Provider Claims and Billing Manual

for

AmeriHealth Caritas North Carolina

Updated February 17, 2025

Contents

Claim Filing

AmeriHealth Caritas North Carolina, hereafter referred to as the Plan (where appropriate), is required by the North Carolina and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

In accordance with 42 C.F.R. §438.602(b), health care providers (including ordering, prescribing, or referring only providers) interested in participating in the AmeriHealth Caritas North Carolina network must be screened and enrolled as a Medicaid provider by the North Carolina Department of Health and Human Services (NCDHHS) and shall be reenrolled every three years, except as otherwise specifically permitted by DHHS in the Revised and Restated RFP 30-190029-DHB, Section V. This applies to non-participating in and/or out of the State providers as well. Claims for all services provided to Plan members must be submitted by the provider who performed the services.

Submitting Claims

Electronic/EDI

Use the payer ID for AmeriHealth Caritas North Carolina: **81671.**

Paper/Mail

AmeriHealth Caritas North Carolina
Attn: Claims Processing Department
P.O. Box 7380
London, KY 40742-7380

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

- Verification that all required fields are completed, and all required information was provided.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of member eligibility for services under the Plan during the time in which services were provided.
- Verification that the services were provided by a participating provider or that an out-of-network provider has received authorization to provide services to the eligible member.
- Verification that a participating or out-of-network provider is enrolled in North Carolina's state Medicaid program.
- Verification that a provider is not excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act.
- Verification that a provider is not identified as excluded under any of the Exclusion Lists that the State requires AmeriHealth Caritas North Carolina to monitor.
- Verification that an authorization has been given for services that require prior authorization by AmeriHealth Caritas North Carolina.
- 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 AmeriHealth Caritas North Carolina.
- 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). When required data elements are missing or are invalid, claims will be rejected by the Plan for correction and re-submission.

Medical Claims

AmeriHealth Caritas North Carolina will notify the provider within eighteen (18) calendar days of receipt of the claim whether the claim is clean, or whether the claim will pend to request from the provider all additional information needed to process the claim. The Plan will pay or deny clean medical claims at the lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication. A pended claim will be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

Provider must submit an itemized bill with any claim type that will pay **greater than** the following amounts if paid as billed:

Claim Type	Threshold amount
Hospital Inpatient claims	$250,000
Hospital Outpatient claims	$75,000
Professional claims	$25,000

To simplify the submission process, ACNC has added functionality for network providers to submit electronic attachments (275 transactions) to support medical claims via a claim's clearinghouse. See more on our website here.

Once the claim and itemized bill are received, our medical claim review vendor, will conduct a prospective review and submit its findings to ACNC for claim adjudication. Your remittance advice will reflect any payment differences resulting from that review. If billing issues have been identified, our medical claim review vendor will send a facility packet, which includes the Forensic Review Report outlining review findings within **20** business days of the date of your remittance advice.

General questions regarding these prospective reviews should be directed to our medical claim review vendor on our website to discuss any inquiries you may have regarding the report's findings or the documentation and explanations necessary to clarify the charges in question.

Pharmacy Claims

AmeriHealth Caritas North Carolina will notify the provider within fourteen (14) calendar days of receipt of a pharmacy claim whether the claim is clean, or whether the claim will pend to request from the provider all additional information needed to process the claim. A pended pharmacy claim will be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.

If the requested additional information on a medical or pharmacy claim is not submitted within ninety (90) calendar days of the notice requesting the required additional information, AmeriHealth Caritas North Carolina may deny the claim.

Please consider the following definitions of clean, rejected, corrected, and denied claims.

Definition: A ***Clean claim*** is a claim for services submitted to a health plan by a Medicaid Managed Care medical or pharmacy service provider which can be processed without obtaining additional information from the submitter to adjudicate the claim.

Definition: ***Rejected claims*** are those returned to provider or EDI source without being processed or adjudicated, due to a billing issue and defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 365 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

- Rejected paper claims have a letter attached with a document control number (DCN).
- A DCN is **not** an AmeriHealth Caritas North Carolina claim number. Rebilling of a rejected claim should be done as an original claim.
- Since rejected claims are considered original claims the timely filing limits should be followed.

Definition: ***Denied claims*** are those that were processed in the claims system. They may have a payment attached or may have been denied. A corrected claim (see below) may be submitted to have the claim reprocessed.

Definition: ***Corrected claim*** is defined as a claim that ACNC paid based on the information submitted but the provider submits a claim correcting the original data. A corrected claim must be submitted within 365 days of the original date of service. The original claim number must be submitted as indicated below as well as the correct Frequency Code.

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 365 calendar days from the date services were rendered (or the date of discharge for inpatient admissions) 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 data.

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

Exceptions

Unless otherwise agreed to by the PHP and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

Claims with Explanation of Benefits (EOBs) from primary insurers, including Medicare, must be submitted within 180 Calendar days of the date of the primary insurer's EOB.

In the event of an accidental injury (personal or automobile) where a third-party payer is deemed to have liability and makes payment for services that have been considered and paid under AmeriHealth Caritas North Carolina contract, the Plan will be entitled to recover any funds up to the amount owed by the third-party payer.

While this is a requirement in most cases, there are exceptions when providers are not required to bill the third party prior to AmeriHealth Caritas North Carolina. The exceptions are claims related to:

- Preventive pediatric services (including EPSDT) that are covered by the Medicaid program.
- Vocational Rehabilitation Services
- Division of Service for the Blind
- Division of Public Health "Purchase of Care" Program
- Sickle cell program
- Crime Victims Compensation Fund
- Parts B and C of the Individuals with Disabilities Education Act (IDEA)
- Ryan White Program
- Indian Health Services
- Veteran's Benefits for state nursing home per diem payments
- Veteran's Benefits, for emergency treatment provided to certain Veterans in a non- Veteran's Affairs (VA) facility.
- Women, Infants and Children Program
- Older Americans Act Programs
- World Trade Center Health Program
- Grantees under Title V of the Social Security Act (Maternal and Child Block Grant)

Following reimbursement to the provider in these cost avoidance exception cases, AmeriHealth Caritas North Carolina shall actively seek reimbursement from responsible third parties and will adjust claims accordingly.

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 data.

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

Claims **originally rejected for missing or invalid data elements** must be corrected and **submitted as a new claim within 365 calendar days from the date of service**. Rejected claims are not registered as received in the claim processing system.

Corrected Claims

A corrected claim must be submitted within 365 days of the original date of service. The original claim number must be submitted, as indicated below, as well as the correct Frequency Code.

- You can find the original claim number from the 835 ERA, the paper Remittance Advice or from the claim status search in NaviNet.
- **If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to determine the claim number.**

Corrected/replacement and voided claims may be sent electronically or on paper.

- If sent electronically, the ***claim Frequency Code*** (found in the **2300 Claim Loop** in the field **CLM05-3** of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values '**7**' for the Replacement (correction) of a prior claim and '**8**' for the void of a prior claim. The value '**6**' should not be sent.
- In addition, the submitter must also provide the original Plan claim number in ***Payer Claim Control Number*** (found in the **2300 Claim Loop** in the **REF*F8** segment of the HIPAA Implementation Guide for 837 Claim Files).

Claim Inquiries

Providers may file an inquiry about claims no later than 365 days from the date of service or 60 calendar days after the payment, denial, or recoupment of a timely claim submission, whichever is latest. Inquiries are questions from providers regarding how a claim was processed. Inquiries can be submitted via phone, online or written correspondence. An inquiry may or may not result in a change in the payment.

If a provider does not receive payment for a claim within 45 days or has concerns regarding any claim issue, claims status information is available by:

- Visiting the NaviNet provider website, our secure provider portal. Log on to www.navinet.navimedix.com for web-based solutions for electronic transactions and information.
- You may open a claims investigation via NaviNet with the claim's adjustment inquiry function.
- Calling Provider Services at 1-888-738-0004 and following the prompts.
- Calling your Account Executive for assistance.

Provider Appeals

Provider appeals must be submitted in writing to the appropriate address below. Provider appeals may also be submitted through the provider portal in the "*Provider Grievance and Appeals*" section of the Plan's website.

