Claims Filing Instructions

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PROCEDURES FOR CLAIM SUBMISSION

Welcome to Home State Health Plan (Home State). We are pleased to provide a comprehensive set of instructions for submitting and processing claims with us. You will find detailed information in this manual for initiating transactions, addressing rejections and denials, and processing payments. For questions regarding billing requirements not addressed in this manual, or for any other questions, contact a Home State Provider Services Representative at 1-855-694-HOME (4663).

In general, Home State follows the CMS (Centers for Medicare & Medicaid Services) billing requirements for paper, electronic data interchange (EDI), and web-submitted claims. Home State is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. **Claims will be rejected or denied if not submitted correctly. Please Note:** Any previous arrangements between a member and provider for private payment will become *null and void* once a claim for the service is submitted to Home State.

Accurate Billing Information

It is important that providers ensure Home State has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

- **Provider name (**as noted on current W-9 form**)**
- **National Provider Identifier (NPI)**
- **Tax Identification Number (TIN)**
- **Taxonomy code**
- **Physical location address (**as noted on current W-9 form**)**
- **Billing name and address**

Home State requires notification **30 days in advance of changes pertaining to billing information.** Please submit this information on a W-9 form. Changes to a provider's TIN and/or address are *not* acceptable when conveyed via a claim form.

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

- For EDI claims, rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason(s) for the rejection.

- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP) or Electronic Remittance Advice (ERA).

Claims for billable services provided to Home State members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Verification Procedures

All claims filed with Home State are subject to verification procedures. These include but are not limited to verification of the following:

- All claims will be subject to 5010 validation procedures based on CMS and MO HealthNet requirements.
- All required fields are to be completed on the current industry standard paper CMS 1500 Claim Form (HCFA), CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted individually or batch on our Secure Provider Portal.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
    - The date of service
    - Provider type/specialty billing
    - Bill type
    - Age/sex of the patient
- All Diagnosis Codes are billed to the greatest specificity
- The Principal Diagnosis billed reflects an allowed Principal Diagnosis as defined in the current volume of ICD-9 CM, or ICD-10 CM for the date of service billed.
    - For a CMS 1500 claim form, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary and that code is not valid as a primary diagnosis code, that service line will deny.
    - All inpatient facilities are required to submit a *Present on Admission (POA) indicator* on all claims. Claims will be denied or rejected if the POA indicator is missing. Please reference the CMS billing guidelines regarding POA for more information and for excluded facility types.
- The Member identification number is located in Box 1A of the paper CMS 1500 claim form and Loop ID 2010 BA Segment NM109 of the 837*p.*
- A member is eligible for services under Home State during the time period in which services were provided.

- Appropriate authorizations must be obtained for the services performed if required.
- Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims Filing Deadlines

Original claims (first time claims) must be submitted to Home State within 180 calendar days from the date services were rendered or reimbursable items were provided. Corrected claims must be submitted 180 days from the date of the original EOP or remit date. When Home State is the secondary payer, claims must be received within 365 calendar days from date of the final determination of the primary payer. Claims received outside of these time frames will deny for untimely submission. All requests for reconsideration or claim disputes must be received within 180 calendar days from the original date of notification of payment or denial. Prior processing will be upheld for provider claim requests for reconsideration or disputes received outside of the time frame, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Home State or the Missouri Department of Health and Human Services.
- The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if *all* of the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide their ID card or information.
    - The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered.
    - The provider can substantiate that a claim was filed within 180 days of discovering Plan eligibility.
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

Medical Necessity Appeals may be filed by a provider, with knowledge of the member's medical condition, acting on behalf of the member. These Medical Necessity Appeals will be accepted within 90 calendar days from Home State's notice of action.

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 95% of clean claims will be processed within 30 business days of receipt.
- 99% of clean claims will be processed within 90 business days of receipt

Adjusted claims, requests for reconsideration and disputed claims will be finalized to a paid or denied status 30 calendar days of receipt.

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

Corrected claims must be submitted within 180 days from the original date of the EOP. All claim requests for reconsiderations and claim disputes must be received within 180 days from the date of original notification of payment or denial.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are five ways in which the provider can address the claim:

1. Review the claim in question on the secure Provider Portal:
    - Participating providers, who have registered for access to Home State's secure provider portal, can access claims to obtain claim status, submit claims or submit a corrected claim.
2. Contact a Home State Provider Service Representative at 1-855-694-HOME (4663):
    - Providers may inquire about claim status, payment amounts or denial reasons. A provider may also make a request for reconsideration by clearly explaining the reason the claim is not adjudicated correctly.
3. Submit an Adjusted or Corrected Claim to Home State:
    - Corrected claims must clearly indicate they are corrected in one of the following ways:
        - Submit corrected claim via the secure Provider Portal
            - Follow the instructions on the portal for submitting a correction
        - Submit corrected claim electronically via Clearinghouse
            - Institutional Claims (UB): Field CLM05-3 = 7 and REF*F8 = Original Claim Number
            - Professional Claims (HCFA): Field CLM05-3 = 6 and REF*F8 = Original Claim Number
        - Mail corrected claims to:

          Home State Health Plan
          Attn: Corrected Claim
          PO Box 4050
          Farmington MO 63640- 3829
            - Paper claims must clearly be marked as **"RE-SUBMISSION"** or **"CORRECTED CLAIM"** and *must* include the original claim number; or the original EOP must be included with the resubmission.
            - Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim

being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

4. Submit a "Request for Reconsideration" to Home State:
    - A request for reconsideration is a written communication (i.e. a letter) from the provider about a disagreement with the manner in which a claim was processed, but does not require a claim to be corrected and does not require medical records.
    - The request must include sufficient identifying information which includes, at a minimum, the patient name and patient ID number, date of service, total charges, and provider name.
    - The documentation must also include a detailed description of the reason for the request.
    - Mail Requests for Reconsideration to:

      Home State Health Plan
      Attn: Reconsideration
      PO Box 4050
      Farmington, MO 63640- 3829

5. Submit a "Claim Dispute Form" to Home State:
    - A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.
    - The Claim Dispute Form is located on the Home State provider website at www.HomeStateHealth.com.
    - To expedite processing of your dispute, please include the original Request for Reconsideration letter and the response.
    - Mail your "Claim Dispute Form" and all other attachments to:

      Home State Health Plan
      Attn: Claim Dispute
      PO Box 4050
      Farmington, MO 63640-3829

If the Provider Services discussion, or the corrected claim, or the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Home State shall process and finalize all corrected claims, requests for reconsideration and disputed claims to a "paid" or "denied" status within 30 calendar days of receipt of the corrected claim, request for reconsideration or claim dispute.

PROCEDURES FOR ELECTRONIC SUBMISSION

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 healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:

- Reduction of overhead and administrative costs:
  - Eliminates the need for paper claim submission
  - Reduces claim re-work (adjustments)
- Receipt of clearinghouse reports as proof of claim receipt
- Faster transaction time for claims submitted electronically
- Validation of data elements on the claim format

All the same requirements for paper claim filing apply to electronic claim filing. Claims not submitted correctly or not containing the required field data will be rejected and/or denied.

