justified Line a: Enter the complete provider name. Line b: Enter the complete address Line c: City, State, and Zip code + 4 Line d: Enter the area code, telephone number.	R	R	2010 AA	NM1/85 N3 N4	Billing Provider Name (NM102 should always be 2) Billing Provider Address
2	**Unlabeled Field NUBC – Pay-to Name and Address**	**Enter Remit Address. No PO Boxes** Enter the Facility PROMISe Provider ID (PPID) number. Left justified	R	R	2010 AB	NM1/87 N3 N4	Pay-To Name Pay-To Address
3a	**Patient Control No.**	Provider's patient account/control number	R	R	2300	CLM01	Patient's Control Number
3b	**Medical/Health Record Number**	The number assigned to the patient's medical/health record by the provider	C	C	2300	REF02 where REF01 = EA	Medical Reference Number
4	**Type Of Bill**	Enter the appropriate	R	R	2300	CLM05	If Adjustment or Replacement or Void

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		three or four - digit code. 1st position is a leading zero – Do not include the leading zero on electronic claims. 2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates billing sequence.					claim, include frequency code as the last digit. Include the frequency code by using bill type in loop 2300. Include the Original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number. (No dashes or spaces.)
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R		REF/EI/02 Where REF01 = EI	Pay to provider = Billing Provider use 2010AA
6	**Statement Covers Period From/Through**	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434	MMDDYY Statement Dates
7	**Unlabeled Field**	Not Used. Leave Blank.	N/A	N/A	N/A	N/A	N/A
8a	**Patient Identifier**	Patient Health Plan ID is conditional if number is different from field 60	R	R	2010 BA 2010 CA	NM109 where NM101 = IL NM109 where NM101 = QC	Patient =Subscriber Use 2010BA Subscriber ID Patient is not =Subscriber, Use 2010CA Patient ID

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
8b	**Patient Name**	Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should **not** be reported in this field. Prefix: No space should be left after the prefix of a name e.g., McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix. Newborns and Multiple Births: If submitting a claim for a	R	R	2010 BA 2010 CA	NM103, NM104, NM107 where NM101=IL NM103, NM104, NM107 where NM101 = QC	Patient =Subscriber Use 2010BA Subscriber Name Patient is not =Subscriber, Use 2010CA Patient Name

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name.					
9a-e	**Patient Address**	The mailing address of the patient 9a. Street Address 9b. City 9c. State 9d. ZIP Code + 4 9e. Country Code (report if other than USA)	R	R	2010 BA 2010 CA	N301, N302 N401, 02, 03, 04 N301, N302 N401, 02, 03, 04	Patient =Subscriber, Use 2010BA Subscriber Address Patient is not =Subscriber, Use 2010CA Patient Address
10	**Patient Birth Date**	The date of birth of the patient Right justified; MMDDYYYY	R	R	2010 BA 2010 CA	DMG02 DMG02	Subscriber Demographic Info
11	**Patient Sex**	The sex of the patient recorded at admission, outpatient service, or start of care. M for male, F for female or U for unknown.	R	R	2010 BA 2010 CA	DMG03 DMG03	Subscriber Demographic Info
12	**Admission Date**	The start date for this episode of care. For inpatient	R	R	2300	DTP03 where DTP01=435	Required on inpatient. Admission date/HR

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		services, this is the date of admission. Right Justified					
13	**Admission Hour**	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R for bill types other than 21X.	R	2300	DTP03 where DTP/43/	Required on inpatient. Admission date/HR
14	**Admission Type**	A code indicating the priority of this admission/visit	R	R	2300	CL101	Institutional Claim Code
15	**Point of Origin for Admission or Visit**	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102	Institutional Claim Code
16	**Discharge Hour**	Valid national NUBC Code indicating the discharge hour of the patient from inpatient care.	R	R	2300	DTP03 where DTP01=096	
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the patient at the end service for the period covered on	R	R	2300	CL103	Institutional Claim Code

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		this bill, as reported in Field 6.					
18	**Condition Codes** **The following is unique to Medicare eligible Nursing Facilities. Condition codes should be billed when Medicare Part A does not cover Nursing Facililty Services.** **Applicable condition codes:** **X2- Medicare EOMB on file** **X4- Medicare denial on file**	When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed: Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service for which you are billing: • There was no 3- day prior hospital stay • The resident was not transferred within 30 days of a hospital discharge • The resident's 100 benefit					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		days are exhausted • There was no 60-day break in daily skilled care • Medical necessity requirements are not met. • Daily skilled care requirement are not met. All other fields must be completed as per the appropriate billing guideline					
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. **Required when applicable.**	C	C	2300	REF02 Where REF01 = LU	
30	**Unlabeled Field**	Leave Blank	N/A	N/A	N/A	N/A	N/A
31a, b – 34a, b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code and date. Code must be 01 – 69, or A0-A9 or B1. Dates must be in	C	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BH

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		YYYYMMDD format. **Required** when applicable.					
35a, b – 36a, b	**Occurrence Span Codes and Dates**	A code and the related dates that identify an event that relates to the payment of the claim. Code must be 70 – 99 or M0-Z9. Dates must be in MMDDYY format. **Required** when applicable.	C	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BI
37a, b	**Referral Code**	**Required** when applicable.			2300	NTE	NTE 01 position – input "ADD" Upper case/capital format. NTE 02 position – first six-character (input upper case/capital format where the sixth character will be the = sign.) Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~
38	**Responsible Party Name and Address**	The name and address of the party	C	C	N/A	N/A	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		responsible for the bill.					
39a,b,c, d – 41a, b, c, d	**Value Codes and Amounts**	A Code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization Value Codes and amounts. If more than one value code applies, list in alphanumeric order. **Required** when applicable. **Note: If value code is populated then value amount must also be populated and vice versa.** Please see NUCC Specifications Manual Instructions for value codes and descriptions.	C	C	2300	HIXX-2 HIXX-5 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BE

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		Documenting covered and non-covered days: Value Code 81 – non- covered days; 82 to report co-insurance days; 83- Lifetime reserve days. Code in the code portion and the Number of Days in the "Dollar" portion of the "Amount" section. Enter "00" in the "Cents" field.					
42	**Rev. Cd.**	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.	R	R	2400	SV201	Revenue Code
43	**Revenue Description**	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC	R	R	N/A	N/A	Not mapped 837I

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		instructions for Field 42 for description of each revenue code category.					
44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	1.The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills. 2.The accommodation rate for inpatient bills. 3.Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several	R	R	2400	SV202-2	SV202-1=HC/HP

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		prospective payment systems. Enter the applicable rate, HCPCs or HIPPS cofe and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all outpatient claims (**Note:** NDC numbers are require for all physician administered drugs.)					
45	**Serv. Date**	Report line-item dates of service for each revenue code or HCPCS/HIPPS code.	R	R	2400	DTP03 where DTP01=472	Date of Service
46	**Serv. Units**	Report units of services. A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days,	R	R	2400	SV205	Service Units

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		miles, pints of blood, renal dialysis treatments, etc. **Note:** For drugs, service units must be consistent with the NDC code and its unit of measure. NDC unit of measure must be a valid HIPAA UOM code or claim may be rejected.					
47	**Total Charges**	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and non-covered charges. Report grand total of submitted charges. Enter a zero ($0.00) or	R	R	2300	SV203	Total Charges

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		actual charged amount.					
48	**Non-Covered Charges**	To reflect the non- covered charges for the destination payer as it pertains to the related revenue code. **Required** when Medicare is Primary.	C	C	2400	SV207	Non-Covered Charges
49	**Unlabeled Field**	N/A	Not required	Not required	N/A	N/A	Not Mapped
50	**Payer**	Enter the name for each Payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2000 B 2010 BB 2320 2330 B 2330 B	SBR NM103 where NM101=PR SBR NM103 where NM101=PR	Other Payer Name
51	**Health Plan Identification Number**	The number used by the health plan to identify itself.	R	R	2330 B 2010 BB 2330 B	NM109 where NM101=PR	Payer ID Other Plan Payer ID

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
52	**Rel. Info**	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the provider has all necessary release information on file. It is expected that all released invoices contain "Y"	R	R	2300	CLM09	Release of Information code
53	**Asg. Ben.**	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	R	R	2300	CLM08	Benefits Assignment Certification Indicator

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
54	**Prior Payments**	The A, B, C indicators refer to the information in Field 50. The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01=D	Prior Payment Amounts
55	**Est. Amount Due**	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage). The amount up to two decimal places in the format XXXXX.XX	C	C	2430	AMT02 where AMT01 =EAF	Payment Estimated Amount Due
56	**National Provider Identifier – Billing Provider**	The unique identification number assigned to the provider submitting the bill; NPI is	R	R	2010 AA	NM109 where NM101 = 85	NPI

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		the national provider identifier. **Required** if the health care provider is a Covered Entity as defined in HIPAA Regulations.					
57 A, B, C	**Other (Billing) Provider Identifier**	A unique identification number assigned to the provider submitting the bill by the health plan. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A, B and C.	C	C	2010 AA 2010 BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U	Tax ID Only sent if needed to determine the Plan ID Legacy ID
58	**Insured's Name**	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the	R	R	2010 BA 2330 A	NM103, NM104, NM105 where NM101 = IL NM103, NM104, NM105 where	Use 2010BA is insured is subscriber Other Insured Name