Provider Appeals Department
AmeriHealth Caritas North Carolina
P.O. Box 7379
London, KY 40742-7379

AmeriHealth Caritas North Carolina will acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request. Please refer to the *Provider Manual* for complete instructions on submitting appeals.

Refunds for Claims Overpayments or Errors

The Plan and the North Carolina Department of Health and Human Services (DHHS) encourage providers to conduct regular self-audits to ensure accurate payment.

Medicaid program funds that were improperly paid or overpaid must be returned within 60 Calendar Days of the overpayment. 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 DHHS protocols for returning improper payments or overpayment.

Contact Provider Claim Services at 1-888-738-0004 to arrange the repayment. There are two ways to return overpayments to the Plan:

1. Have the Plan deduct the overpayment/improper payment amount from future claims payments.

2. Submit a check for the overpayment/improper amount directly to:

    AmeriHealth Caritas North Carolina
    Attn: Claims Processing Department
    P.O. Box 7380
    London, KY 40742-7380

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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.

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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

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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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 365 days from the date of service**.

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

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
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 I.D. Number**	Health Plan's member identification (ID) number is preferred; however, member's NC Medicaid or NC Health Choice ID numbers will be accepted. If submitting a claim for a newborn that does not have an ID number, enter the mother's ID number. Enter the member's ID number exactly as it appears on their plan-issued or state-issued ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan I.D. card. If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Refer to page 75 for additional newborn billing information, including Multiple Births.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
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 I.D. 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,**	If same as the patient, enter "Same". Otherwise, enter insured's information.	C	2010BA	N301 N302	Titled Subscriber

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
	State, Zip+4 Code) Telephone (Include Area Code)				N401 N402 N403	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 Policy Or Group #**	**Required** if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P.
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.

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				**X12 837P Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
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 c) Other Accident	R	2300	CLM11	Titled related causes code in 873P.
10d	**Claim Codes (Designated by NUCC)**	To comply with DHS' EPSDT reporting requirements, continue to use this field to report EPSDT referral codes as follows: YD – Dental (Required for Age 3 and above) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical For all other claims enter new Condition Codes as appropriate. Available 2-digit Condition Codes include 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	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.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		• W3 – Level 1 Appeal				Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows: 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.
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	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		Enter qualifier to the left of the vertical, dotted line, identifier to the right of the vertical, dotted line.				
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.
11d	**Is There Another Health Benefit Plan?**	Y or N by check box. If yes, complete # 9 a-d.	R	2320		If yes, indicate Y for yes. Presence of Loop 2320 indicates Y (yes) to the question on 837P.
12	**Patient's Or Authorized Person's Signature**	On the 837, the following values are addressed as follows at the PHP's 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

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		• 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy.				Date – Last Menstrual Period
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	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

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
						Date of First Contact If Patient Has Had Same or Similar Illness does not exist in 837P.
16	**Dates Patient Unable To Work In Current Occupation**		C	2300	DTP01 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's primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Qualifiers include: • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM 101 NM103 NM104 NM105 NM107	

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
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 Identifier, 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	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	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 in- patient. **MMDDYY** (indicate **from** and **to** date)	C	2300	DPT01 DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P.

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				**X12 837P Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
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. The NUCC defines the following qualifiers: • G2 Provider Commercial Number • ZZ Provider Taxonomy (ZZ Qualifier should be used for paper claims **ONLY)** 1. Provider shall populate Box 19 on the CMS1500 form with the Locum Tenens NPI number as follows: LTNPI#XXXXXXXXXX replacing the X with the provider NPI number. The NPI number contained in Box 19 must be different than the NPI number in Box 24j 2. Box 19 shall contain the Locum Tenens Provider's NPI number and will be listed as the following: LTNPI#XXXXXXXXXX replacing the X with the provider NPI number 3. Map box 19 of the CMS1500 form to	Required	2300 2310 (Rendering Provider Taxonomy)	NTE PWK PRV03	

		2300/NTE01 in the following format: LTNPI#XXXXXXXXXX replacing the X with the NPI number as sent in Box 19, such as LTNPI#1231231230 There is to be no spaces in this format				
20	**Outside Lab**		C	2400	PS102	

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
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. "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 Clinical Laboratory Improvement Amendment Number (CLIA Number) in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field	
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Segment**	**Notes**
24A	**Date(s) Of Service**	"From" date: MMDDYY. If the service was performed on one day leave "To" blank or re-enter "From" Date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R	DTP01 DTP03	Titled Service Date in 837P.
24B	**Place Of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	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	SV109	Titled Emergency Indicator in 837P.
24 D	**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 DME W Codes: • Box 24d shaded portion shall contain a Local NC Code that will begin with a W and have 4 digits following. • State W codes with the additional procedure description shall be sent on the CMS1500 form	R	SV101 (2- 6) DME W Codes Shaded Portion Data Should go to SV101-7 837P Loop 2400 Professional Service (SV1) Segment Example: **SV1✻HC:E1399:25:::W4001✻12.25✻UN✻1✻11✻✻1:2:3✻✻Y~** 837P Loop 2400 additional information Note (NTE) Segment Example: **NTE✻ADD✻ADDITIONAL NON DESCRIPT PROCEDURE DESCRIPTION UP TO 80 character/bytes~** **Below is a breakdown on the 7 components for the highlighted SV101 element from the above example:** **SV101-1:** Provider/Service ID Qualifier = HC (Health Care Financing Administration Common Procedural Coding System (HCPCS) Code) **SV101-2:** Product/Service ID =E1399 (HCPCS code used for example only) **SV101-3:** Procedure Modifier = 25 (Modifier used for example only) **SV101-4, SV101-5 and SV101-6:** Procedure Modifier- additional modifier components were not used in the example and represented by three colons (:) **SV101-7**: Description = W4001 (Local W Code used for example only)	Titled Product/Service ID and Procedure Modifier in 837P.

		in box 24d in the shaded area, above the National Procedure Code • National Procedure Codes are defined by ICD-10		**NTE: NTE✻ADD✻ADDITIONAL NON DESCRIPT PROCEDURE DESCRIPTION UP TO 80 character/bytes~:**	

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		Locum Tenens: • Provider shall populate the Q6 modifier with the Procedure Code in the CMS1500 form Box 24d any time a Locum Tenens provider is used. • Box 24d shall be populated with Procedure Code Modifiers in any one of the 4 modifier position. • Map all qualifiers present in 24d to the SV101-3 to SV1016 including the Q6 modifier as received.				
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.	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.

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
24H	**EPSDT 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 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	C	2300 2400	CRC SV111 SV112	
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. G2 Provider Commercial 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	REF01 NM108	Titled Reference Identification Qualifier in 837P. XX required for NPI 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 Taxonomy in shaded area. • ZZ Provider Taxonomy	R	2310B	REF02 PRV03	The PHP's Clearinghouse will pass this ID on the claim when present.

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		• ZZ Qualifier should be used for paper claims **ONLY.** Box 19 can also be used for sending Rendering Provider taxonomy. Enter the NPI number in the unshaded area of the field. Use qualifier.				NPI
25	**Federal Tax I.D. 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
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.

