Billing Manual

EFFECTIVE JANUARY 1, 2015

AmbetterHealth.com

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PROCEDURES FOR CLAIM SUBMISSION

Welcome to Ambetter and IlliniCare Health. We are pleased to provide a comprehensive set of instructions for submitting and processing claims with us. You will find detailed information in this guide for initiating transactions, addressing upfront rejections and denials, and processing of payments. For questions regarding billing requirements not addressed in this guide, or for any other questions, please feel free to contact Ambetter and IlliniCare Health Provider Services at:

Ambetter Health Plan	Phone	TTY/TDD	Website
Ambetter of Arkansas	1-877-617-0390	1-877-617-0392	AmbetterofArkansas.com
Ambetter from Sunshine Health	1-877-687-1169	Relay FL – 1-800-955-8770	Ambetter.SunshineHealth.com
Ambetter from Peach State Health Plan	1-877-687-1180	1-877-941-9231	Ambetter.pshpgeorgia.com
Ambetter from MHS	1-877-687-1182	1-877-941-9232	Ambetter.mhsindiana.com
Ambetter from CeltiCare Health	1-877-687-1186	1-877-941-9234	Ambetter.CeltiCareHealthPlan.com
Ambetter from Magnolia Health	1-877-687-1187	1-877-941-9235	Ambetter.MagnoliaHealthPlan.com
Ambetter from Buckeye Health Plan	1-877-687-1189	1-877-941-9236	Ambetter.BuckeyeHealthPlan.com
Ambetter from Superior HealthPlan	1-877-687-1196	Relay TX – 1-800-735-2989	Ambetter.SuperiorHealthPlan.com
Ambetter from Coordinated Care	1-877-687-1197	1-877-941-9238	Ambetter.CoordinatedCareHeatlh.com
Ambetter from MHS Health Wisconsin	1-855-745-5506	1-800-947-3529	Ambetter.mhswi.com
IlliniCare Health	1-855-745-5507	1-866-585-8576	Marketplace.IlliniCare.com

In general, Ambetter and IlliniCare Health follow the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Ambetter and IlliniCare Health are 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 upfront rejections or denials on the explanation of payment if not submitted correctly. **Claims will be rejected or denied if not submitted correctly.**

ACCURATE BILLING INFORMATION

It is important that providers ensure Ambetter and IlliniCare Health has accurate billing information on file. Please confirm with Provider Services that the following information is current in our files:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Group National Provider Identifier (NPI) (if applicable)

- Tax Identification Number (TIN)
- Physical Location Address (as noted on current W-9 form). A W-9 must be submitted if the address to which the end of the year 1099 IRS form will be mailed.
- Billing Name and Address. A W-9 must be submitted if the address to which the end of the year 1099 IRS form will be mailed.

We recommend that providers notify Ambetter and IlliniCare Health 30-60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of the year 1099 IRS form will be mailed, a new W-9 form will be required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form or a 277 electronic file.

When required data elements are missing or are invalid, claims will be upfront rejected or denied by Ambetter and IlliniCare Health for correction and re-submission.

- For EDI claims, upfront rejections happen through one of our EDI clearinghouses if the appropriate information is not contained on the claim.
- For paper claims, upfront 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 for the upfront 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 Ambetter and IlliniCare Health 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 Ambetter and IlliniCare Health are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or claims submitted on our Secure Provider Portal, individually or batch.
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.
- Claims must contain the CLIA number when CLIA waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- Taxonomy codes are required. Please see further details in this Manual for taxonomy requirements.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
    - Date of Service
    - Provider Type and/or provider specialty billing
    - Age and/or sex for the date of service billed
    - Bill type
- All Diagnosis Codes are to their highest number of digits available.

- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
    - F2 – International Unit
    - GR – Gram
    - ME – Milligram
    - ML – Milliliter
    - UN - Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-9-CM and/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. 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. Valid 5010 POA codes are:
        - N – No
        - U – Unknown
        - W – Not Applicable
        - Y - Yes
- Member is eligible for services under Ambetter and IlliniCare Health during the time period in which services were provided.
- Services were provided by a participating provider, or if provided by an "out of network" provider authorization has been received to provide services to the eligible member. (Excludes services by an "out of network" provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.)
- An authorization has been given for services that require prior authorization by Ambetter and IlliniCare Health.
- Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service and prior authorization processes were followed.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

CLAIM FILING DEADLINES

Please see the Table below for claim filing deadlines. Claims received outside of these timeframes will be denied for untimely submission.

	*Initial Claims		Reconsiderations or Claim Dispute/Appeals		**Coordination of Benefits	
	Calendar Days		Calendar Days		Calendar Days	
	Par	**Non-Par**	**Par**	**Non-Par**	**Par**	**Non-Par**
Ambetter of Arkansas	180	90	180	90	180	90
Ambetter from Sunshine Health	180	180	180	90	180	180
Ambetter from Peach State Health Plan	180	90	180	90	180	90
Ambetter from MHS	180	90	180	90	180	90
Ambetter from CeltiCare Health	180	90	180	90	180	90
Ambetter from Magnolia Health	180	90	180	90	180	90
Ambetter from Buckeye Health Plan	180	90	180	90	180	90
Ambetter from Superior HealthPlan	95	95	120	95	95	95
Ambetter from Coordinated Care	180	90	24 months	24 months	180	30 months
Ambetter from MHS Health Wisconsin	180	90	180	90	180	90
IlliniCare Health	180	90	180	90	180	90
	*Days are calculated from the Date of Service to the date received by Ambetter and IlliniCare Health or from the EOP date			**Days are calculated from the date of the Explanation of Payment from the primary payer to the date received.		

ADDING A NEWBORN OR ADOPTED CHILD

Coverage applicable for children will be provided for a newborn child or adopted child of an Ambetter and IlliniCare Health member or for a member's covered family member from the moment of birth or moment of placement if the newborn is enrolled timely as specified in the member's Evidence of Coverage. The timely enrollment period is:

Health Plan	Coverage Period
Ambetter of Arkansas	Date of birth until the 91st day after birth
Ambetter from Sunshine Health	Date of birth until the 31st day after birth
Ambetter from Peach State Health Plan	Date of birth until the 31st day after birth
Ambetter from MHS	Date of birth until the 31st day after birth
Ambetter from CeltiCare Health	Up to 96 hours after birth. Coverage is also provided for adoptive children of a member from the date of the filing of a petition to adopt, and the child has been residing in the home of the Member as a foster child for whom the Member has

Health Plan	Coverage Period
	been receiving foster care payments, or, in all other cases, adoptive children from date of placement of the child for the purpose of adoption
Ambetter from Magnolia Health	Date of birth until the 31st day after birth
Ambetter from Buckeye Health Plan	Date of birth until the 31st day after birth
Ambetter from Superior HealthPlan	Date of birth until the 31st day after birth
Ambetter from Coordinated Care **Ambetter from MHS Health Wisconsin**	Date of birth until the 31st day after birth Date of birth until the 31st day after birth
IlliniCare Health	Date of birth until the 31st day after birth