The Home State Companion Guides for electronic billing are available on our website at. See www.homestatehealth.com section on electronic claim filing for more details.

Important Steps to a Successful Submission of EDI Claims

1. Select clearinghouse to utilize or Home State website.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Home State.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Provider Relations at Home State that the provider is set up in the Home State system before submitting EDI claims.
5. You will receive two reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Home State and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Home State. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted correct and resubmit.
6. MOST importantly, all claims must be submitted with provider identifying numbers. See the companion guide on the Home State website for claim form instructions and claim forms for details. **NOTE**: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the fields are empty.

Electronic Claim Submission

Providers are encouraged to participate in Home State's Electronic Claims/Encounter Filing Program through Centene, Home State's parent company. Home State (Centene) has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, Home State (Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

Home State Health Plan
c/o Centene EDI Department
1-800-225-2573, extension 25525
Or by e-mail at: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically *must* monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters

Electronic Secondary Claims

Home State has the ability to receive coordination of benefit (COB or Secondary) claims electronically. The field requirements for successful electronic COB submission are below (5010 Format):

COB Field Name **The below should come from the primary payer's Explanation of Payment**	**837I - Institutional EDI Segment and Loop**	**837P - Professional EDI Segment and Loop**
COB Paid Amount	If 2320/AMT01=**D**, MAP AMT02 or 2430/SVD02	If 2320/AMT01=**D**, MAP AMT02 or 2430/SVD02
COB Total Non Covered Amount	If 2320/AMT01=**A8**, map AMT02	If 2320/AMT01=**A8**, map AMT02
COB Remaining Patient Liability	If 2300/CAS01 = PR, map CAS03 Note: Segment can have 6 occurrences. Loop2320/AMT01=**EAF**, map AMT02 which is the sum of all of CAS03 with CAS01 segments presented with a PR	If 2320/AMT01=**EAF**, map AMT02
COB Patient Paid Amount		If 2320/AMT01 = **F5**, map AMT02
COB Patient Paid Amount Estimated	If 2300/AMT01=**F3**, map AMT02	
Total Claim Before Taxes Amount	If 2400/AMT01 = **N8**, map AMT02	If 2320/AMT01 = **T**, map AMT02
COB Claim Adjudication Date	IF 2330B/DTP01 = 573, map DTP03	IF 2330B/DTP01 = 573, map DTP03
COB Claim Adjustment Indicator	IF 2330B/REF01 = T4, map REF02	IF 2330B/REF01 = T4, map REF02 with a Y

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this manual. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The Companion Guide for this process is located on Home State's website at www.homestatehealth.com.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Home State, all EDI claims must first be forwarded to one of Home State's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are rejected and sent back to the sender via a clearinghouse error report. **It is very important to review this error report daily to identify any claims that were not transmitted to Home State.** The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Home State, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Home State by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in-turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). **It is very important to review this report daily.** The report shows rejected claims and these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

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

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

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to clearly mark your claim as a corrected claim per the instructions above.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Home State must first pass the clearinghouse proprietary 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 by Home State. In these cases, the

claim must be corrected and re-submitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

Exclusions

There are certain transactions excluded from EDI submissions, outlined below:

Excluded Claim Categories - Excluded from EDI Submission Options - Must be Filed Paper - Applies to Inpatient and Outpatient Claim Types
Claim records requiring supportive documentation or attachments (i.e., consent forms) Note: **COB claims can be filed electronically**, but if they are not, the primary payer EOB must be submitted with the paper claim.
Medical records to support billing miscellaneous codes
Claim for services that are reimbursed based on purchase/rental price (e.g. DME, prosthetics) Provider is required to submit the invoice with the claim.
Claim for services requiring clinical review (e.g. complicated or unusual procedure) Provider is required to submit medical records with the claim.
Claim for services requiring documentation and a Certificate of Medical Necessity (e.g. Oxygen, Motorized Wheelchairs)

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Clearinghouses Submitting Directly to Home State	Emdeon SSI Gateway EDI
Home State Payer ID	68069

	NOTE: Please reference the vendor provider manuals at h www.HomeStateHealth.com for their individual payer ID's.
General EDI Questions:	Contact EDI Support at 1-800-225-2573 Ext. 25525 or (314) 505-6525 or via e-mail at EDIBA@centene.com.
Claims Transmission Report Questions:	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?):	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
Remittance Advice Questions:	Contact Home State Provider Services at 866-769-3085or the secure Provider Portal at www.HomeStateHealth.com
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Services in writing at: Home State Health Plan 16090 Swingley Ridge Road, Suite 500 Chesterfield, MO 63017

PROCEDURES FOR ONLINE CLAIM SUBMISSION

For providers who have internet access and choose not to submit claims via EDI or paper, Home State has made it easy and convenient to submit claims directly to us on our secure provider portal.

To register, please go directly to www.HomeStateHealth.com,register for a user name and password, and select the "Claims Role Access" module.. If you have technical support questions, please contact Provider Services at 1-855-694-HOME (4663).

Once you have access to the secure portal you may file first-time claims individually, or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims.

EFT AND ERA

Home State partners with PaySpan to provide Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers. EFT and ERA services help providers reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straight forward reconciliation of payments. As a provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying

- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep **total** control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily
- For more information on our EFT and ERA services, please visit our website at www.HomeStateHealth.com, contact Provider Services at 1-855-694-HOME (4663) or directly contact PaySpan at 1-877-331-7154.

PAPER CLAIM FORM REQUIREMENTS

Claim Forms

Home State only accepts the CMS 1500 (02/12 version) and CMS UB-04 paper claim forms. Other claim form types will be rejected and returned to the provider

Professional providers and medical suppliers complete the CMS 1500 (02/12) form and institutional providers complete the CMS UB-04 claim form. Home State does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms *must* be typed or printed, and in the original red and white version to ensure clean acceptance and processing. No handwritten information will be accepted on the claim form. . If you have questions regarding what type of form to complete, contact Home State Provider Services at 1-855-694-HOME (4663).