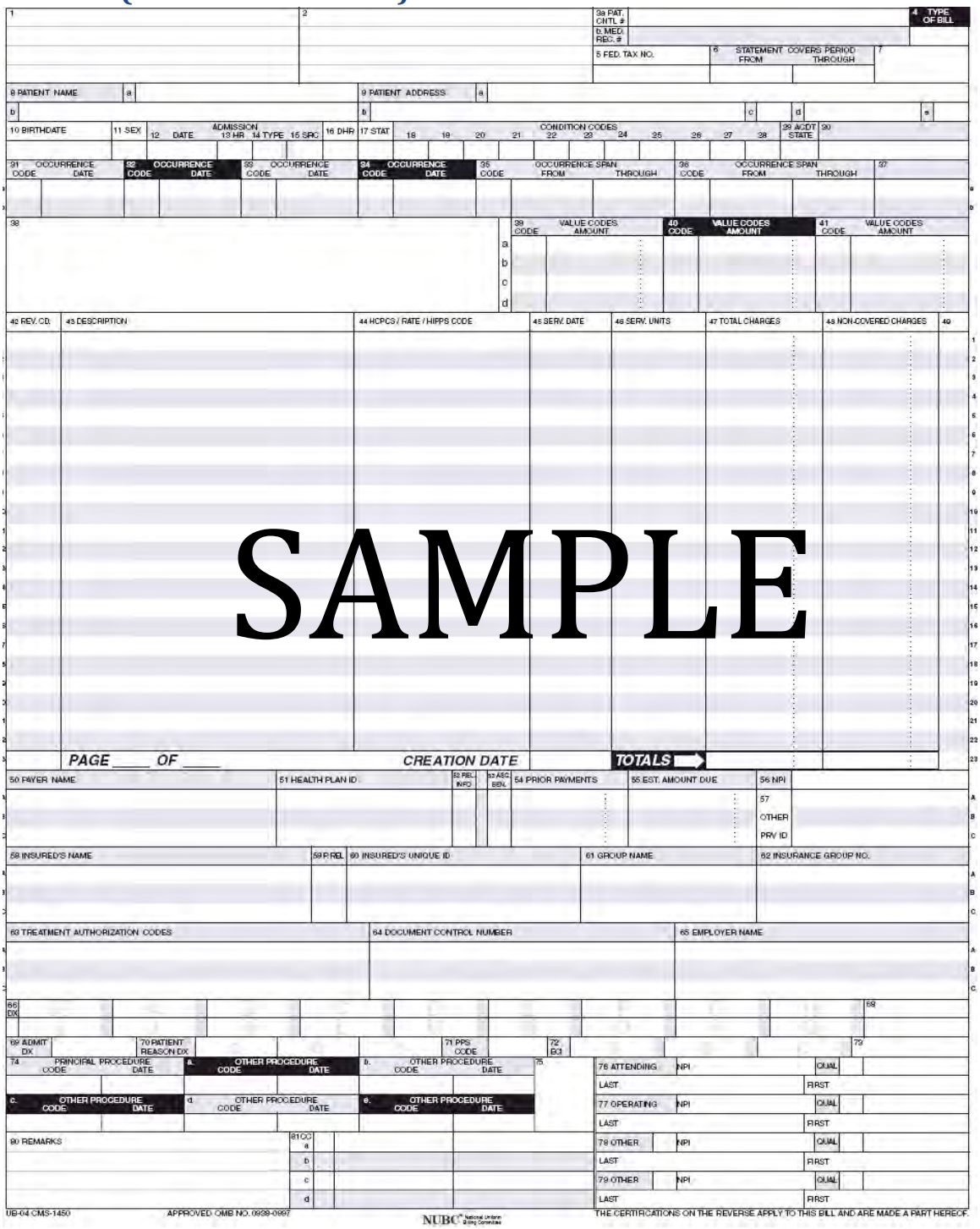
CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				**X12 837P Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment 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 # is 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.

CMS-1500 Claim Form						
Paper Claim – CMS-1500 Field				**X12 837P Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
32b.	**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 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.	C Recommended	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility 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.	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.

CMS-1500 Claim Form

Paper Claim – CMS-1500 Field				X12 837P Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
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: OB State License Number G2 Provider Commercial Number **ZZ Provider Taxonomy** ZZ Qualifier should be used for paper claims **ONLY.** **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 R	2000A 2010BB	PRV03 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			
Paper Claim – UB 04 Field					X12 837I Claim Field		
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** Left justified. Line a: Enter the complete provider's name. Line b: Enter the complete address. Line c: City, State, and Zip code + 4 Lined: Enter the area code, telephone number.	R	R	2010 AA	NM1/ 85 N3 N4	
2	**Unlabeled Field** **NUBC – Pay-to Name and Address**	**Enter Remit Address. No PO Boxes** Enter the Facility Provider I.D. 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

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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 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.	R	R	2300	CLM05	If Adjustment or Replacement or Void 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.

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010 AA	REF02 Where REF01 = EI	Pay to provider = Billing Provider use 2010AA Billing Provider Tax ID
6	**Statement Covers Period From/Through**	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 Where DTP01= 434	MMDDCCYY 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 NM10 1 = IL NM109 Where NM10 1 = QC	Patient =Subscriber Use 2010BA Subscriber ID Patient is not =Subscriber, Use 2010CA Patient ID
8b	**Patient Name**	Patient name is required. Last name, first name, and middle initial.	R	R	2010 BA	NM103, NM104, NM107 Where NM101= IL	Patient =Subscriber Use 2010BA Subscriber Name

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		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.			2010 CA	NM103, NM104, NM107 where NM101 = QC	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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		Newborns and Multiple Births: If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Refer to page 75 for additional newborn billing information, including Multiple Births.					
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

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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 services, this is the date of admission. Right-justified	R	R	2300	DTP03 where DTP01= 43 5	Required on inpatient.
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 DTP01= 43 5	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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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= 09 6	
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6.	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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
18 - 28	**Condition Codes** **The following is unique to Medicare eligible Nursing Facilities.** **Condition codes should be billed when Medicare Part A does not cover Nursing Facility 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 stays.	C	C	2300	HIXX-2 Where XX = 01,02,03, 04,05,06, 07,08,09, 10,11,12	HIXX-1=BG Condition info

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		• The resident was not transferred within 30 days of a hospital discharge. • The resident's 100 benefit days are exhausted. • There was no 60-day break in daily skilled care. • Medical Necessity Requirements are not met. • Daily skilled care requirements are not met. All other fields must be completed as per the appropriate billing guide.					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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	Reserved for future use
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 YYYYMMDD 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 = BH
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 M0Z9. 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

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
37a,b	**EPSDT Referral Code**	**Required** when applicable. Enter the applicable 2- character EPSDT Referral Code for referrals. made or needed as a result of the screen. YD – Dental *(Required for Age 3 and Above) YO – Other YV – Vision YH – Hearing YB – Behavioral YM – medical	C C C C C C C	C C C C C 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 follows: NTE*ADD*EPSDT=YD_YM_YO~ Use NTE with HIPAA Compliant codes.

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
38	**Responsible Party Name and Address**	The name and address of the party responsible for the bill.	C	C	N/A	N/A	N/A
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.**	C	C	2300	HIX X-2 HIX X-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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		Please see NUCC Specifications Manual Instructions for value codes and descriptions. **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.					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
42	**Rev. Cd.**	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. **Hospital:** Enter the rev code that corresponds to the rev description in field 43. Refer to NUBC for valid rev codes. The last entry on the claim detail lines should be 0001 for total charges. **PPED:** use the rev code that appears on the approved prior authorization letter for covered services. **LTC state facility:** use rev code 0100 for room and board, plus ancillary	R	R	2400	SV201	Revenue Code

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		LTC non-state/assisted living: use rev code 0101 for room and board, without ancillary. Use appropriate rev code for covered ancillary service. **Leave of Absence codes: LTC – state and non-state facilities:** use LOA rev codes 0183, 0185 and 0189 as appropriate. **Assisted Living Facilities:** use only 0189 as a LOA code, no payment is made for days billed with rev code 0189. Use for any days when patient is out of the facility for the entire day.					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
43	**Revenue Description**	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category. Use this field to enter NDC information. Refer to supplemental information section.	R	R	N/A	N/A	Not mapped in 837I
44	**HCPCS/ Accommodation Rates/HIPPS Rate Codes**	1. The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills. 2. The accommo-dation rate for inpatient bills	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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristic s (or case-mix groups) on which payment determinations are made under several prospective payment systems. Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all Outpatient Claims. (Note: NDC numbers are required for all administered or supplied drugs.)					

