Claims Filing Instructions

Diamond State Health Plan (DSHP)

Delaware Healthy Children Program (DHCP)

Diamond State Health Plan-Plus (DSHP-Plus)

Diamond State Health Plan-Plus LTSS (DSHP-Plus LTSS)

Revised November 20, 2019

www.amerihealthcaritasde.com

AmeriHealth Caritas™

Delaware

Contents

Claim Filing

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

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

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

Important note: This applies to non-participating out-of-state providers as well.

This means all providers must enroll and meet applicable Medical Assistance provider requirements of the Department of Health and Human Services (DHHS) and receive a Delaware. The enrollment requirements for facilities, physicians, practitioners and atypical providers include registering every service location with DHHS and having a different service location extension for each location.

DHHS fully intends to terminate Medical Assistance enrollment of all non-compliant providers. AmeriHealth Caritas Delaware will comply with DHHS's expectation that non-compliant providers will also be terminated from out network, since medical assistance enrollment is a requirement for participation with AmeriHealth Caritas Delaware.

DHHS also requires that Providers obtain an NPI and share it with DHHS. Further information on DHHS requirements can be found at https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx.

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

Claims for billable services provided to Plan members must be submitted by the provider who performed the services.

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

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification for electronic claims against 837 edits at Change Healthcare™ (formerly Emdeon, and heretofore referred to as Change Healthcare).

- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to the Plan.

Important: ***Rejected claims*** are those returned to provider or EDI source without being processed or adjudicated, due to a billing issue and defined as claims with missing or invalid data elements, such as the provider tax identification number or member ID number. Rejected claims are not registered in the claim processing system and can be re-submitted as a new claim. Claims originally rejected for missing or invalid data elements must be re-submitted with all necessary and valid data within 120 calendar days from the date services were rendered (or the date of discharge for inpatient admissions).

Rejected claims.

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

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

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

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

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

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

Important: For more information on rejected, denied and correctedclaims, please see the Best Practices for Submitting Corrected Claims section in this booklet.

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

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

Claim Mailing Instructions

Submit claims to the Plan at the following address:

Claim Processing Department
AmeriHealth Caritas Delaware
P.O. Box 80100
London, KY 40742-0100

The Plan encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or **Change Healthcare's Provider Support Line at 1-800-845-6592** to arrange transmission.

Any additional questions may be directed to the AmeriHealth Caritas Delaware EDI Technical Support Hotline at **1-866-935-6686** or by email at: edi.acde@amerihealthcaritas.com

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 120 calendar days from the date services were rendered or compensable items were provided.

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

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

Exceptions

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

Important: Claims **originally rejected for missing or invalid data elements** must be corrected and re-submitted **within 120 calendar days from the date of service**. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 6.)

Important: You may open a claims investigation via NaviNet with the claims adjustment inquiry function. Requests for adjustments may also be submitted by telephone to Provider Claims Services at 1-855-707-5818

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

If you prefer to write, please address the letter to:

Claim Processing Department
AmeriHealth Caritas Delaware
P.O. Box 80100
London, KY 40742-0100

Outpatient medical appeals must be submitted in writing to:

Provider Appeals Department
AmeriHealth Caritas Delaware
P.O. Box 80105
London, KY 40742-0105

Inpatient medical appeals must be submitted in writing to:

Provider Appeals Department
AmeriHealth Caritas Delaware
P.O. Box 80106
London, KY 40742-0106

Written Complaints should be mailed to:

Provider Complaint
Claims Department
AmeriHealth Caritas Delaware
PO Box 80101

London, KY 40742-0101

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

Note: AmeriHealth Caritas Delaware EDI Payer ID #**77799**

Refunds for Claims Overpayments or Errors

The Plan and the Delaware Department Health and Social Services (DHSS) encourage providers to conduct regular self-audits to ensure accurate payment.

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

There are two ways to return overpayments to the Plan:

1. Contact Provider Claim Services at 1-855-707-5818 to arrange the repayment. Have the Plan deduct the overpayment/improper payment amount from future claims payments.
2. Submit a check for the overpayment/improper amount directly to AmeriHealth Caritas Delaware:

Claim Processing Department
AmeriHealth Caritas Delaware
P.O. Box 80100
London, KY 40742-0100

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

HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Claim Form Field Requirements

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

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. **All claims must be submitted within the required filing deadline of 120 days from the date of service**.

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

Required Fields (CMS 1500 Claim Form):

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

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
N/A	**Carrier Block**	Check the Medicaid block at the top of the form		2010BB	NM103 N301 N302 N401 N402 N403	
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R	2000B	SBR09	Titled Claim Filing Indicator code in 837P.

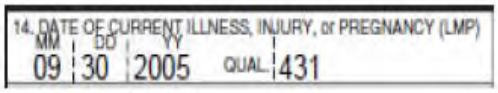
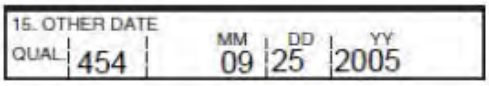
CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
1a	**Insured I.D. Number**	Health Plan's member identification number. If submitting a claim for a newborn that does not have an identification number, enter the mother's ID number. Enter the member's ID number exactly the way it appears on their Plan-issued ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P.
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan I.D. card. If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Refer to page 71 for additional newborn billing information, including Multiple Births.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	**Patient's Birth Date / Sex**	MMDDYY / M or F If submitting a claim for a newborn, enter "newborn" and DOB/Sex	R	2010CA or 2010BA	DMG02 DMG03	Titled Gender in 837P.
4	**Insured's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan I.D. card, or Enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in 837P.
5	**Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	

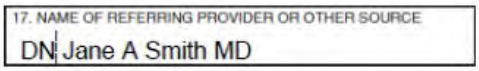
CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
6	**Patient Relationship To Insured**	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01	Titled Individual Relationship code in 837P.
7	**Insured's Address (Number, Street, City, State, Zip+4 Code) Telephone (Include Area Code)**	If same as the patient, enter "Same". Otherwise, enter insured's information.	C	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in 837P.
8	**Reserved for NUCC use**		Not Required			
9	**Other Insured's Name (Last, First, Middle Initial)**	Refers to someone other than the patient. **Completion of fields 9a through 9d is Required** if patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique member ID then the patient is the subscriber and identified in this loop. Titled Other Subscriber Name in 837P.
9a	**Other Insured's**	**Required** if # 9 is completed.	C	2320	SBR03	Titled Group or Policy

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
	Policy Or Group #					Number in 837P.
9b	**Reserved for NUCC use**		Not Required	N/A	N/A	Does not exist in 837P.
9c	**Reserved for NUCC use**		Not Required	N/A	N/A	Does not exist in 837P.
9d	**Insurance Plan Name Or Program Name**	**Required** if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other Medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other insurance group in 837P.
10a, b,c	**Is Patient's Condition Related To:**	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident c) Other Accident	R	2300	CLM11	Titled related causes code in 873P.
10d	**Claim Codes (Designated by NUCC)**	To comply with DHSS' EPSDT reporting requirements, continue to use this field to report EPSDT referral codes as follows; YD – Dental (Required for Age 3 and above) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical *Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of the screening, he/she is required to refer	C	2300	NTE	NTE 01 position – input "ADD" Upper case/capital format). NTE 02 position – first six character input "EPSDT=" (upper

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		the child (ages birth to age 5) through the *Birth to Three Early Intervention system at 1-302-255-9134*, document the referral in the child's medical record and submit the YO EPSDT referral code. For all other claims enter new Condition Codes as appropriate. Available 2-digit Condition Codes includes nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include: • AD – Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or Exacerbated by the Pregnancy Itself W3 – Level 1 Appeal				case/capital format where the sixth character will the = sign. Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~
11	**Insured's Policy Group Or FECA #**	Required when other insurance is available. Complete if more than one other Medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P.
11a	**Insured's Birth Date / Sex**	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P.
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P.

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line; identifier to the right of the vertical, dotted line.				
11c	**Insurance Plan Name Or Program Name**	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.
11d	**Is There Another Health Benefit Plan?**	Y or N by check box. If yes, indicate Y for yes. If yes, complete # 9 a-d.	R	2320		Presence of Loop 2320 indicates Y (yes) to the question on 837P.
12	**Patient's Or Authorized Person's Signature**	On the 837, the following values are addressed as follows at Change Healthcare: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	R	2300	CLM09	Titled Release of Information code in 837P.
13	**Insured's Or Authorized Person's Signature**		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P.
14	**Date Of Current Illness Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: • 431 – Onset of Current Symptoms or Illness	C	2300	DTP01 DTP03	

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		• 439 – Accident Date • 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy. Example:  				
15	**Other Date**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) • 444 – First Visit or Consultation Example:  	C	2300	DTP01 DTP03	
16	**Dates Patient Unable To Work In Current Occupation**		C	2300	DTP01 DTP03	Titled Disability from Date and Work Return Date in 837P.
17	**Name Of Referring**	**Required** if a provider other than the member's primary care physician rendered invoiced services. Enter	R	2310A (Referring)	NM 101 NM103	

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
	Physician Or Other Source	applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Qualifiers include: • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider Example:  		2310D (Supervising) 2420E (Ordering)	NM104 NM105 NM107	
17a	**Other I.D. Number Of Referring Physician**	Enter the Health Plan provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The NUCC defines the following qualifiers: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) Required if #17 is completed.	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P.