CORRECTED CLAIMS, REQUESTS FOR RECONSIDERATION, AND CLAIM DISPUTES/APPEALS

Below are relevant definitions:

1. Corrected Claim: A provider is CHANGING the original claim
2. Request for Reconsideration: A provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
3. Claim Dispute/Appeal: A provider disagrees with the outcome of the request for reconsideration

Please see the Table below for timeframes for submission of corrected claims, requests for reconsideration or claim disputes/appeals. The timeframes specified are from the date of the notification of original payment or denial is issued. Prior processing will be upheld for corrected claims, requests for reconsideration or claim dispute/appeals received outside of the timeframes stipulated below unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A 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, administrative delays or errors by Ambetter or IlliniCare or the governing authority.
- The member was eligible; however the provider was unaware that the member was eligible for services at the time the 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 his or her ID card or information.
    - The provider can substantiate that he or she continually pursued reimbursement from the patient until eligibility was discovered.
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

CORRECTED CLAIMS

Corrected Claims may be submitted in any of the following ways:

1. Submit a corrected claim via the Secure Provider Portal
2. Submit a corrected claim electronically via a clearinghouse
    - Institutional Claims (UB-04): Field CLM05-3=7 and Ref*F8=Original Claim Number
    - Professional Claims (CMS-1500): Field CLM05-3=6 and Ref*F8=Original Claim Number
3. Mail corrected paper claims to:

Ambetter and IlliniCare Health
P.O. Box 5010
Farmington, MO 63640-5010

- Upon resubmission of a corrected paper claim, the original claim number must be **typed** in field 22 (CMS 1500) and in field 64 (UB-04) with the corresponding frequency codes in field 22 of the CMS1500 form and in field 64 of the UB-04 form.
- Corrected paper claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.
- The original Explanation of Payment (EOP) must be submitted along with the standard red and white form. Failure to submit the original EOP may result in the claim being denied as a duplicate, a delay in reprocessing or denial for exceeding the timely filing limit.

REQUEST FOR RECONSIDERATION

A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. Generally, medical records are not required for requests for reconsideration. However, if there is disagreement with a code audit, code edit or authorization denial, medical records **must** accompany the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. Phone call to Provider Services
    - This method may be utilized for requests for reconsiderations that do not require submission of supporting or additional information. An example of this would be when a provider may believe a particular service should be reimbursed at a particular rate but the payment amount did not reflect that particular rate.
2. Providers may utilize the Request for Reconsideration form found our website (preferred method). (Please see the applicable website address found at the beginning of this Manual).
3. Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information which includes, at a minimum, the member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a UB-04 form.

Written requests for reconsideration and any applicable attachments must be mailed to:

Ambetter and IlliniCare Health
P.O. Box 5010
Farmington, MO 63640-5010

When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps to submit a Claim Dispute/Appeal.

CLAIM DISPUTE/APPEAL

A claim dispute/appeal may only be used when a provider has received an unsatisfactory response to a request for reconsideration.

A claim dispute/appeal must be submitted on a claim dispute/appeal form found on our website. (Please see the applicable website address at the beginning of this Manual). The claim dispute/appeal form must be completed in its entirety. The completed claim dispute/appeal form may be mailed to:

Ambetter and IlliniCare Health
P.O. Box 5000
Farmington, MO 63640-5000

A claim dispute/appeal will be resolved within 30 calendar days. A provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision.

CLINICAL LAB IMPROVEMENT ACT (CLIA) BILLING INSTRUCTIONS

CLIA numbers are required for CMS 1500 claims where CLIA Certified or CLIA waived services are billed. If the CLIA number is not present, the claim will be upfront rejected. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim type submissions:

Paper Claims

If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

*Note: An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

***Note:** The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

Please refer to the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.

Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

***Note:** An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

TAXONOMY CODE BILLING REQUIREMENT

Taxonomy numbers are required for all Ambetter and IlliniCare Health claims. Claims submitted without taxonomy numbers will be upfront rejected with an EDI Reject Code of 06. If the claim was submitted on paper, a rejection letter will be returned indicating that the taxonomy code was missing.

The verbiage associated with Reject 06 is as follows: The provider identification, tax identification and/or taxonomy numbers are either missing or do not match the records on file. Please contact Provider Services to resolve this issue.

Below are three scenarios involving the Taxonomy Code Billing Requirement.

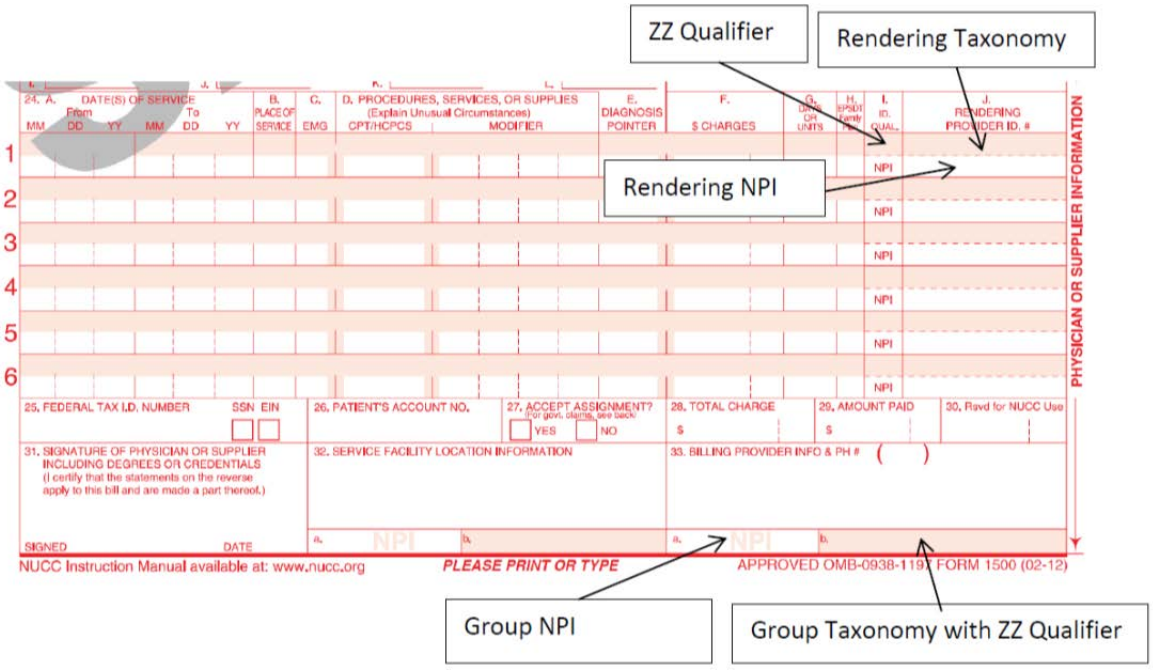
Scenario One: Rendering NPI is *different* than the Billing NPI
CMS 1500 Form

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
		2310B	NM109
Rendering NPI	Unshaded portion of box 24J	2420A	NM109
		2310B	PRV02 REF01
Taxonomy Qualifier ZZ	Shaded portion of box 24 I	2420A	PRV02 REF01
Rendering Provider Taxonomy Number	Shaded portion of box 24J	2310B	PRV03 REF02
		2420A	PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Billing Provider Group Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") e.g. box 33b ZZ208D00000X EDI PRV*PE*PXC*208D00000X		2000A	PRV03
Billing Provider Group FTIN(EI)/SSN(SY)	Box 33b	2010AA	REF01 REF02

Scenario Two: Rendering NPI and Billing NPI are the *same*
CMS 1500 Form
It is NOT necessary to submit the Rendering NPI and Rendering Taxonomy in this Scenario; however, if box 24 I and 24 J are populated, then all data MUST be populated.