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
45	**Serv. Date**	Report line item dates of service for each revenue code or HCPCS/HIPPS code. Multiple- day service codes require an RR modifier.	R	R	2400	DTP03 where DTP01= 47 2	Date of Service
46	**Serv. Units**	Report units of service. A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, 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.	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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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 actual charged amount.	R	R	2300	SV203	Total Charges
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

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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	SBR NM103 where NM101=PR SBR NM103 where NM101=PR	Subscriber Information Payer Name Other Subscriber Information Other Payer Name
51	**Health Plan Identification Number**	The number used by the health plan to identify itself.	R	R	2010 BB 2330 B	NM109 where NM101=PR 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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
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 have 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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
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.	C	C	2300	AMT02 where AMT01 =EAF	Payment Estimated Amount Due

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
56	**National Provider Identifier Billing Provider**	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. **Required** if the health care provider is a Covered Entity as defined in HIPAA Regulations.	R	R	2010 AA	NM109 where NM101 = 85	NPI
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. Use Modifier G2 if using health plan legacy ID.	C	C	2010 AA 2010 BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U	Tax ID Only sent if need to determine the Plan ID Legacy ID

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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 insured is indicated here.	R	R	2010 BA 2330 A	NM103, NM104, NM105 where NM101 = IL NM103, NM104, NM105 where NM101 = IL	Use 2010BA is insured is subscriber Other Insured Name
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

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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 online 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. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000 B	SBR04	Subscriber Group Name

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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. **New field.** The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained	C	C	2300	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			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		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, secondary; and C, tertiary.	C	C	2320	SBR04	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. **Note:** Claims with invalid codes will be denied for payment.	Not Required	Not Required	N/A	N/A	Not Required
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 = BK or ABK	Principal Diagnosis POA

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
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 and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	C	C	2300	HIXX-2 HIXX-9 Where HI01-1 = BF or ABF	Other Diagnosis Information
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.	R	R	2300	HI01-2 Where HI01-1= BJ or ABJ	Admitting diagnosis

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional ***	**Required or Conditional ***	**Loop**	**Segment**	**Notes**
70	**Patient's Reason for Visit**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2 HI01-1= APR Where XX = 01,02,03	Patient Reason for visit
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

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional ***	**Loop**	**Segment**	**Notes**
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 "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	C	C	2300	HIXX-2 Where HIXX-1 = BN or ABN	External Cause of Injury
73	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not Mapped
74	**Principal Procedure code and Date**	The appropriate ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corresponding date.	C	C	2300	HI012 HI01- 4 Where HI01-1 = BR or BBR	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		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			
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 code) on which the procedures were performed.	C	C	2300	HIXX-2 Where HI01-1 = BQ or BBQ	Other Procedure Information

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		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 attending physician has	R	R	2310A 2310A 2310A	NM103 where NM101 =7 1 NM104 where NM101= 71 REF02	REF01G2

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
		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** *Qualifier should be used for paper claims **ONLY***			2301 A 2310A	Where REF01 = G2 PRV01 PRV03	Attending Provider Taxonomy

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Paper Claim – UB 04 Field					**X12 837I Claim Field**		
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***	**Loop**	**Segment**	**Notes**
77	**Operating Physician Name and Identifiers – NPI#/Qualifier/ Other ID#**	**Enter the** NPI of the physician who performed the surgery on the patient in the upper line, and their name in the lower line, 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. **Required when** a surgical procedure code is listed.	**C** R	**C** R	2310B 2310B	NM103 where NM101= 7 2 NM104 where NM101= 72 REF02 Where REF01 = G2	

UB-04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X,32X	Outpatient, Bill Types 13X, 3X, 33X 83X			
Paper Claim – UB 04 Field					X12 837I Claim Field		
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 2310 C 2310 C	NM103 where NM101 =Z Z NM104 where NM101 = llll REF02 Where REF01 = G2	
80	**Remarks Field**	Area to capture additional information necessary to adjudicate the claim.	C	C	2300	NTE02 Where NTE01= ADD	Billing Note
81CC, a-d	**Code-Code Field**	To report additional 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	R	R	2000 A	PRV 01 PRV 03	Billing Provider Taxonomy

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

I. General Information

A. CMS 1500 Paper Claims – Field 24:

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 EPSDT, Anesthesia Minutes, and corrected claims may be sent in Notes (NTE). 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. Note: AmeriHealth Caritas North Carolina EDI Payer ID#: **81671**.

E. 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

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

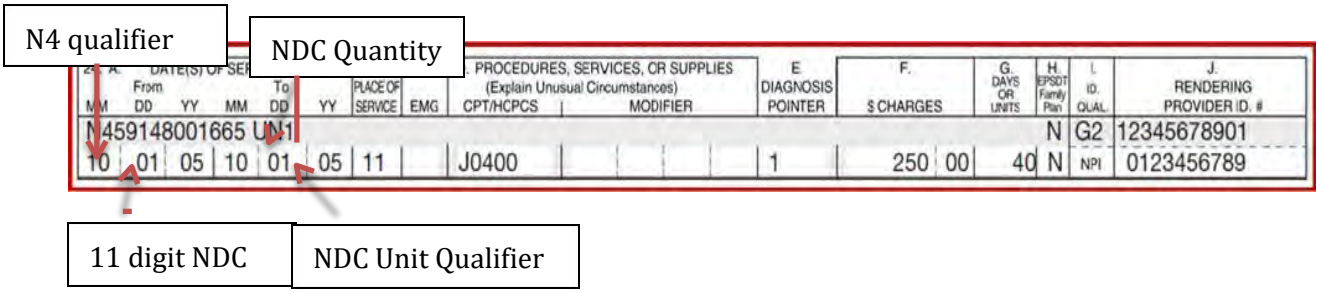
1. NDC on CMS 1500

- 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.
- o Do not enter spaces
- o Enter the 11 character NDC number in the 5-4-2 format (no hyphens).
- o 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
  - ME Milligram

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.

4. 340B Drugs

The 340B Drug Pricing Program was enacted under the Veterans Health Care Act of 1992, or Section 340B of the Public Health Service Act. Under this program, providers may acquire drugs at significantly discounted rates. Because of the discounted rates, these drugs are not eligible for the Medicaid Drug Rebate Program. AmeriHealth Caritas North Carolina and the North Carolina Medicaid Program are obligated to ensure that rebates are not claimed on 340B drugs.

It is important for providers to identify 340B drugs dispensed in outpatient or clinic settings by using the UD modifier on the CMS-1500/837 Professional and the UB04/837 Institutional claims forms, associated with the applicable HCPCS code and NDC. The UD modifier is to be used only in this circumstance. All non-340B drugs are billed using the applicable HCPCS and NDC pair without a modifier.

CMS-1500/837 Professional Claims:

To identify outpatient hospital and physician-administered claims submitted for drugs purchased through the 340B program, please use UD in the "Modifier" field following input of the HCPCS code.

UB-04/837 Institutional Claims:

When reporting 340B-qualified NDCs, use Form Locator 44, skip one space and input the HCPCS Level II code followed by the UD modifier.

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

AmeriHealth Caritas North Carolina will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions. For general information about, and definitions of, PPCs, please refer to the "Quality Assessment and Performance Improvement Program" section of the *Provider Manual*.

The category of Health Care Acquired Conditions (HCAC) applies to Medicaid inpatient hospital settings only. Under this category, the Plan does not reimburse providers for procedures when any of the following conditions are not present upon admission in an inpatient setting, but subsequently acquired in that setting:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Catheter Associated Urinary Tract Infection
- Pressure Ulcers (Decubitus Ulcers)
- Vascular Catheter Associated Infection
- Mediastinitis after Coronary Artery Bypass Graft (CABG)
- Hospital Acquired Injuries (fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes)
- Manifestations of Poor Glycemic Control
- Surgical Site Infection Following Certain Orthopedic Procedures
- Surgical Site Infection Following Bariatric Surgery for Obesity
- Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures Except for Pediatric and Obstetric Populations

The category of Other Provider-Preventable Conditions (OPPC) includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs. Under this category, the Plan will not reimburse providers for any of the following events in any inpatient or outpatient setting:

- Surgery Performed on the Wrong Body Part
- Surgery Performed on the Wrong Patient
- Wrong Surgical Procedure Performed on a Patient

Mandatory Reporting of Provider Preventable Conditions

In addition to broadening the definition of PPCs, the ACA requires payers to make pre- payment adjustments. **Therefore, a PPC must be reported by the provider at the time a claim is submitted.** Note that this requirement applies even if the provider does not intend to submit a claim for reimbursement for the service(s) rendered.

Under specific circumstances, the PPC adjustment is not applied or is minimized. For example:

- No payment reduction is imposed if the condition defined as a PPC for a particular member existed prior to the initiation of treatment for that member by the provider. This situation may be reported on the claim with a "Present on Admission" indicator.
- Payment reductions may be limited to the extent that the identified PPC would otherwise result in an increase in payment; the Plan will reasonably isolate the portion of payment directly related to the PPC and identify that portion for nonpayment.

For Professional Claims (CMS-1500)

- 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.
- Report the E diagnosis codes, such as E876.5, E876.6 or E876.7 in field 21 [and/or] field 24E.