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
17b	**National Provider Identifier (NPI)**	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P.
18	**Hospitalization Dates Related To Current Services**	**Required** when place of service is in-patient. **MMDDYY** (indicate **from** and **to** date)	C	2300	DTP01 DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P.
19	**Additional Claim Information (Designated by NUCC)**	Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and data combination. The NUCC defines the following qualifiers: • ZZ Provider Taxonomy • G2 AmeriHealth Caritas DE Provider ID Number	R	2300	NTE PWK	
20	**Outside Lab**	If applicable, indicate Yes if the patient had outside lab work completed. Otherwise, leave blank.	C	2400	PS102	

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

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		for completing the shaded portion of field 24.				
24B	**Place Of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	2300 2400	CLM05-1 SV105	Titled Facility Code Value in 837P. Titled Place of Service Code in 837P.
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	C	2400	SV109	Titled Emergency Indicator in 837P.
24D	**Procedures, Services Or Supplies CPT/HCPCS Modifier**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. **Note:** Modifiers affecting reimbursement must be placed in the 1st modifier position *See additional information below for EDI requirements	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P.
24E	**Diagnosis Pointer**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service, and must be entered in field 21. Do not enter diagnosis codes in 24E. Note: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107(1-4)	Titled Diagnostic Code Pointer in 837P.

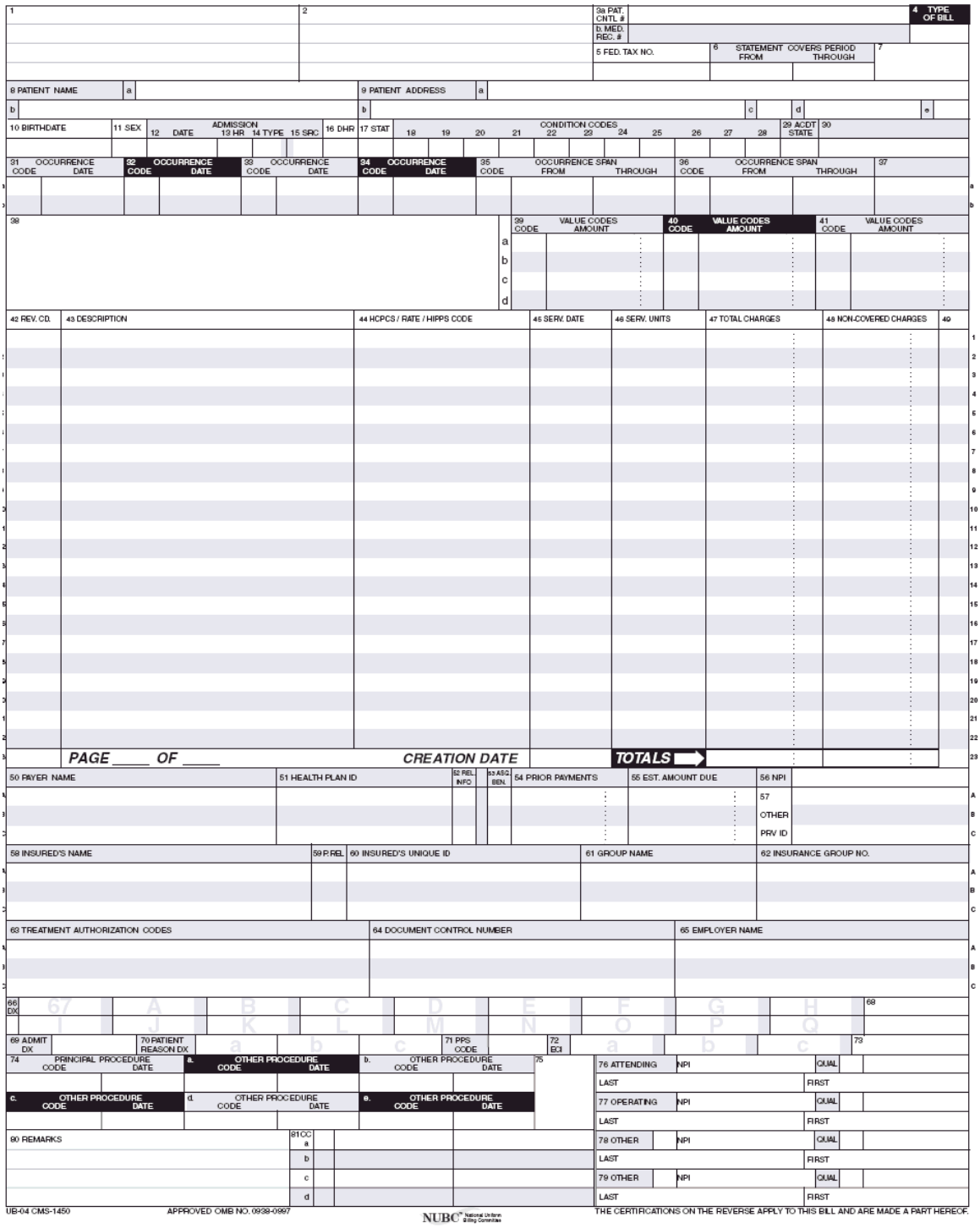
CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount.	R	2400	SV102	Titled Line Item Charge Amount in 837P.
24G	**Days Or Units**	Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable. (Field allows up to 3 digits)	R	2400	SV104	Titled Service Unit Count in 837P.
24H	**EPSDT/Family Planning**	**In Shaded area of field:** AV - Patient refused referral; S2 - Patient is currently under treatment for referred diagnostic or corrective health problems; NU - No referral given; or ST - Referral to another provider for diagnostic or corrective treatment. **In unshaded area of field:** "Y" for Yes – if service relates to a pregnancy or family planning "N" for No – if service does not relate to pregnancy or family planning	C	2300 2400	CRC SV111 SV112	
24I	**ID Qualifier**	If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I. G2 Provider Commercial Number If the rendering provider does have an NPI see field 24J below... If the Other ID number is the Health Plan ID number, enter G2.	R	2310B	REF(01) NM108	Titled Reference Identification Qualifier in 837P. XX required for NPI in NM109.

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
24J	**Rendering Provider ID**	The individual rendering the service is reported in 24J. Enter the Provider Health Plan legacy ID number in the shaded area of the field. Use Qualifier G2 for Provider Health Plan legacy ID. Enter the NPI number in the unshaded area of the field. Use qualifier "82"	R	2310B	REF02 NM109	Change HealthCare will pass this ID on the claim when present. NPI
25	**Federal Tax I.D. Number SSN/EIN**	Physician or Supplier's Federal Tax ID numbers.	R	2010AA	REF01 REF02	EI Tax SY SSN
26	**Patient's Account No.**	The provider's billing account number.	R	2300	CLM01	Titled Patient Control Number in 837P.
27	**Accept Assignment**	Always indicate **Yes**. Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P.
28	**Total Charge**	Enter charges. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated services. Blank is not acceptable.	R	2300	CLM02	May be $0.
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	**Reserved for NUCC Use**		Not Required			

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
31	**Signature Of Physician Or Supplier Including Degrees Or Credentials / Date**	Actual signature is required.	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P.
32	**Name and Address of Facility Where Services Were Rendered (If other than Home or Office)**	**Required** unless #33 is the same information. Enter the physical location. **(P.O. Box #'s are not acceptable here)**	R	2310C	NM103 N301 N401 N402 N403	
32a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	
32b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number LU Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other	C Recommended	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility secondary Identifier in 837P.

CMS 1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		separator between the qualifier and number.				
33	**Billing Provider Info & Ph. #**	**Required** – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. **Enter physical location; P.O. Boxes are not acceptable for EDI claims.**	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	
33a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.
33b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers: G2 Provider Commercial Number ZZ Provider Taxonomy **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	C Recommend ed	2000A 2010AA	PRV03 REF02 where REF01 = G2	Titled Provider Taxonomy Code in 837P. Titled Reference Identificatio n Qualifier and Billing Provider Additional Identifier in 837P.