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC")		2000A	PRV03
Billing Provider Group FTIN(EI)/SSN(SY) e.g. REF*EI*999999999	Box 33b	2010AA	REF01 REF02

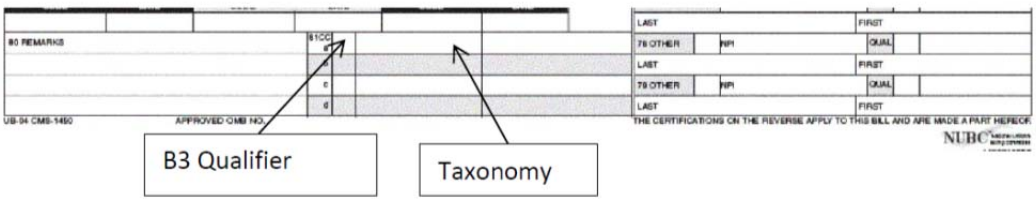
Below is an example of the fields relevant to Scenario One and Scenario Two above.



Scenario Three: Taxonomy Requirement for UB 04 Forms

Required Data	Paper UB 04	Electronic Submission
Taxonomy Code with B3 Qualifier	Box 81 CC	Billing Level 2000A Loop and PRVR segment

Below is an example of the UB 04 form



PROCEDURES FOR ELECTRONIC SUBMISSION

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submissions 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.

ELECTRONIC CLAIM SUBMISSION

Providers are encouraged to participate in Ambetter and IlliniCare Health's Electronic Claims/Encounter Filing Program through Centene. Ambetter and IlliniCare Health (Centene) has the capability to receive an ANSI XS12N 837 professional, institutional, or encounter transaction. In addition, Ambetter and IlliniCare Health (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:

Ambetter and IlliniCare Health
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.

Ambetter and IlliniCare Health have the ability to receive coordination of benefits (COB or secondary) claims electronically. Ambetter and IlliniCare Health follow the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

SPECIFIC DATA RECORD REQUIREMENTS

Claims transmitted electronically must contain all of the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements.

ELECTRONIC CLAIM FLOW DESCRIPTION & IMPORTANT GENERAL INFORMATION

In order to send claims electronically to Ambetter and IlliniCare Health, all EDI claims must first be forwarded to one of Ambetter and IlliniCare Health'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 immediately 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 Ambetter and IlliniCare Health. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Ambetter and IlliniCare Health and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Ambetter and IlliniCare Health by a clearinghouse is validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the upfront 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; 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 Ambetter and IlliniCare Health.

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 instruction provided in the corrected claim section.

INVALID ELECTRONIC CLAIM RECORD UPFRONT REJECTIONS/DENIALS

All claim records sent to Ambetter and IlliniCare Health 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 Ambetter and IlliniCare Health. In these cases, the claim must be corrected and re-submitted within the required filing deadline of the guidelines within 180 days (95 days for Superior) by contracted providers (in-network) from the date of service and non-contracted providers (out of network), the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in this Manual. 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.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

SPECIFIC AMBETTER AND ILLINICARE HEALTH ELETRONIC EDIT REQUIREMENTS – 5010 INFORMATION

- Institutional Claims – 837Iv5010 Edits
- Professional Claims – 837Pv5010 Edits

Please refer to the EDI HIPAA Version 5010 Implementation section on our website for detailed information.

CORRECTED EDI CLAIMS

- CLM05-3 Required 6 or 7.
- IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned.
    - Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

EXCLUSIONS

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 price (e.g., custom 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
Submitting Claims through clearinghouses Ambetter and IlliniCare Health Payer ID number for all clearinghouses (Medical and Cenpatico) is 68069	• Allscripts/Payerpath • Availity • Capario • Claim Remedi • Claimsource • CPSI • DeKalb • Emdeon • First Health Care • Gateway EDI • GHNonline • IGI • MDonLine • Physicians CC • Practice Insight • Relay/McKesson • Smart Data • SSI

Action	Contact
	• Trizetto Provider Solutions, LLC • Viatrack
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 Ambetter Provider Services or the Secure Provider Portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes:	Notify Provider Service in writing.

IMPORTANT STEPS TO A SUCCESSFUL SUBMISSION OF EDI CLAIMS:

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse regarding what data records are required.
3. Verify with Provider Services at Ambetter and IlliniCare Health that the provider is set up in the Ambetter and IlliniCare Health system prior to submitting EDI claims.
4. You will receive two (2) 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 Ambetter and IlliniCare Health, and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Ambetter and IlliniCare Health. ALWAYS review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit.
5. MOST importantly, all claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

PROCEDURES FOR ONLINE CLAIM SUBMISSION

For providers who have internet access and choose not to submit claims via EDI or paper, Ambetter and IlliniCare Health has made it easy and convenient to submit claims directly to Ambetter and IlliniCare Health on the Secure Provider Portal at the following Plan websites:

Health Plan	Website
Ambetter of Arkansas	AmbetterofArkansas.com
Ambetter from Sunshine Health	Ambetter.SunshineHealth.com
Ambetter from Peach State Health Plan	Ambetter.pshpgeorgia.com
Ambetter from MHS	Ambetter.mhsindiana.com
Ambetter from CeltiCare Health	Ambetter.CeltiCareHealthPlan.com
Ambetter from Magnolia Health Plan	Ambetter.MagnoliaHealthPlan.com
Ambetter from Buckeye Health Plan	Ambetter.BuckeyeHealthPlan.com

Ambetter from Superior HealthPlan	Ambetter.SuperiorHealthPlan.com
Ambetter from Coordinated Care	Ambetter.CoordinatedCareHealth.com
Ambetter from MHS Health Wisconsin	Ambetter.mhswi.com
IlliniCare Health	Marketplace.IlliniCare.com

You must request access to our secure site by registering for a user name and password. To register, please go directly to one of the following plan websites at the website address previously mentioned in this Manual. If you have technical support questions, please contact Provider Services.

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. Detailed instructions for submitting via Secure Web Portal are also stored on our website; you must login to the secure site for access to this manual.

ELECTRONIC FUNDS TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE (ERA)

Ambetter partners with specific vendors to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment. Providers are able to enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact Provider Services.