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		insured is indicated here.				NM101 = IL	
59	**P. Rel**	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured Code 18: Self	R	R	2000 B	SBR02	Individual Relationship code
60	**Insured's Unique Identifier**	Enter the patient's Health Plan ID on the appropriate line, exactly as it appears on the patient's ID card on line B or C. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2010 BA	NM109 where NM101= IL REF02 where REF01 = SY	Insured's Unique ID
61	**Group Name**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage.	C	C	2000 B	SBR04	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		Line A refers to the primary payer; B, secondary; and C, tertiary.					
62	**Insurance Group No.**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000 B	SBR03	Subscriber Group or Policy Number
63	**Treatment Authorization Codes**	Enter the Health Plan referral or authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2300	REF02 where REF01 = G1	Prior Authorization Number
64	**DCN**	Document Control Number. The control number assigned to the original	C	C	2320	REF02 where REF01 = F8	Original Claim Number

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code. The ESC field has been eliminated. **Note:** Resubmitted claims must contain the original claim ID.					
65	**Employer Name**	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B,	C	C	2320	SBR04	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		secondary; and C, tertiary.					
67	**Prin. Diag. Cd. and Present on Admission (POA) Indicator**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	R	R	2300	HIXX-2 HIXX-9 Where HI01-1 = ABK	Principal Diagnosis
67 A - Q	**Other Diagnosis Codes**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received	C	C	2300	HIXX-2 HIXX-9 Where HI01-1 = ABF	Other Diagnosis Information

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.					
68	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
69	**Admitting Diagnosis Code**	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician. **Required** for inpatient and outpatient. External diagnosis codes cannot be submitted as the primary diagnosis.	R	R	2300	HI01-2 Where HI01- 1= ABJ	Admitting diagnosis
70	**Patient's Reason for Visit**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration.	C	R	2300	HIXX-2 Where HIXX-1=APR Where XX = 01, 02, 03	Patient reason for visit

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B, and C.					
71	**Prospective Payment System (PPS) Code**	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.	C	C	2300	HI01-2 Where HI01-1 = DR	DIAGNOSIS Related Group (DRG) Information
72a-c	**External Cause of Injury (ECI) Code**	The appropriate ICD code(s) pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury diagnosis codes should	C	C	2300	HIXX-2 Where HIXX-1 = ABN	HIXX-1 = BN or ABN External Cause of Injury

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		not be billed as primary and/or admitting diagnosis. Required if applicable.					
73	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
74	**Principal Procedure code and Date**	by this bill and the corresponding date. **Inpatient facility** – Surgical procedure code is required if the operating room was used. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	R	R	2300	HI01-2 HI01-4 Where HI01-1 = BBR	
74a-e	**Other Procedure Codes and Dates**	The appropriate ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by	C	C	2300	HIXX-2 Where HI01-1 = BBQ	Other Procedure Information

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		code) on which the procedures were performed. **Inpatient facility** – Surgical procedure code is required when a surgical procedure is performed. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C	C			
75	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
76	**Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#**	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the	R	R	2310 A 2310 A	NM109 where NM101 = 71 REF02	REF01=G2/

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		attending physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician. **Note:** If a qualifier is entered, a secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will reject. **ZZ Attending Provider Taxonomy**				PRV01 PRV03	Attending Provider Taxonomy
77	**Operating Physician Name and Identifiers** **NPI#/Qualifier/Other ID#**	**Enter the** NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line,	C	C	2310 B	NM103, NM104, NM107, NM109 where NM101 = 72 REF02 where	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		last name first. If the operating physician has another unique ID# enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending physician when a surgical procedure code is listed.				REF01=G2	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
78 – 79	**Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID#**	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#	R	R	2310 C 2310 C	NM103, NM104, NM107, NM109 where NM101 = ZZ REF02where REF01 = G2	
80	**Remarks Field**	Area to capture additional information necessary to adjudicate the claim. Claim Attachment Report Type codes in 837I defines the following qualifiers	C R	C R	2300 2300	NTE02 Where NTE01=ADD PWK01	Billing Note Claim Attachment Report Type codes in 837I

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet					
81CC, a-d	**Code-Code Field**	To report additional	C	C	2000 A	PRV01 PRV03	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		codes related to					
		Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. B3 Billing Provider Taxonomy					

Special Instructions and Examples for CMS 1500, UB-04 and EDI Claims Submissions

1. Supplemental Information

A. CMS 1500 Paper Claims – Field 24:

Important Note: All unspecified Procedure or HCPCS codes require a narrative description be reported in the shaded portion of field 24. The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24 (or 2410/LIN and CTP segments when submitting via 837):

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services:

Qualifiers	Service
7	Anesthesia information
ZZ	Narrative description of unspecified code (all miscellaneous fields require this section be reported)
N4	National Drug Codes
VP	Vendor Product Number Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
CTR	Contract rate

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of Item Number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

B. EDI – Field 24D (Professional)

Details pertaining to Anesthesia Minutes, and corrected claims may be sent in Notes (NTE) or Remarks (NSF format).

- Details sent in NTE that will be included in claim processing:

- Please include L1, L2, etc. to show line numbers related to the details. Please include these letters AFTER those specified below:
    - EPSDT claims need to begin with the letters EPSDT followed by the specific code as per DHS instructions
    - Anesthesia Minutes need to begin with the letters ANES followed by the specific times
    - Corrected claims need to begin with the letters RPC followed by the details of the original claim (as per contract instructions)
    - DME Claims requiring specific instructions should begin with DME followed by specific details

C. EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=G2, REF02+=Plan's Provider Network Number. Less than 13 Digits Alphanumeric. Field is required. Note: do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims D. EDI – Field 45 and 51 (Institutional)

Field 45 – Service Date must not be earlier than the claim statement date. Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – Health Plan ID – the number used by the health plan to identify itself. AmeriHealth Caritas PA CHC's EDI Payer ID# is 77062. AmeriHealth Caritas PA's EDI Payer ID# is 22248.

D. EDI – Reporting DME

DME Claims requiring specific instructions should begin with DME followed by specific details. Example: NTE*ADD*DME AEROSOL MASK, USED W/DME NEBULIZER

E. Reporting NDC on CMS-1500 and UB-04 and EDI

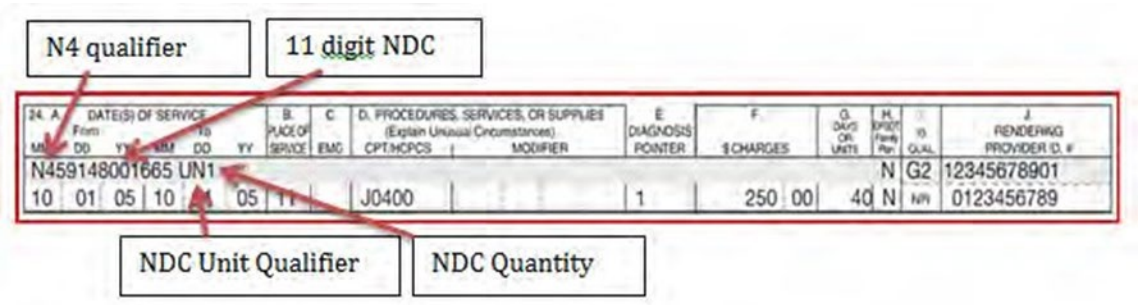
1. NDC on CMS 1500

- NDC must be entered in the shaded sections of item 24A through 24G.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information.
    - Do not enter a space between the qualifier and the 11 digit NDC number.
    - Enter the 11 digit NDC number in the 5-4-2 format (no hyphens).
    - Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Enter the NDC quantity unit qualifier

- F2 – International Unit
- GR – Gram
- ML – Milliliter
- UN – Unit

- Enter the NDC quantity
  - Do not use a space between the NDC quantity unit qualifier and the NDC quantity
  - Note: The NDC quantity is frequently different than the HCPC code quantity

Example of entering the identifier N4 and the NDC number on the CMS 1500 claim form:



2. NDC on UB-04

- NDC must be entered in Form Locator 43 in the Revenue Description Field.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- Report the N4 qualifier in the first two (2) positions, left-justified.
  - Do not enter spaces
  - Enter the 11 character NDC number in the 5-4-2 format (no hyphens).
  - Do not use 99999999999 for a compound medication, bill each drug as a separate line
  - item with its appropriate NDC
- Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
  - Any unused spaces for the quantity are left blank.

Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible. The description field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	4	5	.	5	6	7

3. NDC via EDI

The NDC is used to report prescribed drugs and biologics as required by government regulation.

EDI claims with NDC info must be reported in the LIN segment of Loop ID-2410. This segment is used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line.

Claims requiring multiple NDC's sent at claim line level should be submitted using CMS-1500 or UB-04 paper claim.

When submitting NDC in the LIN segment, the CTP segment is required. This segment is to be submitted with the Unit of Measure and the Quantity.

When submitting this segment, CTP03, Pricing; CTP04, Quantity; and CTP05, Unit of Measure are required.

Provider Preventable Conditions Payment Policy and Instructions for Submission of POA Indicators for Primary and Secondary Diagnoses

The Plan payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions. It is the Plan's policy to deny payment for PPCs.