Submit claims to Home State at the following address:

First Time Claims, Corrected Claims and Requests for Reconsiderations:
Home State Health Plan
Claim Processing Department
P. O. Box 4050
Farmington, MO 63640- 3829

Claim Dispute Forms:
Home State Health Plan
Attn: Claim Disputes
P. O. Box 4050
Farmington, MO 63640-3829

Home State encourages all providers to submit claims electronically. Our Companion Guides for electronic billing are available on our website at www.homestatehealth.com. Paper submissions are subject to the same edits as electronic and web submissions

Coding of Claims/Billing Codes

Home State requires claims to be submitted using codes from the current version of ICD-9-CM, ICD-10 (October 2015), ASA, DRG, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Below are some code related reasons a claim may reject or deny:

- Code billed is missing, invalid, or deleted at the time of service
- Code inappropriate for the age or sex of the member
- Diagnosis Code missing the 4th or 5th digit (until ICD-10 implemented)
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

Documentation Required with Claims

- The cost of acquiring corneal tissue for corneal transplants may be billed in addition to the ambulatory surgical center (ASC) facility charge. An invoice from an eye bank or organ procurement organization showing the actual cost of acquiring the tissue *must* be attached to claims in order to receive reimbursement for the facility charge and the corneal tissue. Claims submitted for corneal transplant procedure codes without the required invoice are denied.
- An invoice of cost is required for most purchase/rental DME codes with claim submission. Refer to Section 19 of Mo HealthNet Manual.
- An invoice of cost is required when billing for B5200.
- An invoice of the provider's cost for manually-priced ostomy supplies *must* accompany each CMS-1500 claim for payment.
- When billing for an approved repair, copies of the invoices showing the MSRP, or the invoice of cost, *must* be submitted with the claim.
- A copy of the repair invoice *must* be attached to the claim for out of shop repairs.
- An implantable intravenous infusion pump or a venous access port is a covered service. Providers are to use procedure A4300, Implantable vascular access portal/catheter (venous or arterial), for this service**.** This service is manually priced; therefore, providers *must* attach an invoice to their claim.
- When billing nuclear medicine procedures involving pharmacy charges, use procedure code A4641 for supply of radiopharmaceutical diagnostic imaging agent and A9699 for supply of therapeutic radiopharmaceuticals. These procedure codes are manually priced and an invoice *must* be attached to the claim reflecting the cost of the isotopes.
- 99070-Supplies and materials, provided by the nurse midwife over and above those usually included in the office visit, or other services rendered (list drugs, trays, supplies or materials provided). An invoice of costs for the supplies *must* be submitted with the claim for manual pricing.
- An electronic invoice of cost attachment is available to providers through the billing website at www.emomed.com.

Consent Forms

When required, consent forms must be included with the claim during the time of Admission, to avoid any delay in claim process.

Commented [MW1]: Should this be submission?

Consent forms are located on the Missouri Medicaid website at:

- Sterilization Consent Form- http://manuals.momed.com/forms/(Sterilization)Consent_Form(MO-8812).pdf

- Hysterectomy Consent Form - http://manuals.momed.com/forms/Acknowledgement_of_Receipt_of_Hysterectomy.pdf

CODE AUDITING AND EDITING

Home State uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes. Claims billed in a manner that does not adhere to the standards of the code editing software will be denied.

The code editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider's View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA's CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides examples where the software will make a change on submitted codes:

Unbundling of Services – Identifies Services that have been unbundled, such as lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim:

Examples: Unbundling of Services

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Add

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

Bilateral Surgery – Identical Procedures Performed on Bilateral Anatomical Sites during the Same Operative Session:

Example: Bilateral Surgery

Code	Description	Status
69436 DOS=01/01/10	Tympanostomy	Disallow

69436 50 DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

Explanation: identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). **Note:** *Modifiers RT (right), or LT (left) should not be billed for bilateral procedures*

Duplicate Services – Submission of same procedure more than once on same date of service that cannot be or are normally not performed more than once on same day:

Example: Excluding a Duplicate CPT

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation:

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.
- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services (E/M) – Submission of E/M service either within a global surgery period or on the same date of service as another E/M service:

Global Surgery:
Procedures that are assigned a 30-day global surgery period are designated as *major* surgical procedures.

Example: Global Surgery Period

Code	Description	Status

27447 DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 DOS=06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face w/patient &/or family.	Disallow

Explanation:

- Procedure code 27447 has a global surgery period of 30 days.
- Procedure code 99213 is submitted with a date of service that is within the 30-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Example: E/M with Minor Surgical Procedures

Code	Description	Status
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
99213 DOS=01/23/10	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face with patient and/or family.	Disallow

Explanation:

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Same Date of Service - One evaluation and management service is recommended for reporting on a single date of service.

Example: Same date of service

Code	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with patient and/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with patient/family.	Disallow

Explanation:

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation

Note:

Modifier -24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.
Modifier -25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.
Modifier -79 is used to report an unrelated procedure or service by the same physician during the post-operative period.

When modifiers -24 and -25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

When modifier -79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

Modifiers – Codes added to the main procedure code to indicate the service has been altered by a specific circumstance:

Modifier -26 (professional component)
Definition: Modifier -26 identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier -26 appended.

Example:

Code	Description	Status
78278 POS=Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS=Inpatient	Acute gastrointestinal blood loss imaging	Allow

Explanation:

- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier -26.

Modifier -80, We only recognize mod 80 by the state.
Definition: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Example:

Code	Description	Status
42820-80	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation:

- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of

CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

CXT 5.X EX CODE DESCRIPTIONS: REVISED 8-19-2013	
Ex code	**Description**
EXx1	INAPPROPRIATE LEVEL OF E/M SERVICE BILLED
EXx2	SERVICE(S) OR SUPPLIES DURING GLOBAL SURGICAL PERIOD
EXx3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
EXx4	PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBERS GENDER
EXx5	PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE
EXx6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
EXx7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
EXx8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
EXx9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
EXxa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
Ex66	CODE IS BEING QUESTIONED BY CODE AUDITING SOFTWARE
EXxb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
EXxc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID
EXxd	PROCEDURE CODE APPENDED WITH BILATERAL 50 MODIFIER
EXxe	PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE
EXxf	MAXIMUM ALLOWANCE EXCEEDED
EXxg	SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS
EXxh	SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED
EXxi	UNRESOLVED STATUS
EXxj	PRODUCT WARNING
EXxl	PRODUCT ERROR
EXxm	SYSTEM ERROR
EXxn	NO EX CODE RETURNED
EXxo	MISSING MODIFIER 26
EXxp	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
EXxq	PROCEDURE CODE ALLOWED ONCE PER DATE OF SERVICE
EXxr	BASE CODE CANNOT BE BILLED IN QTY GREATER THAN ONE
EXxy	PCP CANNOT BE REIMBURSED FOR THIS SERVICE
EXxO	POTENTIAL OBSTETRICAL CARE OVERPAYMENT
EXxG	PROCEDURE CODE IS DISALLOWED PER FEDERAL OR STATE FEE SCHEDULE
EXxC	SERVICE MODIFIER PREVIOUSLY SUBMITTED

EXxN	PROCEDURE CODE(S) BILLED IN AN INAPPROPRIATE SETTING
EXxH	REDUCED FOR MULTIPLE SURGERY PRICING
EXxJ	SERVICES BILLED REPRESENT OVERLAP OF PREVIOUSLY REPORTED SERVICES
EXxD	CMS MUE QUANTITY LIMIT EXCEEDED
EXxB	CMS MEDICAID NCCI UNBUNDLING

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Code Editing Assistant

A web-based code auditing reference tool designed to "mirror" how Home State code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers via the secure provider portal. This allows Home State to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims. You can access the tool in the "Claims Module" by clicking "Claim Auditing Tool".