Benefits include:

- **Elimination of paper checks** - all deposits transmitted via EFT to the designated bank account
- **Convenient payments & retrieval of remittance information**
- **Electronic remittance advices presented online**
- **HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System**
- **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 can 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. Multiple practices and accounts are supported
- **Match payments to advices quickly –** You can associate electronic payments with electronic remittance advices quickly and easily
- **Manage multiple Payers –** Reuse enrollment information to connect with multiple Payers Assign different Payers to different bank accounts, as desired

For more information visit Ambetter's Provider website.

PAPER CLAIM SUBMISSIONS

The mailing address for first time claims, corrected claims and requests for reconsideration:

Ambetter and IlliniCare Health
Attn: Claims
P.O. Box 5010
Farmington, MO 63640- 5010

The mailing address for claim disputes/appeals:

Ambetter and IlliniCare Health
P.O. Box 5000
Farmington, MO 63640- 5000

Ambetter encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available on our websites. Paper submissions are subject to the same edits as electronic and web submissions.

Ambetter only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper Claims forms. Other claim form types will be upfront rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Ambetter does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10 or 12 Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms or handwritten forms will be upfront rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact Provider Services.

CODING OF CLAIMS/ BILLING CODES

Ambetter requires claims to be submitted using codes from the current version of ICD-9-CM/ ICD-10-CM (effective 10-01-15), ASA, DRG, CPT, 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 services
- Code inappropriate for the age or sex of the member
- Diagnosis code missing the 4th and 5th digit as appropriate (ICD-9)
- 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

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Ambetter and IlliniCare Health.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. A separate claim needs to be submitted for the mother, and her newborn.

Billing from independent provider-based Rural Health Clinics (RHC) and Federally

Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code / modifier combinations.

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

For more information regarding billing codes, coding, and code auditing/editing, please contact Ambetter Provider Services.

IMPORTANT STEPS TO SUCCESSFUL SUBMISSION OF PAPER CLAIMS:

1. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red and handwritten claim forms will be rejected back to the provider.
2. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
3. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.
4. Ensure all Diagnosis Codes are coded to their highest number of digits available
5. Ensure member is eligible for services during the time period in which services were provided.
6. Ensure that services were provided by a participating provider or that the "out-of-network" provider has received authorization to provide services to the eligible member.
7. Ensure an authorization has been given for services that require prior authorization by Ambetter.

AMBETTER CODE AUDITING AND EDITING

Ambetter uses HIPAA compliant code auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting. The software will detect, correct, and document coding errors on provider claims submissions prior to payment. The software analyzes CPT, HCPCS, Diagnosis codes and modifiers against correct coding principles established by the AMA and CMS. Moreover, the software contains additional edit logic that is sourced from medical and provider societies for billing rules for their membership on correct coding principles. These policies are based on correct coding principles established by the AMA and CMS clinical policies for correct coding. Claims billed in a manner that do not adhere to the standards of the code auditing software will be denied or pended for further review by a coding analyst.

The code auditing 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 website, 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 (OCE 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, and 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 conditions where the software will make a change on submitted codes:

Unbundling of Service - Identifies Services That Have Been Unbundled

Example: Unbundling lab panel. 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.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, Automated and 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; therefore, they are not separately reimbursable. Those claims 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 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; therefore, they 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 site during same operative session.

Code	Description	Status
69436 DOS=01/01/10	Tympanostomy	Allow
69436 50 DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Reduce payment

Duplicate Services- Submission of same procedure more than once on same date of service that cannot be, or 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 anteropsterior 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 services 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 90 day global surgery period are designated as major surgical procedures; those assigned a 10 day or 0 day global surgery period are designated as minor surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90 day) and minor surgical procedures (10 day), are not recommended for separate reporting because they are part of the global services.
- Evaluation and management services, submitted with minor surgical procedures (0 day), are not recommended for separate reporting or reimbursement because these services are part of the global services.

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. Typically 15 minutes are spent face-to-face w/patient &/or family	Disallow

Explanation:

- Procedure Code 27447 has a global surgery period of 90 days.
- Procedure Code 99213 is submitted with a date of service that is within the 90 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 & 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. Typically 15 minutes are spent face-to-face w/patient &/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. Typically 40 minutes are spent 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. Typically 30 minutes are spent face-to-face with patient/family.	Disallow

- 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 or other qualified health care professional on the same day of a procedure. The evaluation and management service will be reviewed through the code edit and audit process and may require the submission of medical records. The following guidelines are utilized to determine whether or not a modifier 25 was used appropriately:

- If the E and M service is the first time a provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient’s condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services

- If a provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required E and M services to determine the patient's need.

Providers should assign all applicable diagnosis code(s) that indicate the need for additional E and M services. E and M codes appended with a modifier 25 will not automatically be reimbursed. Medical records will be required to support the billing of the modifier.

Modifier- 50 is used to indicate a procedure performed on bilateral anatomical sites and applied to a surgical, radiological or diagnostic procedure.

Modifier – 59 is used to report distinct procedures/services not normally reported together, but appropriately billable under the circumstances. Procedures/services reported with modifier 59 will be reviewed through the code edit and audit process and may require the submission of medical records. The following guidelines will be utilized to determine if a modifier 59 was used correctly:

- The diagnosis codes on the claim indicate multiple conditions or sites were treated or are likely to be treated
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.

Providers should assign to the claim all applicable diagnosis and procedure codes and utilize all applicable anatomical modifiers designating which areas of the body were treated. Procedures/services appended with a modifier 59 will not automatically be reimbursed. Medical Records will be needed to support the billing of the modifier.

Modifier- 79 is used to report an unrelated procedure or service by the same physician or other qualified health care professional during the post-operative period.

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 separating reporting.
- When a claim line is submitted without the modifier – 26 in a facility setting (for example: POS 21, 22, 23, 34), 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 a modifier – 26.

Modifier – 80 and -82 (Assistant Surgeon)

Definition: This edit identifies claim lines containing Procedure Codes billed with an assistant surgeon modifier that typically do not require as 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.

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 of this procedure.

Other Edits

The following provides examples of other types of edits that will be used during the adjudication process:

- Validity edits – edits due to invalid data submitted, for example:

ICD-CM diagnosis codes – Wrong codes

HCPCS procedure codes without Revenue codes (for APC)

Invalid age – Inappropriate procedures for the age of the member

Invalid sex – Inappropriate procedure for the gender of the member

Diagnosis/procedure and age or sex conflicts – Inappropriate procedure for the age and gender of the member

- Volume/unit edits—Medically Unlikely Edits – Example: the code audit and edit process will review the number of doses billed for allergen immunotherapy. This is based upon chapter 15 of the Medicare Benefits Policy Manual
- Claim lacks required device or procedure code
- Specific nuclear medicine services on claims that do not contain specific radiopharmaceuticals
- National Correct Coding Initiative (CCI) Edits
- Outpatient Code Editor (OCE) Edits

Claim Reconsiderations related to Code Auditing and Editing

As mentioned previously in this Manual, if you disagree with a code audit or edit and request claim reconsideration, you must submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code audit or edit will be upheld.

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.