Health Care Acquired Conditions (HCAC) apply to Medicaid inpatient hospital settings only. An HCAC is defined as "condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D) of the Social Security Act. HCACs presently include the full list of Medicare's hospital acquired conditions, except for DVT/PE following total knee or hip replacement in pediatric and obstetric patients.

Other Provider-Preventable Conditions (OPPC) is more broadly defined to include inpatient and outpatient settings. An OPPC is a condition occurring in any health care setting that: (i) is identified in the Commonwealth of Pennsylvania State Medicaid Plan; (ii) has been found by the Commonwealth to be reasonably preventable through application of procedures supported by evidence-based guidelines; (iii) has a negative consequence for the Member/Participant; (iv) can be discovered through an audit; and (v) includes, at a minimum, three existing Medicare National

Coverage Determinations for OPPCs (surgery on the wrong patient, wrong surgery on a patient and wrong site surgery).

For a list of PPCs for which the Plan will not provide reimbursement, please refer to the Appendix of this Manual.

Submitting Claims Involving a PPC

In addition to broadening the definition of PPCs, the ACA requires payers to make pre-payment adjustments. That is, a PPC must be reported by the Provider at the time a claim is submitted.

There are some circumstances under which a PPC adjustment will not be taken, or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the Provider. Please refer to the Reporting a Present on Admission section for details.
- Reductions in Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to the PPC.

Practitioner/Dental Providers

- If a PPC occurs, Providers must report the condition through the claims submission process. Note that this is required even if the Provider does not intend to submit a claim for reimbursement for the services. The requirement applies to Providers submitting claims on the CMS-1500 or 837-P forms, as well as dental Providers billing via ADA claim form or 837D formats.
- For professional service claims, please use the following claim type and format:

Claim Type:

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D of the CMS 1500 claim form.
- Dental Providers must report a PPC on the paper ADA claim form using modifier PA, PB or PC on the claim line, or report modifiers PA, PB or PC in the remarks section or claim note of a dental claim form.

Claim Format:

- Report the external cause of injury codes, such as Y65.51, Y65.52 or Y65.53in field 21 [and/or] field 24E of the CMS 1500 claim form.
- Inpatient/Outpatient Facilities
- Providers submitting claims for facility fees must report a PPC via the claim submission process. Note that this reporting is required even if the Provider does not intend to submit a claim for

reimbursement of the services. This requirement applies to Providers who bill inpatient or outpatient services via UB-04 or 837I formats.

For Inpatient facilities

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired. When submitting a claim which includes treatment as a result of a PPC, facility providers are to include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury on the claim in field 67 A – Q. Examples of ICD-10 and external cause of injury include:

- Wrong surgery on correct patientY65.51;
- Surgery on the wrong patient,Y65.52;
- Surgery on wrong site Y65.53
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

For per-diem or percent of charge based hospital contracts, claims including a PPC must be submitted via paper claim with the patient's medical record. These claims will be reviewed against the medical record and payment adjusted accordingly. Claims with PPC will be denied if the medical record is not submitted concurrent with the claim. All information, including the patient's medical record and paper claim should be sent to:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC**
Medical Claim Review	Medical Claim Review
P.O. Box 7304	**P.O. Box 7110**
London, KY 40742	London, KY 40742

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC DRG. Facilities need not submit copies of medical records for PPCs associated with this payment type.

For Outpatient Providers

Outpatient facility providers submitting a claim that includes treatment required because of a PPC must include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury codes on the claim in field 67 A – Q. Examples of ICD-10 and external cause of injury codes diagnosis codes include:

- Wrong surgery on correct patient Y65.51;
- Surgery on the wrong patient, Y65.52; and
- Surgery on wrong site Y65.53.

UB-04 or 837I

Valid POA indicators are as follows:

- "Y" = Yes = present at the time of inpatient admission

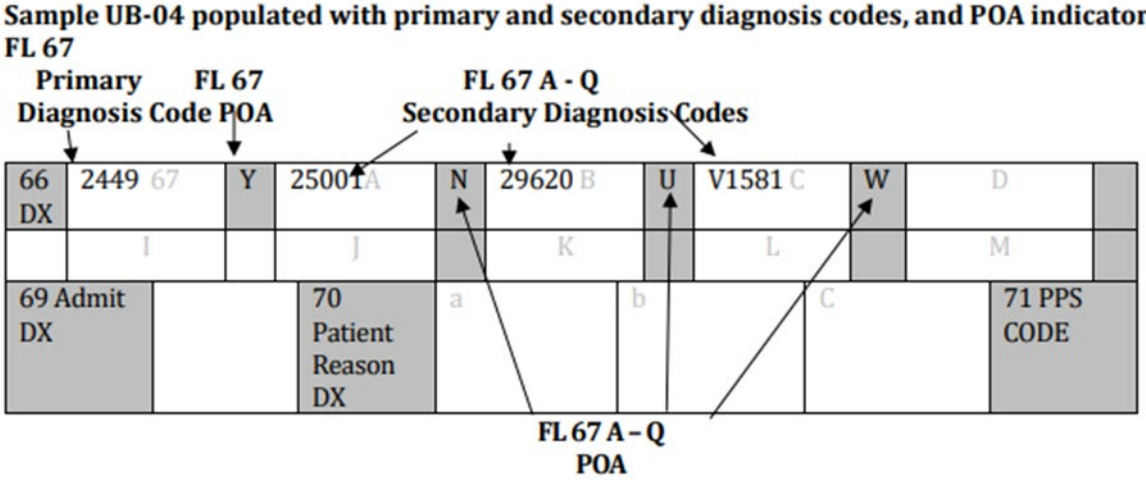
- "N" = No = not present at the time of inpatient admission
- "U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
- "W" = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not
- Exempt from POA reporting – leave blank

A. Reporting POA on the UB-04 Claim Form

Fields 67 A – Q:

- Valid primary and secondary diagnosis codes (up to 5 digits), are to be placed in the unshaded portion of 67 A – Q, followed by the applicable POA indicator (1 character) in the shaded portion of 67 A – Q.

Sample UB-04 populated with primary and secondary diagnosis codes, and POA indicators:



B. Reporting POA in Electronic 837I Format

Provider is to submit their POA data via the NTE segment on all 837I claims, (005010X223A2), for Pennsylvania.

- Although this segment can repeat, Plan requires provider submit POA data on a single NTE Segment. No additional K3 segments with the letters POA will be validated.
- NTE segment must contain POA as the first three characters or the POA data will not be picked up. NTE*ADD *POA~
- NTE02 Segment must only contain details pertaining to the Principal and Other Diagnosis found in the HI segment with qualifiers BK for Principal and BF for Other Diagnosis prior to the ending Z (or X).
- The POA indicator for the BN – External Cause of Injury on the NTE segment with POA is entered following the ending Z (or X). This is required by Optum/Change Healthcare, Availity, or other clearinghouses for Medicare Claims as well.
- No POA Indicator is to be sent for the BJ/ZZ – Admitting Diagnosis Data. Following the letters POA in the NTE Segment is to be only those identified on the Medicare Bulletin. 1, Y, N, U, W are valid, with ending characters of X or Z and E Code indicator.

Example: 1st claim:
1 Principal and 2 Other Diagnosis
NTE*ADD*POAYNUZ~

2nd Claim:
1 Principal and 3 Other Diagnosis and an ECode
NTE*ADD*POAYYNIZY~

Common Causes of Claim Processing Delays, Rejections or Denials

Authorization Invalid or Missing - A valid authorization number must be included on the claim form for all services requiring prior authorization.

Attending Physician ID Missing or Invalid – Inpatient claims must include the name of the physician who has primary responsibility for the patient's medical care or treatment, and the medical license number on the appropriate lines in field number 82 (Attending Physician ID) of the UB-04 (CMS 1450) claim form. A valid medical license number is formatted as 2 alpha, 6 numeric, and 1 alpha character (AANNNNNNA) OR 2 alpha and 6 numeric characters (AANNNNNN)
.

Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.

Diagnosis Code Missing Required Digits – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM or ICD-10 manual for the appropriate categories, subcategories, and extensions. After October 1, 2015, three-digit category codes are required at a minimum. Refer to the coding manuals to determine when additional alpha or numeric digits are required. Use "X" as a place holder where fewer than seven digits are required. Submit the correct ICD qualifier to match the ICD code being submitted.

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.
DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG codes must include this information on the claim form.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages. Payment from the previous payer may be submitted on the 837I or 837P. Besides the information supplied in this document, the line item details may be sent in the SVD segment. Include the adjudication date at the other payer in the DTP, qualifier 573. COB pertains to the other payer found in 2330B. For COB, the plan is considered the payer of last resort.

External Cause of Injury Codes – External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Include applicable POA Indicators with ECI codes.
Future Claim Dates – Claims submitted for Medical Supplies or Services with future claim dates will be denied, for example, a claim submitted on October 1 for bandages that are delivered for October 1 through October 31 will deny for all days except October 1.

Handwritten Claims – Handwritten claims are no longer accepted. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity; therefore, handwritten claims will be rejected.

Highlighted Claim Fields (See Illegible Claim Information)

Illegible Claim Information – Information on the claim form must be legible in order to avoid delays or inaccuracies in processing. Review billing processes to ensure that forms are correct, that no fields are highlighted (this causes information to darken when scanned or filmed), and that spacing and alignment are appropriate.