Required Fields (UB-04 Claim Form):



UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
1	**Unlabeled Field** **NUBC – Billing Provider Name, Address and Telephone Number**	**Service Location, no PO Boxes** Left justified Line a: Enter the complete provider name. Line b: Enter the complete address Line c: City, State, and Zip code + 4 Line d: Enter the area code, telephone number.	R	R	2010 AA	NM1/85 N3 N4	Billing Provider Name Billing Provider Address
2	**Unlabeled Field** **NUBC – Pay-to Name and Address**	**Enter Remit Address. No PO Boxes** Enter the Facility Provider I.D. number. Left justified	R	R	2010 AB	NM1/87 N3 N4	Pay-To Name Pay-To Address

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
3a	**Patient Control No.**	Provider's patient account/control number	R	R	2300	CLM01	Patient's Control Number
3b	**Medical/Health Record Number**	The number assigned to the patient's medical/health record by the provider	C	C	2300	REF02 where REF01 = EA	Medical Reference number
4	**Type Of Bill**	Enter the appropriate three or four - digit code. 1st position is a leading zero – Do not include the leading zero on electronic claims. 2nd position indicates type of facility. 3rd position indicates type of care.	R	R	2300	CLM05	If Adjustment or Replacement or Void claim, include frequency code as the last digit. Include the frequency code by using bill type in loop 2300. Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number. No

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		4th position indicates billing sequence.					dashes or spaces.
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010 AA	REF02 Where REF01 = EI	Pay to provider = Billing Prov, use 2010AA Billing Provider Tax ID
6	**Statement Covers Period From/Through**	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434	MMDDCCYY Statement Dates
7	**Unlabeled Field**	Not Used. Please Leave Blank.					
8a	**Patient Identifier**	Patient Health Plan ID is conditional if number is different from field 60	R	R	2010 BA 2010 CA	NM109 where NM101 = IL NM109 where NM101 = QC	Patient =Subscriber, Use 2010BA Subscriber ID Patient is not =Subscriber, Use 2010CA Patient ID

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

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix. Newborns and Multiple Births: If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Refer to page 74 for additional newborn billing information, including Multiple Births.					
9a-e	**Patient Address**	The mailing address of the patient 9a. Street Address	R	R	2010 BA	N301, N302 N401, 02, 03, 04	Patient =Subscriber, Use 2010BA Subscriber Address

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

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		admission. Right-justified					
13	**Admission Hour**	The valid NUBC code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R for bill types other than 21X.	R	2300	DTP03 where DTP01=435	Required on inpatient. Admission date/HR
14	**Admission Type**	A national NUBC code indicating the priority of this admission/visit.	R	R	2300	CL101	Institutional Claim Code
15	**Point of Origin for Admission or Visit**	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102	Institutional Claim Code
16	**Discharge Hour**	Valid national NUBC code indicating the discharge hour of the patient from inpatient care.	R	R	2300	DTP03 where DTP01=096	

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6.	R	R	2300	CL103	Institutional Claim Code
18 - 28	**Condition Codes** **The following is unique to Medicare eligible Nursing Facilities. Condition codes should be billed when Medicare Part A does not cover Nursing Facility Services** **Applicable Condition Codes:** **X2 – Medicare EOMB on File**	When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed: Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service	C	C	2300	HIXX-2	HIXX-1=BG Condition Info

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
	X4 – Medicare Denial on File	for which you are billing: There was no 3-day prior hospital stay The resident was not transferred within 30 days of a hospital discharge The resident's 100 benefit days are exhausted There was no 60-day break in daily skilled care Medical Necessity Requirements are not met Daily skilled care requirements are not met All other fields must be completed as per the					

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		appropriate billing guide					
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. **Required when applicable.**	C	C	2300	REF02 Where REF01 = LU	
30	**Unlabeled Field**	Please Leave Blank					Reserved for future use
31a,b – 34a,b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code and date. Code must be 01 – 69, or A0-A9 or B1. Dates must be in YYYYMMDD format. **Required** when applicable.	C	C	2300	HIXX-2	HIXX-1 = BH

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
35a,b – 36a,b	**Occurrence Span Codes And Dates**	A code and the related dates that identify an event that relates to the payment of the claim. Code must be 70 – 99 or M0-Z9. Dates must be in MMDDYY format. **Required** when applicable.	C	C	2300	HIXX-2	HIXX-1 = BI
37a,b	**EPSDT Referral Code**	**Required** when applicable. Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YD – Dental *(Required for Age 3 and Above) YO – Other YV – Vision	C C C C	C C C	2300	NTE	NTE 01 position – input “ADD” Upper case/capital format). NTE 02 position – first six character input “EPSDT=” (upper case/capital format where the sixth

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		YH – Hearing YB – Behavioral YM – medical	C C C	C C C			character will the = sign. Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~
38	**Responsible Party Name and Address**	The name and address of the party responsible for the bill.	C	C			Not required Not mapped 837I
39a,b,c,d – 41a,b,c,d	**Value Codes and Amounts**	A code structure to relate amounts or values to identify data elements necessary to process this claim as	C	C	2300	HIXX-2 HIXX-5	HIXX-1 = BE

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		qualified by the payer organization. Value Codes and amounts. If more than one value code applies, list in alphanumeric order. **Required** when applicable. **Note: If value code is populated then value amount must also be populated and vice versa.** Please see NUCC Specifications Manual Instructions for value codes and descriptions. **Documenting covered and non-covered days**: Value 80 – Hospice, Inpatient and					

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		LTC covered days; Value Code 81 – non-covered days; 82 to report co-insurance days; 83- Lifetime reserve days. Code in the code portion and the Number of Days in the "Dollar" portion of the "Amount" section. Enter "00" in the "Cents" field.					
42	**Rev. Cd.**	Codes that identify specific accommodation , ancillary service or unique billing calculations or arrangements. Hospital: Enter the rev code that corresponds to the rev description in	R	R	2400	SV201	Revenue Code

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		field 43. Refer to NUBC for valid rev codes. The last entry on the claim detail lines should be 0001 for total charges. PPED: use the rev code that appears on the approved prior authorization letter for covered services. LTC state facility: use rev code 0100 for room and board, plus ancillary LTC non-state/assisted living: use rev code 0101 for room and board, without ancillary. Use					

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		appropriate rev code for covered ancillary service. Leave of Absence codes: LTC – state and non-state facilities: use LOA rev codes 0183, 0185 and 0189 as appropriate. Assisted Living Facilities: use only 0189 as a LOA code, no payment is made for days billed with rev code 0189. Use for any days when patient is out of the facility for the entire day.					
43	**Revenue Description**	The standard abbreviated description of the related	R	R	N/A	N/A	Not mapped 837I

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category. Use this field to enter NDC information. Refer to supplemental information section.					
44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills. The accommodation rate for inpatient bills.	R	R	2400	SV202-2	SV202-1=HC/HP

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all Outpatient Claims. (Note: NDC numbers are required for					

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		all administered or supplied drugs.)					
45	**Serv. Date**	Report line item dates of service for each revenue code or HCPCS/HIPPS code. Multiple-day service codes require an RR modifier.	R	R	2400	DTP03 where DTP01=472	Date of Service
46	**Serv. Units**	Report units of service. A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Note: for drugs, service units	R	R	2400	SV205	Service Units

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

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

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
					2330 B	NM103 where NM101=P R	Other Payer Name
51	**Health Plan Identification Number**	The number used by the health plan to identify itself. Enter ACDE Payer ID # here 77799	R	R	2010 BA 2330 B	NM109 where NM101=P R	Payer ID Other Plan Payer ID
52	**Rel. Info**	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the provider have all necessary release	R	R	2300	CLM09	Release of Information Code

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		information on file. It is expected that all released invoices contain "Y"					
53	**Asg. Ben.**	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	R	R	2300	CLM08	Benefits Assignment Certification Indicator
54	**Prior Payments**	The A, B, C indicators refer to the information in Field 50. The A, B, C indicators refer to the information in Field 50. Line A	C	C	2320	AMT02 where AMT01=D	Prior Payment Amounts

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.					
55	**Est. Amount Due**	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage).	C	C	2300	AMT02 where AMT01 =EAF	Patient Estimated Amount Due
56	**National Provider Identifier – Billing Provider**	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. **Required** if the health care provider is a Covered Entity as defined in	R	R	2010 AA	NM109 where NM101 = 85	NPI

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

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		name. When other coverage is available, the insured is indicated here.			2330 A	NM103,NM104,NM105 where NM101 = IL	Other Insured Name
59	**P. Rel**	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured Code 18: Self	R	R	2000 B	SBR02	Individual Relationship Code
60	**Insured's Unique Identifier**	Enter the patient's Health Plan ID on the appropriate line, exactly as it appears on the patient's ID card on line B or C. Line A refers to the primary payer; B,	R	R	2010 BA	NM109 where NM101= IL REF02 where REF01 = SY	Insured's Unique ID

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		secondary; and C, tertiary.					
61	**Group Name**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000 B	SBR04	Subscriber Group Name
62	**Insurance Group No.**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer;	C	C	2000 B	SBR03	Subscriber Group or Policy Number

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		B, secondary; and C, tertiary.					
63	**Treatment Authorization Codes**	Enter the Health Plan referral or authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2300	REF02 where REF01 = G1	Prior Authorization Number
64	**DCN**	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code. The ESC field has been eliminated. **Note:**	C	C	2300	REF02 where REF01 = F8	Original Claim Number