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 the code auditing product(s) evaluate code and code combinations during the auditing of claims. The tool is available for providers who are registered on our Secure Provider Portal. You can access the tool in the Claims Module by clicking “Claim Auditing Tool” in our Secure Provider Portal.

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. The tool is a guideline and the results displayed do not guarantee how the claim will be processed.

UPFRONT 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. If a paper claim has been rejected, provider should submit the rejection letter with the corrected claim.

UPFRONT REJECTION

An upfront 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 our website. A list of common upfront rejections can be located in Appendix 1of this Manual. Upfront 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 with explanations in Appendix II.

APPENDIX

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 (02/12) Form, Shaded Field 24a-G
V. Common HIPAA Compliant EDI Rejection Codes
VI. Claim Form Instructions
VII. Billing Tips and Reminders
VIII. Reimbursement Policies

APPENDIX I: COMMON CAUSES FOR UPFRONT REJECTIONS

Common causes for upfront rejections include but are not limited to:

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or hand written information is not legible.
- 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.
- A missing CLIA Number in Box 23 or a CMS 1500 for CLIA or CLIA waived service
- Incorrect Form Type used.
- A missing taxonomy code and qualifier in box 24 I, 24 J or Box 33b on the CMS 1500 form or Box 81 CC on the UB04 form (see further requirements in this Manual).

APPENDIX II: COMMON CAUSE OF CLAIMS PROCESSING DELAYS AND DENIALS

- Procedure or Modifier Codes entered are invalid or missing.
- This includes GN, GO, or GP modifier for therapy services.
- Diagnosis Code is missing the 4th or 5th digit.
- 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 do 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.

Code	DESCRIPTION
07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
18	DENY: DUPLICATE CLAIMS/SERVICE
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
46	DENY: THIS SERVICE IS NOT COVERED
86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
99	DENY: MISC/UNLISTED CODES CAN NOT BE PROCESED W/O DESCRIPTION/REPORT
K1	DENY: CPT CODE IS NOT VALID FOR AGE OF PATIENT
3D	DENY: NON-SPECIFIC DIAGNOSIS-REQUIRES 4TH DIGIT PLEASE RESUBMIT
4D	DENY: NON-SPECIFIC DIAGNOSIS-REQUIRES 5TH DIGIT PLEASE RESUBMIT
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 INCORRET ON CLAIM, PLEASE RE-SUBMIT
BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
CF	DENY: WAITING FOR CONSENT FORM
DW	DENY: INAPPROPRIATE DIAGNOSIS BILLED CORRECT AND RESUBMIT
DX	DENY: DIAGNOSIS IS MISSING OR INVALID
EC	DENY: DIAGNOSIS CANNOT BW USED AS PRIMARY DIAGNOSIS, PLEASE RESUMIT
HQ	DENY: EDI CLAIM MUST BE SUBMITTED HARDCOPY WITH ADDITIONAL DOCUMENTATION
IM	DENY: MODIFIER MISSING OR INVALID
L6	DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB

Code	DESCRIPTION
MQ	DENY: MEMBER NAME/NUMBER/DOB, DO NOT MATCH PLEASE RESUBMIT
NT	DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
U1	CLAIM CANNOT BE PROCESSED WITHIOUT MEDICAL RECORDS
AQ	ACE CLAIM LEVEL RETURN TO PROVIDER. MUST CALL PROVIDER SERVICES FOR MORE DETAIL
ya	DENY: DENIED AFTER REVIEW OF PATIENT'S CLAIM HISTORY
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	ICD-9 CONFLICTS WITH MEMBERS AGE
x5	PROCEDURE CODE CONFLICTS WITH MEMBERS AGE
x6	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
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID
xd	PROCEDURE CODE APPENDED WITH BIALATERAL 50 MODIFIER

APPENDIX IV: INSTRUCTIONS FOR SUPLEMENTAL INFORMATION

CMS- 1500 02/12) FORM, SHADED FIELD 24A-G

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

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract Rate

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

ZZ Narrative description of unspecified/miscellaneous/unlisted codes

N4 National Drug Code (NDC)

CTR Contract Rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

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

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

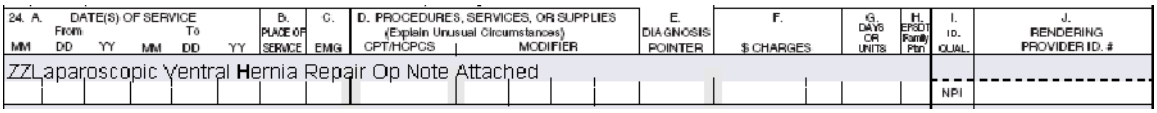
For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

Additional Information for Reporting NDC:

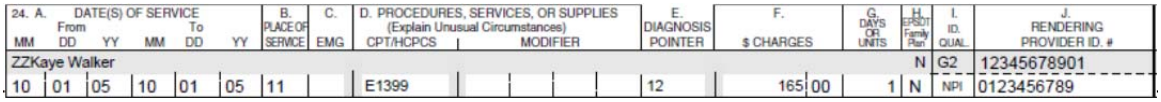
When adding supplemental information for NDC, enter the information in the following order:

- Qualifier
- NDC Code
- One space
- Unit/basis of measurement qualifier
    - F2- International Unit
    - ME – Milligram
    - UN – Unit
    - GR – Gram
    - ML - Milliliter
- Quantity
    - The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999).
    - When entering a whole number, do not use a decimal (ex. 2).
    - Do not use commas.

Unspecified/Miscellaneous/Unlisted Codes

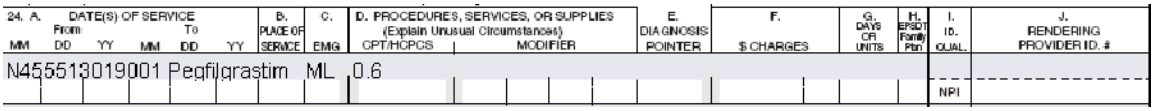


24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral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

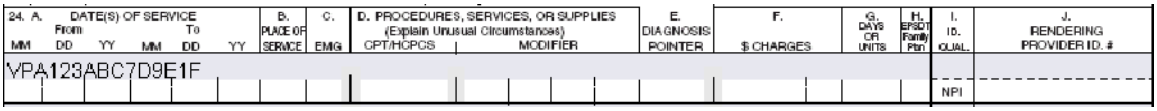


24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker													N	G2	12345678901
10	01	05	10	01	05	11		E1399		12	165 00	1	N	NPI	0123456789

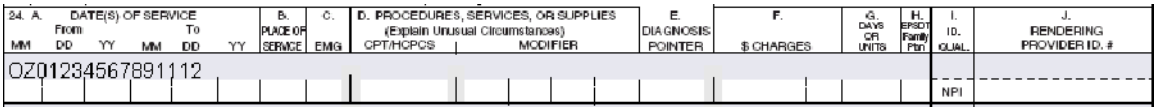
NDC Codes



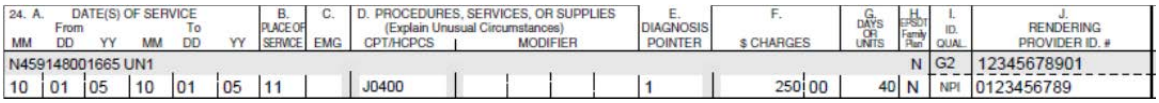
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N455513019001 Pegfilgrastim						ML		0.6						NPI	



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	



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. #
OZ01234567891112														NPI	



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. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

APPENDIX V: COMMON HIPAA COMPLIANT EDI REJECTION CODES

These codes on the follow page are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

APPENDIX VI: CLAIM FORM INSTRUCTIONS

Billing Guide for a CMS 1500 and CMS 1450 (UB-04) Claim Form.