Incomplete Forms – All required information must be included on the claim forms in order to ensure prompt and accurate processing.

Member/Participant Name Missing – The name of the Member/Participant must be present on the claim form and must match the information on file with the Plan.

Member/Participant Plan Identification Number Missing or Invalid – The Plan's assigned identification number must be included on the claim form or electronic claim submitted for payment.

Member/Participant Date of Birth does not match Member/Participant ID Submitted – a newborn claim submitted with the mother's ID number will be pended for manual processing causing delay in prompt payment.

Newborn Claim Information Missing or Invalid – Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert "Baby Girl" or "Baby Boy" in front of the mother's last name as the baby's first name. Verify that the appropriate last name is recorded for the mother and baby.

Payer or Other Insurer Information Missing or Incomplete – Include the name, address and policy number for all insurers covering the Plan Member/Participant.
Place of Service Code Missing or Invalid – A valid and appropriate two digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Plan.
Provider NPI Number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included on the claim form.

Revenue Codes Missing or Invalid – Facility claims must include a valid four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Spanning Dates of Service Do Not Match the Listed Days/Units – Span-dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field.

Signature Missing – The signature of the practitioner or provider of service must be present on the claim form and must match the service provider name, NPI and TIN on file with the Plan.

Tax Identification Number (TIN) Missing or Invalid - The Tax I. D. number must be present and must match the service provider name and payment entity (vendor) on file with the Plan.

Taxonomy –The provider's taxonomy number is required wherever requested in claim submissions.

CMS-1500 field 19 (Rendering Taxonomy) and 33b (Billing Taxonomy)

UB04 field 76 (Attending Taxonomy) and 81 (Billing Taxonomy)

Third Party Liability (TPL) Information Missing or Incomplete – Any information indicating a work-related illness/injury, no fault, or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

Reminder: When billing Electronic Data Interchange (EDI) 837 coordination of benefit services to AmeriHealth Caritas PA/AmeriHealth Caritas PA CHC as a secondary payor for a Member/Participant that has traditional Medicare or a Medicare Advantage plan (including AmeriHealth Caritas VIP Care), indicate the appropriate primary insurer. Claims submitted indicating the primary payor is a commercial carrier rather than Medicare may be delayed or processed incorrectly.

Correct EDI submission:
The claims filing indicator (located in Loop 2320, segment SBR09) identifies whether the primary payer is Medicare or another commercial payer. When the Member/Participant has a Medicare Advantage plan, the claim should be billed to the secondary payer with a Medicare Part A or B indicator, not as commercial insurance. Please ensure you are using the appropriate indicator on EDI claims as follows:

- MA -the primary payer is Medicare Part A (use for both traditional Medicare and Medicare Advantage)
- MB -the primary payer is Medicare Part B (use for both traditional Medicare and Medicare Advantage)
- Cl -the primary payer is commercial insurance (non-Medicare)

Type of Bill – A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. Do not include the leading zero on electronic claims. Adjusted claims may be sent via paper or EDI.

IMPORTANT BILLING REMINDERS:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.
- Append the appropriate modifiers to the HCPCS/CPT code when performing a service or separate, distinct or independent procedure on the same day that a procedure or other service is performed; refer to modifier 25 or 59 guide on the claims section of the provider website for details.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- Submitting the original copy of the claim form will assist in assuring claim information is legible.
- The individual provider name and NPI number as opposed to the group NPI number must be indicated on the claim form.
- Reimbursement for all rendering network providers for claims subject to the ordering/referring/prescribing (ORP) requirement is determined by validating that participating ordering/referring/prescribing Practitioners have a valid Pennsylvania Medical Assistance (MA) Provider ID. Claims subject to the ORP requirement will be denied when billed with the NPI of a network ordering/referring/prescribing provider that is not enrolled in MA. For more information on claims subject to ORP requirements please go to https://www.amerihealthcaritaspa.com/pdf/provider/communications/bulletins/mab-99-17-02.pdf

- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.
- Although the newborn claim is submitted under the mother's ID, the claim must be processed under the baby's ID. The claim will not be paid until the state confirms eligibility and enrollment in the plan.
- The claim for *baby* must include the *baby's date of birth* as opposed to the mother's date of birth. Claim must also include *baby's birth weight (value code 54).*
- On claims for twins or other multiple births, indicate the birth order in the patient name field, e.g., Baby Girl Smith A, Baby Girl Smith B, etc.
- Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- The *individual service provider name and NPI number* must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.
- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI number's results in inaccurate payments or denials.
- When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.
- Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately. Contact your Provider Account Executive to assist in updating the Plan's records.
    - If there is a third-party resource regarding a payment for **prenatal care**, providers are to submit claims to that resource prior to submitting a claim for prenatal services to the Plan.
    - Providers must verify whether a Member/Participant has insurance coverage in addition to Medical Assistance (MA). Providers can verify Member/Participant eligibility and benefits through any of the following methods:
- NaviNet (www.navinet.net)
- AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC eligibility line – **1-800-521- 6007**
- Pennsylvania Eligibility Verification System (EVS) – **1-800-766-5387**

Electronic Data Interchange (EDI) for Medical and Hospital Claims
Electronic Data Interchange (EDI) allows faster more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker.

All the same requirements for paper claim filing apply to electronic claim filing.

Important: Please allow for normal processing time before resubmitting the claim either through EDI or paper claim. This will reduce the possibility of your claim being rejected as a duplicate claim.

Important: In order to verify satisfactory receipt and acceptance of submitted records, please review both the Optum/Change Healthcare, Availity, or other clearinghouse Acceptance report and the R059 Plan Claim Status Report.

Refer to the Claim Filing section for general claim submission guidelines.

Electronic Claims Submission (EDI)

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high-level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Hardware/Software Requirements

There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims to Optum/Change Healthcare or Availity, whether through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

Contracting with Optum/Change Healthcare, Availity, and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Optum/Change Healthcare or Avality EDI capabilities, you can contact the Optum/Change Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.

You may also choose to contract with another EDI clearinghouse or vendor who already has Optum/Change Healthcare capabilities.

Contacting the EDI Technical Support Group

Providers interested in sending claims electronically may contact the EDI Technical Support Group for information and assistance in beginning electronic submissions. When ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your EDI software vendor and/or clearinghouse to inform them you wish to initiate electronic submissions to the Plan.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

Important: Contact EDI Technical Support at **1-866-695-1330** or by email at: edi.support@amerihealthcaritas.com

Important: Providers are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

Important: The Payer ID for AmeriHealth Caritas PA is 22248. The Payer ID for AmeriHealth Caritas PA CHC is 77062.

NOTE: Plan payer specific edits are described in Exhibit 99 at Optum/Change Healthcare.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Any EDI clearinghouse or vendor may require additional data record requirements.

Electronic Claim Flow Description

In order to send claims electronically to the Plan, all EDI claims must first be forwarded to Optum/Change Healthcare or Availity. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once the clearinghouse receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits as described in Exhibit 99 at Optum/Change Healthcare. Claims not meeting the requirements are immediately rejected and sent back to the sender via an Optum/Change Healthcare error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or clearinghouse.

Accepted claims are passed to the Plan, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to the Plan by the clearinghouse are immediately validated against provider and Member/Participant eligibility records. Claims that do not meet this requirement are rejected and sent back to the clearinghouse, which also forwards this rejection to its trading partner – the intermediate EDI vendor or provider. Claims passing eligibility requirements are then passed to the claim processing queues. **Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or Member/Participant data.**

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse or other contracted EDI software vendors, must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to the Plan.

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Optum/Change Healthcare Provider Support Line at **1-800-522-8133. Option 2 or** Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.
- If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support Hotline at **1-866-695-1330** or by email at: edi.support@amerihealthcaritas.com

Important: Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Important: The clearinghouse will produce an Acceptance report * and a R059 Plan Claim Status Report** for its trading partner whether that is the EDI vendor or provider. Providers are responsible for arranging to have these reports forwarded to the appropriate billing or open receivable departments.

* An Acceptance report verifies acceptance of each claim by the clearinghouse.

** A R059 Plan Claim Status Report is a list of claims that passed the clearinghouse's validation edits. However, when the claims were submitted to the Plan, they encountered provider or Member/Participant eligibility edits.

Important: Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or Member/Participant data.

Timely Filing Note: Your claims must be received by the EDI vendor by 9 p.m. in order to be transmitted to the Plan the next business day.

Important: Contact Optum/Change Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.

Important: Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI software vendor or clearinghouse to verify you receive the reports necessary to obtain this information.

Important: When you receive the Rejection report from the clearinghouse or your EDI vendor, the plan does not receive a record of the rejected claim.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass clearinghouse HIPAA edits and Plan specific edits

prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from the clearinghouse or your EDI software vendor in order to identify and re-submit these claims accurately.

Plan Specific Electronic Edit Requirements

The Plan currently has two specific edits for professional and institutional claims sent electronically.

837P –005010X222A1– Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
837I – 005010X223A2 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups and apply to inpatient and outpatient claim types.