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		Resubmitted claims must contain the original claim ID					
65	**Employer Name**	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2320	SBR04	
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. **Note:**	Not Required	Not Required	2300	Determine d by the qualifier submitted on the claim	Not Required

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

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.				Where HI01-1 = BF or ABF	
68	**Unlabeled Field**						
69	**Admitting Diagnosis Code**	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician. **Required** for inpatient and outpatient	R	R	2300	HI01-2 Where HI01-1=BJ or ABJ	Admitting DIagnosis

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
70	**Patient's Reason for Visit**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2 HI01-1=PR or APR Where XX = 01,02,03	Patient Reason for Visit
71	**Prospective Payment System (PPS) Code**	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.	C	C	2300	HI01-2 Where HI01-1 = DR	DIAGNOSIS Related Group (DRG) Information

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
72a-c	**External Cause of Injury (ECI) Code**	The appropriate ICD code(s) pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	C	C	2300	HIXX-2 Where HIXX-1 = BN or ABN	External Cause of Injury
73	**Unlabeled Field**						

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
74	**Principal Procedure code and Date**	The appropriate ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corres-ponding date. **Inpatient facility** – Surgical procedure code is required if the operating room was used. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C R	C R	2300	HI01-2 HI01-4 Where HI01-1 = BR or BBR	

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
74a-e	**Other Procedure Codes and Dates**	The appropriate ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. **Inpatient facility** – Surgical procedure code is required when a surgical procedure is performed. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical	C	C	2300	HIXX-2 Where HI01-1 = BQ or BBQ	Other Procedure Information

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		procedure is performed.					
75	**Unlabeled Field**						
76	**Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#**	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the attending physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician. Note: If a qualifier is entered, a	R	R	2310 A 2310 A	NM103,NM104,NM107,NM109 where NM101 = 71 REF02 Where REF01 = G2	

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will reject.					
77	**Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#**	**Enter the** NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.	R	R	2310 B 2310 B	NM103,NM104,NM107,NM109 where NM101 = 72 REF02 Where REF01 = G2	

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		Required when a surgical procedure code is listed.					
78 – 79	**Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID#**	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#	R	R	2310 C 2310 C	NM103,NM104,NM107,NM109 where NM101 = ZZ REF02 Where REF01 = G2	
80	**Remarks Field**	Area to capture additional information necessary to	C	C	2300	NTE02	Billing Note

UB 04 Claim Form							
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X			
Field #	**Field Description**	Instructions and Comments	Required or Condi-tional*	Required or Conditional *	Loop	Segment	Notes
		adjudicate the claim.				Where NTE01=ADD	
81CC, a-d	**Code-Code Field**	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C	2000 A	PRV01 PRV03	

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

I. Supplemental Information

A. CMS 1500 Paper Claims – Field 24:

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

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

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

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

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

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

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

B. EDI – Field 24D (Professional)

Details pertaining to EPSDT, Anesthesia Minutes, and corrected claims may be sent in Notes (NTE)

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

C. EDI – Field 33b (Professional)

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

D. EDI – Field 45 and 51 (Institutional)

Field 45 – **Service Date** must not be earlier than the claim statement date.

Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – **Health Plan ID** – the number used by the health plan to identify itself. AmeriHealth Caritas Delaware's EDI Payer ID# is77799.

E. EDI – Reporting DME

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

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

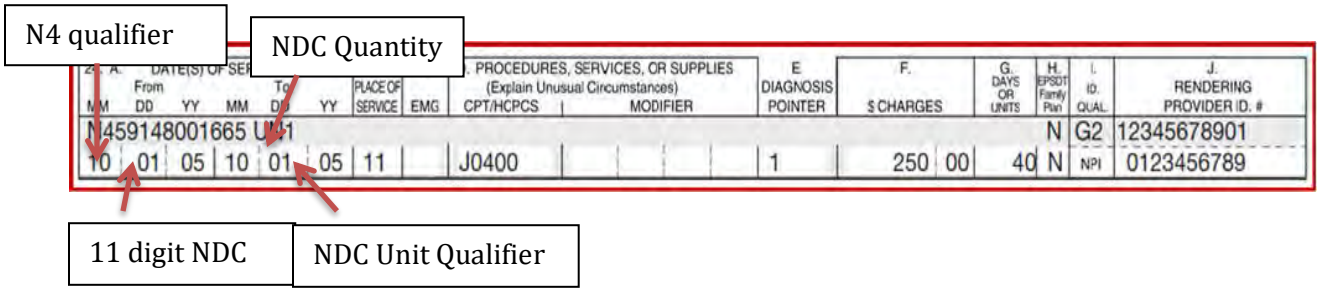
1. NDC on CMS 1500

- NDC must be entered in the shaded sections of item 24A through 24G.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information.

- Do not enter a space between the qualifier and the 11 digit NDC number.
- Enter the 11 digit NDC number in the 5-4-2 format (no hyphens).
- Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC

- Enter the NDC quantity unit qualifier
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Enter the NDC quantity
  - Do not use a space between the NDC quantity unit qualifier and the NDC quantity
  - Note: The NDC quantity is frequently different than the HCPC code quantity

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



2. NDC on UB-04

- NDC must be entered in Form Locator 43 in the Revenue Description Field.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- Report the N4 qualifier in the first two (2) positions, left-justified.
  - Do not enter spaces
  - Enter the 11 character NDC number in the 5-4-2 format (no hyphens).
  - Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
  - Do not enter a revenue code description if you are entering an NDC

Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.

  - F2 – International Unit
  - GR – Gram

- ML – Milliliter
- UN – Unit
- ME – Milligram

- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
    - Any unused spaces for the quantity are left blank.

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

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

3. NDC via EDI

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

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

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDC's sent at claim line level should be submitted using CMS-1500 or UB-04 paper claim.

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

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

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

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

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

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

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

Submitting Claims Involving a PPC

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

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

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

Practitioner

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

Claim Type:

- Report a PPC by billing the procedure of the service performed with the applicable modifier: PA (surgery, wrong body part); PB (Surgery, wrong patient) or PC (wrong site surgery) in 24D of the CMS 1500 claim form.

Claim Format:

- Report the external cause of injury codes, such as Y65.51, Y65.52 or Y65.53 in field 21 [and/or] field 24E of the CMS 1500 claim form.

Inpatient/Outpatient Facilities

- Providers submitting claims for facility fees must report a PPC via the claim submission process. Note that this reporting is required even if the Provider does not intend to submit a claim for reimbursement of the services. This requirement applies to Providers who bill inpatient or outpatient services via UB-04 or 837I formats.

For Inpatient facilities

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

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

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

Medical Claim Review
AmeriHealth Caritas Delaware
P.O. Box 80100
London, KY 40742-0100

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

For Outpatient Providers

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

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

UB-04 or 837I

- Valid POA indicators are as follows, blanks are not acceptable:
- "Y" = Yes = present at the time of inpatient admission
- "N" = No = not present at the time of inpatient admission
- "U" = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
- "W" = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not
- 1 = Exempt from POA reporting for paper claims
- Blank = Exempt from POA reporting for electronic claims

A. Reporting POA on the UB-04 Claim Form

Fields 67 A – Q:

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

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

66 DX	2449 67	Y	25001A	N	29620 B	U	V1581 C	W	D	
	I		J		K		L		M	

69 Admit DX		70 Patient Reason DX	a	b	C	71 PPS CODE

FL 67 A – Q

B. Reporting POA in Electronic 837I Format

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

- Although this segment can repeat, Plan requires provider submit POA data on a single NTE Segment. No additional NTE segments with the letters POA will be validated.
- NTE01 must contain POA as the first three characters or the POA data will not be picked up. NTE*POA~
- NTE segment must only contain details pertaining to the Principal and Other Diagnosis found in the HI segment with qualifiers BK for Principal and BF for Other Diagnosis prior to the ending Z (or X).
- The POA indicator for the BN – External Cause of Injury on the NTE segment with POA is entered following the ending Z (or X). This is required by Change Healthcare (formerly Emdeon) for Medicare Claims as well.
- No POA Indicator is to be sent for the BJ/ZZ – Admitting Diagnosis Data. Following the letters POA in the NTE segment is to be only those identified on the Medicare Bulletin. 1, Y, N, U, W are valid, with ending characters of X or Z and E Code indicator.

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

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

Common Causes of Claim Processing Delays, Rejections or Denials

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

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

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

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

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG codes must include this information on the claim form.

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

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

External Cause of Injury Codes – External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Include applicable POA Indicators with ECI codes.

Future Claim Dates – Claims submitted for Medical Supplies or Services with future claim dates will be denied, for example, a claim submitted on October 1 for bandages that are delivered for October 1 through October 31 will deny for all days except October 1.

Handwritten Claims – Handwritten claims are not recommended. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity.

Highlighted Claim Fields (See Illegible Claim Information)

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

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

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

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

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

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

Payer or Other Insurer Information Missing or Incomplete – Include the name, address and policy number for all insurers covering the Plan member.

Place of Service Code Missing or Invalid – A valid and appropriate two digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Plan.