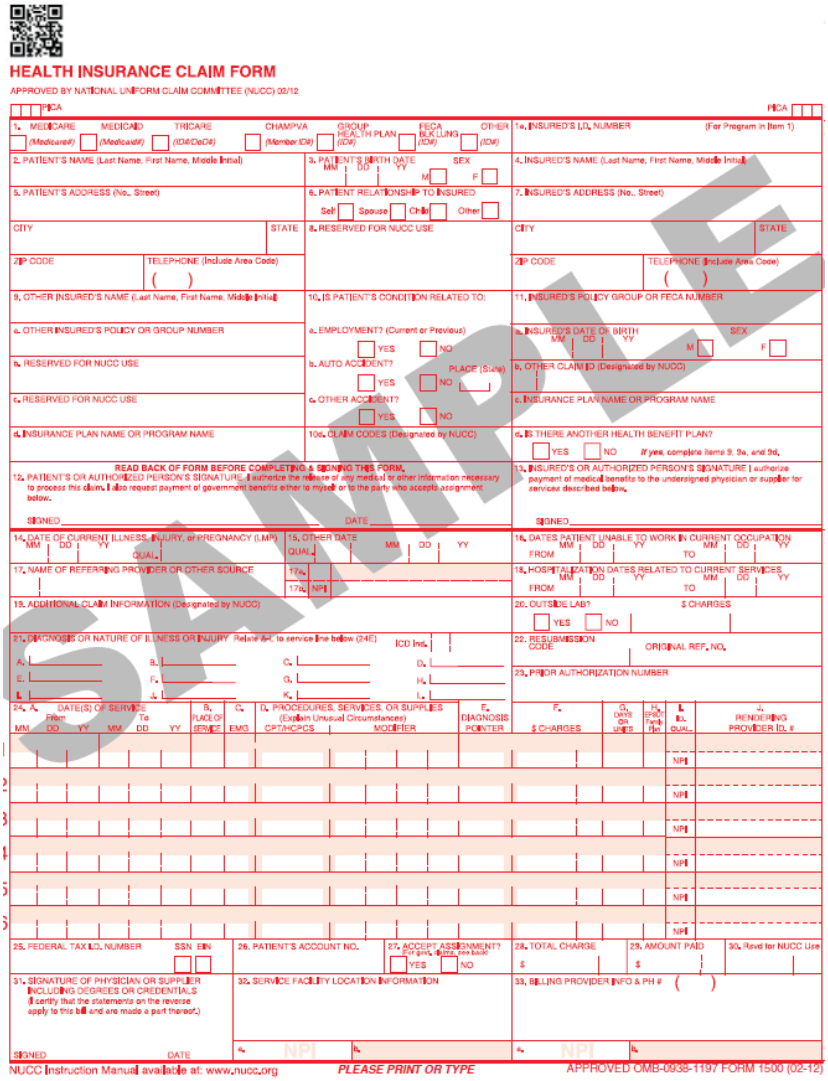
Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided

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

COMPLETING A CMS 1500 CLAIM FORM

Updated format (Form 1500 (02-12)) can be accepted as of Jan. 1, 2014, and is required after October 1, 2014.

Please see the following example of a CMS 1500 form.



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

SAMPLE

Field #	Field Description	Instruction or Comments	Required or Conditional
1	**INSURANCE PROGRAM IDENTIFICATION**	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter “X” in the box noted “Other”	R
1a	**INSURED’S I.D. NUMBER**	The 9-digit identification number on the member’s Ambetter I.D. Card	R
2	**PATIENTS NAME (Last Name, First Name, Middle Initial)**	Enter the patient’s name as it appears on the member’s Ambetter 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 Ambetter 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 codes), 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
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 codes),	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
8	**RESERVED FOR NUCC USE**		Not Required
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 field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	**RESERVED FOR NUCC USE**		Not Required
9c	**RESERVED FOR NUCC USE**		Not Required
9d	**INSURANCE PLAN NAME OR PROGRAM NAME**	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 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. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	**CLAIM CODES (Designated by NUCC)**	When reporting more than one code, enter three blank spaces and then the next code.	C
11	**INSURED POLICY OR FECA NUMBER**	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	**INSURED'S DATE OF BIRTH / SEX**	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	**OTHER CLAIM ID (Designated by NUCC)**	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	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 field's 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	**INSURED'S OR AUTHORIZED PERSONS SIGNATURE**	Obtain signature if appropriate.	Not Required
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 of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	**IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE**	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.	C
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**		C
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).	C
17a	**ID NUMBER OF REFERRING PHYSICIAN**	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code	C
17b	**NPI NUMBER OF REFERRING PHYSICIAN**	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**		C

19	**RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION**		C
20	**OUTSIDE LAB / CHARGES**		C
21	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR**	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	**RESUBMISSION CODE / ORIGINAL REF.NO.**	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	**PRIOR AUTHORIZATION NUMBER or CLIA NUMBER**	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services	If auth = C If CLIA = R *(If both, always submit the CLIA number)*
24a-j	**GENERAL INFORMATION**	Box 24 contains six 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 four 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 Number. Shaded boxes 24 a-g is for line item supplemental information and provides 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.	

24 A-G Shaded	**SUPPLEMENTAL INFORMATION**	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24A Unshaded	**DATE(S) OF SERVICE**	Enter the date the service listed in field 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 Unshaded	**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 Unshaded	**EMG**	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D Unshaded	**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 four 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
24 E Unshaded	**DIAGNOSIS CODE**	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. 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

24 F Unshaded	**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 eight 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
24 G Unshaded	**DAYS OR UNITS**	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	**EPSDT (Family Planning)**	Leave blank or enter "Y" if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	**EPSDT (Family Planning)**	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	**ID QUALIFIER**	Use ZZ qualifier for Taxonomy Use 1D qualifier for ID, if an Atypical Provider.	R
24 J Shaded	**NON-NPI PROVIDER ID#**	<u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. <u>Atypical Providers:</u> Enter the Provider ID number.	R
24 J Unshaded	**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	C
27	**ACCEPT ASSIGNMENT**	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Ambetter recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments	C
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 eight characters are allowed (i.e. 199999.99). Do not use commas. 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 Ambetter. Ambetter programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	**BALANCE DUE**	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). 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 numbers 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 codes), 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. (555)555-5555). 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 OTHERS ID**	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