For Facility Claims (UB-04 or 837I)

When submitting a claim which includes treatment required as a result of a PPC, inpatient and outpatient facility providers are to include the appropriate ICD-10 (or successor) diagnosis codes, including applicable external cause of injury or E codes on the claim in field 67 A – Q. Examples of ICD-10 and "E" diagnosis codes include:

- Wrong surgery on correct patient E876.5;
- Surgery on the wrong patient, E876.6;
- Surgery on wrong site E876.7
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

Inpatient Claims

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.

For per-diem or percent-of-charge based hospital contracts, claims including a PPC must be submitted via the paper claims process with the member's medical record. These claims will be reviewed against the medical record and payment will be adjusted accordingly.

Claims with PPC will be denied if the medical record is not submitted concurrent with the claim.

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

Indicating Present on Admission (POA)

If a condition described as a PPC leads to a hospitalization, the hospital should include the "Present on Admission" (POA) indicator on the claim submitted for payment. Report the applicable POA Indicator in the shaded portion of field 67 A – Q. DRG- based facilities may submit POA via 837I in loop 2300; segment NTE, data element NTE02.

Valid POA Indicators Include:

- "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 "null" = Exempt from POA reporting.

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.

EPSDT Information Missing or Incomplete – The Plan requires EPSDT screening claims to be submitted by mail using the CMS 1500 Federal claim form, the Universal Billing form (UB-04), or electronically using the HIPAA compliant 837 Professional Claims (837P) transaction or the Institutional Claims (837I) transaction.

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 not accepted. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity.

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 typed in black ink, 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 Name Missing – The name of the member must be present on the claim form and must match the information on file with the Plan.

Member 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 Date of Birth does not match Member 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.

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.

Process for Ordering, Rendering, Prescribing (ORP) Provider Claims -To reimburse for services or medical supplies resulting from a practitioner's order, prescription, or referral, the ordering, prescribing, or referring (ORP) provider must be enrolled in the North Carolina's Medicaid program.

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 24J. (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.

AmeriHealth Caritas of NC reviews Third Party Liability (TPL/COB) information on a routine basis. Providers must report primary payments and denials to AmeriHealth Caritas of NC to avoid rejected claims. A provider who has been paid by AmeriHealth Caritas of NC and subsequently receives reimbursement from a third party must repay AmeriHealth Caritas of NC the difference between the primary carrier's contractual obligation and the patient liability.

For TPL Validation:

PROVIDER SERVICES CONTACTS

1-888-738-0004 (TTY 1-866-209-6421) • Member eligibility checking and claims status inquiry.

Eligibility and Benefits Inquiry

NaviNet: 1-888-482-8057 Log on to www.navinet.com for web-based solutions for electronic transactions and information.

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.
- 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.
- EPSDT services may be submitted electronically or on paper.
- Submitting the original copy of the claim form will assist in assuring claim information is legible.
- 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.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims.
- 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.

Electronic Data Interchange (EDI), often referred to as a clearing house 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. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

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.

To verify satisfactory receipt and acceptance of submitted records, please review both the ACNC claims clearinghouse. Acceptance report, and the R059 Plan Claim Status Report.

Electronic Claims Submission (EDI)

Electronic Claims

AmeriHealth Caritas North Carolina participates with the claims clearinghouse(s) listed on our website. As long as you have the capability to send EDI claims to our claims clearinghouse, whether through direct submission or through another clearinghouse/vendor, you may submit claims electronically. Electronic claim submissions to AmeriHealth Caritas North Carolina should follow the same process as other electronic commercial submissions.

To initiate electronic claims:

- Contact your practice management software vendor or EDI software vendor.
- Inform your vendor of AmeriHealth Caritas North Carolina's EDI Payer ID#: **81671**.

AmeriHealth Caritas North Carolina does not require ~~CHC~~ clearinghouse payer enrollment to submit EDI claims.

Any additional questions may be directed to the AmeriHealth Caritas North Carolina EDI Technical Support Hotline by calling 1-833-885-2262 and selecting the appropriate prompts or by emailing to edi.acnc@amerihealthcaritasnc.com.

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. If you have the capability to send EDI claims to our claims clearinghouse, whether through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

Contracting with a Claims Clearinghouse and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have claims clearinghouse EDI capabilities, you can contact the clearinghouse via the phone numbers provided on our website. You may also choose to contract with another EDI clearinghouse or vendor who already has-clearinghouse 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 our claims 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.

Contact EDI Technical Support by calling 1-833-885-2262 or by email at edi.acnc@amerihealthcaritasnc.com.

Providers using clearinghouses and vendors are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments. **The Payer ID for AmeriHealth Caritas North Carolina is 81671.**

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. 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 the Plan's clearinghouse. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once our claims clearinghouse receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits. Claims not meeting the requirements are immediately rejected and sent back to the sender via a claims clearinghouse error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or claims clearinghouse.

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

Claims forwarded to the Plan by our claims clearinghouse are immediately validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to the Plan's 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 data.**

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

Because our claims clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by to the Plan's 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 **clearinghouse via the contact information on our website.**

If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support at 1-833-885-2262 or by emailing edi.acnc@amerihealthcaritasnc.com.

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

Our claims 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 using to the Plan's clearinghouse clearinghouses and vendors 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 at the claims clearinghouse.

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

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.

Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI software vendor or to the Plan's clearinghouse to verify you receive the reports necessary to obtain this information. For support, view our **website**

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass our claims 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 submitted as a new claim within the required filing deadline of 365 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from our claims clearinghouse or your EDI software vendor 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.

Important: Provider NPI number validation is not performed at our claims clearinghouse. Our claims 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 full 9-character ZIP code + 4 is used.
3. If no service location is available, include the billing address full 9-character ZIP code + 4 will be used.
4. If no single match is found, the required Taxonomy is used.
5. If no single match is found, the claim is sent to the Invalid Provider queue (IPQ) for processing.
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 to have your claim processed effectively.

EDI 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 to the Plan's clearinghouse or providers sending to Vendors that are not transmitting (through our claims clearinghouse) NCPDP Claims

Common EDI Rejections

Invalid Electronic Claim Records – Common Rejections from our claims clearinghouse
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 numbers
Claims in which the date of birth submitted does not match the member ID.
Claims without Billing Taxonomy IDs, Attending Taxonomy IDs, Rendering Taxonomy IDs

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 numbers
Claims received with invalid member date of birth

Electronic Billing Inquiries

Action	Contact
If you would like to transmit claims electronically…	Contact to the Plan's clearinghouse on the website.
If you have general EDI questions …	Contact EDI Technical Support at: 1-833-885-2262 Or via email: edi.acnc@amerihealthcaritasnc.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports…	Contact your EDI Software Vendor or call our claims clearinghouse via the contact information on our website.
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	Contact Provider Claim Services at 1-888-738-0004.
If you have questions about claims that are reported on the Remittance Advice….	Contact Provider Claim Services at 1-888-738-0004.
If you need to know your provider NPI number…	Contact Provider Claim Services at 1-888-738-0004.
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…	Please Contact Provider Services at 1-888-738-0004.
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 or open a claims investigation for submitted claims on NaviNet at www.navinet.net via the claims adjustment inquiry function.
Sign up for NaviNet	www.navinet.net NaviNet Customer Service: 1-888-482-8057.

Best Practices for Submitting Corrected Claims

The corrected claims process begins when you receive a remittance advice from AmeriHealth Caritas North Carolina detailing the claims processing results.

A corrected claim should only be submitted for a claim that has already paid and you need to correct information on the original submission.

EDI is the preferred method for submitting corrected claims due to its speed, versatility and accuracy. For convenience, the instructions for submitting paper claims are also included at the end of this section.

	File a New Claim When….		File a Corrected Claim When…
1	The claim was never previously billed	1	You received a full or partial payment on a claim, but you identified that information must be corrected (some examples: billed wrong # of units, missing claim line, updates to charge amounts, adding a modifier)
2	No payment was received - If the entire claim allows zero dollars, make the appropriate changes and resubmit as a new claim. Do not submit as a corrected claim.	2	You submitted a claim for the wrong member. Submit a Frequency Code 8 and request a void of the original submission
3	Receive a rejection letter to a paper claim indicating invalid or required missing data elements, such as the provider tax identification number or member ID number.		
4	Received a rejection notice at your electronic claim clearinghouse (277CA) indicating invalid or missing a required data element.		
5	The original claim denied for primary carrier EOB and now you have the primary carrier EOB.		
6	The claim denied for eligibility and now the eligibility has been updated and the member has active coverage.		