Provider NPI Number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included on the claim form.

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

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

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

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

Taxonomy –The provider's taxonomy number and qualifier is required wherever requested in claim submissions. CMS-1500 field 19 and 33b.

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

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

IMPORTANT BILLING REMINDERS:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global

coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.

- EPSDT services may be submitted electronically or on paper.
- Submitting the original copy of the claim form will assist in assuring claim information is legible.
- The *individual provider name* and NPI number as opposed to the group NPI number must be indicated on the claim form.
- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.
- Although the newborn claim is submitted under the mother's ID, the claim must be processed under the baby's ID. The claim will not be paid until the state confirms eligibility and enrollment in the plan.
- The claim for baby *must* include the *baby's date of birth* as opposed to the mother's date of birth. Claim must also include *baby's birth weight (value code 54)*.
- On claims for twins or other multiple births, indicate the birth order in the patient name field, e.g., Baby Girl Smith *A*, Baby Girl Smith *B*, etc.
- Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- The *individual service provider name and NPI number* must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.
- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI number's results in inaccurate payments or denials.
- When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 120 calendar days from the date of service.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 120 calendar days from the date of service.
- Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately. Contact your Provider Account Executive to assist in updating the Plan's records.

Electronic Data Interchange (EDI) for Medical and Hospital Claims

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

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

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

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

Important: In order to verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare (formerly Change Healthcare) Acceptance report, and the R059 Plan Claim Status Report.

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

ELECTRONIC CLAIMS SUBMISSION (EDI)

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

Hardware/Software Requirements

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

Contracting with Change Healthcare and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Change Healthcare EDI capabilities, you can contact the Change Healthcare

Provider Support Line at **1-800-845-6592**. You may also choose to contract with another EDI clearinghouse or vendor who already has Change Healthcare capabilities.

Contacting the AmeriHealth Caritas Delaware EDI Technical Support Group

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

When ready to proceed:

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

Important: Change Healthcare is the largest clearinghouse for EDI Healthcare transactions in the world. It has the capability to accept electronic data from numerous providers in several standardized EDI formats and then forwards accepted information to carriers in an agreed upon format.

Important: Contact AmeriHeath Caritas Delaware EDI Technical Support at: **1-866-935-6686.**

Or by email at: edi.acde@amerihealthcaritas.com

Important: Providers using Change Healthcare or other clearinghouses and vendors are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

Important: the Payer ID for AmeriHealth Caritas Delaware is 77799

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

Specific Data Record Requirements

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

Electronic Claim Flow Description

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

Once Change Healthcare receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits as described in Exhibit 99 at Change Healthcare. Claims not meeting the requirements are immediately rejected and sent back to the sender via a

Change Healthcare error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or Change Healthcare.

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

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

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

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

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Change Healthcare Provider Support Line at **1-800-845-6592.**

If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the AmeriHealth Caritas Delaware EDI Technical Support Hotline at **1-866-935-6686** or by email at: edi.acde@amerihealthcaritas.com.

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

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

* An Acceptance report verifies acceptance of each claim at Change Healthcare.

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

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

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

Important: Contact Change Healthcare Provider Support Line at **1-800-845-6592.**

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

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

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass Change Healthcare HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 120 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Change Healthcare or your EDI software vendor in order to identify and re-submit these claims accurately.

Plan Specific Electronic Edit Requirements

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

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

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

Important: Provider NPI number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider NPI only if the provider number fields are empty.

Important: The Plan's Provider ID is recommended as follows:

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2 [PIN]

NPI Processing – The Plan's Provider Number is determined from the NPI number using the following criteria:

1. Plan ID, Tax ID and NPI number
2. If no single match is found, the Service Location's full 9 character ZIP code + 4 is used

3. If no service location is include, the billing address full 9 character ZIP code + 4 will be used
4. If no single match is found, the required Taxonomy is used
5. If no single match is found, the claim is sent to the Invalid Provider queue (IPQ) for processing
6. If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim The legacy Plan ID is used as the primary ID on the claim
7. If you have submitted a claim, and you have not received a rejection report, but are unable to locate your claim via NaviNet, it is possible that your claim is in review by the Plan. Please check with provider services and update you NPI data as needed. It is essential that the service location of the claim match the NPI information sent on the claim in order to have your claim processed effectively.

Exclusions

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

Excluded Claim Categories. At this time, these claim records must be submitted on paper.
Claim records for medical, administrative or claim appeals

Excluded Provider Categories. Claims issued on behalf of the following providers must be submitted on paper.
Providers not transmitting through Change Healthcare or providers sending to Vendors that are not transmitting (through Change Healthcare) NCPDP Claims

Important: Requests for adjustments may be submitted three ways:

1. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.
2. Requests for adjustments may also be submitted by telephone to Provider Claims Services at 1-855-707-5818.
3. If you prefer to write, address the letter to:

   Claim Processing Department
   AmeriHealth Caritas Delaware
   P.O. Box 80100
   London, KY 40742-0100

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Change Healthcare
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
Claims without provider numbers
Claims without member numbers
Claims in which the date of birth submitted does not match the member ID.

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers
Claims received with invalid member numbers
Claims received with invalid member date of birth

Best Practices for Submitting Corrected Claims

The corrected claims process begins when you receive an explanation of payment (EOP) from AmeriHealth Caritas Delaware detailing the claims processing results.

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

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

	File a New Claim When….		**File a Corrected Claim When…**
1	The claim was never previously billed	1	You received a full or partial payment on a claim but you identified that

			information must be corrected (some examples:. billed wrong # of units, missing claim line, updates to charge amounts, adding a modifier)
2	No payment was received - If the entire claim allows zero dollars, make the appropriate changes and resubmit as a new claim. Do not submit as a corrected claim.	2	You submitted a claim for the wrong member. Submit a frequency code 8 and request a void of the original submission
3	Receive a rejection letter to a paper claim indicating invalid or required missing data elements, such as the provider tax identification number or member ID number.		
4	Received a rejection notice at your electronic claim clearinghouse (277CA) indicating invalid or missing a required data element.		
5	The original claim denied for primary carrier EOB and now you have the primary carrier EOB		
6	The claim denied for eligibility and now the eligibility has been updated and the member has active coverage.		

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

1. Submit all services on the corrected claim that were on the original claim plus the corrected information. This includes services that may have already paid on the original claim submission. The corrected claim will replace all of the information on the original claim. As an example, the original claim had two lines; the correction was to add a third line. Submit all three lines not just the third line you are attempting to add.
2. Do not submit corrected services from multiple claims on one corrected claim.
3. Do not submit a corrected claim if additional information is requested, such as medical records, UNLESS a change is made to the original claim submission.
4. When changing a member ID number for a processed claim: Submit a voided claim (frequency 8) canceling charges for the original claim, AND submit a new claim with the correct member ID number.

5. Always provide the appropriate original claim number associated with the corrected claim.
6. Apply the appropriate frequency code in the defined location of the 1500/UB claim form,
7. Handwriting or stamping the words “corrected, resubmitted or voided” on the paper claim will cause the claim to be rejected.

Corrected claim instruction table:

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

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

*Corrected claims are resubmissions of an existing claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. The successful submission of a corrected claim will cause the retraction and complete replacement of the original claim.

Your EDI clearinghouse or vendor needs to:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
    - o For more information, please contact the AmeriHealth Caritas Delaware EDI Hotline at **1-866-935-6686.**
    - o or via email at: edi.acde@amerihealthcaritas.com
    - o Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

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

Your EDI clearinghouse or vendor needs to:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Include the original claim number in Loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)

- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
    - For more information, please contact the EDI Hotline at: **1-866-935-6686**
    - or via email at: edi.acde@amerihealthcaritas.com
    - Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

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

Requirements for corrected claims using the 1500 paper form:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Place the number in the "Submission Code" section of the field.
- ✓ Include the original claim number in "Original Ref. No." section of the field with no dashes or spaces.
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied).
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
    - For more information, please contact the EDI Hotline at **1-866-935-6686**
    - edi.acde@amerihealthcaritas.com
    - Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

Send all corrected or resubmitted paper claims to:

Claim Processing Department
AmeriHealth Caritas Delaware
P.O. Box 80100
London, KY 40742-0100

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

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

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Include the original claim number in field 64, "DCN" (Document Control Number).
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied).
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
    - For more information, please contact the EDI Hotline at **1-866-935-6686**
    - or via email at: edi.acde@amerihealthcaritas.com
    - Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

Send all corrected or resubmitted paper claims to:

Claim Processing Department
AmeriHealth Caritas Delaware
P.O. Box 80100
London, KY 40742-0100

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 120 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 1 and to detailed instructions in the Best Practices for Submitting Corrected Claims section.)

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

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

Contact Change Healthcare Provider Support Line at: **1-800-845-6592**

Contact AmeriHealth Caritas Delaware EDI Technical Support at: **1-866-935-6686**

Important: Provider NPI number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider NPI only if the provider number fields are empty.