COMPLETING A UB-04 CLAIM FORM

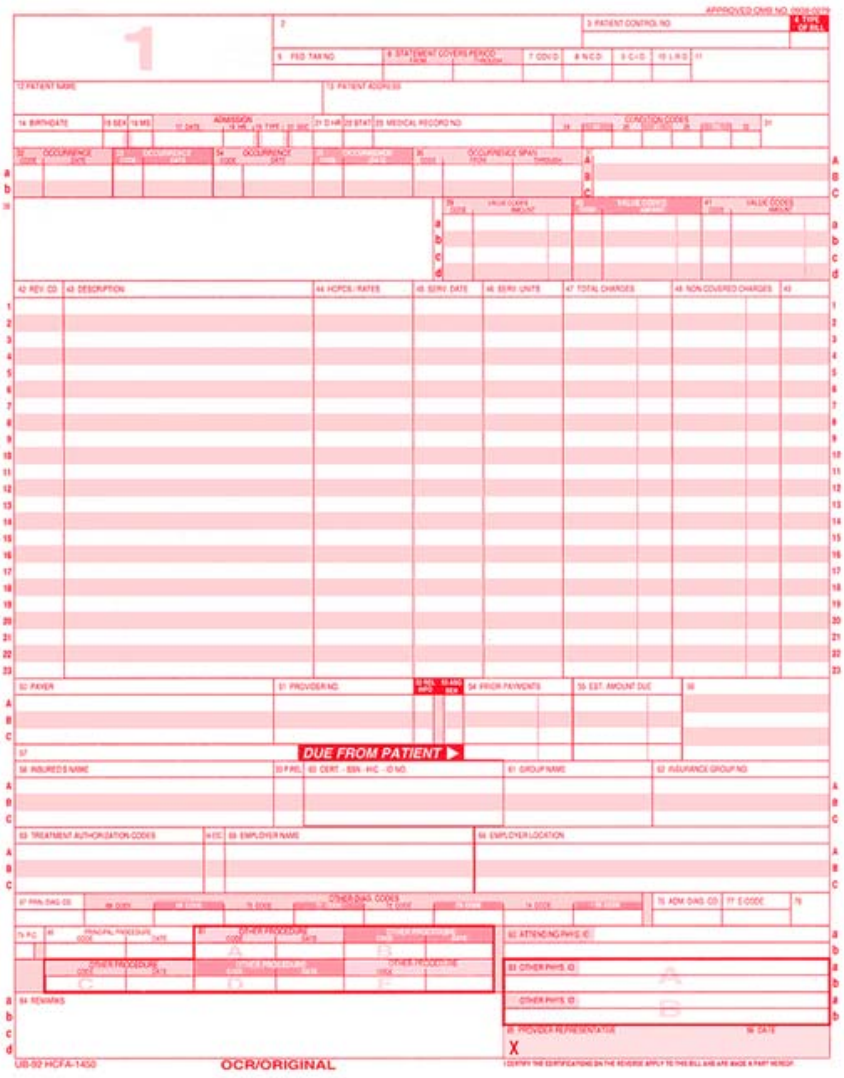
A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Ambetter. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services,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

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.
- Please refer to your provider contract with Ambetter or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

Below is an example of a UB-04 form



FIELD #	Field Description	Instruction or Comments	Required or Conditional
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 codes (include hyphen). NOTE: The 9 digit zip (zip +4 codes) 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 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. 3rd Digit- Indicating the bill sequence (Frequency code).	R
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
8a	**PATIENT NAME**	8a – Enter the first 9 digits of the identification number on the member's Ambetter I.D. card	Not Required
8b	**PATIENT NAME**	8b – enter the patient's last name, first name, and middle initial as it appears on the Ambetter 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. Enter the patient's complete mailing address of the patient.	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
9	**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. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R
13	**ADMISSION HOUR**	0012:00 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 05-05:00:00 to 05:59 17-05:00:00 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**	Require for inpatient and outpatient admissions (Enter the 1-digit code indicating the of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
15	**ADMISSION SOURCE**	Required for inpatient and outpatient admissions. 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 Clinic Referral 4 Health Maintenance Referral (HMO) 5 Transfer from a hospital 6 Transfer from Skilled Nursing Facility 7 Transfer from another health care facility 8 Emergency Room 9 Court/Law Enforcement 10 Information not available For Type of admission 4 (newborn): 1 Physician Referral 2 not available	R
16	**DISCHARGE HOUR**	Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 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 05-05:00:00 to 05:59 17-05:00:00 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

FIELD #	Field Description	Instruction or Comments	Required or Conditional
		REQUIRED for inpatient and outpatient 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) 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)	
17	**PATIENT STATUS**		R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
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 for 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 for 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)**	REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C

FIELD #	Field Description	Instruction or Comments	Required or Conditional
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 for 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 eight 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
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

FIELD #	Field Description	Instruction or Comments	Required or Conditional
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"). (Limited to 4 pages per claim)	C
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 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.	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 A-C	**PAYER**	Enter the name of 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

FIELD #	Field Description	Instruction or Comments	Required or Conditional
51 A-C	HEALTH PLAN IDENTIFCATION 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 Ambetter is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. 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 ID exactly as it appears on the patient's ID card. Enter the Insurance 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

FIELD #	Field Description	Instruction or Comments	Required or Conditional
64	**DOCUMENT CONTROL NUMBER**	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Ambetter Health Plan from field 50. 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.	C
65	**EMPLOYER NAME**		Not Required
66	**DX VERSION QUALIFIER**		Not 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.	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 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	**PRESENT ON ADMISSION INDICATOR**		R
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 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. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
70	**PATIENT REASON CODE**	Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry, fields 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" codes 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	**UNLABLED**		Not Required
74	**PRINCIPAL PROCEDURE CODE/DATE**	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
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 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-9 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	**UNLABLED**		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 #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R

FIELD #	Field Description	Instruction or Comments	Required or Conditional
77	**OPERATING PHYSICIAN**	REQUIRED when a surgical procedure is performed. 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 #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending 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:	C
80	**REMARKS**		Not Required
81	**CC**	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	**ATTENDING PHYSICIAN**	Enter name or 7 digit Provider number of ordering physician	R

APPENDIX VII: BILLING TIPS AND REMINDERS

Adult Day Health Care

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 99

Ambulance

- Must be billed on a CMS 1500 Claim Form.
- Appropriate modifiers must be billed with the Transportation Codes

Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers must submit charges using the CMS 1500 Claim Form
- Must be billed in place of service 24

- Invoice must be billed with Corneal Transplants
- Most surgical extractions are billable only under the ASC

Anesthesia

- Bill total number of minutes in field 24G of the CMS 1500 Claim Form and must be submitted with the appropriate modifier.
- Failure to bill total number of minutes may result in incorrect reimbursement or claim denial
- Appropriate modifiers must be utilized

APC Billing Rules

- Critical Access Hospitals (CAHs) are required to bill with 13x-14x codes.
- Bill type for APC claims are limited to 13xs-14x range
- Late charge claims are not allowed. Only replacement claims. Claims with late charges will be denied to be resubmitted.
- Claims spanning two calendar years will be required to be submitted by the provider as one claim.
- CMS Maximum Unit Edits (MUEs) will be applied per line, per claim.
    - Claim lines exceeding the MUE value will be denied.
- Observation: Providers are required to bill HCPCS G0378 along with the revenue code. The Observation G code will allow the case rate. CMS is proposing significant changes to observation rules and payment level for 2014, and this will be updated accordingly.
- Ambulance Claims: Need to be submitted on a CMS 1500 form. Any Ambulance claim submitted on a UB will be denied.
- Revenue codes and HCPCs codes are required for APC claims.