Adhering to the following claims filing best practices may reduce duplicate service denials and other unexpected processing results:

1. Submit all services on the corrected claim that were on the original claim plus the corrected information. This includes services that may have already paid on the original claim submission. The corrected claim will replace all of the information on the original claim. As an example, the original claim had two lines; the correction was to add a third line. Submit all three lines not just the third line you are attempting to add.

2. Do not submit corrected services from multiple claims on one corrected claim.

3. Do not submit a corrected claim if additional information is requested, such as medical records, UNLESS a change is made to the original claim submission.

4. When changing a member ID number for a processed claim: Submit a voided claim (frequency 8) canceling charges for the original claim AND submit a new claim with the correct member ID number.

5. Always provide the appropriate original claim number associated with the corrected claim.

6. Apply the appropriate Frequency Code in the defined location of the 1500/UB claim form.

7. Handwriting or stamping the words “corrected, resubmitted or voided” on the paper claim will cause the claim to be rejected.

Corrected claim instruction table:

1a: Submit Corrected Claim After receiving an 835 showing claim was paid or Denied				
	EDI 1500	**Paper 1500**	**EDI UB**	**Paper UB**
Use frequency 7 for replacing a claim	2300, CLM05-3=7	Field 22, 1st character=7	2300, CLM05-3=7	Field 8, 4th character=7
Use Frequency 8 to void or cancel a prior claim	2300, CLM05-3=8	Field 22, 1st character=8	2300, CLM05-3=8	Field 8, 4th character=8
Always Submit the Original Claim Number	2300, REF01= F8 and REF02= the original claim number from the 835	Field 22, characters 2-13	2320, REF01=F8 and REF02= original claim number from the 835	Field 64, characters 1-12.
1b: Submit (Re-Submit) A Claim After receiving an 835 showing claim was Rejected				
	Address the rejection reason(s) and re-submit the claim using the same Frequency Code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.	Address the rejection reason(s) and re-submit the claim using the same frequency code originally submitted.

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

*Corrected claims are resubmissions of an existing 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. The successful submission of a corrected claim will cause the retraction and complete replacement of the original claim.

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" to void a prior claim
- ✓ Include the original claim number in loop 2300, 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.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.
- ✓ **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

Providers using electronic data interchange (EDI) or a clearing house can submit "Institutional" corrected claims electronically rather than via paper to the Plan.

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" to void a prior claim
- ✓ Include the original claim number in Loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected. ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.
- ✓ **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 support by calling 1-833-885-2262 or emailing to edi.acnc@amerihealthcaritasnc.com. Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims. You may open a claims investigation via NaviNet with the claim's adjustment inquiry function.

Providers can submit "Professional" corrected claims on the 1500 paper form.

Requirements for corrected claims using the 1500 paper form:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Place the number in the "Submission Code" section of the field.
- ✓ Include the original claim number in "Original Ref. No." section of the field with no dashes or spaces.
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied).
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.
- ✓ **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

Providers can submit "Institutional" corrected claims on the UB-04 paper form.

Requirements for corrected claims using the UB-04 paper form:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Include the original claim number in field 64, "DCN" (Document Control Number).
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied).
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.
- ✓ **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

Send all corrected or resubmitted paper claims to:

AmeriHealth Caritas North Carolina
Attn: Claims Processing Department
P.O. Box 7380
London, KY 40742-7380

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and submitted as a new claim within 365 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 at the beginning of this document and to detailed instructions in the Best Practices for Submitting Corrected Claims section.)

Suggestion: Before resubmitting claims, check the status of both your original and corrected claims online at www.navinet.net. You may open a claims investigation via NaviNet with the claim's adjustment inquiry function.

NPI Reminder: Provider NPI number validation is not performed at our claim's clearinghouse. Our claims clearinghouse will reject claims for provider NPI only if the provider number fields are empty.

The Plan's Provider ID is recommended as follows:

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2 [PIN]

Supplemental Information:

Billing Federally Qualified Health Center (FQHC) Claims

FQHC services are covered when furnished to patients at the center, in a skilled nursing facility or at the client's place of residence. Service provided to hospital patients, including emergency room services, are not considered FQHC services.

Encounter Rate
A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner. Group services should never be billed using the encounter rate. FQHC providers are entitled to a special FQHC encounter rate on the evaluation and management code.

AmeriHealth Caritas North Carolina (ACNC) submits encounter data to the state using standard ICD and CPT coding. Therefore, providers must submit claims using standard ICD and CPT coding. Claims submitted without "T" codes will be denied. FQHC services should be billed using place of service (50) — federally qualified health clinic and under the FQHC NPI number.

Non-FQHC services should be billed under the community-based provider (CBP) NPI number using places of service:

- (21) — Inpatient hospital.
- (22) — Outpatient hospital.
- (23) — Emergency room.

Submit claims for all services provided. For E/M, diabetic education, including behavioral health codes — use the FQHC NPI number in box 33. For services rendered inpatient, at the ER or skilled nursing facility, laboratory, and SBIRT use the CBP NPI number in box 33. Supplies, lab work, and injections are not billable services. These services and supply costs are included in the encounter rate.

Secondary FQHC claims are coordinated up to the encounter rate; the benefit amount will be the difference between the encounter rate and the other carrier's payment.

Wrap Around Payments FQHCs and RHCs

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) will receive two separate payment streams under managed care: service payments from ACNC and wrap-around payments from DHHS.

Payment Component	Description
Service Payments	• ACNC will reimburse FQHCs and RHCs at least 100% of the FFS rate for covered services. • Medicaid FFS unique FQHC/RHC encounter codes serve as the Rate floor for all "core" services.
Wrap-Around Payments	• Federal rules permit DHHS to continue making additional wrap-around payments to FQHCs and RHCs, over and above
	• ACNC payments for services, after the transition to managed care **Note:** FQHC/RHC will receive wrap-around payments to PPS rate or to costs based on current status prior to managed care transition. • DHHS will make quarterly wrap payments to FQHC/RHCs to ensure FQHC/RHCs receive aggregate payments equal to the PPS per-visit rate, as required by federal law* • Annually, for FQHCs/RHCs that are cost settled, DHHS will make additional wraparound payments representing the difference between Medicaid costs and payments

*Section §1902(bb)(5) of the Social Security Act

Billing for Obstetrics Providers

As permitted pursuant to NC Medicaid Obstetrics Clinical Coverage Policy 1E-5, obstetrics providers Physicians may bill valid global obstetrics claims as an all-inclusive service (combining antepartum care, labor and delivery and postpartum care), using CPT codes 59400 or 59510, when:

1. Antepartum care was initiated at least three (3) months prior to the delivery; and
2. The same obstetrics provider who renders the antepartum care performs the delivery and postpartum care.

Billing for Optical Providers

Primary Optical Services

- Routine Eye Exam Services
  - –Routine Eye Exam
  - –Refraction Only
- Visual Aid Services
  - –Eyeglasses
  - –Medically Necessary Contact Lenses

CHILDREN
Routine Eye Examination and Visual Aids for Beneficiaries
Under 21 Years of Age
ADULTS
Routine Eye Examination and Visual Aids for Beneficiaries 21
Years of Age and Older

Medically Necessary Contact Lenses

Examples of Conditions Dictating Medical Necessity

- Keratoconus
- Anisometropia
- Progressive Myopia

Members fit with medically necessary contact lenses are also eligible for back-up eyeglasses.

Frequency for Medically Necessary Contact Lenses

CHILDREN and ADULTS
Generally, once every year (365 days) Frequency can be influenced by:

- Type of contact lens
- Prescription change

Billing Coding

Routine Eye Exam

- Only S0620 and S0621 may billed for routine eye exams (includes refraction)
- Only International Classification of Disease (ICD-10) diagnoses codes listed in CCP 6A and 6B may be billed with S0620 and S0621
- 92-range ophthalmological CPT codes may NOT be billed for routine eye exams – guidelines for these medical eye exam codes are found in the General Ophthalmological Services Policy (1T-1)

Dispensing Fee

Providers are to bill AmeriHealth Caritas North Carolina for the fitting and dispensing the eyeglasses (including fitting) for AmeriHealth Caritas North Carolina members.