Excluded Claim Categories. At this time these claim records must be submitted on paper.
Claim records for medical administrative or claim appeals
Excluded Provider Categories. Claims issued on behalf of the following providers must be submitted on paper.
Providers not transmitting through Optum/Change Healthcare or Availity, or providers sending to Vendors that are not transmitting (through Optum/Change Healthcare, Availity or other clearinghouse)) NCPDP Claims
Pharmacy (through Optum/Change Healthcare, Availity, or other clearinghouse)

Important: Requests for adjustments may be submitted by telephone to:
Provider Claim Services: **1-800-521-6007**

If you prefer to write, please be sure to stamp each claim submitted "corrected" or "resubmission" and address the letter to:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC**
Claim Processing Department	Claim Processing Department
P.O. Box 7118	**P.O. Box 7110**
London, KY 40742-7118	London, KY 40742-7110

AmeriHealth Caritas PA appeals and disputes must be submitted in writing to:

Clinical provider medical appeals	**InformalWritten disputes**
Clinical Provider Appeals Department	Informal Provider Disputes
AmeriHealth Caritas PA	AmeriHealth Caritas PA
P.O. Box 7316	**P.O. Box 7329**
London, KY 40742	London, KY 40742

AmeriHealth Caritas PA CHC appeals and disputes must be submitted in writing to:

Clinical provider medical appeals	**Informal Written disputes**
Clinical Provider Appeals Department	Informal Provider Disputes
AmeriHealth Caritas PA CHC	AmeriHealth Caritas PA CHC
P.O. Box 80113	**P.O. Box 7110**
London, KY 40742-0113	London, KY 40742

Refer to the Provider Manual for complete instructions on submitting administrative or medical appeals at:
https://www.amerihealthcaritaspa.com/provider/resources/manual/index.aspx
https://www.amerihealthcaritaschc.com/provider/manual-forms/index.aspx

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Optum/Change Healthcare, Availity, or other clearinghouses
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
Claims without provider numbers
Claims without Member/Participant numbers
Claims in which the date of birth submitted does not match the Member/Participant ID.
Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers
Claims received with invalid Member/Participant numbers
Claims received with invalid Member/Participant date of birth
Claims without Billing Taxonomy IDs, Attending Taxonomy IDs, Rendering Taxonomy IDs

Resubmitted Professional Corrected Claims

Providers using electronic data interchange (EDI) can submit "professional" corrected claims* electronically rather than via paper to the Plan.

* A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.

Your EDI clearinghouse or vendor needs to:

- Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)
- Use "8" for void/cancel of prior claim, utilizing bill type in loop 2300, CLM05-03 (837P)
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces

- **Do** include the plan's claim number to submit your claim with the 7 or 8
- **Do** use this indicator for claims that were previously processed (approved or denied)
- **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- **Do not** submit corrected claims electronically and via paper at the same time

For more information, please contact the EDI Hotline at **1-866-695-1330** or by email at: edi.support@amerihealthcaritas.com

Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims faster than available with paper submission processing.

Important: Claims originally rejected for missing or invalid data elements must be corrected and re-submitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 6.)

Important: Before resubmitting claims, check the status of your submitted claims online at www.navinet.net

Important: Corrected Professional Claims may be sent in on paper via CMS 1500 or via EDI.
If sending paper, please stamp each claim submitted "corrected" or "resubmission" and send all corrected or resubmitted claims to:

Claim Processing Departments

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC w/o Medicare**	**AmeriHealth Caritas PA CHC w/ Medicare**
Claims Processing Department	Claims Processing Department	Claims Processing Department
P.O. Box 7118	**P.O. Box 7110**	**P.O. Box 7143**
London, KY 40742	London, KY 40742	London, KY 40742

Important: Corrected Institutional and Professional claims can be resubmitted electronically using the appropriate bill type to indicate that it is a corrected claim.

Contact Optum/Change Healthcare Provider Support Line at: **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.
Contact EDI Technical Support at: **1-866-695-1330**

Important: Provider NPI number validation is not performed by the clearinghouse. The clearinghouse will reject claims for provider NPI only if the provider number fields are empty.

Important: The Plan's Provider ID is recommended as follows: 837P – Loop 2310B, REF*G2[PIN] 837I – Loop 2310A, REF*G2 [PIN]

NPI Processing – The Plan's Provider Number is determined from the NPI number using the following criteria:
1. Plan ID, Tax ID and NPI number
2. If no single match is found, the Service Location's ZIP code is used
3. If no service location is included, the billing address ZIP code will be used

4. If no single match is found, the Taxonomy is used
5. If no single match is found, the required Taxonomy is used
6. If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim The legacy Plan ID is used as the primary ID on the claim
7. If you have submitted a claim, and you have not received a rejection report, but are unable to locate your claim via NaviNet, it is possible that your claim is in review by the Plan. Please check with provider services and update you NPI data as needed. It is essential that the service location of the claim match the NPI information sent on the claim in order to have your claim processed effectively.

Electronic Claims Submission (EDI)

Claims can be submitted electronically through any clearinghouse. Contact your EDI clearinghouse or Optum/Change Healthcare at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548)** to inform them that you wish to initiate electronic claim submissions . Or visit https://support.changehealthcare.com/customer-resources/enrollment-services for information on enrolling.

The Plan does not require you to enroll with Optum/Change Healthcare or Availity to submit electronic claims. If you already use another EDI vendor to submit claims electronically, inform your vendor of the EDI payer ID.

- **AmeriHealth Caritas PA payer ID: 22248**
- **AmeriHealth Caritas PA CHC payer ID 77062**

Direct Submission

Providers can submit claims directly to Optum/Change Healthcare ConnectCenter or PCH Global. The Optum/Change Healthcare direct entry claims portal, Connect Center, provides two methods for submitting claims: key them in manually or import batches of claims. There is no cost to manually key claims in using Connect Center, but claims must be entered one at a time, which may not be feasible for practices with high claim volume. Providers should call Optum/Change Healthcare at **1-800-527-8133, option 2** and follow the appropriate prompts, or go to https://support.changehealthcare.com/customer-resources/enrollment-services to enroll for direct submission with Optum/Change Healthcare. Optum/Change Healthcare will also provide information on their various electronic solutions, the requirements for connectivity, and setup instructions.

Electronic Claim Payment Options

Optum/Change Healthcare is now partnering with ECHO Health, Inc. (ECHO Health), a leading innovator in electronic payment solutions, to offer more electronic payment options to our healthcare providers so that they can select the payment method that best suits their accounts receivable workflow.

Virtual Credit Card (VCC)

ECHO Health offers Virtual Credit Cards as an optional payment method. Virtual Credit Cards are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. Major advantages to VCC are that providers do not have to enroll or fill out multiple forms in order to receive VCC, and personal information, like practice bank account information, will never be requested. Providers will also be able to access their payment the day the VCC is received. In the future, providers who are not currently registered to receive payments

electronically will receive VCC payments as their default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction with an instruction page for processing and a detailed Explanation of Payment /Remittance Advice (EOP/RA). **Normal transaction fees apply based on your merchant acquirer relationship**. If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health directly at **1-888-492-5579**.

Electronic Funds Transfers (EFT)
Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be accessible to download from the ECHO provider portal (www.providerpayments.com). If you are new to EFT, you will need to enroll with ECHO Health for EFT from AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC.

Please note: Payment will appear on your bank statement from PNC Bank and ECHO as "PNC – ECHO."

To sign-up to receive EFT from AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC, visit https://enrollments.ECHOhealthinc.com/efteradirect/enroll. There is no fee for this service.

To sign-up to receive EFT from all of your payers processing payments on the Settlement Advocate platform, visit https://enrollments.ECHOhealthinc.com. A fee for this service may be required.

If you have questions regarding how to enroll in EFT, please reference the AmeriHealthCaritas PA EFT Enrollment Guide located on our websites: www.amerihealthcaritaspa.com and www.amerihealthcaritaschc.com

Electronic Remittance Advice (ERA)
AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC now also offers ERAs (also referred to as an 835 file) through Optum/Change Healthcare/ECHO Health. To receive ERAs from Optum/Change Healthcare and ECHO, you will need to include both the Plan and Optum/Change Healthcare payer IDs.

- AmeriHealth Caritas PA payer ID is **22248** and the ECHO payer ID is **58379.**
- AmeriHealth Caritas PA CHC payer ID is **77062** and the ECHO payer ID is **58379**.

Contact your practice management/hospital information system for instructions on how to receive ERAs from the payer IDs listed above. If your practice management/hospital information system is already set up and can accept ERAs from AmeriHealth Caritas PA and/or AmeriHealth Caritas PA CHC, then it is important to check that the system includes both AmeriHealth Caritas PA payer ID **22248** and ECHO Health payer ID **58379** or AmeriHealth Caritas PA CHC payer ID **77062** and ECHO Heath Payer ID **58379**, as applicable, for ERAs.

If you are not receiving any payer ERAs, please contact your current practice management/hospital information system vendor to inquire if your software has the ability to process ERAs. Your software vendor is then responsible for contacting Optum/Change Healthcare to enroll for ERAs under AmeriHealth Caritas PA payer ID **22248** and ECHO Health payer ID **58379** and/or AmeriHealth Caritas PA CHC payer ID **77062** and ECHO Health Payer ID **58379**, as applicable.