Important: The Plan's Provider ID is recommended as follows:

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2 [PIN]

Electronic Billing Inquiries

Action	Contact
If you would like to transmit claims electronically…	Contact Change Healthcare Provider Support Line at: 1-800-845-6592
If you have general EDI questions …	Contact AmeriHealth Caritas Delaware EDI Technical Support at: **1-866-935-6686** Or via email: edi.acde@amerihealthcaritas.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports…	Contact your EDI Software Vendor or call the Change Healthcare Provider Support Line at 1-800-845-6592
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	Contact Provider Claim Services at 1-855-707-5818
If you have questions about claims that are reported on the Remittance Advice….	Contact Provider Claim Services at 1-855-707-5818
If you need to know your provider NPI number…	Contact Provider Claim Services at 1-855-707-5818

If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information… For questions about changing or verifying provider information…	Notify Provider Network Management in writing at: AmeriHealth Caritas Delaware Christiana Executive Campus 220 Continental Drive, Suite 300 Newark, DE 19713
If you would like information on the 835 Remittance Advice:	Contact your EDI Vendor
Check the status of your claim:	Review the status of your submitted claims on NaviNet or open a claims investigation for submitted claims on NaviNet at www.navinet.net via the claims adjustment inquiry function.
Sign up for NaviNet	www.navinet.net NaviNet Customer Service: 1-888-482-8057

Guidance on Submitting Interim Claims

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

	EDI 1500	Paper 1500	EDI UB	Paper UB
Professional claims and inpatient stays that fall within the statement period:				
New admit through discharge claim; use Frequency Code 1 Admit – Discharge and make sure to include all dates of service	2400, DTP03 = DOS, 2400 SV104 = Days or Units, Otherwise N/A.	Field 24A, dates of Service: Enter From and To dates ('To' S/B blank for single day services. Field 24G, Days or Units, Otherwise N/A.	2300, CLM05=1, also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103	Field 4, Type of Bill, last character=1 also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103
Interim billing: frequency codes for use when the inpatient stay spans statement periods or the claim exceeds claim line limits.				

New INTERIM - FIRST CLAIM for continuing services, Use frequency code (sequence code) **2** INTERIM – FIRST CLAIM	N/A	N/A	2300, CLM05, Type of Bill (TOB), last position = '2', example 112 for "Inpatient – 1st Claim",	Field 4, Type of Bill (TOB) last position = '2' example 112 for "Inpatient – 1st Claim", Field 22 Patient Status of 30 "Still Patient"
Submit second claim for continuing services, Use Frequency Code (sequence code) **3** , INTERIM - CONTINUING CLAIM	N/A	N/A	2300, CLM05, Type of Bill last position = '3', example: 113 for "Inpatient – Cont. Claim"	Field 4, Type of Bill last position = '3', example: 113 for "Inpatient – Cont. Claim" Field 22 Patient Status of 30 "Still Patient"
	EDI 1500	**Paper 1500**	**EDI UB**	**Paper UB**
Interim billing: frequency codes for use when the inpatient stay spans statement periods or the claim exceeds claim line limits.				
Submit final claim for continuing services, Use Frequency Code (sequence code) **4**, INTERIM - INTERIM - LAST CLAIM	N/A professional	N/A	2300, CLM05, Type of Bill last position = '4', example: 114 for "Inpatient – Last Claim", also required are Discharge Hour: 2300, DTP03 and Patient Discharge Status: 2300 CL103	Field 4, Type of Bill last position = '4', example: 114 for "Inpatient – Last Claim", also required are Field 16: Discharge Hour, Field 17: Patient Discharge Status and Field 22 Patient Status, use the appropriate code for Discharged or Expired.

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

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

Why are retrospective chart reviews necessary?

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

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

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

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

Have you coded for all chronic conditions for the member?

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

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

What are your responsibilities?

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

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:

- E11.40 Diabetes with neurological manifestations and E08.40 for diabetic polyneuropathy

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

Documentation Guidelines

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

Physician Documentation Tips

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

Physician Communication Tips

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

SOAP stands for:

Subjective: How the patients describe their problems or illnesses.

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

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

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

Supplemental Information:

Allergy Injections

Ambulance

Anesthesia

Audiology

Chemotherapy

Chiropractic Care

Dialysis

Durable Medical Equipment (DME)

EPSDT Supplemental Billing Information

Factor Carve Out

Family Planning

Home Health Care (HHC)

Infusion Therapy

Injectable Drugs

Maternity

Physical/Occupational and Speech Therapies

Provider Preventable Conditions

Reimbursement Policy

Termination of Pregnancy

Most Common Claims Errors

Allergy Injections

The injectable substance is billed using the appropriate procedure code for preparation and provision of antigens. The injection is billed using the appropriate allergen immunotherapy injection-only procedure code. If a significant separately identifiable Evaluation and Management (E/M) service is performed on the same day as the allergy injection, the appropriate E/M service code should be reported using modifier 25.

Ambulance

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

Note: Non-emergent transportation (NEMT) is covered by the Delaware Medicaid Program. AmeriHealth Caritas Delaware members should contact Logisticare at 1-866-412-3778 to arrange non-emergent transportation to and from medical appointments.

When billing for Procedure Codes A0426 – A0429 and A0433 – A0434 for Ambulance Transportation services, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit Procedure Code. Different modifiers may be used for the same Procedure Code.

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

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

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

E - Residential, domiciliary or custodial facility (other than skilled nursing facility)

G - Hospital-based dialysis facility (hospital or hospital-related)

H - Hospital

I - Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport

J - Non hospital-based dialysis facility

N - Skilled nursing facility

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

R - Residence

S - Scene of accident or acute event

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

Anesthesia

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

- Anesthesia claims must be submitted using anesthesia (ASA) procedure codes only (base plus time units);
- All services must be billed in minutes;
- 15 minute time increments will be used to determine payment.
- When multiple surgical procedures are performed during a single anesthetic administration, the anesthesiologist must use the CPT procedure code of the primary anesthesia procedure only.

Audiology

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

Chemotherapy

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

Chiropractic Care

- Claims for chiropractic services are billed on a CMS 1500 or via 837 electronic format.
- Must bill appropriate CPT code and modifiers.
- Members 18 and over to receive 24 visits before an authorization is required for services (PAR only).
- Authorization requirement for members 0-17 will remain the same (PAR and Non-PAR).

CLIA – Using your CLIA ID when Filing Claims

To ensure the accuracy, reliability and timeliness of patients’ test results, the Centers for Medicare & Medicaid Services (CMS) requires that virtually all laboratories, including physician

office laboratories, meet applicable federal requirements and have a CLIA certificate to operate.[1]

As a reminder, providers that perform laboratory testing are required to indicate their CLIA ID number when submitting claims.

For electronic and paper claims, please enter your CLIA ID numbers in the fields indicated below:

- For the 837 professional electronic claim submission: Please enter your CLIA ID number in Loop ID 2300, segment/data element REF02 where REF01 = X4
- For the CMS 1500 paper form, please enter your CLIA in field 23 (titled prior authorization number).
- It is not necessary to indicate your CLIA ID number on institutional claims.

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

For additional information regarding CLIA, applying for or renewing a certificate, or regarding assigned test complexity levels, please visit the CMS CLIA website.

Dialysis

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

Durable Medical Equipment

- Services are billed on a CMS 1500 claim form.
- An "RR" modifier is required for all rentals.
- Repair codes on the DME Fee Schedule require the submission of procedure code K0739.

[1] CMS.gov, August 2017, "CLIA Program and Medicare Laboratory Services" MLN Fact Sheet, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CLIABrochure.pdf.

- Refer to the Provider Manual for DME authorization rules and guidelines.
- Program Exceptions - codes K0868 through K0891 will be reviewed on a case by case basis.
- Benefit Exceptions – items/services not listed on the Plan's DME fee schedule will be reviewed on an individual basis based on coverage, benefit guidelines, and medical necessity.
- Miscellaneous codes will not be used if an appropriate code is on the Plan's DME fee schedule.

EPSDT Supplemental Billing Information

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

EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions

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

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

- Use Z76.1, Z76.2, Z00.121 or Z00.129 as the primary diagnosis code
- Accurate payment of EPSDT claims will be determined solely by the presence of EPSDT modifiers to identify an EPSDT Claim. Failure to append EPSDT modifiers will cause claims to be processed as non-EPSDT related encounters
- Use one of the individual age-appropriate procedure codes outlined on the most current EPSDT Periodicity Schedule (listed below), as well as any other EPSDT related service, e.g., immunizations, etc.

Use EPSDT Modifiers as appropriate: EP - Complete Screen; 52 - Incomplete Screen; Age Appropriate Evaluation and Management Codes

(As listed on the current EPSDT Periodicity Schedule and Coding Matrix)

Newborn Care:

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

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

Billing example: New Patient EPSDT screening for a 1 month old. The diagnosis and procedure code for this service would be:

- Z76.2 (Primary Diagnosis)
- 99381EP (E&M Code with "Complete" modifier)

* Enter charges. Value entered must be greater than zero ($0.00) including capitated services.