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services *before* claims are submitted.
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes.

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a 'what if' or hypothetical reference tool. It is meant to apply coding logic only**.** The tool *does not* take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements or other coverage considerations.

REJECTIONS VS. DENIALS

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied.

Rejection:A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.HomeStateHealth.com. A list of common upfront rejections can be found listed below and a more comprehensive list with explanations can be located in Appendix 1. Rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial: If all edits pass and the claim is accepted, it will then be entered into the system for processing. A **denial** is defined as a claim that has passed edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent that includes the denial reason. A list of common delays and denials can be found listed below and a more comprehensive list with explanations can be located in Appendix II.

I. Common Causes for Upfront Rejections

II. Common Causes of Claim Processing Delays and Denials

III. Common EOP Denial Codes

IV. Instructions for Supplemental Information CMS-1500 (8/05) Form, Shaded Field 24a-G

V. Common HIPAA Compliant EDI Rejection Codes

APPENDIX I: COMMON CAUSES OF UPFRONT REJECTIONS

- **Unreadable Information -** The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), or the font is too small**.**
- **All hand written and/or black and white forms are rejected.**
- **Member Date of Birth** is missing
- **Member Name or Identification Number** is missing
- **Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number** is missing

- **Attending Provider** information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22 or 72 or missing from box 48 on the paper UB claim form
- **Date of Service** is not prior to the received date of the claim (future date of service)
- **Date of Service or Date Span** is missing from required fields
    - Example: "Statement From" or “Service From" dates
- **Type of Bill** is invalid
- **Diagnosis Code** is missing, invalid, or incomplete
- **Service Line Detail** is missing
- **Date of Service** is prior to member’s effective date
- **Admission Type** is missing (Inpatient Facility Claims – UB-04, field 14)
- **Patient Status** is missing (Inpatient Facility Claims – UB-04, field 17)
- **Occurrence Code/Date** is missing or invalid
- **Revenue Code** is missing or invalid
- **CPT/Procedure Code** is missing or invalid
- **Incorrect Form Type** used

APPENDIX II: COMMON CAUSES OF CLAIMS PROCESSING DELAYS AND DENIALS

- **Diagnosis Code** invalid or incorrect
- **Procedure** or **Modifier Codes** entered are invalid or missing
    - **This includes GN, GO or GP modifier for therapy services**
- **DRG** code is missing or invalid
- **Explanation of Benefits (EOB)** from the primary insurer is missing or incomplete
- **Third Party Liability** (TPL) information is missing or incomplete
- **Member ID** is invalid
- **Place of Service Code** is invalid

- **Provider TIN and NPI** does not match
- **Revenue Code** is invalid
- **Dates of Service** span do not match the listed days/units
- **Tax Identification Number (TIN)** is invalid

APPENDIX III: COMMON EOP DENIAL CODES AND DESCRIPTIONS

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

EX_CODE	DESCRIPTION
7	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT S SEX
9	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT S AGE
10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT S SEX
18	DENY: DUPLICATE CLAIM SERVICE
1K	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT
46	DENY: THIS SERVICE IS NOT COVERED

4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT
50	DENY:NOT A MCO COVERED BENEFIT
86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
99	DENY:MISC UNLISTED CODES CAN NOT BE PROCESSED W O DESCRIPTION REPORT
9M	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS
A1	DENY: AUTHORIZATION NOT ON FILE
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
DS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
DW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE
EC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
HQ	DENY - EDI CLAIM MUST BE SUBMITTED IN HARD COPY W CONSENT FORM ATTACHED
IM	DENY: RESUBMIT WITH CORRECT MODIFIER
L6	DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB
LO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT
MG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
MO	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE
MQ	DENY: MEMBER NAME NUMBER DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT
NT	DENY:PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
NV	DENY - CONSENT FORM NOT VALID MISSING INFORMATION
U1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
V1	DENY: SERVICE IS INCLUDED IN THE DELIVERY PAYMENT
Y6	DENY:INSUFFICIENT INFO FOR PROCESSING,RESUBMIT W PRIME S ORIGINAL EOB
ZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY
ZW	AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	PROCEDURE CODE ICD-9 CODE INCONSISTENT WITH MEMBERS GENDER
x5	PROCEDURE CODE CONFLICTS WITH MEMBER S AGE
x6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
x7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID
xd	PROCEDURE CODE APPENDED WITH BILATERAL 50 MODIFIER
xe	PROCEDURE CODE INCONSISTENT WITH MEMBER S AGE

xf	MAXIMUM ALLOWANCE EXCEEDED
xh	SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED
xp	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
xq	PROCEDURE CODE EXCEEDS MAXIMUM ALLOWED PER DATE OF SERVICE
xO	POTENTIAL OBSTETRICAL CARE OVERPAYMENT
xG	PROCEDURE CODE IS DISALLOWED PER FEDERAL OR STATE FEE SCHEDULE
xC	SERVICE MODIFIER PREVIOUSLY SUBMITTED
xN	PROCEDURE CODE(S) BILLED IN AN INAPPROPRIATE SETTING
xH	REDUCED FOR MULTIPLE SURGERY PRICING
xJ	SERVICES BILLED REPRESENT OVERLAP OF PREVIOUSLY REPORTED SERVICES
xD	CMS MUE QUANTITY LIMIT EXCEEDED
xB	CMS MEDICAID NCCI UNBUNDLING
ya	DENY: DENIED AFTER REVIEW OF PATIENTS CLAIM HISTORY
ye	CLAIMS CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
xE	PROCEDURE CODE IS DISALLOWED WITH THIS DIAGNOSIS CODE(S) PER PLAN POLICY
w1	CO-SURGEON/TEAM SURGEON DISALLOWED PER CMS SURGICAL BILILNG GUIDELINES
w2	ASSISTANT & PRIMARY SURGEON PROCEDURE CODES MUST MATCH PER CMS
w3	ASSISTANT, CO-SURGEON, OR TEAM SURGEONS NOT TYPICALLY REQUIRED PER CMS
w4	INAPPROPRIATE LEVEL OF E/M SERVICE BILLED PER AMA GUIDELINES
w5	PRIMARY SERVICE IS DENIED; THEREFORE, ADD-ON SERVICE IS DENIED PER AMA
yf	HCI PARTIALLY APPROVED UNITS; CLAIM NEEDS MANUAL PRICING
yq	DUPLICATE CLAIMS OR MULTIOPLE PROVIDERS BILLING SAME/SIMILAR CODE(S)
yr	INCORRECT PROCEDURE CODE FOR DIAGNOSIS PER NCD/CMS
ys	REIMBURSEMENT INCLUDED IN ANOTHER CODE PER CMS/AMA/MEDICAL GUIDELINES
yt	INCORRECT PROCEDURE CODE FOR MEMBER AGE OR GENER PER CMS/AMA/PLAN
yu	INCORRECT CPT/HCPCS/REV/MODIFIER OR UNLISTED CODE BASED ON CPT/CMS GUIDELINES
yv	OUTPATIENT SERVICES INCLUDEED IN INPATIENT ADMIT PER CMS/PLAN GUIDELINES
yw	NOT COVERED OR ELIGIBLE SERVICE PER CMS OR PLAN GUIDELINES
yx	INCLUDED IN GLOBAL SURGICAL OR MATERNITY PACKAGE PER CMS OR ACOG
yy	REIMBURSEMENT REDUCTION BASED ON CPT AND/ OR CMS GUIDELINES
yz	INCORRECT USE OF MODIFIER -26 OR –TC BASED ON CMS

APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS-1500 (02/12 version) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 ((02/12 version) form field 24A-G:

- Anesthesia duration
- Narrative description of unspecified/miscellaneous/unlisted codes
- 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

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

7 Anesthesia information
ZZ Narrative description of unspecified/miscellaneous/unlisted codes
OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
VP Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

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 supplemental information.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one supplemental item can be reported in a single shaded claim line *if* the information is related to the un-shaded claim line item it is entered on. When entering more than one supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the HIBCC, or GTIN number/code.

Examples:

Anesthesia

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. #
7Begin 1315 End 1445 Time 90 minutes											
										NPI	

Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code

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. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached											
										NPI	

Vendor Product Number- HIBCC

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. #
VPA123ABC7D9E1F											
										NPI	

Product Number Health Care Uniform Code Council – GTIN

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. #
OZ0123456789 1112											
										NPI	

APPENDIX V: COMMON HIPAA COMPLIANT EDI REJECTION CODES

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see Home State's list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

Code	Description
01	Invalid Mbr DOB
2	Invalid Mbr
6	Invalid Prv
7	Invalid Mbr DOB & Prv
8	Invalid Mbr & Prv
9	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
23	Invalid Prv; Invalid Diag

34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Mbr DOB, Invalid Prv; Invalid Proc
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prv; Invalid Proc
51	Invalid Diag; Invalid Proc
74	Services performed prior to Contract Effective Date
75	Invalid units of service

APPENDIX VII: CLAIMS FORM INSTRUCTIONS

Below is a Billing Guide for forms CMS-1500 and CMS UB-04.

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.

Note: Claims with missing or invalid Required (R) field information will be rejected or denied

Completing a CMS 1500 Form

CLAIMS FILING INSTRUCTIONS

FIELD#	Field Description	Instruction or Comments	Required or Conditional

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

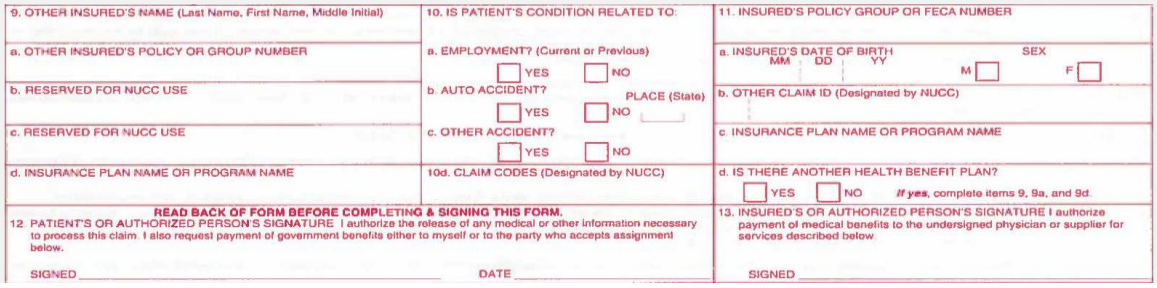
CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

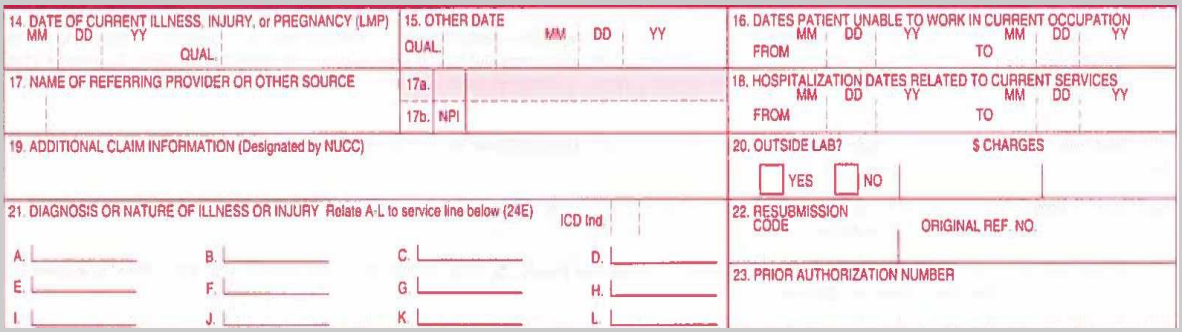
1	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Enter "X" in the box noted Medicaid (Medicaid #).	R
1a	INSURED I.D. NUMBER	The 8-digit Medicaid identification number on the member's Home State I.D. card.	R
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Home State I.D. card. Do not use nicknames.	R
3	PATIENT'S BIRTH DATE / SEX	Enter the patient's 8-digit date of (MM|DD|YYYY) and mark the appropriate box to indicate the patient's sex/gender. M = male F = female	R
4	INSURED'S NAME	Enter the patient's name as it appears on the member's Home State I.D. card.	C
5	PATIENT'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	C
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C

FIELD#	Field Description	Instruction or Comments	Required or Conditional
7	INSURED'S ADDRESS (Number, Street, City, State, Zip code) Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's Telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
8	PATIENT STATUS		Not Required


9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME
10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (Current or Previous) YES NO
b. AUTO ACCIDENT? YES NO PLACE (State)
c. OTHER ACCIDENT? YES NO
10d. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER CLAIM ID (Designated by NUCC)
c. INSURANCE PLAN NAME OR PROGRAM NAME
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

9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if # 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	OTHER INSURED'S BIRTH DATE / SEX	REQUIRED if # 9 is completed. Enter the 8-digit date of birth (MM|DD|YYYY) and mark the appropriate box to indicate sex/gender. M = male F = female for the person listed in box 9.	C
9c	EMPLOYER'S NAME OR SCHOOL NAME	Enter the name of employer or school for the person listed in box 9. Note: Employer's Name or School Name does not exist in the electronic 837 Professional 4010A1.	C
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	IS PATIENT'S CONDITION RELATED TO:	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line.	R
10d	RESERVED FOR LOCAL USE		Not Required
11	INSURED'S POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	INSURED'S DATE OF BIRTH / SEX	Same as field 3.	C