If your software does not support ERAs or you continue to reconcile manually, and you would like

to start receiving ERAs only, please contact the ECHO Health Enrollment team at **1-888-834-3511**.

For enrollment support, please contact ECHO Health Inc. at **1-888 -834-3511**.

If you have additional questions regarding VCC, EFT, or ERAs, please reference our FAQ or call ECHO Health Support team at 1-888-492-5579.

For additional detailed resources visit our website at:
https://www.amerihealthcaritaspa.com/provider/billing/electronic-billing-services.aspx
https://www.amerihealthcaritaschc.com/provider/claims-billing/electronic.aspx

Electronic Billing Inquiries

Action	Contact
If you would like to transmit claims electronically…	Contact Optum/Change Healthcare Provider Support Line at**1-877-363-3666** or Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.
If you have general EDI questions …	Contact EDI Technical Support at: **1-877-234-4271** Or via email: edi.support@amerihealthcaritas.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports…	Contact your EDI Software Vendor or call the Optum/Change Healthcare Provider Support Line at **1-877-363-3666** or Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	Contact Provider Claim Services at-**1-800-521-6007**
If you have questions about claims that are reported on the Remittance Advice….	Contact Provider Claim Services at **1-800-521-6007**
If you need to know your provider NPI number…	Contact Provider Claim Services at **1-800-521-6007**
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information… For questions about changing or verifying provider information…	Notify Provider Network Management in writing at: 8040 Carlson Rd, Suite 500 Harrisburg, PA 17112 Or by fax at: **717-651-1673**
If you would like information on the 835 Remittance Advice:	Contact your EDI Vendor
Check the status of your claim:	Review the status of your submitted claims on NaviNet at www.navinet.net
Sign up for NaviNet	www.navinet.net Navinet Customer Service: **1-888-482-8057**

Tips for Accurate Diagnosis Coding: How to Minimize Retrospective Chart Review

What is the Risk Score Adjustment Model?

The Department of Human Services (DHS) utilizes medical encounter data supplied by the Plan to evaluate disease severity and risk of increased medical expenditures. DHS employs the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, to support health-based capitation payments to the Plan. Accurate payments from DHS help us ensure that providers are reimbursed appropriately for services provided to our Members/Participants.

- We must obtain health status documentation from the diagnoses contained in claims data.

Why are retrospective chart reviews necessary?

Although the Plan captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews

What is the significance of the ICD-10-CM Diagnosis code?

International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) codes are identified as 3 to 7 alpha-numeric codes used to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-10-CM Official Guidelines for Coding and Reporting (October, 1, 2015), providers must code all documented conditions that were present at time of the encounter/visit, and require or affect patient care treatment or management.

Have you coded for all chronic conditions for the Member/Participant?

Examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

Amputation status	HIV/AIDS
Bipolar disorder	Hypertension
Cerebral vascular disease	Lung, other severe cancers
COPD	Metastatic cancer, acute leukemia (Prostate, breast, etc.)
Chronic renal failure	Multiple sclerosis
Congestive heart failure	Paraplegia
CAD	Quadriplegia
Depression	Renal failure
Diabetes mellitus	Schizophrenia
Dialysis status	Simple chronic bronchitis
Drug/alcohol psychosis	Tumors and other cancers

What are your responsibilities?

Physicians must accurately report the ICD-10-CM diagnosis codes to the highest level of specificity.

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:
    - E11.40 Diabetes with neurological manifestations and E08.40 for diabetic polyneuropathy

Accurate coding can be easily accomplished by keeping accurate and complete medical record

documentation.

Documentation Guidelines

- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation is clear; concise, consistent, complete, and legible.

Physician Documentation Tips

- First list the ICD-10CM code for the diagnosis, condition, problem or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- Strike through, initial, and date. Do not obliterate.
- Use only standard abbreviations.
- Identify patient and date on each page of the record.
- Ensure physician signature and credentials are on each date of service documented.
- Update physician super bills annually to reflect updated ICD-10CM coding changes, and the addition of new ICD-10CM codes.

Physician Communication Tips

When used, the SOAP note format can assist both the physician and record reviewer/coder in identifying key documentation elements. **SOAP** stands for:

Subjective: How the patients describe their problems or illnesses.

Objective: Data obtained from examinations, lab results, vital signs, etc.

Assessment: Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.

Plan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

Supplemental Information:

Ambulance
Anesthesia
Audiology
Chiropractic Care
Clinical Laboratory Improvement Amendments (CLIA)
Dialysis
Dual Medicare/Medicaid Claim Submission
Durable Medical Equipment (DME)
EPSDT Supplemental Billing
Family Planning
Home Health Care (HHC)
Infusion Therapy
Injectable Drugs
Maternity
Multiple Surgical Reduction
Payment Policy
Physical/Occupational and Speech Therapies
Termination of Pregnancy
Most Common Claims Errors

Information Factor Carve Out

Ambulance

Ground and Air Ambulance Services are billed on CMS 1500 or 837 Format

When billing for Procedure Codes A0425 – A0429 and A0433 – A0434 for Ambulance Transportation services, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit Procedure Code. Different modifiers may be used for the same Procedure Code.

- Providers must bill the transport codes with the appropriate destination modifier.
- Mileage must also be billed with the ambulance transport code and be billed with the appropriate transport codes.
- Effective January 1, 2024, starting with mile 1, loaded miles must be billed with the appropriate ambulance transport codes. Providers must use the Place of Service Codes for ground and air transportation.
- Providers who submit transport codes without a destination modifier will be denied for invalid/missing modifier.
- Providers who bill mileage alone will be denied for invalid/inappropriate billing.
- Mileage when billed will only be paid when billed in conjunction with a PAID transport code.
- A second trip is reimbursed if the recipient is transferred from first hospital to another hospital on same day in order to receive appropriate treatment. Second trip must be billed with a (HH) destination modifier.
- For 837 claims, all ambulance details are required. Ambulance Transport information; Ambulance Certification; pick-up and drop-off locations.

Procedure Code Modifiers: The following procedure code modifiers are required with all transport procedure codes. The first-place alpha code represents the origin and the second place alpha code represents the client's destination. Codes may be used in any combination unless otherwise noted.

D - Diagnostic or therapeutic site (other than physician's office or hospital)

E - Residential, domiciliary or custodial facility (other than skilled nursing facility) G - Hospital-based dialysis facility (hospital or hospital-related)

H - Hospital

I - Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport J - Non hospital-based dialysis facility

N - Skilled nursing facility

P - Physician's office (includes HMO non-hospital facility, clinic, etc.)

R – Residence

S - Scene of accident or acute event

X - (DESTINATION CODE ONLY) Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

Anesthesia

Procedure codes in the Anesthesia section of the Current Procedural Terminology manual are to be used to bill for surgical anesthesia procedures.

- Anesthesia claims must be submitted using anesthesia (ASA) procedure codes only (base plus time units);
- All services must be billed in minutes;
- 15-minute time increments will be used to determine payment.

Audiology

Audiology services must be billed on a CMS 1500 claim form or via 837P.

Chemotherapy

- Services may be billed electronically via 837 electronic format or via paper on a CMS 1500 or UB-04.
- Providers are to use the appropriate chemotherapy administration procedure code in addition to the "J-code" for the chemotherapeutic agent.
    - If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M procedure code may also be reported.

Chiropractic Care

- Claims for chiropractic services are billed on a CMS 1500 or via 837 electronic format.
- First visit does not require a referral or prior authorization. Refer to Referral and Authorization Requirements in the Provider Manual for information related to chiropractic services.
- Must bill appropriate CPT code and modifiers.

Clinical Laboratory Improvement Amendments (CLIA)

Providers that perform laboratory testing are required to indicate their CLIA ID number when submitting professional claims. Professional claims submitted for laboratory services are validated for the following to be processed and paid:

- Is the lab code submitted subject to CLIA requirements?
- Is there an active CLIA number on the claim?
- Is the lab code billed within the scope of the CLIA certification number submitted on the claim?

*Codes appearing on the CMS clinical waiver list should be billed with a QW modifier. Failure to do so will result in claim payment denials.

Please note that it is the responsibility of providers to make sure the laboratory tests performed are within the scope of their certification and that they have a valid (not expired) CLIA number.

Dialysis

- Reimbursement for dialysis services must be billed using the UB-04 claim form or via 837I electronic format.
- The Plan's Claims Department will automatically adjudicate Claims for payment for cumulative monthly amounts of erythropoietin equal to or less than 50,000 units. Dialysis centers and/or physicians will be required to submit documentation to the Plan Specialty Drug Program to establish the medical necessity of cumulative monthly doses of erythropoietin greater than 50,000 units. With the exception of facilities contracted at a case rate for Epogen, units over these amounts require Prior Authorization and will be denied if they are billed without an authorization. Once a specific dose is authorized, it will be approved for up to three months.
- Epogen must be reported with revenue code 634 and revenue code 635.

Dual Medicare/Medicaid Claims

Providers only need to submit claims for Plan Members/Participants who are dual-eligible for both Medicare and Medicaid coverage to CMS (or any other Medicare carrier). Providers are no longer required to submit the Medicare EOB and secondary claim to the Plan. CMS (or any other Medicare carrier) will automatically forward claims to the Plan for Members/Participants who are dual-eligible." For the types of providers listed in the table below, claims will not come to the Plan via the Medicare crossover process outlined above and these provider types must submit their claims directly to us along with the Medicare EOB.