Please consult the EPSDT Program Periodicity Schedule and Coding Matrix, as well as the Recommended Childhood Immunization Schedule for screening timeframes and the services required to bill for a complete EPSDT screen. Both are available in a printable PDF format online at the Provider Center at: www.amerihealthcaritasde.com

Completing the CMS 1500 or UB-04 Claim Form

The following blocks must be completed when submitting a CMS 1500 or UB-04 claim form for a complete EPSDT screen:

- EPSDT Referral Codes (when a referral is necessary, use the listed codes in the example below to indicate the type of referral made)
- Diagnosis or Nature of Illness or Injury
- Procedures, Services or Supplies CPT/HCPCS Modifier
- EPSDT/Family Planning

UB-04	CMS 1500	Item	Description	C/R
	10d	Reserved for Local Use	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen.	
		EPSDT Referrals	YD – Dental (Required for ages 3 and over) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical * *Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 3) through the Birth to Three Early Intervention system at 1-302-255-9134, document the referral in the child's medical	C C C C C C

			record and submit the YO EPSDT referral code.	
18	N/A	Condition Codes	Enter the Condition Code A1 EPSDT	R
67	21	Diagnosis or Nature of Illness or Injury	When billing for EPSDT screening services, **diagnosis code Z76.1, Z76.2, Z00.121 or Z00.129** (Routine Infant or Child Health Check) must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2, 21.3, 21.4. **An appropriate diagnosis code must be included for each referral.** Immunization V-Codes are not required.	R
42	N/A	Revenue code	Enter Revenue **Code 510**	R
44	24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Populate the first claim line with the age appropriate E & M codes along with the EP modifier when submitting a "complete' EPSDT visit, as well as any other EPSDT related services, e.g., immunizations	R
N/A	24H	EPSDT/Family Planning	**Enter Visit Code 03** when providing EPSDT screening services.	R

Key:

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

Dental Referral

- In completing a dental referral, providers should advise the child's parent or guardian that a dental exam is required according to the periodicity schedule.

- Documentation of the dental referral should be recorded in the child's medical record and on the claim form by utilizing the appropriate EPSDT dental referral code, YD.

Dental Referral:

- Use the EPSDT modifier EP (Complete Screen) when the process outlined above has been followed.
- Enter the EPSDT referral code YD (dental referral) in field 10d on the CMS 1500 claim form, or field 37 on the UB-04 form.
- When the dental referral has not occurred, submit the claim with the EPSDT modifier 52 (Incomplete Screen).
- *Payment for a complete screen is determined by the presence of both the EP modifier and YD referral code.
- **Important:** Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

Factor Drug Carve-Out

Note: These instructions are only applicable for in-patient facilities for which factor are a carve-out in their Plan contract.

Submit clinical information for Factor via secure email to nbessler@performrx.com.

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

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

Family Planning

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

Member Services at DSHP: 1-855-349-6281 or DSHP Plus: 1-855-362-5769. Use Modifier FP with the appropriate code when examination includes family planning.

Flouride Varnish

- This service is covered one time in six months and must be completed on the same visit as a Medicaid well-child visit for children between the ages of six months through age five, using CPT code 99188.
- Providers choosing to bill for fluoride varnish on the CMS 1500 or UB-04 claim form, or the 837 electronic formats must:
    - Include the certificate serial number for the Smiles for Life Course 6 in the comment section of the electronic claim.
    - Indicate one of the following codes D0601- low caries risk, D0602- Moderate caries risk, D0603- High caries risk based upon your oral health assessment.
        - For paper 1500 form submission submit this information in box 19.

Sterilization

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

A Member seeking sterilization must voluntarily give informed consent on the Consent form or an Awareness Form, which must accompany each claim.

Consent Form

Awareness Form

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

DMAP's Sterilization Consent Form and/or

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

Home Health Care (HHC)

- Provider must bill on CMS 1500, UB04, 837 electronic format (whichever format is designated in their Plan contract).
- When billing on a UB04, bill the appropriate revenue code for the homecare service.
- Providers must bill the appropriate modifier in the first position when more than one modifier is billed.

- Refer to NDC instructions in the manual.

Infusion Therapy

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

Injectable Drugs

All drugs billed are required to be submitted with NDC information and may be submitted via CMS-1500 or 837 electronic format. Refer to NDC instructions in Supplemental Information section on pages 36- 37.

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

Maternity

- Bill an appropriate office visit code with a pregnancy diagnosis in addition to T1001-U9.
- Last menstrual period (LMP) is a required field to be submitted on all claim types.
- The completed ONAF form must be faxed to Bright Start 1-855-558-0488 within seven calendar days of the date of the prenatal visit as indicated on the form.
- ONAF forms not meeting the seven calendar day submission requirement will not be reimbursed for T1001-U9.
- The prenatal outreach bonus (99429) is eligible when the initial visit is within the first trimester and billed in conjunction with a pregnancy diagnosis and an appropriate office visit code.

Postpartum:

- Render the postpartum visit within 21 to 56 days after delivery.
- Fax the ONAF form again to the Bright Start department 1-855-558-0488 at the post-partum visit with all post-partum information and any additional visit dates as needed.
- Procedure code 99429, appropriate post-partum diagnosis codes and the appropriate post-partum visit code (59430) must be reported and billed together on the same claim form within 21-56 days after the delivery date to receive payment.

Physical/Occupational and Speech Therapies

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

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

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

Provider Preventable Conditions and Critical Incidents

All critical incidents require notification to the Plan immediately or as reasonably possible following the incident. A critical incident includes but is not limited to the following incidents:

- Unexpected death of a member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended by a physician;
- Suspected physical, mental or sexual mistreatment, abuse and/or neglect of a member;
- Suspected theft or financial exploitation of a member;
- Severe injury sustained by a member;
- Medication error involving a member; or
- Inappropriate/unprofessional conduct by a provider involving a member.

In addition to the list above, critical incidents include Sentinel and Never events as defined below:

- **Sentinel Event** – Real-time identification of an unexpected occurrence that causes a member death or serious physical or psychological injury, or risk thereof, that included permanent loss of function. This includes medical equipment failures that could have caused a death and all attempted suicides. These events are referred to as “sentinel” because they signal the need for immediate investigation and response. Please note, the terms “sentinel event” and “medical error” as not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events. Examples of a sentinel event include:
    - Maternal death after delivery.
    - Suicide while inpatient.

- **Never Event** – Reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability. These events are clearly identifiable and measurable. Never events are also considered sentinel events, as defined above. Examples of Never Events include:
    - Surgery performed on the wrong patient.

- Surgery on the wrong body part.
- Unintended retention of a foreign object after surgery.

See www.CMS.gov for a complete list.

Provider Preventable Conditions

AmeriHealth Caritas Delaware will comply with the Patient Protection and Affordable Care Act of 2010 (ACA) in regard to the reimbursement of Provider Preventable Conditions (PPC). The ACA defines PPCs in two distinct categories: Health Care Acquired Conditions and Other Provider-Preventable Conditions. Providers must also report Critical Incidents to the health plan.

Health Care Acquired Conditions

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

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

Reporting of critical incidents is required for all health plan members.

AmeriHealth Caritas Delaware monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies and other providers of health care services. The purpose of monitoring care is to identify those unusual and unexpected occurrences involving death or serious physical or psychological injury, or the risk

thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of the Plan. .

AmeriHealth Caritas Delaware's goals are to:

- Have a positive impact on improving patient care, treatment and services and prevent unusual occurrences;
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future; and,
- Increase general knowledge about unusual occurrences, their causes and strategies for prevention.

Reporting Critical Incidents

Providers are expected to report critical incidents, as described above, to the Plan in real-time. The Plan recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore, allowance is made for the stabilization of the member prior to reporting. All critical incidents must be reported to the Plan within 24 hours of occurrence through the identified critical incident reporting process noted earlier.

AmeriHealth Caritas Delaware will not take punitive action or retaliate against any person for reporting occurrence critical incident. The practitioners involved will be offered the opportunity to present factors leading to the event and to respond to any questions arising from the review of the critical incident.

Once an AmeriHealth Caritas Delaware staff member identifies or is notified of a critical incident, as defined above, the following procedures will take place to investigate and address the occurrence:

1. The Quality Management department is notified of the event via an incident report, telephone, or email as soon as reasonably possible after identification of the occurrence.
2. The Quality Management Director will collaborate with the Market Chief Medical Officer and investigate as appropriate. Certain occurrences may require review of medical records to assist in the investigation.
3. The Quality Management department leads the investigation; analysis and reporting of all identified unusual occurrences.
4. All critical incidents require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlies variation in performance, including the occurrence or possible occurrence of an unusual event. A root cause analysis focuses primarily on systems and processes, not on individual performance.
5. As appropriate, issues are identified for correction and corrective action plans are developed by the provider to prevent reoccurrence of the event. The corrective action

plan will identify strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The corrective action plan by the provider will address responsibility for implementation, oversight, time lines and strategies for measuring the effectiveness of the actions.