Fabrication and Materials

Per the North Carolina General Assembly, eyeglasses fabrication, including complete glasses, eyeglass lenses, and ophthalmic frames, is carved out and remains fee-for-service.

Nash Optical Plant will bill for the fabrication of one pair of eyeglasses and the frame and lenses.

VALUE ADDED BENEFIT – ADULT VISION

AmeriHealth Caritas North Carolina is offering the **enhanced benefit** of an additional pair of eyeglasses for adults aged 21-64 every 2 years so that adults will be able to get a pair each year. Inquiries regarding this ACNC value added benefit should be directed to Provider Services at 1-888- 738-0004.
NOTE: For both children and adults, an additional routine eye exam, refraction only, and eyeglasses during the time limit, maybe approved based on medical necessity.

Guidance on Submitting Interim Claims

Reminder: Claim dates of service must always fall within the statement period.

	EDI 1500	Paper 1500	EDI UB	Paper UB
Professional claims and inpatient stays that fall within the statement period:				
New admit through discharge claim; use Frequency Code 1 Admit – Discharge and make sure to include all dates of service	2400, DTP03 = DOS, 2400 SV104 = Days or Units, Otherwise N/A.	Field 24A, dates of Service: Enter From and To dates ('To' S/B blank for single day services. Field 24G, Days or Units, Otherwise N/A.	2300, CLM05=1, also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103	Field 4, Type of Bill, last character=1 also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103
Interim billing: Frequency Codes for use when the inpatient stay spans statement periods or the claim exceeds claim line limits.				
New INTERIM - FIRST CLAIM for continuing services, Use Frequency Code (sequence code) **2** INTERIM – FIRST CLAIM	N/A	N/A	2300, CLM05, Type of Bill (TOB), last position = '2', example 112 for "Inpatient – 1st Claim",	Field 4, Type of Bill (TOB) last position = '2' example 112 for "Inpatient – 1st Claim", Field 22 Patient Status of 30 "Still Patient"
Submit second claim for continuing services, Use Frequency Code (sequence code) **3** , INTERIM - CONTINUING CLAIM	N/A	N/A	2300, CLM05, Type of Bill last position = '3', example: 113 for "Inpatient – Cont. Claim"	Field 4, Type of Bill last position = '3', example: 113 for "Inpatient – Cont. Claim" Field 22 Patient Status of 30 "Still Patient"

	EDI 1500	Paper 1500	EDI UB	Paper UB
Interim billing: Frequency Codes for use when the inpatient stay spans statement periods or the claim exceeds claim line limits.				
Submit final claim for continuing services, Use Frequency Code (sequence code) **4**, INTERIM - INTERIM - LAST CLAIM	N/A professional	N/A	2300, CLM05, Type of Bill last position = '4', example: 114 for "Inpatient – Last Claim", also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103	Field 4, Type of Bill last position = '4', example: 114 for "Inpatient – Last Claim", also required are Field 16: Discharge Hour, Field 17: Patient Discharge Status and Field 22 Patient Status, use the appropriate code for Discharged or Expired.

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

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 (October1, 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?

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

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.

Have you coded for all Social Determinants of Health (SDoH) for the member?
Please include the appropriate supplemental ICD-10 diagnosis codes on your claim to report SDoH.
Note: SDoH should not be used as the admitting or principal diagnosis.

SDoH Description	Applicable ICD-10 Codes	
Education	Z550	Illiteracy and low-level literacy
	Z551	Schooling unavailable and unattainable
	Z558	Other problems related to education and literacy
	Z559	Problems related to education and literacy, unspecified
Employment	Z56.0	Unemployment, unspecified;
	Z56.2	Threat of job loss;

	Z56.3 Stressful work schedule; Z56.6 Other physical and mental strain related to work; sexual Z56.81 S harassment on the job; Z56.82 Military deployment status; Z56.4 Discord with boss and workmates;
Housing and Economic	Z590 Homeless Z591 Inadequate housing Z592 Discord with neighbors, lodgers, and landlord Z593 Problems related to living in residential institution Z594 Lack of adequate food and safe drinking water Z595 Extreme poverty Z596 Low income Z597 Insufficient social insurance and welfare support Z598 Other problems related to housing and economic circumstances Z599 Problem related to housing and economic circumstances, unspecified
Social Environment	Z600 Problems of adjustment to life-cycle transitions Z602 Problem related to living alone Z603 Acculturation difficulty Z604 Social exclusion and rejection Z605 Target of (perceived) adverse discrimination and persecution Z608 Other problems related to social environment Z609 Problem related to social environment, unspecified
Upbringing	Z6221 Child in welfare custody Z6222 Institutional upbringing Z6229 Other upbringing away from parents Z62810 Personal history of physical and sexual abuse in childhood Z62811 Personal history of psychological abuse in childhood Z62812 Personal history of neglect in childhood Z62819 Personal history of unspecified abuse in childhood

Family and Social Support Issues	Z630 Problems in relationship with spouse or partner Z6331 Absence of family member due to military deployment Z6332 Other absence of family member Z634 Disappearance and death of family member Z635 Disruption of family by separation and divorce Z636 Dependent relative needing care at home Z6371 Stress on family due to return of family member from military deployment Z6372 Alcoholism and drug addiction in family Z6379 Other stressful life events affecting family and household
Experiences with Crime, Violence, and Judicial System	Z650 Conviction in civil and criminal proceedings without imprisonment Z651 Imprisonment and other incarceration Z652 Problems related to release from prison Z653 Problems related to other legal circumstances Z654 Victim of crime and terrorism Z655 Exposure to disaster, war, and other hostilities
Inadequate Material Resources	Z753 Unavailability and inaccessibility of health care facilities Unavailability and Z754 inaccessibility of other helping agencies
Contact with and Suspected Exposure	Z77010 Contact with and suspected exposure to arsenic Z77011 Contact with and suspected exposure to lead Z77090 Contact with and suspected exposure to asbestos Z570 Occupational exposure to noise Z571 Occupational exposure to radiation Z572 Occupational exposure to dust Z5731 Occupational exposure to environmental tobacco smoke Z5739 Occupational exposure to other air contaminants Z574 Occupational exposure to toxic agents in agriculture Z575 Occupational exposure to toxic agents in other industries Z578 Occupational exposure to other risk factors
Stress	Z733 Stress, not elsewhere classified Z734 Inadequate social skills, not elsewhere classified Z7389 Other problems related to life management difficulty Z739 Problem related to life management difficulty, unspecified Z658 Other specified problems related to psychosocial circumstances Z659 Problem related to unspecified psychosocial circumstances

Evaluation and Management Codes

Supplemental Billing Information for Modifiers 25 & 59

The Current Procedural Terminology (CPT) defines modifier 25 as a "significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service." The CPT defines modifier 59 as a "distinct procedural service."

General Guidelines for Modifier 25:

- Modifier 25 may be appended only to Evaluation and Management (E&M) codes within the range of 92002 – 92014 and 99201 – 99499.
- To appropriately append modifier 25 to an E&M code, the provided service must meet the definition of "significant, separately identifiable E&M service" as defined by CPT.
- When appending modifier 25 to an E&M service billed on the same date of service as a procedure or other service, documentation for the additional E&M must be entered in a separate section of the medical record in order to validate the separate and distinct nature of the E&M service. The additional E&M service must be able to stand alone as a billable service with no overlapping of key E&M components (e.g., medical history, medical examination, and medical decision-making performed).

General Guidelines for Modifier 59:

- Modifier 59 is used to identify procedures/services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances.
- Modifier 59 should not be appended to an E&M code. To report a separate and distinct E&M service with a non-E&M service performed on the same date, see modifier 25.
- When appending modifier 59, documentation must support that the procedure/service represents a different session or patient encounter, procedure or surgery, anatomic site or organ system, lesion (through a separate performed incision/excision or for a separate injury or area of extensive injuries), or procedure not typically performed on the same day by the same individual.
- Modifier 59 should only be reported if no more descriptive modifier (e.g., Modifier XE, XP, XS, or XU) is available, and it is the most accurate modifier that is available to describe the circumstances of the procedure or service.