FIELD#	Field Description	Instruction or Comments	Required or Conditional
11b	EMPLOYER'S NAME OR SCHOOL NAME	REQUIRED if Employment is marked Yes in box 10a.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance Health Plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete # 9a-d and #11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File", "SOF", or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	PATIENT'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required


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 FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date reflecting the first date of onset for the: Present illness Injury LMP (last menstrual period) if pregnant	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE		Not Required
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		Not Required
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (First name, middle initial, last name, and credentials).	Not Required
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		Not Required

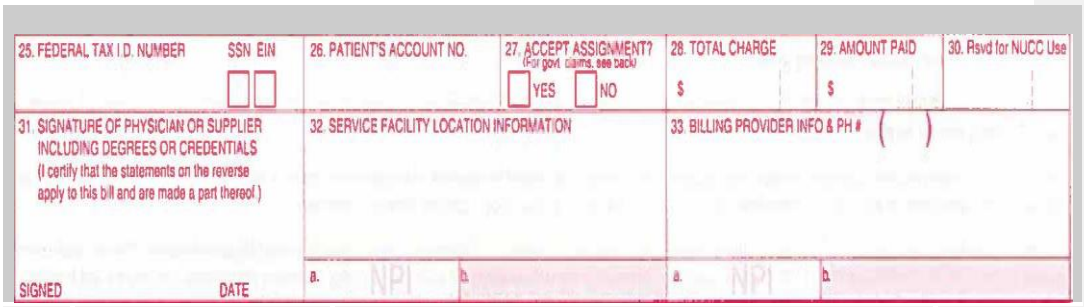
FIELD#	Field Description	Instruction or Comments	Required or Conditional
19	RESERVED FOR LOCAL USE		Not Required
20	OUTSIDE LAB / CHARGES		Not Required
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L TO ITEM 24E BY LINE)	Enter the diagnosis or condition of the patient using the appropriate release/update of ICD-9/ICD-10 CM Volume 1 for the date of service. Diagnosis codes submitted must be valid ICD-9/ICD-10 (October 2015) codes for the date of service. "E" codes are NOT acceptable as a primary diagnosis. Note: Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	MEDICAID RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the DCN (Document Control Number) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with "RESUBMISSION" to avoid denials for duplicate submission.	C
23	PRIOR AUTHORIZATION NUMBER	Enter the Home State (HSHP) authorization or referral number. Refer to the HSHP Provider Manual for information on services requiring referral and/or prior authorization.	Not Required

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. #
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	
														NPI	

24a-j General Information	Box 24 contains 6 claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are 4 individual fields labeled 24A-24G, 24H, 24J and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Medicaid Number. Shaded boxes a-g is for line item supplemental information and is a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.

FIELD#	Field Description	Instruction or Comments	Required or Conditional
24a-g Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Anesthesia Start/Stop time & duration Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions. HIBCC or GTIN number/code. For detailed instructions and qualifiers refer to Appendix 4 of this manual.	C
24a Un-shaded	DATE(S) OF SERVICE	Enter the date the service listed in 24D was performed (MM|DD|YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line.	R
24b Un-shaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website.	R
24c Un-shaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24d Un-shaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier– - if applicable. Only one CPT or HCPC and up to 4 modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24e Un-shaded	DIAGNOSIS CODE	Enter the alpha character diagnosis pointer (A-L) from field 21. List the primary diagnosis for the service provided or performed first followed by any additional or related diagnosis listed in field 21 (using the alpha character diagnosis pointer, not the diagnosis code.) Do not use commas between the diagnosis pointer numbers. Diagnosis codes must be valid ICD-9/10 codes for the date of service or the claim will be rejected/denied.	R
24f Un-shaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24g Un-shaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of 1.	R
24h Shaded	EPSDT (Family Planning)	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C

FIELD#	Field Description	Instruction or Comments	Required or Conditional
24h Un-shaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit	C
24i Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy Use 1D qualifier for Medicaid ID, if an Atypical Provider	C
24j Shaded	NON-NPI PROVIDER ID#	Enter as designated below the Medicaid ID number or taxonomy code. Typical Providers: Enter the Provider taxonomy code that corresponds to the qualifier entered in 24I shaded. Use ZZ qualifier for taxonomy code. Atypical Providers: Enter the Medicaid Provider ID number.	R
24j Un-shaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. . Enter the billing NPI if services are not provided by an individual (e.g. DME, Independent Lab, Home Health, RHC/FQHC general Medical Exam, etc.)	R



25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number and mark the box labeled EIN.	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	Not Required
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid Payments.	R
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Home State. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

30	BALANCE DUE	REQUIRED when #29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed. Note: Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box #'s are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 code), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers Enter the 2-character qualifier ZZ followed by the taxonomy code (no spaces). Atypical Providers Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH #	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission	R
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHER ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider taxonomy code. Use ZZ qualifier. Atypical Providers: Enter the Medicaid Provider ID number.	C

Completing a UB-04 Claim Form

A UB-04 form is the only acceptable claim form for submitting inpatient or outpatient Hospital claims charges for reimbursement by Home State. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, independent rural health clinics, and dialysis services.
Incomplete or inaccurate information will result in the claim/encounter being rejected for corrections.

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

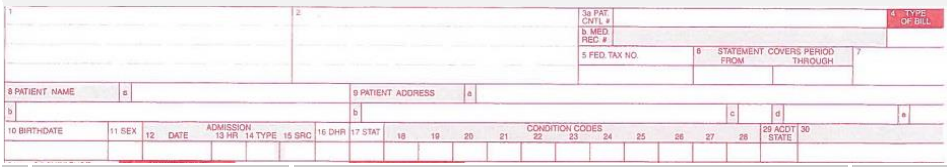
The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500-claim form
- Include the appropriate CPT code next to each revenue code.

Exceptions

Please refer to your provider contract with Home State or to the Missouri Department of Health and Human Services Hospitals Provider Manual for Revenue Codes that do not require a CPT 4 code.