6. Critical incidents will be reported to the Delaware Division of Medicaid and Medical Assistance (DMMA) and other appropriate investigative agencies by the Plan within contractual reporting requirements.
7. As appropriate, other state and federal agencies will also be notified of critical incidents.
8. As appropriate, information from the investigation of critical incidents will be provided to the Credentialing Committee to support the re-credentialing process.

Reporting Provider Preventable Conditions

Please refer to the "Claims Submission Protocols and Standards" section of the *Provider Manual* for more information regarding AmeriHealth Caritas Delaware's policy on provider preventable conditions and how to report such conditions via the claims process.

To report suspected abuse or neglect, please contact AmeriHealth Caritas Delaware at 1-855-396-5770.

Reimbursement Policy

Prospective Claims Editing Policy

- AmeriHealth Caritas Delaware's claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health Problems (ICD) manual and the National Uniform Billing Code (NUBC).
- Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include, but are not limited to: legislative or regulatory mandates, a provider's contract, and/or a member's eligibility to receive covered health care services.

Termination of Pregnancy

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

1. The member's life is endangered if she were to carry the pregnancy to term; or
2. The pregnancy is the result of an act of rape or incest.
   - Submit the physician's certification on the **Abortion Justification Form and the complete medical record.** The form must be completed in accordance with the instructions and must accompany the claims for reimbursement. All claims and certification forms will be retained by the Plan.
   - Submit the Abortion Justification Form with the claim for reimbursement. The Physician's Abortion Justification Form must be submitted in accordance with the instructions on the certification/form. The claim form, medical records and Abortion Justification form will be retained by the Plan.

Submit claims and all appropriate forms to:

Claim Processing Department
AmeriHealth Caritas Delaware
P.O. Box 80100
London, KY 40742-0100

Most Common Claims Errors

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"**Member date of birth (DOB) is missing.**" (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	"**Member's sex is required.**" (If no box is checked, the claim will be rejected.)
4	Insured's Name	"**Insured's name missing or illegible.**" (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address(number, street, city, state, zip+4) phone	"**Patient address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"**Patient relationship to insured is required.**" (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address(number, street, city, state, zip+4) phone	**"Insured's address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	"Diagnosis code is missing or illegible." (The claim will be rejected.)
22	Resubmission Code and Original Ref. No.	All resubmitted claims must contain a resubmission or frequency code to indicate that the claim is an adjustment, replacement, or voided claim. (If frequency code and/or original reference (claim) number is missing or invalid, the claim will be rejected.)
24	Supplemental Information	"**National Drug Code (NDC) data is missing/incomplete/invalid.**" (The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.)
24A	Date of Service	**"Date of service (DOS) is missing or illegible.**" (The claim will be rejected if both the" From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
		the “From” or “To” DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	"Place of service is missing or illegible." (Claim will be rejected.)
24D	Procedure, Services or Supplies	"Procedure code is missing or illegible." (Claim will be rejected.)
24E	Diagnosis Pointer	"**Diagnosis (DX) pointer is required on line ___” [lines 1-6].** (For each service line with a “From” DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	"**Line item charge amount is missing on line ___” [lines 1-6].** (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"**Days/units are required on line ___” [lines 1-6].** (For each line with a “From” DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering Provider identification	"National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible." (If NPI is missing or illegible, claim will be rejected.)
26	Patient Account/Control Number	"Patient Account/Control number is missing or illegible" (If missing or illegible, claim will reject)
27	Assignment Number	"**Assignment acceptance must be indicated on the claim.**" (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	"**Total charge amount is required.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
31	Signature of physician or supplier including degrees or credentials	**"Provider name is missing or illegible."** (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
33	Billing Provider Information and Phone number	"**Billing provider name and/or address is missing or incomplete.**" (If the name and/or street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
33	Billing Provider Information and Phone number	"Field 33 of the CMS1500 claim form requires the provider's physical service address including the full 9 character ZIP code + 4." (If a PO Box is present, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) Effective January 1, 2018
1	Billing Provider Name, Address and Telephone Number	"**Billing provider name and/or address missing or incomplete.**" (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
1	Billing Provider Name, Address and Telephone Number	"**Field 1 of the UB04 claim form requires the provider's physical service address."** (If a PO Box is present, the claim will be rejected.)
3a	Patient Account/ Control Number	"**Patient account/control number is missing or illegible.**" (If the number is missing or illegible, the claim will be rejected.)
4	Type of Bill	If claim is a resubmission,include frequency code as the last digit. Include original claim number in Field 64. (If frequency code is missing or invalid, the claim will be rejected.)
8b	Patient Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
9a-e	Patient Address	"**Patient address is missing.**" (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
10	Patient Birth Date	"**Member DOB is missing.**" (If missing month and/or day and/or year, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) Effective January 1, 2018
11	Patient Sex	"**Member's sex is required**" (If missing, the claim will be rejected.)
12	Admission Date	"**Admission Date is missing or illegible.**" (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If it is OP, do not reject claim. If it is IP and a valid date is not billed, the claim will be rejected.)
12	Admission Date	"**Based on the date the claim was received, the admission date is a future date.**" (Use bill type table to identify if it is an IP or an OP claim. If it is OP, do not reject claim. If it is IP and a future date is billed, reject the claim.)
13	Admission Hour	"**Admission hour is required.**" (Use bill type table to identify if it is an IP or OP claim. If it is OP, do not reject the claim. If it is IP and bill type is anything except 21x and a numeric value is not billed on the claim, the claim will be rejected.)
14	Admission Type	"**Admission type is required.**" (If a numeric value is not present, claim will be rejected.)
15	Point of Origin for Admission or Visit	"**Point of Origin for admission or visit is missing.**" (If claim has any bill type except 14x and the field is blank, claim will be rejected.)
16	Discharge Hour	"**Discharge hour is required.**" (Use type if bill table to determine if it is an IP or OP bill type. If IP, the frequency code is either 1 or 4, and this field is blank, claim will be rejected.)
17	Patient Discharge Status	"**Patient discharge status is required.**" (If left blank, claim will be rejected.)
42	Revenue Code	"**Revenue code is missing or illegible.**" (If the revenue code is missing or illegible, the claim will be rejected.)
45	Service Date	"**DOS is missing or illegible.**" (Claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)
45	Creation Date	"**Creation date is missing or illegible.**" (If the creation date is missing or illegible, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) Effective January 1, 2018
46	Service Days/Units	"**Days/units are required on line ___." [lines 1-22].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)
47	Line Item Charges	"**Line item charge amount is missing on line___." [lines 1-22].** (If a value greater than or equal to zero is not present, the claim will be rejected.)
47	Total Charges	"**Total charge amount is missing.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
50	Payer	"**Payer name is required.**" (If left blank, the claim will be rejected.)
52	Release of Information	"Valid r**elease of information certification indicator is required.**" (If blank or invalid, the claim will be rejected.)
53	Assignment of Benefits	"Valid a**ssignment of benefits certification indicator is required.**" (If blank or invalid, the claim will be rejected.)
58	Insured's Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
59	Patient's Relationship	"Valid p**atient's relationship to insured is required.**" (If blank or invalid, the claim will be rejected.)
64	Document Control Number (DCN)	If claim is a resubmission, include the original claim number. Note: include frequency code in Field 4. (If original claim number is missing or invalid, the claim will be rejected.)
67A-Q	Other Diagnosis Codes and Present on Admission Indicator	"**Diagnosis codes are missing or illegible.**" (If diagnosis codes are missing or illegible, the claim will be rejected.)
69	Admitting Diagnosis Code	"**Admitting diagnosis code is missing or illegible.**" (If it is an IP claim and field is blank or illegible, the claim will be rejected.)
70	Patient's Reason for Visit	"**Patient's reason for visit is missing.**" (If the claim is OP and field is blank, the claim will be rejected.)
74	Other/Procedure Date	"**Based on the date the claim was received, procedure date is a future date.**" (Use the bill type table to identify if it is an IP or an OP

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria) Effective January 1, 2018
		claim; If it is OP, do not reject the claim; If it is IP and a future date is billed, reject the claim.)
74	Other/Procedure Date	"**Procedure date is missing or illegible.**" (Use bill type table to identify if it is an IP or and OP claim. If OP, do not reject the claim. If IP and a valid date is not billed, reject the claim.)
76	Attending Provider Identifiers: Name and NPI	"**Attending physician name and/or number is missing."** (If attending physician name or NPI number are missing, the claim will be rejected.)
76	Attending Provider Qualifier	"**Attending provider qualifier is missing/ invalid.**" (The claim will be rejected if the "Other provider ID" is present and either: 1.) The 'Qualifier' box is blank or 2.) A qualifier other than 0B/1G/G2 is present.
76	Attending Provider Other ID#	**"Attending Provider NPI is missing."**(The claim will be rejected if qualifier is present and Other ID box is blank.)

NOTES

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