Providers and other interested parties should refer to the National Correct Coding Initiative (*NCCI)Policy Manual for Medicaid Services* (NCCI Policy Manual) and the *Modifier 59* article (Modifier 59 Article) for detailed information regarding appropriate modifier usage, which can be found on the CMS Medicaid.gov website.

Most Common Claims Errors* for CMS-1500

*The following information includes the most common claims errors observed by the AmeriHealth Caritas Family of Companies, 2018.

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	"**Member 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 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's sex is required.**" (If no box is checked, the claim will be rejected.)
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 (umber, street, city, state, zip+4) phone	"**Patient address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 is 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+4) phone	**"Insured's address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 is missing, the claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
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 online ___" [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 online ___" [lines 1-6].** (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"**Days/units are required online ___" [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.)
Field #	**CMS-1500 (02/12) Field/Data Element**	**"Reject Statement" (Reject Criteria)**
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's 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+4 is 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 including the full 9 character ZIP code + 4." (If a PO Box is present, the claim will be rejected.)

Most Common Claims Errors* for UB-04

*The following information includes the most common claims errors observed by the AmeriHealth Caritas Family of Companies, 2018.

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
1	Billing Provider Name, Address and Telephone Number	"**Billing provider name and/or address 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.)
1	Billing Provider Name, Address and Telephone Number	"**Field 1 of the UB04 claim form requires the provider's physical service address.**" (If a PO Box is present, the claim will be rejected.)
3a	Patient Account/ Control Number	"**Patient account/control number is missing or illegible.**" (If the number is missing or illegible, the claim will be rejected.)
4	Type of Bill	If claim is a resubmission, include Frequency Code as the last digit. Include original claim number in Field 64. (If Frequency Code is missing or invalid, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
8b	Patient Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
9ae	Patient Address	"**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.)
10	Patient Birth Date	"**Member DOB is missing.**" (If missing month and/or day and/or year, the claim will be rejected.)
11	Patient Sex	"**Member's sex is required**" (If missing, the claim will be rejected.)

12	Admission Date	"**Admission Date is missing or illegible.**" (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If it is OP, do not reject claim. If it is IP and a valid date is not billed, the claim will be rejected.)
12	Admission Date	"**Based on the date the claim was received, the admission date is a future date.**" (Use bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject claim. If it is IP and a future date is billed, reject the claim.)
13	Admission Hour	"**Admission hour is required.**" (Use bill type table to identify if it is an IP or OP claim. If it is OP, do not reject the claim. If it is IP and bill type is anything except 21x and a numeric value is not billed on the claim, the claim will be rejected.)
14	Admission Type	"**Admission type is required.**" (If a numeric value is not present, claim will be rejected.)
15	Point of Origin for Admission or Visit	"**Point of Origin for admission or visit is missing.**" (If claim has any bill type except 14x and the field is blank, claim will be rejected.)
16	Discharge Hour	"**Discharge hour is required.**" (Use type if bill table to determine if it is an IP or OP bill type. If IP, the Frequency Code is either 1 or 4, and this field is blank, claim will be rejected.)
17	Patient Discharge Status	"**Patient discharge status is required.**" (If left blank, claim will be rejected.)
42	Revenue Code	"**Revenue code is missing or illegible.**" (If the revenue code is missing or illegible, the claim will be rejected.)
45	Service Date	"**DOS is missing or illegible.**" (Claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
45	Creation Date	"**Creation date is missing or illegible.**" (If the creation date is missing or illegible, the claim will be rejected.)
46	Service Days/Units	"**Days/units are required online ___." [lines 1-22].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)

47	Line-Item Charges	"**Line-item charge amount is missing online___." [lines 1-22].** (If a value greater than or equal to zero is not present, the claim will be rejected.)
47	Total Charges	"**Total charge amount is missing.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
50	Payer	"**Payer name is required.**" (If left blank, the claim will be rejected.)
52	Release of Information	"Valid r**elease of information certification indicator is required.**" (If blank or invalid, the claim will be rejected.)
53	Assignment of Benefits	"Valid a**ssignment of benefits certification indicator is required.**" (If blank or invalid, the claim will be rejected.)
58	Insured's Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
59	Patient's Relationship	"Valid p**atient's relationship to insured is required.**" (If blank or invalid, the claim will be rejected.)
64	Document Control Number (DCN)	If claim is a resubmission, include the original claim number. Note: include Frequency Code in Field 4. (If original claim number is missing or invalid, the claim will be rejected.)
67A -Q	Other Diagnosis Codes and Present on Admission Indicator	"**Diagnosis codes are missing or illegible.**" (If diagnosis codes are missing or illegible, the claim will be rejected.)
69	Admitting Diagnosis Code	"**Admitting diagnosis code is missing or illegible.**" (If it is an IP claim and field is blank or illegible, the claim will be rejected.)
70	Patient's Reason for Visit	"**Patient's reason for visit is missing.**" (If the claim is OP and field is blank, the claim will be rejected.)
Field #	**UB-04 Field/Data Element**	**"Reject Statement" (Reject Criteria)**
74	Other/Procedure Date	"**Based on the date the claim was received, procedure date is a future date.**" (Use the bill type table to identify if it is an IP or an OP claim; If it is OP, do not reject the claim; If it is IP and a future date is billed, reject the claim.)
74	Other/Procedure Date	"**Procedure date is missing or illegible.**" (Use bill type table to identify if it is an IP or and OP claim. If OP, do not reject the claim. If IP and a valid date is not billed, reject the claim.)

76	Attending Provider Identifiers: Name and NPI	"**Attending physician name and/or number is missing."** (If attending physician name or NPI number are missing, the claim will be rejected.)
76	Attending Provider Qualifier	"**Attending provider qualifier is missing/ invalid.**" (The claim will be rejected if the "Other provider ID" is present and either: 1.) The 'Qualifier' box is blank or 2.) A qualifier other than 0B/1G/G2 is present.
76	Attending Provider Other ID#	**"Attending Provider NPI is missing."**(The claim will be rejected if qualifier is present and Other ID box is blank.)

AmeriHealth Caritas North Carolina Claims and Billing Manual
Revision Log 2/17/2025

Page	Heading/Section Title	Change	Comments
Cover	Version 11	Date changed to 1/1/2025	Updated the version number and cover date
5	Medical Claims	Vendor name references removed to keep the website the single source of truth	Change Healthcare changed to claims clearing house. Equian changed to medical claim review vendor. Etc.
7	Claim Filing Deadline EXCEPTIONS	Prenatal care for a pregnant woman deleted	This was removed per SPA 10/1/2021: https://medicaid.ncdhhs.gov/spa-21-0026-proposed-amendmenttplpdf/open
7	EXCEPTIONS	Clarification on claim submission as a new claim	
17	Paper Claim 1500 field – line 12 was updated	Removed Change Healthcare vendor reference	removed to keep the website the single source of truth
26-27	Procedures, Services Or Supplies CPT/HCPCS Modifier	Removed strikethrough	Information was correct and did not need to have a line thru the copy
90-91	Electronic Data Interchange (EDI) for Medical and Hospital Claims	Removed Change Healthcare vendor reference	removed to keep the website the single source of truth
90-91	Electronic claims	Removed Change Healthcare vendor reference	removed to keep the website the single source of truth
92	Contracting with Claims Clearinghouses and Other Electronic Vendors Contracting the EDI Technical Support Group	Removed Change Healthcare phone # reference. Removed info re: Change Healthcare	removed to keep the website the single source of truth
93-94	Electronic claims Flow Description	Removed Change Healthcare vendor reference	removed to keep the website the single source of truth
94	Invalid Electronic Claim Record Rejections/Denials	Filing deadline updated from 180 to 365 calendar days.	Clarified language re: submitting a new claim.
95-96	EDI exclusions, Common EDI rejections, electronic billing inquiries	Removed Change Healthcare vendor reference	removed to keep the website the single source of truth

102	Providers can submit “Institutional” corrected claims on the UB-04 paper form.	Filing deadline updated from 180 to 365 calendar days. Removed Change Healthcare vendor reference	Clarified language re: submitting a new claim.