Completing a CMS UB-04 Form



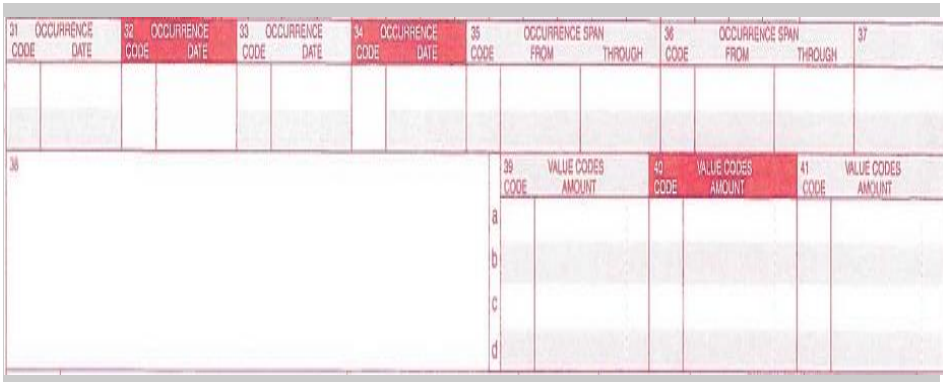
1	(UNLABELED FIELD)	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the City, State, and zip+4 code (include hyphen). NOTE: the 9-digit zip (zip + 4 code) is a requirement for paper and EDI claims. Line 4: Enter the area code and phone number.	R
2	(UNLABELED FIELD)	Enter the Pay-To Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate 3-digit type of bill (TOB) code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows: 1st digit - Indicating the type of facility. 2nd digit - Indicating the type of care	R

		3rd digit - Indicating the billing sequence.	
5	FED. TAX NO.	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service. (MMDDYY)	R
7	(UNLABELED FIELD)	Not Used	Not Required
8 a-b	PATIENT NAME	8a – Enter the patient's 13-digit Medicaid identification number on the member's Home State I.D. card.	Not Required

8 a-b	PATIENT NAME	8a – Enter the patient's 13-digit Medicaid identification number on the member's Home State I.D. card.	Not Required
		8b – Enter the patient's last name, first name, and middle initial as it appears on the Home State 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. H Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.	R
9 a-e	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY)	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims.	C
13	ADMISSION HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. 00-12:00 midnight to 12:59 — 12- 12:00 noon to 12:59 01- 01:00 to 01:59 — 13- 01:00 to 01:59 02- 02:00 to 02:59 — 14- 02:00 to 02:59 03- 03:00 to 03:39 — 15- 03:00 to 03:59 04- 04:00 to 04:59 — 16- 04:00 to 04:59 05- 05:00 to 05:59 — 17- 05:00 to 05:59 06- 06:00 to 06:59 — 18- 06:00 to 06:59 07- 07:00 to 07:59 — 19- 07:00 to 07:59 08- 08:00 to 08:59 — 20- 08:00 to 08:59 09- 09:00 to 09:59 — 21- 09:00 to 09:59 10- 10:00 to 10:59 — 22- 10:00 to 10:59 11- 11:00 to 11:59 — 23- 11:00 to 11:59	R
14	ADMISSION TYPE	Required for inpatient admissions (TOB 11X, 118X, 21X, 41X). Enter the 1-digit code indicating the priority of the admission using one of the following codes: 1 Emergency	C

		2 Urgent 3 Elective 4 Newborn	
15	ADMISSION SOURCE	Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes: For Type of admission 1,2,3 or 5 1 Physician Referral 2 Clinic Referral 3 Health Maintenance Referral (HMO) 4 Transfer from a hospital 5 Transfer from Skilled Nursing Facility (SNF) 6 Transfer from another health care facility 7 Emergency Room 8 Court/Law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	
16	DISCHARGE HOUR	Enter the time using 2-digit military time (00-23) for the time of inpatient or outpatient discharge. 00-12:00 midnight to 12:59 — 12- 12:00 noon to 12:59 01- 01:00 to 01:59 — 13- 01:00 to 01:59 02- 02:00 to 02:59 — 14- 02:00 to 02:59 03- 03:00 to 03:39 — 15- 03:00 to 03:59 04- 04:00 to 04:59 — 16- 04:00 to 04:59 05- 05:00 to 05:59 — 17- 05:00 to 05:59 06- 06:00 to 06:59 — 18- 06:00 to 06:59 07- 07:00 to 07:59 — 19- 07:00 to 07:59 08- 08:00 to 08:59 — 20- 08:00 to 08:59 09- 09:00 to 09:59 — 21- 09:00 to 09:59 10- 10:00 to 10:59 — 22- 10:00 to 10:59 11- 11:00 to 11:59 — 23- 11:00 to 11:59	C
17	PATIENT STATUS	REQUIRED for inpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)	C

		40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	(UNLABELED FIELD)	Not Used	Not Required



31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	Leave Blank	Not Required
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to 8 characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted enter a “1” in both fields (i.e. PAGE “1” OF “1”).	R
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use a spaces, commas, dashes or the like between the CPT/HCPC and modifier(s) Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract with HSHP or to the Department of Health and Hospitals Medicaid Provider Procedures Manual	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted. (MMDDYY)	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R

48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 57 OTHER PRV ID

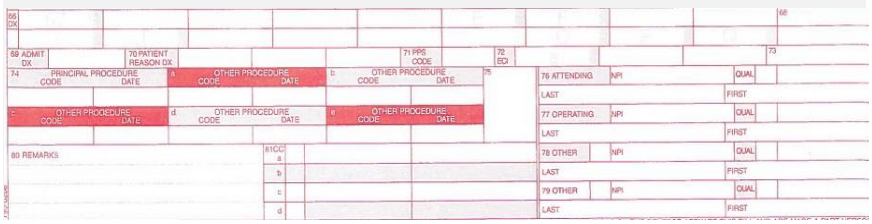
58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

50 A-C	PAYER	Enter the name for each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary.	R
51 A-C	HEALTH PLAN IDENTIFICATION NUMBER		Not Required
52 A-C	REL. INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter “Y” (yes) or “N” (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y”.	R
53	ASG. BEN.	Enter “Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when	C

		Medicaid/Home State Health Plan is listed as secondary or tertiary.	
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER or PROVIDER ID	Required: Enter provider's 10-character NPI ID.	R
57	OTHER PROVIDER ID	a. Enter the numeric provider Medicaid identification number assigned by the Medicaid program. b. Enter the TPI number (non -NPI number) of the billing provider	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the Insurance /Medicaid ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character Document Control Number (DCN) of the paid HEALTH claim when submitting a replacement or void on the corresponding A, B, C line reflecting Home State from field 50.	C

		Applies to claim submitted with a Type of Bill (field 4) Frequency of “7” (Replacement of Prior Claim) or Type of Bill Frequency of “8” (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section	
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Required



67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis code submitted must be a valid ICD-9/10 code for the date of service and carried out to its highest level of specificity– 4th or“5” digit. "E" and most “V” codes are **not** acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9/10 codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" and most “V” codes are **not** acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied.	C
68	(UNLABELED)	Not Used	Not Required
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be a valid ICD-9/10 codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" codes and most “V” are **not** acceptable as a primary diagnosis.	R

		Note: Claims with missing or invalid diagnosis codes will be denied.	
F70 a,b,c	PATIENT REASON CODE	Enter the ICD-9/10-CM code that reflects the patient's reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be valid ICD-9/10 codes for the date of service and carried out to its highest digit – 4th or"5". "E" codes and most "V" are **not** acceptable as a primary diagnosis. **Note**: Claims with missing or invalid diagnosis codes will be denied	R
71	PPS / DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	(UNLABELED)		Not Required
74	PRINCIPAL PROCEDURE CODE / DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/10 procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
		REQUIRED for EDI Submissions.	
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 (October 2015) procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to 5 ICD-9/ICD-10 (October 2015) procedure codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	(UNLABELED)		Not Required
76	ATTENDING PHYSICIAN	Enter the NPI and Name of the physician in charge of the patient care: NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code QUAL: Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code	R