Comprehensive Day Rehab

- Must be billed on a CMS 1500 Claim Form
- Must be billed in location 99
- Acceptable modifiers

Deliveries

- Use appropriate value codes as well as birth weight when billing for delivery services.

DME/Supplies/Prosthetics and Orthotics

- Must be billed with an appropriate modifier
- Purchase only services must be billed with modifier NU
- Rental services must be billed with modifier RR

Hearing Aids

- Must be billed with the appropriate modifier LT or RT

Home Health

- Must be billed on a UB 04
- Bill type must be 3XX
- Must be billed in location 12
- Both Rev and CPT codes are required

- Each visit must be billed individually on separate service line

Long Term Acute Care Facilities (LTACs)

- Long Term Acute Care Facilities (LTACs) must submit Functional Status Indicators on claim submissions.

Maternity Services

- Providers must utilize correct coding for Maternity Services.
- Services provided to members prior to their Ambetter effective date, should be correctly coded and submitted to the payer responsible.
- Services provided to the member on or after their Ambetter effective date, should be correctly coded and submitted to Ambetter.

Modifiers

- Appropriate Use of – 25, 26, TC, 50, GN, GO, GP
- **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. Modifier 25 is subject to the code edit and audit process. Appending a modifier 25 is not a guarantee of automatic payment and may require the submission of medical records. Well-Child and sick visit performed on the same day by the same physician). *NOTE: 25 modifiers are 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 result 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.
    - RT and LT modifiers or quantities greater than one should not be billed when using modifier 50
- **GN, GO, GP Modifiers** – therapy modifiers required for speech, occupational, and physical therapy

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.

Outpatient Hospital Laboratory Services

- Bill Type 141 – Must be utilized when a non-inpatient or non-outpatient hospital member's specimen is submitted for analysis to the Hospital Outpatient Laboratory. The Member is not physically present at the hospital.

- Bill Type 131 and Modifier L1 – Must be utilized when the hospital only provides laboratory tests to the Member and the Member does not also receive other hospital outpatient services during the same encounter. Must also be utilized when a hospital provides a laboratory test during the same encounter as other hospital outpatient services that are clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered is by a different practitioners than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.
- Services not billed following the above guidelines will be denied as EX code AT.

POA

- Present on Admission (POA) Indicator is required on all inpatient facility claims

Failure to include the POA may result in a claim denial/rejection

Rehabilitation Services – Inpatient Services

- Functional status indicators must be submitted for inpatient Rehabilitation Services.

Telemedicine

- Physicians at the distant site may bill for telemedicine services and MUST utilize the appropriate modifier to identify the service was provided via telemedicine.
    - E&M CPT plus the appropriate modifier
    - Via interactive audio and video tele-communication systems.

APPENDIX VIII: REIMBURSEMENT POLICIES

As a general rule, Ambetter and IlliniCare Health follow Medicare reimbursement policies.

Instances that vary from Medicare include:

Physician Rules

Calculating Anesthesia
Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Certified Nurse Midwife (CNM) Rules
Payment for CNM services is made at 100% of the contracted rate.

EKG Payment
EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Physician Site of Service
Physicians will be paid at Physician rate only at the following Sites of Service: Office, Home, Assisted Living Facility, Mobile unit, walk in retail health clinic, urgent care facility, birthing center, nursing facility, SNFs, independent clinic, FQHC, Intermediate HC Facility, Resident Substance Abuse Facility, Nonresident Substance Abuse Facility, Comprehensive OP Rehab facility, ESRD Facility, State or Local Health Clinic, RHC, Indy lab, Other POS.

Endoscopic Multiple Procedure Rules
When you have two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608) - identify the primary code within the family, and then apply multiple procedure discounts to the two primary codes. Secondary codes are not paid because you consider the total payment for each set of endoscopies as one service.

When you have two related endoscopies and a third, unrelated procedure - identify the primary code in the related endoscopies. Then apply multiple procedure discounts to the unrelated code and the identified primary code. The secondary code is not paid because you consider the total payment for each set of endoscopies as one service.

Diagnostic Testing Of Implants
Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Lesser of Language
Pay Provider lesser of the Providers allowable charges or the negotiated rate

Multiple Procedure Rules For Surgery
Payment should be paid at 100%/50%/50%, starting with procedure ranked highest. Max of 3 procedures. Procedures 4+ are subject to manual review and payment if appropriate.

Multiple Procedure Ranking Rules
If two or more multiple surgeries are of equal payment value and bill charges do not exceed the payment rate, rank them in descending dollar order billed pay based on multiple procedure discounts.

Multiple Procedure Rules For Radiology
Multiple procedure radiology codes follow Multiple Procedure discount rules: 100%/50%/50%, max three radiology codes.

Physician Assistant (PA) Payment Rules
Physician assistant services are paid at 8% of what a physician is paid under the Ambetter Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid 85% of what a physician is paid under the Ambetter Physician Fee Schedule.
- PA assistant-at-surgery services at 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Payment Rules
In general, NPs and CNSs are paid for covered services at 85% of what a physician is paid under the Ambetter Physician Fee Schedule.

- NP or CNS assistant-at-surgery services at 85% of what a physician is paid under the Ambetter Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Ambetter Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Surgical Physician Payment Rules
For surgeries billed with either modifier 54, 55, 56, or 78 pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.

Incomplete Colonoscopy Rule
Incomplete colonoscopies should be billed with CPT 45378 and MOD 53. This will pay 25% of the FS rate for the incomplete procedures. The rest of the claim pays according to the FS.

Injection Services
Injection service codes must pay separately if no other physician service is paid and when not billed with office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Unpriced Codes
In the event that the CMS/Medicare RBRVS does not contain a published fee amount, an alternate “gap fill” source is utilized to determine the fee amount. If there is no fee available on the alternate “gap fill”

source, Ambetter will reimburse 40% of billed charges less any applicable copay, coinsurance or deductible, unless contracted differently. Unlisted codes are subject to the code edit and audit process and will require the submission of medical records.

Rental Or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Payment For Capped Rental Items During Period Of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than 15 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 15 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Ambetter coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers new medical necessity.

If the beneficiary changes suppliers during or after the 15-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 15th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 15-month period. If the supplier changes after the 10th month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (Pens) Rent Status While Hospitalized

An entire month's rent may not be paid when a patient is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Transcutaneous Electrical Nerve Stimulator (Tens)

In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two months rental.