Comprehensive Coordination of Benefits Agreement (COBA) exclusions list Fiscal Intermediary/Medicare Administrative Contractor (MAC) Types of Bills (TOBs)		
Institutional	**TOB**	**Description**
Part A	13	Hospital: Outpatient
Part A	18	Hospital: Swing Bed
Part A	21	Skilled Nursing Facility: Inpatient Part A
Part A	22	Skilled Nursing Facility: Inpatient Part B
Part A	23	Skilled Nursing Facility: Outpatient
Part A	71	Clinic: Rural Health
Part A	72	Clinic: Freestanding Dialysis
Part A	74	Clinic: Outpatient Rehabilitation Facility
Part A	75	Clinic: Comprehensive Outpatient Rehabilitation Facility (CORF)
Part A	76	Clinic: Comprehensive Mental Health Clinic
Part A	83	Special Facility: Ambulatory Surgical Center
Part A	85	Primary Care Hospital
Specialty Fiscal Intermediary TOBs		
Part A	24	Skilled Nursing Facility: Other Part B (Non-patient)
Part A	28	Skilled Nursing Facility: Swing Bed
Part A	41	Christian Science/Religious Non-Medical Services (Hospital)
Part A	77	Clinic: Federally Qualified Health Center (formerly TOB 73)
Part A	79	Clinic: Other
Regional or Rural Home Health Intermediary TOBs		
Part A	32	Home Health: Part B Trust Fund
Part A	33	Home Health: Part A Trust Fund

Part A	34	Home Health: Outpatient
Part A	81	Specialty Facility: Hospice Non-Hospital
Part A	82	Specialty Facility: Hospice Hospital

Durable Medical Equipment

- Services are billed on a CMS 1500 claim form.
- An "RR" modifier is required for all rentals.
- Repair codes on the DME Fee Schedule require the submission of procedure code K0739.
- Refer to the Provider Manual for DME authorization rules and guidelines.
- Program Exceptions - codes K0868 through K0891 will be reviewed on a case by case basis.
- Benefit Exceptions – items/services not listed on the Plan's DME fee schedule will be reviewed on an individual basis based on coverage, benefit guidelines, and medical necessity.
- Miscellaneous codes will not be used if an appropriate code is on the Plan's DME fee schedule or is nationally recognized.

EPSDT Supplemental Billing Information

The information below is applicable to AmeriHealth Caritas Pennsylvania Members only.

EPSDT Billing Guidelines – CMS 1500, UB-04 or Electronic 837 Format

EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions

Providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens may bill using the CMS 1500 or UB-04 paper claim forms or electronically, using the 837 format.

Providers choosing to bill for complete EPSDT screens, including immunizations, on the CMS 1500 or UB-04 claim form or the 837 electronic formats must:

- Use Z76.1, Z76.2, Z00.121 or Z00.129 as the primary diagnosis code
- Use diagnosis codes Z00.00 or Z00.01 for Members aged 15 to 21 years of age
- Providers may use the following additional ICD-10 diagnosis codes in conjunction with ESPDT claims:
  - Z00.110 (Health examination for newborn under 8 days old)
  - Z00.111 (Health examination for newborn 8 to 28 days old)
  - Z38.00 (Single liveborn infant, delivered vaginally)
  - Z38.01 (Single liveborn infant, delivered by cesarean)
  - Z38.1 (Single liveborn infant, born outside hospital)
  - Z38.2 (Single liveborn infant, unspecified as to place of birth)
  - Z38.3-Z38.8 (Range of codes for multiple births)
- Accurate payment of EPSDT claims will be determined solely by the presence of EPSDT modifiers to identify an EPSDT Claim. Failure to append EPSDT modifiers will cause claims to be processed as non-EPSDT related encounters
- Use one of the individual age-appropriate procedure codes outlined on the most current EPSDT Periodicity Schedule (listed below), as well as any other EPSDT related service, e.g., immunizations, etc.
- Use EPSDT Modifiers as appropriate: EP - Complete Screen; 52 - Incomplete Screen; 90 -

Outpatient Lab; U1 - Autism.
- Use U1 modifier in conjunction with CPT code 96110 for Autism screening
- CPT code 96110 without a U1 modifier is to be used for a Developmental screening

Age-Appropriate Evaluation and Management Codes
(As listed on the current EPSDT Periodicity Schedule and Coding Matrix)

Newborn Care:
99460 Newborn Care (during the admission) 99463 Newborn (same day discharge)

New Patient:	**Established Patient:**
99381 Age < 1 yr	99391 Age < 1 yr
99382 Age 1-4 yrs	99392 Age 1-4 yrs
99383 Age 5-11 yrs	99393 Age 5-11 yrs
99384 Age 12-17 yrs	99394 Age 12-17 yrs
99385 Age 18-20 yrs	99395 Age 18-20 yrs

Billing example: New Patient EPSDT screening for a 1 month old. The diagnosis and procedure code for this service would be:
- Z76.2 (Primary Diagnosis)
- 99381EP (E&M Code with "Complete" modifier)

* Enter charges. Value entered must be greater than zero ($0.00) including capitated services. Please consult the EPSDT Program Periodicity Schedule and Coding Matrix, as well as the Recommended Childhood Immunization Schedule for screening timeframes and the services required to bill for a complete EPSDT screen. Both are available in a printable PDF format online at the Provider Center at: https://www.amerihealthcaritaspa.com/provider/resources/index.aspx

Completing the CMS 1500 or UB-04 Claim Form
The following blocks must be completed when submitting a CMS 1500 or UB-04 claim form for a complete EPSDT screen:
- EPSDT Referral Codes (when a referral is necessary, use the listed codes in the example below to indicate the type of referral made)
- Diagnosis or Nature of Illness or Injury
- Procedures, Services or Supplies CPT/HCPCS Modifier
- EPSDT/Family Planning

UB-04	CMS 1500	Item	Description	C/R
37	10d	Reserved for Local Use	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen.	
		EPSDT Referrals	YD – Dental (Required for ages 3 and over) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical	C C C C C C

UB-04	CMS 1500	Item	Description	C/R
			**Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through the CONNECT Helpline at 1-800-692-7288, document the referral in the child's medical record and submit the YO EPSDT referral code.*	
18	N/A	Condition Codes	Enter the Condition Code A1 EPSDT	R
67	21	Diagnosis or Nature of Illness or Injury	When billing for EPSDT screening services, **diagnosis code Z76.1, Z76.2, Z00.121, Z00.129, Z00.110, Z00.111, Z38.01, Z38.1 or Z38.3-Z38.8** (Routine Infant or Child Health Check) must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2,21.3,21.4. **An appropriate diagnosis code must be included for each referral.** Immunization V-Codes are not required.	67
42	N/A	Revenue code	Enter Revenue **Code 510**	R
44	24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Populate the first claim line with the age appropriate E & M codes along with the EP modifier when submitting a "complete' EPSDT visit, as well as any other EPSDT related services, e.g., immunizations	R
N/A	24H	EPSDT/Family Planning	Enter Visit Code 03 when providing EPSDT screening services.	R

Key:

- **Block Code** – Provides the block number as it appears on the claim.
- C – Conditional must be completed if the information applies to the situation or the service provided.
- **R** – Required – must be completed for all EPSDT claims.

Dental Referral:

The information below is applicable to AmeriHealth Caritas Pennsylvania Members only.

- In completing a dental referral, providers should advise the child's parent or guardian that a dental exam is required according to the periodicity schedule.
- AmeriHealth Caritas PA Member Services will then coordinate with the Member and their family to locate a participating dentist and arrange an appointment for the child.
- Documentation of the dental referral should be recorded in the child's medical record and on the claim form by utilizing the appropriate EPSDT dental referral code.
    - Use the EPSDT modifier EP (Complete Screen) when the process outlined above has been followed.
    - Enter the EPSDT referral code YD (dental referral) in field 10d on the CMS 1500 claim form, or field 37 on the UB-04 form.

- When the dental referral has not occurred, submit the claim with the EPSDT modifier 52 (Incomplete Screen).

*Payment for a complete screen is determined by the presence of both the EP modifier and YD referral code.

Important: Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

Factor Drug Carve-Out

Note: These instructions are only applicable for in-patient facilities for which factor are a carve-out in their Plan contract. Submit clinical information for Factor via **fax** to: **1-888-981-5202**.

The request is reviewed by hemophilia Nurse Case Manager who has thirty (30) days from receipt of complete information to review the case.

- Questions regarding status should be directed to the PerformRx Bleeding Disorder Program at **484-496-7610**. Upon Nurse Case Manager approval and authorization, an approval notice is sent to the Attending Physician, Member/Participant and Hospital contact.
- Upon Case Manager recommendation of denial, the case is sent to a Medical Director for review.
  - After review of the request and the Medical Director concurs with the denial recommendation, a denial notice is sent to the Attending Physician, Member/Participant and Hospital Contact.
  - Any appeal should follow the instructions and process that are provided on the denial letter.
  - After review, if the Medical Director decides to approve and authorizes the request, an approval notice is sent to the Attending Physician, Member/Participant and Hospital Contact.