		LAST: Enter the attending physician's last name FIRST: Enter the attending physician's first name.	
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed: NPI: Enter the operating physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code QUAL: Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # ZZ – Taxonomy Code LAST: Enter the operating physician's last name FIRST: Enter the operating physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and Name of the physician in charge of the patient care: (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider ZZ – Other Operating MD 82 – Rendering Provider NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number 0B – State License # 1G – Provider UPIN G2 – Provider Commercial # LAST: Enter the other physician's last name. FIRST: Enter the other physician's first name.	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use ZZ qualifier	C

APPENDIX VIII: BILLING TIPS AND REMINDERS

- **Ambulance**
  - Must be billed on a CMS 1500
  - Air ambulance must be billed in place of service 21, 23, 26 or 51
  - Transportation services billed for an HCY member can bill in locations 03, 04, 11, 12, 13, 14, 20, 21, 22, 23, 24, 25, 26, 31, 32, 33, 34, 49, 50, 51, 52, 53, 54, 55, 56, 57, 61, 62, 65, 71, 72, 81 or 99
  - Location 41 is *not* accepted
  - All other transportation should be billed in 21, 23, 26, 51, 55, 56, or 61
  - Acceptable modifiers for transportation are GM, EP (HCY), HH, and HD
  - Acceptable modifier for medical necessary service or supply is SC

- **Ambulatory Surgery Center (ASC)**
  - Ambulatory surgery centers must submit charges using the CMS 1500 claim form
  - Must be billed in place of service 24
  - Must be billed with modifier SG
  - Invoice must be billed with Corneal Transplants
  - Most surgical extractions are billable only under the ASC

- **Anesthesia**
  - Services for which anesthesia is billed *must* be a covered service.
  - Bill total number of minutes in Block 24G of the CMS 1500 Claim Form
  - Failure to bill total number of minutes may result in incorrect reimbursement or claim denial
  - Anesthesiologist must bill modifiers listed below for all ASA codes:
    - AA- Anesthesia service performed personally by anesthesiologist ; or
    - QX - CRNA/AA service with medical direction by a physician
    - QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.
  - CRNA'a must bill with modifiers listed below for all ASA codes:
    - QZ - CRNA service without medical direction by a physician
  - Qualifying Circumstances are billed in addition to ASA services
    - Only billable with a count of 1
    - There are no acceptable modifiers billable for these services
  - Injections of anesthetic substance *must* be billed using the appropriate CPT procedure code.
    - Only billable with a count of 1
    - Spinal anesthesia is *not* covered with modifiers AA, QK, QX and QZ.

- **Comprehensive Day Rehab**
  - Must be billed on a CMS 1500
  - Must be billed in location 99-Other Unlisted Facility Other service facilities.
  - Must be prior authorized by the MO HealthNet Division.

- **DME/Supplies/Prosthetics and Orthotics**
  - Must be billed with appropriate modifier; please refer to the MO HealthNet Durable Medical Equipment Manual, Section 19 for appropriate billing of modifiers. http://manuals.momed.com/collections/collection_dme/print.pdf
  - Purchase only services must be billed with modifier NU.
  - Submit invoice for all DME codes that require invoice with claim submission.
  - DME reimbursements will not pro-rate, monthly rates will apply.

- **EPSDT/HCY**
  - Must be billed with modifier EP
  - Must be billed in location 03, 11, 12, 19, 21, 22, 25, 71, 72, OR 99
  - Populate 24h with appropriate indicator "E" if the service is an EPSDT/HCY screening, "F" if the service is family planning related, "B" if the service is both EPSDT/HCY and Family Planning related

- **Hearing Aids**
  - Must be billed with the modifier LT or RT

- **Home Health**
  - Must be billed on a UB 04
  - Bill type must be 3XX
  - Must be billed in location 12
  - Acceptable modifiers TD, SC and EP (HCY)

- **Laboratory-Clinical Laboratory Improvement Amendments Act (CLIA) 1988**
  - All Laboratory sites, including independent laboratories, hospitals, physician offices, nursing homes, etc. as defined at 42 CFR 493.2, must have either a CLIA Certificate of Waiver or Certificate of Registration to legally perform clinical laboratory testing anywhere in the United States; or be exempt by virtue of the fact that the lab is licensed by an approved state program.
  - The CLIA number is a ten digit number.
  - Providers must have the appropriate CLIA certification on their MO HealthNet provider file to allow accurate claims processing.

- **Modifiers**
  - 25 Modifier
    - 25 Modifier should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of another procedure e.g. 99381 and 99211-25 Well-Child and sick visit performed on the same day by the same physician **Note***: 25 modifier **is not** appended to non E&M procedure codes, e.g. lab*
  - 26 Modifier – should never be appended to an office visit CPT code
    - Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes
    - Inappropriate use may results in a claim denial/rejection
  - TC Modifier – used to indicate the technical component of a test or study is performed
  - 50 Modifier – indicates a procedure performed on a bilateral anatomical site

        - Procedure must be billed on a single claim line with the 50 modifier and quantity of one (1)
        - RT and LT modifiers or quantities greater than one should not be billed when using modifier 50
    - Therapy Modifiers –
        - GN- speech therapy
        - GO- occupational therapy
        - GP- physical therapy
    - Specific Modifiers for Distinct Procedural Services
        - XE- Separate encounter: A service that is distinct because it occurred during a separate encounter
        - XS- Separate structure: A service that is distinct because it was performed on a separate organ/structure
        - XP- Separate practitioner: A service that is distinct because it was performed by a different practitioner
        - XU- Unusual non-overlapping service: The use of a service that is distinct because it does not overlap usual components of the main service

- **Multi page claims**
    - The page leading up to the last page of a multi-page claim should contain the word "continued" or "cont."
    - Totaling each page will result in separate claims that may incorrectly reimburse

- **Nurse Midwife**
    - Must be billed on a CMS 1500
    - Must be billed in location 11, 12, 21, 22, or 25
    - Acceptable modifiers EP (HCY)

- **Office Supplies**
    - Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.
    - Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may *not* be billed separately. Providers may *not* bill for any reusable supplies.

- **Physician Assistant**
    - Physician assistant services must be billed by a supervising physician using modifier AR

- **Delivery Services**
  - Use appropriate value codes as well as birth weight when billing for delivery services

- **Vaccines/VFC Program**
  - Vaccines associated with the Vaccine for Children Program (VFC) must be billed with the vaccine code and modifier SL indicating the administration.
  - Vaccines provided through the Vaccine for Children's Program (VFC) reimburse on the vaccine code with modifier SL
  - The vaccine without the modifier SL should also be billed otherwise the administration will be denied