Family Planning

Participants are covered for Family Planning Services without a referral or Prior Authorization from the Plan. Participants may self-refer for routine Family Planning Services and may go to any physician or clinic, including physicians and clinics not in the Plan's Network.
Members/Participants that have questions or need help locating a Family Planning Services provider can be referred to Member/Participant Services at:

- **1-888-991-7200 (AmeriHealth Caritas PA)**
- **1-855-235-5115 (AmeriHealth Caritas PA CHC)**

Sterilization

Sterilization is defined as any medical procedure, treatment or operation for the purpose of rendering an individual permanently incapable of reproducing.

A Member/Participant seeking sterilization must voluntarily give informed consent on the Department of Human Services' Sterilization Consent Form (MA 31 form) found at:

- http://www.amerihealthcaritaspa.com/pdf/provider/resources/forms/family-planning/sterilization- consent.pdf (AmeriHealth Caritas PA)
- https://www.amerihealthcaritaschc.com/assets/pdf/provider/sterilization-consent.pdf (AmeriHealth Caritas PA CHC)

The Member/Participant must give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 calendar days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days before the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

DHS' Sterilization Consent Form must accompany all claims for reimbursement for sterilization services. The form must be completed correctly in accordance with the instructions. The claim and consent forms will be retained by the Plan.

Home Health Care (HHC)

- UB-04 claim forms do not include a "Place of Service" field, therefore, to determine if services were provided in a home or home-like setting, all claims for home health services must be submitted on a CMS-1500 form or the claim will be denied.*
- Providers must bill the appropriate modifier in the first position when more than one modifier is billed.
- Refer to NDC instructions in the manual.

Incontinence Supplies (Diapers)

- **For AmeriHealth Caritas PA Members (age 3 and over)**: Prior authorization is required for any quantity of diapers/pull-up diapers supplied by a DME Provider, other than J&B Medical Supply. The prior authorization criteria listed below applies to J&B Medical Supply.
  - More than 300 generic diapers and/or pull-up diapers per month.
  - Brand-specific diapers.

- **For AmeriHealth Caritas PA CHC Participants**: Prior authorization is required. Requests are reviewed for medical necessity for diapers/pull-up diapers as follows:
  - More than 300 generic diapers and/or pull-up diapers per month.
  - Brand-specific diapers.

Infusion Therapy

- Drugs administered by physician or outpatient hospital require prior authorization.
- Drugs require the provider to also bill the NDC and related NDC information.
- Failure to bill the NDC required information will result in denial.

Injectable Drugs

Reminder: All drugs (including vaccines and radiopharmaceuticals) billed are required to be submitted with NDC information and may be submitted via CMS-1500 or 837 electronic formats. Refer to the NDC instructions.

The NDC number and a valid HCPCS code for drug products are required on both the 837 electronic format and the CMS-1500 for reimbursable medications. For 837I claims, submit only one NDC per line; Optum/Change Healthcare only considers the first NDC on a claim line.

Maternity

- Bill an appropriate office visit code with a pregnancy diagnosis in addition to T1001-U9.
- Last menstrual period (LMP) is a required field to be submitted on all claim types.
- The completed ONAF form must be submitted electronically through the Optum® OB Care website* (obcare.optum.com).
- OB/GYN groups will be incentivized and paid at the contracted rate for the timely and accurate electronic submission of their Members' complete series of the ONAF forms via the Optum OB Care website as indicated in the Maternity Quality Enhancement Program manual for each trimester.

Postpartum

- Render the postpartum visit within 7 to 84 days after delivery.
- Submit the ONAF form electronically online through the Optum® OB Care website at the post-partum visit with all post-partum information and any additional visit dates as needed.
- Appropriate post-partum diagnosis codes and the appropriate post- partum visit code (59430) must be reported and billed together on the same claim form within 7-84 days after the delivery date to receive payment.

The OB Care User Guide and link to the Optum website is available at
www.amerihealthcaritaspa.com→Providers → Initiatives →Bright Start
www.amerihealthcaritaschc.com →Providers → Resources →Bright Start program

Multiple Surgical Reduction Payment Policy

The Plan adheres to the following payment procedure:

- When two or more surgical inpatient or outpatient procedures are performed by the same practitioner on the same day, the practitioner will be reimbursed at 100 percent for the highest allowable payment for one procedure and 25 percent for the second-highest paying procedure, with no payment for additional procedures—including add-on codes.
- When two or more surgical inpatient or outpatient procedures are performed at the same facility on the same day, the facility will be reimbursed at 100% for the highest allowable payment for one procedure and no payments made for additional procedures.
- When two or more surgical procedures are performed and anesthesia is provided by the same anesthesiologist during the same period of hospitalization, the anesthesiologist will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures.
- Providers are directed to bill all anesthesia services performed by the same anesthesiologist during the same period of hospitalization on a single professional claim submission for anesthesia services. Providers are also instructed to list the anesthesia service with the highest fee on the first claim line and the anesthesia service with the next highest fee on the second claim line, etc. No payment will be made for additional anesthesia procedures provided during that surgical event, with the exception of codes 01967, 01968, and 01969.
- If 01967 alone is submitted, it will reimburse at 100 percent of rate.
    - If 01968 is submitted with 01967, both codes will reimburse at 100 percent of the rate.
    - If 01967 is submitted with 01969, both codes will reimburse at 100 percent of the rate.

Physical/Occupational and Speech Therapies

Members/Participants are entitled to 24 physical, 24 occupational, and 24 speech therapy outpatient visits within a calendar year. A prescription or order from the Member's/Participant's PCP is required for the initial visit to the therapist. Initial visits are not considered part of the 24 visits.

Once the Member/Participant exceeds the 24 visits of physical, occupational, and/or speech therapy, an authorization is required to continue services.

Therapy services may be billed on a UB-04 or CMS 1500 claim form or via 837 electronic format.

Termination of Pregnancy

First and second trimester terminations of pregnancy require prior authorization and are covered in the following two circumstances:

1. The Member's/Participant's life is endangered if she were to carry the pregnancy to term; or
2. The pregnancy is the result of an act of rape or incest.
    - Submit the physician's certification on the Pennsylvania Department of Human Services' Physician's Certification for an Abortion (MA 3 form). The form must be completed in accordance with the instructions and must accompany the claims for reimbursement. All claims and certification forms will be retained by the Plan. If the Member/Participant is under the age of 18, a Recipient Statement Form (MA368) must be completed and submitted.
    - Submit the Pennsylvania Department of Human Services' Physician's Certification for an Abortion (MA3) and the Pennsylvania Department of Human Services' Recipient Statement for an Abortion and Recipient Statement Form must be submitted in accordance with the instructions on the certification/form. The claim form, Physician's Certification for an Abortion, and Recipient Statement Form will be retained by the Plan.

Submit claims and all appropriate forms to:

AmeriHealth Caritas PA	**AmeriHealth Caritas PA CHC w/o Medicare**	**AmeriHealth Caritas PA CHC w/ Medicare**
Claims Processing Department	Claims Processing Department	Claims Processing Department
P.O. Box 7118	**P.O. Box 7110**	**P.O. Box 7143**
London, KY 40742	London, KY 40742	London, KY 40742

Most Common Claims Errors

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	"**Member/Participant name is missing or illegible**." (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"**Member/Participant date of birth (DOB) is missing**." (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	"**Member/Participant's sex is required**." (If no box is checked, the claim will be
4	Insured's Name	"**Insured's name missing or illegible**." (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address (number, street, city, state, zip) phone	"**Patient address is missing**." (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"**Patient relationship to insured is required**." (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address (number, street, city, state, zip) phone	"**Insured's address is missing.**" (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)." (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	**"Diagnosis code is missing or illegible."** (The claim will be rejected.)
24	Supplemental Information	**"National Drug Code (NDC) data is missing/ incomplete/invalid."** (The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.)
24A	Date of Service	**"Date of service (DOS) is missing or illegible."** (The claim will be rejected if both the" From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	**"Place of service is missing or illegible."** (Claim will be rejected.)
24D	Procedure, Services or Supplies	"**Procedure code is missing or illegible**." (Claim will be rejected.)
24E	Diagnosis Pointer	**"Diagnosis (DX) pointer is required on line ___" [lines 1-6].** (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	**"Line item charge amount is missing on line ___" [lines 1-6].** (If a value greater than or equal to zero is not present on each valid service line, claim will be

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
		rejected.)
24G	Days/Units	**"Days/units are required on line ___" [lines 1-6].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering provider identification	**"National provider identifier (NPI) of the servicing/ rendering provider is missing, or illegible."** (If NPI is missing or illegible, claim will be rejected.)
26	Patient Account/Control Number	**"Patient Account/Control number is missing or illegible"** (If missing or illegible, claim will reject)
27	Assignment Number	**"Assignment acceptance must be indicated on the claim."** (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	**"Total charge amount is required."** (If a value greater than or equal to zero is not present, the claim will be rejected.)
31	Signature of physician or supplier including degrees or credentials	**"Provider name is missing or illegible."** (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)
33	Billing Provider Information and Phone number	**"Billing provider name and/or address is missing or incomplete."** (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
33	Billing Provider Information and Phone number	**"Field 33 of the CMS1500 claim form requires the provider's physical service address."** (If a PO Box is present, the claim will be rejected.)

Notes: