carolina complete health

Provider Billing Manual

1-833-552-3876 (TTY: 711)
carolinacompletehealth.com

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Introductory Billing Information 5
Billing Instructions 5
General Billing Guidance 5
Claim Forms 6
Billing Codes 6
CPT® Category II Codes 6
Encounters vs Claim 7
Clean Claim Definition 7
Non-Clean Claim Definition 7
Rejection versus Denial 7
Contact Information 8
Claims Payment Information 8
Systems Used to Pay Claims 8
Electronic Claims Submission 9
Paper Claim Submission 9
Basic Guidelines for Completing the CMS-1500 Claim Form (detailed instructions in appendix): . 10
Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA) 10
Common Causes of Claims Processing Delays and Denials 11
Common Causes of Up-Front Rejections 11
Paid in Full 12
Prompt Pay 12
Timely Filing 12
Claim Denials 13
Overpayment/Underpayment 14
Interest 14
Wrap Payments 14
Cost-Sharing 15
Third Party Liability / Coordination of Benefits 15
Billing the Enrollee / Enrollee Acknowledgement Statement 15
CLIA Accreditation 16
Carolina Complete Health Code Auditing and Editing 17
CPT and HCPCS Coding Structure 18
International Classification of Diseases (ICD 10) 19
Revenue Codes 19
Edit Sources 19
Code Auditing and the Claims Adjudication Cycle 20
Code Auditing Principles 20
Unbundling 20
PTP Practitioner and Hospital Edits 21

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities 21
Code Bundling Rules not sourced to CMS NCCI Edit Tables 21
Procedure Code Unbundling 21
Mutually Exclusive Editing 21
Incidental Procedures 21
Global Surgical Period Editing/Medical Visit Editing 21
Global Maternity Editing 22
Services Bundled to the Inpatient Admission 22
Multiple Code Rebundling 22
Frequency and Lifetime Edits 22
Duplicate Edits 23
National Coverage Determination Edits 23
Anesthesia Edits 23
Invalid revenue to procedure code editing 23
Assistant Surgeon 23
Co-Surgeon/Team Surgeon Edits: 23
Add-on and Base Code Edits 23
Bilateral Edits 23
Replacement Edits 23
Missing Modifier Edits 24
Administrative and Consistency Rules 24
Prepayment Clinical Validation 24
MODIFER -59 24
MODIFIER -25 25
Modifiers with Outpatient Specialized Therapy Services (Speech, Occupational, and Physical Therapy) 26
Modifier Requirement for Doctoral-Level Licensed Psychologists 26
Hospital Facilities Billing Outpatient Laboratory Pathology Services 27
Inpatient Facility Claim Editing 27
Viewing Claim Coding Edits 28
Code Editing Assistant 28
Other Important Information 28
Health Care Acquired Conditions (HCAC) – Inpatient Hospital 28
Reporting and Non-Payment for Provider Preventable Conditions (PPCS) 29
Non-Payment and Reporting Requirements Provider Preventable Conditions (PPCS) - Inpatient. 29
Other Provider Preventable Conditions (OPPCS) – Outpatient 29
Non-Payment and Reporting Requirements Other Provider Preventable Conditions (OPPCS) – Outpatient 29
POA Indicator 30
Multiple Surgeries 30

Use of Assistant Surgeons....30
Other Relevant Billing Information....31
Abortion....31
DME Miscellaneous Codes....33
Emergency Services....36
Electronic Visit Verification (EVV)....37
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)....37
Hospital Interim Claims....37
Laboratory....37
National Drug Code (NDC) Requirements....38
Newborn Billing....38
Hospice....38
Nursing Facility....38
Swing Bed Nursing Facility....38
Patient Monthly Liability....38
Out of Network Providers....38
Out of State Reimbursement....38
Prosthetic and Orthotic Supplies....39
Therapies....39
Tribal Claims....39
Unlisted CPT Codes....40
Vaccines for Children (VFC) Program....40
Appeals and Grievances....40
Provider Claim Corrections, Reconsiderations, and Claim Grievances....40
APPENDIX I: COMMON HIPAA COMPLIANT EDI REJECTION CODES....42
APPENDIX II: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION....43
APPENDIX III: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION....45
APPENDIX IV: TAXONOMY CODE PLACEMENT ON CLAIMS....47
APPENDIX V: CLAIMS FORM INSTRUCTIONS CMS 1500....48
APPENDIX VI – CLAIMS FORMS INSTRUCTIONS UB....59
APPENDIX VII – ORIGIN AND DESTINATION MODIFIERS FOR TRANSPORTATION....74

Introductory Billing Information

Welcome to Carolina Complete Health (CCH). Thank you for being a part of the CCH network of participating physicians, hospitals, and other healthcare professionals. This guide provides information to support your claims billing needs and can be used in conjunction with the CCH Provider Manual located in the "For Providers" section of our website at: www.carolinacompletehealth.com

Billing Instructions

Carolina Complete Health (CCH) follows Centers for Medicare & Medicaid Services (CMS) rules and regulations, specifically the Federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR § 447.45 and 42 CFR § 447.46; and in accordance with State laws and regulations, as applicable.

General Billing Guidance

Physicians, other licensed health professionals, facilities, and ancillary provider's contract directly with CCH for payment of covered services.

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

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

Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a on the HCF!, to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays; Such claims are not considered "clean" and therefore cannot be accepted into our system.

We recommend that providers notify CCH 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form; Changes to a Provider's TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The enrollee must be effective on the date of service (see information below on identifying the enroll(lee),
- The service provided must be a covered benefit under the enrollee's contract on the date of service, and
- Referral and prior authorization processes must be followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outline in this manual.

When submitting your claim, you need to identify the enrollee. There are two ways to identify the enrollee:

- The CCH enrollee number found on the enrollee ID card or the provider portal.
- The Medicaid number provided by the State and found on the enrollee ID card or the provider portal.

Capitation payments may only be made by the State and retained by Carolina Complete Health for Medicaid-eligible enrollees. CCH shall not use funds paid by NC DHHS for services, administrative costs, or populations not covered under Carolina Complete Health's contract with NC DHHS related to non-Title XIX or non-Title XXI Members. 42 C.F.R. § 438.3(c)(2).

Claim Forms

CCH only accepts the CMS 1500 (2/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (2/12) form and institutional providers complete the CMS 1450 (UB-04) claim form. CCH does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms are required to be typed or printed and in the original red and white version to ensure clean acceptance and processing. All claims with handwritten information or black and white forms will be rejected. If you have questions regarding what type of form to complete, contact CCH at the following phone number:

Carolina Complete Health
1-833-552-3876
TDD/TYY: 800-735-2962

Billing Codes

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

- Code billed is missing, invalid, or deleted at the time of service
- Code is inappropriate for the age or sex of the enrollee
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary
- Code billed is inappropriate for the location or specialty billed
- Code billed is a part of a more comprehensive code billed on same date of service

CPT® Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

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

Encounters vs Claim

An encounter is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our enrollees. For example; if you are the primary medical provider for an enrollee and receive a monthly capitation amount for services, you must file an

encounter (also referred to as a "proxy claim") on a CMS 1500 for each service provided; Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero dollar amounts. It is mandatory that your office submits encounter data. CCH utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by North Carolina Department of Health and Human Service (NC DHHS) and by CMS. Encounters do not generate an Explanation of Payment (EOP).

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted the original claim. Claims will generate an EOP.

You are required to submit either an encounter or a claim for each service that you render to a CCH enrollee.

Clean Claim Definition

A clean claim means a claim received by CCH for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the provider of the services to be processed and paid by CCH.

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. The errors or omissions in claims result in the request for additional information from the provider or other external sources to resolve or correct data omitted from the bill; review of additional medical records; or the need for other information necessary to resolve discrepancies. In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Rejection versus Denial

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

REJECTION: A list of common upfront rejections can be found on page 15. Rejections will not enter our claims adjudication system, so there will be no Explanation. A REJECTION is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. The provider will receive a letter or a rejection report if the claim was submitted electronically.

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

Contact Information

Health Plan Address/Administrative Office	Carolina Complete Health 1701 N. Graham Street Charlotte, NC 28206
Claims Submission Address	Carolina Complete Health ATTN: Claims PO Box 8040 Farmington, MO 63640-8040
Carolina Complete Health Provider Services	833-552-3876 TTY 844-735-2962 Monday through Saturday 7:00AM-6:00PM

Claims Payment Information

Systems Used to Pay Claims

CCH uses three main systems to process reimbursement on a claim. Those systems are:

- Amisys
- DST Pricer
- Rate Manager

AMISYS

Our core system; All claims are processed from this system and structures are maintained to meet the needs of our provider contracts. However, we are not limited within the bounds of this one system.

We utilize multiple systems to expand our universe of possibilities and better meet the needs of our business partners.

DST PRICER

The DST Pricer is a system outside our core system where we have some flexibility on addressing your contractual needs. It allows us to be more responsive to the market demands. It houses both Fee Schedules and procedure codes and mirrors our Amisys system, but with a more attention to detail.

RATE MANAGER

Rate Manager's primary function is to price Facility claims. Inpatient claims are based on the type of DRG and the version. Each Hospital in the country is assigned a base rate and add-ons by Medicaid and Medicare based on state or federal guidelines. The basic DRG calculation:

Hospital Base Rate x DRG Relative weight + Add-ons

The payment can be affected by discharge status, length of stay and other allowed charges. In alignment with NC state policy, outpatient facilities claims are reimbursed through Ratio of Cost to Charge (RCC) and are not priced in Rate Manager.

Electronic Claims Submission

Network providers are encouraged to participate in CCH's electronic claims/encounter filing program. CCH can receive ANSI X12N 837 professional, institution or encounter transactions. In addition, it can generate an ANSI X12N 835 electronic remittance advice known as an EOP. Providers that bill electronically have the same timely filing requirements as providers filing paper claims.

In addition, providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

- On **Professional claims** (ASC X12 837-P) the billing provider taxonomy should be included in EDI loop 2000A and the rendering provider taxonomy, when applicable, should be included in EDI loop 2310B.
- On **Institutional claims** (ASC X12 837-I) the billing provider taxonomy should be included in EDI loop 2000A and the attending provider taxonomy, when applicable, should be included in EDI loop 2310A.

CCH's Payor ID is 68069. Our Clearinghouse vendors include Availity, Change Healthcare (formerly Emdeon) and Ability. Please visit the Carolina Complete Health Network website, review the Provider Resources link, locate then select the Claims and Billing section. This area offers the provider further details on how to register as well as instruction in the use of Payspan. For all questions or for more information on EDI and electronic filing please contact the:

CAROLINA COMPLETE HEALTH CENTENE EDI DEPARTMENT

1-800-225-2573, extension 25525

or by e-mail at EDIBA@centene.com

Paper Claim Submission

For CCH enrollees, all claims and encounters should be submitted to:

Carolina Complete Health

Attn: Claims PO Box 8040

Farmington MO 63640-8040

REQUIREMENTS

CCH uses an imaging process for paper claims retrieval. Please see Appendix 4 and 5 for required fields. To ensure accurate and timely claims capture, please observe the following claims submission rules:

Do's:

- Do use the correct P.O. Box number

- Do submit all claims in a 9” x 12” or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 10-to-12-point font
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do include the EOP from the primary insurance carrier when applicable Note: CCH is able to receive primary insurance carrier EOP [electronically]
- Do submit on a proper original form - CMS 1500 or UB 04

Don’ts

- Don’t submit handwritten claim forms
- Don’t use red ink on claim forms
- Don’t circle any data on claim forms
- Don’t add extraneous information to any claim form field
- Don’t use highlighter on any claim form field
- Don’t submit photocopied claim forms (no black and white claim forms)
- Don’t submit carbon copied claim forms
- Don’t submit claim forms via fax
- Don’t utilize staples for attachments or multi page documents

Basic Guidelines for Completing the CMS-1500 Claim Form (detailed instructions in appendix):

- Use one claim form for each recipient.
- Enter one procedure code and date of service per claim line.
- Enter information with a typewriter or a computer using black type.
- Enter information within the allotted spaces.
- Make sure whiteout is not used on the claim form.
- Complete the form using the specific procedure or billing code for the service.
- Use the same claim form for all services provided for the same recipient, same provider, and same date of service.
- If dates of service encompass more than one month, a separate billing form must be used for each month

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

CCH provides Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) to its participating providers to help them reduce costs, speed secondary billings, and improve cash flow by enabling online access of remittance information, and straight forward reconciliation of payments. As a Provider, you can gain the following benefits from using EFT and ERA:

1. Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re- keying
2. Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow

3. Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
4. Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

Common Causes of Claims Processing Delays and Denials

- Incorrect Form Type
- Diagnosis Code Missing Digits
- Missing or Invalid Procedure or Modifier Codes
- Missing or Invalid DRG Code
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete
- Invalid Enrollee ID
- Invalid Place of Service Code
- Provider TIN and NPI Do Not Match
- Invalid Revenue Code
- Dates of Service Span Do Not Match Listed Days/Units
- Missing Physician Signature
- Invalid TIN
- Missing or Incomplete Third-Party Liability Information

CCH will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Common Causes of Up-Front Rejections

- Unreadable Information
- Missing Enrollee Date of Birth
- Missing Enrollee Name or Identification Number
- Missing Provider Name, Tax ID, or NPI Number
- Missing Medicaid Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim
- Dates Are Missing from Required Fields
- Invalid or Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code
- Missing Service Line Detail
- Enrollee Not Effective on The Date of Service
- Admission Type is Missing
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid CPT/Procedure Code
- Incorrect Form Type
- Claims submitted with handwritten data or black and white forms

CCH will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

Paid in Full

The claim has been adjudicated, processed and reimbursed in accordance and with the executed provider contract on file including the coordination of benefits, as applicable per claim

Prompt Pay

Claim Payment

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

- A clean medical claim within thirty (30) calendar days of receipt of the clean claim.
- A medical pended claim will be paid or denied within thirty (30) calendar days of receipt of the requested additional information.
- Adjusted clean claims will be paid or denied within thirty (30) calendar days of receipt of the complete requested adjustment documentation.
- For the purpose of actions which must be taken by CCH, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.
- For purposes of claims payment, the PHP shall be deemed to have paid the claim as of the Date of Payment, and the PHP shall be deemed to have denied the claim as of the date the remittance advice is sent.

Timely Filing

Effective July 01, 2021 through June 30, 2023 dates of service: Providers must submit all first-time claims for reimbursement no more than one hundred eighty (180) calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty days after the date of the member's discharge from the facility; CCH accommodates exceptions to the one hundred eighty day timely requirement pursuant to N.C. Gen. Stat. §58-3-225(f) and CCH will not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by CCH and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required. When a claim requires financial eligibility determination, the PHP may not limit the time in which claims may be submitted to fewer than one hundred eighty (180) Calendar Days from the date the patient monthly liability (PML) is determined.

Effective July 01, 2023 and after dates of service: **Contracted Providers and Healthy Opportunities Pilots (HOP) providers**, must submit all first-time claims for reimbursement no more than three hundred sixty-five (365) calendar days from the Date of Service, or in the case of a health care provider facility, within three hundred sixty-five days after the date of the member's discharge from the facility; CCH accommodates exceptions to the three hundred sixty-five day timely requirement pursuant to N.C. Gen. Stat. §58-3-225(f) and CCH will not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) calendar days. Unless otherwise agreed to by CCH and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably

possible for the provider to file the claim within that time, provided that the claim is submitted as soon as possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required. When a claim requires financial eligibility determination, the PHP may not limit the time in which claims may be submitted to fewer than three hundred sixty-five (365) Calendar Days from the date the patient monthly liability (PML) is determined.

Effective July 01, 2023 and after dates of service: Non-Contracted Providers must submit all first-time claims for reimbursement no more than one hundred eighty (180) calendar days from the Date of Service, or in the case of a health care provider facility, within one hundred eighty days after the date of the member's discharge from the facility; CCH accommodates exceptions to the one hundred eighty day timely requirement pursuant to N.C. Gen. Stat. §58-3-225(f) and CCH will not limit the time in which claims may be submitted to fewer than one hundred eighty (180) calendar days. Unless otherwise agreed to by CCH and the provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the provider to file the claim within that time, provided that the claim is submitted as soon as possible and in no event, except in the absence of legal capacity of the provider, later than one (1) year from the time submittal of the claim is otherwise required.

Coordination of Benefits (COB)

Federal regulations require Medicaid to be the "payer of last resort," meaning that all third-party insurance carriers must pay before Medicaid processes the claim. This includes Medicare and private health insurance carriers. Providers must report payments from all third parties on Medicaid payment claims. Providers should verify other health insurance information directly with the Medicaid Managed Care Organizations (PHPs) associated with the member prior to submitting claims. NC Tracks should only be used to verify other insurance for NC Medicaid Direct members. NC Medicaid health plans have and will continue to be the primary source of truth for identifying and verifying the existence of other health insurance coverage for the managed care member population. (March 5, 2025 Medicaid Bulletin).

For a secondary claim from a third-party commercial or Medicare insurance regardless of the date of service on the claim, CCH shall allow the Provider three hundred and sixty-five (365) Calendar Days from the primary insurer's Explanation of Benefits/Remittance Advice date (whether the claim was paid or denied) to file the claim to the Member's assigned PHP. The claim should be submitted electronically, and a copy of the third-party commercial or Medicare insurance EOB/RA should be uploaded as an attachment. For timely filing of claim corrections, reconsiderations, and grievances, view the section titled: Claim Correction, Reconsideration, and Grievances in this manual.

Claim Denials

Within eighteen (18) calendar days of receiving a medical claim or within fourteen (14) calendar days of receiving a pharmacy claim, the Plan will notify the provider whether the claim is clean or pend the claim and request from the Provider all additional information needed to timely process the claim. If a claim is pended or denied because more information is required to process it, the claim notice will specifically describe all information and supporting documentation needed to evaluate the claim for processing. If the requested additional information on a medical or pharmacy pended claim is not

submitted within ninety (90) calendar days of the notice requesting the required additional information, the PHP may deny the claim in accordance with N.C. Gen. Stat. § 58-3-225(d).High Dollar Post-Payment Review for Hospital Inpatient Claims

Effective August 1, 2024, Carolina Complete Health will institute high dollar post-payment review requirements for hospital inpatient claims with a header or total billed amount greater than $250k.

- For any hospital inpatient claim greater than $250k, please include an itemized bill along with the claim submission.
- If an itemized bill is not included with the original claim, it will cause delay and/or partial payment. If an itemized bill is not included with the original claim billed at or more than $250k, an itemized bill or additional medical records will be requested in order to determine the appropriate outlier reimbursement. The outlier and DRG will pay but is subject to a post pay review

Overpayment/Underpayment

CCH, to the extent required by Contract, promptly reports overpayments, specifying overpayments due to potential fraud in accordance with 42 C.F.R. §438.608(a)(2). CCH administers recovery of overpayment and underpayment in accordance with N.C. Gen. Stat. §58- 3-225(h).

In meeting the requirement of 42 C.F.R. § 438.608(a)(2), recovery of overpayments and underpayments shall be administered in accordance with NCGS. § 58-3-225(h), except that not less than sixty (60) Calendar Days before Carolina Complete Health seeks to recover any overpayments or offsets any future payments from the provider, Carolina Complete Health shall provide the written notice required under NCGS § 58-3-225(h).

Carolina Complete Health shall coordinate with the Department to ensure overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting.

Interest

Any portion of a claim not paid within Timely Claim Payment limits will be subject to interest at the annual percentage rate of eighteen percent (18%). CCH shall pay interest to the Provider on the portion of the claim payment that is late at the annual percentage rate of eighteen percent (18%) beginning on the first day following the date that the claim should have been paid or was underpaid as specified in the Contract.

Wrap Payments

Federal rules allow DHHS to continue to make additional wrap-around payments to FQHCs and RHCs. The Plan shall reimburse FQHCs and RHCs for covered services at no less than the following rates:

- All ancillary services (i.e., radiology, etc.) shall be based on the North Carolina Medicaid Physician Fee Schedule.
- All cover services shall be based on each FQHC or RHC's respective North Carolina Medicaid Fee Schedule, which is defined as each FQHC or RHC's respective core rate or T1015 code.
- The Plan shall provide the necessary data to DHHS to enable DHHS's payment of federally mandated wrap payments to FQHCs and RHCs using a template to be provided by DHHS on a schedule to be defined by DHHS

Cost-Sharing

CCH imposes the same cost-sharing amounts as specified in North Carolina's Medicaid and North Carolina Health Choice state plans. Plan members are not required to pay for any covered services other than the co-payment amounts required under the state plans. CCH tracks cost- sharing obligations of each member.

Cost-sharing does not apply to:

- Well-child visits and age-appropriate immunizations. Pursuant to 42 C.F.R. §456.505(d), all Plan members receive these services at no cost to their families.
- The subset of the population including children under age twenty-one (21), pregnant women, individuals receiving hospice care, federally-recognized American Indians/Alaska natives, Breast Cancer and Cervical Cancer Control Program (BCCCP) beneficiaries, foster children, disabled children under Family Opportunity Act, and an individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- Behavioral health services as defined by DHHS.

Third Party Liability / Coordination of Benefits

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the enrollee. Any other insurance, including Medicare, is always primary to Medicaid coverage.

CCH, like all Medicaid programs, is always the payer of last resort. Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CCH enrollees. If an enrollee has other insurance that is primary, you must submit your claim to the primary insurance for consideration, and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for an Enrollee with insurance primary to Medicaid, the claim will pend and/or deny until this information is received. If an Enrollee has more than one primary insurance (Medicaid would be the third payer), the claim cannot be submitted through EDI or the secure web portal and must be submitted on a paper claim.

If the provider is unsuccessful in obtaining necessary cooperation from an enrollee to identify potential third party resources, the provider shall inform the health plan that efforts have been unsuccessful. CCH will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, the health plan will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Billing the Enrollee / Enrollee Acknowledgement Statement

CCH reimburses only services that are medically necessary and covered through the program. Providers are not allowed to "balance bill" for covered services if the provider's usually and customary charge for covered services is greater than our fee schedule.

Providers may bill enrollees for services NOT covered by either Medicaid or CCH or for applicable copayments, deductibles or coinsurance as defined by the State of North Carolina.

For a provider to bill an enrollee for services not covered under the program, or if the service limitations have been exceeded, the provider must obtain a written acknowledgment following this language (the Enrollee Acknowledgement Statement):

I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Program as being reasonable and medically necessary for my care. I understand that Carolina Complete Health (CCH) through its contract with the State Medicaid Agency determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

CLIA Accreditation

Labs who participate in the Medicare or Medicaid sector with CCH must be CLIA accredited. Requirements for laboratory accreditation are contained in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB) located at the following link: http://www.jcrinc.com/store/publications/manuals/

How to Submit a CLIA Claim

Via Paper:

Complete Box 23 of a CMS-1500 form with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

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

Via EDI:

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

-Or-

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

*Note - The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4. When the referring laboratory is the billing laboratory, the reference laboratory's name, NPI, address, and Zip Code shall be reported in loop 2310C. The 2420C loop is required if different then information provided in loop 2310C. The 2420C would contain Laboratory name and NPI.

Via AHA Provider Portal:

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

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

Carolina Complete Health Code Auditing and Editing

CCH uses HIPAA compliant clinical claims auditing software for physician and outpatient facility coding verification. The software will detect, correct, and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding "rule;" When the software audits a claim that does not adhere to a coding rule, a recommendation known as an "edit" is applied to the claim; when an edit is applied to the claim,a claim correction should be made. Carolina Complete Health uses WEDI SNIP Level 5 HIPAA Compliance for claims. Claim submissions will be validated for compliance, through SNIP level 5 to ensure integrity based on SNIP guidelines.

While code auditing software is a useful tool to ensure provider compliance with correct coding, a fully automated code auditing software application will not wholly evaluate all clinical patient scenarios. Consequently, the health plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is

warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

Moreover, CCH may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

CPT codes are a component of the HealthCare Common Procedure Coding System (HCPCS). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding. Current Procedural Terminology (CPT) codes belong to the Level I subset and consist of the terminology used to describe medical terms and procedures performed by health care professionals. CPT codes are published by the American Medical Association (AMA). CPT codes are updated (added, revised and deleted) on an annual basis.

1. **Level I HCPCS Codes (CPT):** This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are then used to bill health insurance companies.
2. **Level II HCPCS:** The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics and prosthetics and etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.
3. **Miscellaneous/Unlisted Codes**: The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.
4. **Temporary National Codes:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.
5. **HCPCS Code Modifiers:** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion; certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management

services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period. **The -EP modifier must be used when services provided are considered as part of the Medicaid early periodic screening diagnosis and treatment (EPSDT) program.**

International Classification of Diseases (ICD 10)

These codes represent classifications of diseases. They are used by healthcare providers to classify diseases and other health problems.

Revenue Codes

These codes represent where a patient had services performed in a hospital or the type of services received. These codes are billed by institutional providers. HCPCS codes may be required on the claim in addition to the revenue code.

Edit Sources

The claims editing software application contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, frequency limitations, fragmentation, up-coding, duplication, invalid codes, mutually exclusive procedures and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, research and etc.

The software applies edits that are based on the following sources

- Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) for professional and facility claims. The NCCI edits includes column 1/column 2, medically unlikely edits (MUE), exclusive and outpatient code editor (OCE) edits. These edits were developed by CMS to control incorrect code combination billing contributing to incorrect payments. Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- CMS Claims Processing Manual
- CMS Medicaid NCCI Policy Manual
- State Provider Manuals, Fee Schedules, Periodic Provider Updates (bulletins/transmittals)
- CMS coding resources such as, HCPCS Coding Manual, National Physician Fee Schedule, Provider Benefit Manual, Claims Processing Manual, MLN Matters and Provider Transmittals
- AMA resources
    - CPT Manual
    - AMA Website
    - Principles of CPT Coding
    - Coding with Modifiers
    - CPT Assistant
    - CPT Insider's View
    - CPT Assistant Archives
    - CPT Procedural Code Definitions
    - HCPCS Procedural Code Definitions
- Billing Guidelines Published by Specialty Provider Associations

    - Global Maternity Package data published by the American Congress of Obstetricians and Gynecologists (ACOG)
    - Global Service Guidelines published by the American Academy of Orthopedic Surgeons (AAOS)
- State-specific policies and procedures for billing professional and facility claims
- Health Plan policies and provider contract considerations

Code Auditing and the Claims Adjudication Cycle

Code auditing is the final stage in the claims adjudication process. Once a claim has completed all previous adjudication phases (such as benefits and enrollee/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code auditing cycle, each service line on the claim is processed through the code auditing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the enrollee/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

- **Deny**: Code auditing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- **Pend**: Code auditing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions
- **Replace and Pay**: Code auditing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the enrollee's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Auditing Principles

The below principles do not represent an all-inclusive list of the available code auditing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

Unbundling

CMS National Correct Coding Initiative

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS developed the correct coding initiative to control erroneous coding and help prevent inaccurate claims payment. CMS has designated certain combinations of codes that should never be billed together. These are also known as Column 1/Column II edits. The column I procedure code is the most comprehensive code and reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column I code is considered an integral component of the column II code.

The CMS NCCI edits consist of Procedure to Procedure (PTP) edits for physicians and hospitals and the Medically Unlikely Edits for professionals and facilities. While these codes should not be billed together, there are circumstances when an NCCI modifier may be appended to the column 2 code to identify a significant and separately identifiable or distinct service. When these modifiers are billed, clinical validation will be performed.

PTP Practitioner and Hospital Edits

Some procedures should not be reimbursed when billed together. CMS developed the Procedure to Procedure (PTP) Edits for practitioners and hospitals to detect incorrect claims submitted by medical providers. PTP for practitioner edits are applied to claims submitted by physicians, non-physician practitioners and ambulatory surgical centers (ASC). The PTP-hospital edits apply to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy and speech-language pathology providers and comprehensive outpatient rehabilitation facilities.

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

MUE's reflect the maximum number of units that a provider would bill for a single enrollee, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyst, equipment prescribing information and clinical judgment.

Code Bundling Rules not sourced to CMS NCCI Edit Tables

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public-domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgery period are designated as major procedures. Procedures assigned a 0 or 10 day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1- day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with "MMM - Global periods for maternity services are classified as "MMM" when an evaluation and management service is billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

CCH shall not prohibit physicians from billing valid global obstetrics claims including antepartum care, labor and delivery, and post-partum care as defined in Obstetrics Clinical Coverage Policy 1E-5, regardless if the antepartum care was provided prior to a Member enrolling in Carolina Complete Health.

Services Bundled to the Inpatient Admission

Outpatient hospital services provided by a hospital to a beneficiary within the 24 hours immediately preceding an inpatient admission to the same hospital or hospital wholly owned and operated by the admitting hospital, and that are related to the inpatient admission, must be reported with the inpatient billing.

Multiple Code Rebundling

This rule analyzes if a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a enrollee's lifetime; State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a enrollee's lifetime; Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Duplicate Edits

Code auditing will evaluate prospective claims to determine if there is a previously paid claim for the same enrollee and provider in history that is a duplicate to the prospective claim. The software will also look across different providers to determine if another provider was paid for the same procedure, for the same enrollee on the same date of service. Finally, the software will analyze multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician bill for office visits for the same enrollee on the same day.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services, or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid revenue to procedure code editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Rule evaluates claims billed as an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits:

CMS guidelines define whether an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

Rules look for claims where the add-on CPT code was billed without the primary service CPT code or if the primary service code was denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add- on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims where the modifier -50 has already been billed, but the same procedure code is submitted on a different service line on the same date of service without the modifier -50. This rule is highly customized as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the same provider bills more than one outpatient consultation code for the same enrollee in the enrollee's history. This rule will deny the office consultation code and replace it with a more appropriate evaluation and management service, established patient or subsequent hospital care code. Another example, the rule will evaluate if a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. This rule

will replace the second submission with the appropriate established patient visit. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- **Procedure code invalid rules**: Evaluates claims for invalid procedure and revenue or diagnosis codes
- **Deleted Codes:** Evaluates claims for procedure codes which have been deleted
- **Modifier to procedure code validation:** Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, 26, -57, -58 and -59.
- **Age Rules**: Identifies procedures inconsistent with enrollee's age
- **Gender Procedure:** Identifies procedures inconsistent with enrollee's gender
- **Gender Diagnosis:** Identifies diagnosis codes inconsistent with enrollee's gender
- **Incomplete/invalid diagnosis codes**: Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of CCH's clinical validation services is modifier -25 and -59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1," Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). CCH's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a enrollee on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

MODIFER -59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier 59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was

distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 related to the portion of the definition that allows its use to describe "different procedure or surgery"; NCCI guidelines state that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

CCH uses the following guidelines to determine if modifier -59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated;
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

MODIFIER -25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service"; Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra- and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply; The fact that the patient is "new" to the

provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

CCH uses the following guidelines to determine whether modifier 25 was used appropriately.

If any one of the following conditions is met then, the clinical nurse reviewer will recommend reimbursement for the E/M service:

If the E/M service is the first time the provider has seen the patient or evaluated a major condition

- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a enrollee on or around the same date of the procedure support that an E/M service would have been required to determine the enrollee's need for additional services;
- To avoid incorrect denials providers should assign all applicable diagnosis codes that support additional E/M services.

Modifiers with Outpatient Specialized Therapy Services (Speech, Occupational, and Physical Therapy)

For Outpatient Therapies (Speech, Occupational and Physical), below are the billing guidelines for claim reimbursement, when combined with the appropriate and approved authorization for services:

- GN GO GP modifiers are to be billed primarily for Speech, Occupational and Physical Therapy, respectively, according to services provided.
- GT modifier is to be billed for Teletherapy, secondary to the GN GO GP modifier.
- CQ CO modifiers are to be billed when services are furnished in whole or in part by a PT or OT Assistant, primary to GP or GO modifiers.
    - CO– Occupational Therapy Assistant
    - CQ – Physical Therapy Assistant

Modifier Requirement for Doctoral-Level Licensed Psychologists

To align reimbursement with the Licensed Psychologist Fee Schedule (Doctoral Degree) published by the North Carolina Department of Health and Human Services, **Carolina Complete Health** requires all doctoral-level Licensed Psychologists to include a credential-specific modifier on claims.

Required Modifiers:

- **AH** – Doctorate Level or Clinical Psychologist (Ph.D. or Psy.D.)
- **HP** – Psychologist or Doctorate Level (Psy.D. or Ph.D.)

Billing Guidelines:

- Append the applicable AH or HP modifier to each **CPT or HCPCS code** billed

Filing Corrected Claims: Providers can submit corrected claims with the applicable modifiers for reprocessing if it is determined the incorrect rate was reimbursed. Make sure to include the original claim number being corrected to serve as proof of timely filing.

Hospital Facilities Billing Outpatient Laboratory Pathology Services

TC modifier is not required to be billed on outpatient hospital pathology and laboratory services when all criteria shown below is met:

- Claim Form Type = UB-04
- AND billed with a revenue code '300-319'
- AND any of the following Pathology HCPCS codes listed in the PHP Managed Care Hospital Outpatient Laboratory Fee Schedule: 88104-88125, 88160-88162, 88172-88173, 88177, 88180-88182, 88199, 88300-88319, 88323, 88331-88380, 88399, 88387-88388, G0416-G0419.

Outpatient hospital claims meeting the above criteria will be reimbursed at the technical component (TC) modifier rate on the fee schedule, with or without the TC modifier. While the TC modifier is no longer required, it will not impact claims adjudication, if billed.

Important Reminders:

- Hospitals can only bill for technical and professional reimbursement if the pathologist is employed by the facility.
- Professional claims will continue to require services be billed with a 26 modifier to indicate the charge is for the professional component only.

Above guidance is based on clarification received on April 16, 2025, from NC Department of Health and Human Services

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to a previous admission. For example, a subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of post-admission follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Payment and Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits. These policies are posted online at:

https://network.carolinacompletehealth.com/resources.html referencing Clinical Policies and Payment Policies.

Claim Reconsiderations and Grievances related to Code Auditing and Editing

Claim reconsiderations and grievances resulting from claim-editing are handled per the provider reconsideration and grievance processes outlined in this manual. If you disagree with a code audit or edit and request claim reconsideration or grievance, you must submit medical documentation (medical record) related to the reconsideration. If medical documentation is not received, the original code audit or edit will be upheld.

Viewing Claim Coding Edits

Code Editing Assistant

A web-based code auditing reference tool designed to "mirror" how the code auditing product(s) evaluate code and code combinations during the auditing of claims. The tool is available for providers who are registered on our secure provider portal. You can access the tool in the Claims Module by clicking "Claim Auditing Tool" in our secure provider portal;

This tool offers many benefits:

- PROSPECTIVELY access the appropriate coding and supporting clinical edit clarifications for services BEFORE claims are submitted.
- PROACTIVELY determine the appropriate code/code combination representing the service for accurate billing purposes

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

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool; It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate

The code editing assistant can be accessed from the provider web portal.

Disclaimer

This tool is used to apply coding logic ONLY. It will not take into account individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Other Important Information

Health Care Acquired Conditions (HCAC) – Inpatient Hospital

CCH follows Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute Care Hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as

though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

Reporting and Non-Payment for Provider Preventable Conditions (PPCS)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by Health Plan Name for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.

CCH shall comply with 42 C.F.R. § 438.3(g) which mandates provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. CCH shall submit all identified Provider Preventable Conditions utilizing a quarterly log report.

Non-Payment and Reporting Requirements Provider Preventable Conditions (PPCS) - Inpatient

CCH follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, the health plan follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no- pay TOB claim. CCH follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

Other Provider Preventable Conditions (OPPCS) – Outpatient

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs. Conditions currently identified by CMS include:

- Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive surgery performed on the wrong body part; and
- Surgical or other invasive procedure performed on the wrong patient.

Non-Payment and Reporting Requirements Other Provider Preventable Conditions (OPPCS) – Outpatient

Medicaid follows the Medicare guidelines and NCDs, including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

POA Indicator

All claims involving inpatient admissions to general acute care hospitals using the UB-04 claim form or 837U claim transaction must file their discharge claims with POA/HAC indicators for all primary and secondary diagnoses. The POA/HAC indicator is placed adjacent to the principle and secondary diagnoses after the ICD10-CM diagnosis code.

The codes that are acceptable as POA/HAC indicators are:

- Y = Yes – Present at the time of inpatient admission.
- N = No – Not present at the time of inpatient admission.
- U = Unknown – The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
- W = Clinically Undetermined – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.

*The ICD10-CM Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting.

Hospitals will not receive additional payments for cases in which the selected condition was not present on admission. In other words, the DRG will be paid excluding any code that has a character of N or U; An indicator of "1" will be paid as though the secondary diagnosis were not present; Only diagnosis codes with a character of Y will be considered in the DRG calculations.

Currently the following types of providers are **EXEMPT** from POA/HAC indicator reporting:

- Critical Access Hospitals (CAHs)
- Long-term Care Hospitals (LTCHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Inpatient Psychiatric Hospitals
- Indian Health Centers

Multiple Surgeries

When multiple surgeries are performed the second through fifth surgery is reimbursed at 50%. If six or more procedures are billed on the same day medical records are required for review. If additional procedures are determined medically necessary each subsequent procedure is reimbursed at 50%.

Use of Assistant Surgeons

An Assistant Surgeon is defined as a physician who utilizes professional skills to assist the Primary Surgeon on a specific procedure; All Assistant Surgeon's procedures are subject to retrospective review for Medical Necessity by Medical Management; All Assistant Surgeon's procedures are subject to health plan policies and are not subject to policies established by contracted hospitals.

Hospital medical staff bylaws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity. Nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for

the surgery; Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the procedure.

Other Relevant Billing Information

Abortion

Providers are required to complete and submit the Abortion Statement outlined in Attachment B of the Abortion clinical coverage policy 1E-2 available on the NC DHHS state website. Claims submitting without this form or forms that are incomplete or completed incorrectly could result in claim denial.

Cell & Gene Therapy State-Selected Access Model

1. Overview

Drugs listed on the NC Select Drug List, including Cell & Gene Therapies (CGTs), are covered under the NC Medicaid Benefit if they meet the definition of a covered outpatient drug as defined in 42 CFR § 447.502.

The NC Select Drug List is maintained by NC Medicaid and may be modified by the State to include or exclude additional drugs.

2. Eligibility & Coverage Requirements

Candidate Beneficiary: To be considered for a State-Selected Model Drug under the CGT Access Model, the patient must:

- Have a documented diagnosis of sickle cell disease (SCD).
- Have NC Medicaid as the primary payer for the State-Selected Model Drug.

Provider Eligibility: To administer State-Selected Model Drugs, the provider must:

- Be registered with the CMS-designated patient registry.
- Obtain beneficiary consent for participation in a CMS-specified study.

Criteria for Approval: To qualify for CGT coverage, the therapy must:

- Be FDA-approved.
- Be administered according to the FDA label, including:
    - Indications and usage
    - Dosage and administration
    - Dosage forms and strengths
    - Warnings and precautions
- Be administered at a Qualified Treatment Center (QTC) or Authorized Treatment Center (ATC) approved by the manufacturer.
- If NC Medicaid established PA criteria, those take precedence over the FDA label.
- If no PA criteria are posted, the FDA label serves as the default standard.
- Refer to NC Medicaid Cell & Gene Therapies Clinical Coverage Policy No.: 1S.13 for clinical coverage guidelines: https://medicaid.ncdhhs.gov/1s-13-cell-and-gene-therapies/download?attachment

Prior Authorization

- Providers must submit the following to the DHHS Utilization Review Contractor

    - A completed Prior Authorization (PA) request.
    - Health records and supporting documentation demonstrate the beneficiary meet clinical criteria outlined in Section 3.2 of the policy.
    - Use product-specific CPT/HCPCS codes for the therapy. If unavailable, use J3590 (Unclassified Biologics).

Limitations

- Continued therapy is not authorized, as CGTs are intended to be one-time, lifetime treatments. Exceptions apply for therapies requiring multiple infusions or doses as part of a single treatment course.

3. Billing and Claims Submission

- Inpatient services: Use product-specific ICD-10-PCS code if available; otherwise, use the most specific billing code.
- Hospital outpatient services: Use product-specific HCPCS code if available; otherwise, use HCPCS J3590.
- Professional outpatient services: Use product-specific HCPCS code if available; otherwise, use HCPCS J3590 (Unclassified Biologics).
- In addition, the following applies to all claim submissions:
    - Include PA number on the claim.
    - Drug cost must be submitted on the claim with corresponding HCPCS code and NDC.
    - Drugs must be carved out of DRG or RCC and listed on a separate line for reimbursement.
    - Attach invoice to support actual drug acquisition cost (AAC).
    - The submitted cost must match invoice price net of discounts or rebates.

4. Submission Requirements

- Claims must be submitted by the hospital rendering provider directly to the appropriate Medicaid plan.
- Providers may not use white bagging or specialty pharmacies for billing. NC Medicaid will not reimburse point-of-sale pharmacies.
- The hospital's CEO, CFO, or designee must attest that invoice cost reflects the actual cost incurred, net of rebates and discounts.
- Bona Fide Service Fees (per 42 CFR § 423.501) are allowable and not required to be reported as cost offsets.

5. Reimbursement Guidance

- NC Medicaid's State-Selected Model Drugs are LYFGENIA (lovotibeglogene autotemcel) and CASGEVY (exagamglogene autotemcel).
- Inpatient setting: Reimbursed using DRG methodology based on primary diagnosis code. CGT Drug reimbursed at AAC net of rebates and discounts.
- Outpatient hospital setting: Reimbursed using RCC methodology. CGT Drug reimbursed at lesser of AAC or ASP net of rebates and discounts.

- Professional outpatient setting: CGT services reimbursed based on established fee schedule. CGT drug reimbursed at lesser of AAC or ASP net of rebates and discounts.
- Within 45 calendar days of notification of NC Select Drug List amendment, reimbursement logic will be applied by CCH.
- 340B inventory for NC Select Drugs is not reimbursable.

DME Miscellaneous Codes

When reporting claims for DME Miscellaneous services, providers must submit both the National DME Miscellaneous and corresponding Local W Code based on the chart below. When both codes represent miscellaneous services, e.g. E1399 and W4047, a description of the product/service must also be included. If the provider submits a claim without both the National DME Miscellaneous and corresponding Local W code the claim will be DENIED. **When submitting a claim for manually priced DME items, an invoice must be attached to the claim for reimbursement review. Providers must use the correct modifier for DME services as applicable for the services rendered.**

National	Description	Local	Local Description
E1399	Durable medical equipment, miscellaneous	W4001	CO/2 SATURATION MONITOR WITH ACCESSORIES, PROBES
E1399	Durable medical equipment, miscellaneous	W4002	MANUAL VENTILATION BAG (e.g. AMBU BAG)
K0108	Wheelchair component or accessory, not otherwise	W4005	UNLISTED REPLACEMENT OR REPAIR PARTS
E1399	Durable medical equipment, miscellaneous	W4016	BATH SEAT, PEDIATRIC (e.g. TLC)
E1399	Durable medical equipment, miscellaneous	W4047	MISCELLANEOUS FOR DME
K0108	Wheelchair component or accessory, not otherwise	W4117	WHEELCHAIR SEAT WIDTH, GREATER THAN 27"
K0108	Wheelchair component or accessory, not otherwise	W4118	WHEELCHAIR SEAT DEPTH, GREATER THAN 25"
K0108	Wheelchair component or accessory, not otherwise	W4119	WHEELCHAIR SEAT HEIGHT, COST ADDED OPTION FROM
E1399	Durable medical equipment, miscellaneous	W4120	DISPOSABLE BAGS FOR INSPIREASE INHALER SYSTEM, set of 3,
K0108	Wheelchair component or accessory, not otherwise specified	W4130	CONTOURED OR 3-PIECE HEAD/NECK SUPPORTS WITH HARDWARE, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4131	BASIC HEAD/NECK SUPPORT WITH HARDWARE, EACH

K0108	Wheelchair component or accessory, not otherwise specified	W4132	CONTOURED OR 3-PIECE HEAD/NECK SUPPORT WITH MULTI-ADJUSTABLE HARDWARE, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4133	BASIC HEAD/NECK SUPPORT WITH MULTI-ADJUSTABLE HARDWARE, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4139	SUB-ASIS BARS WITH HARDWARE, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4140	ABDUCTOR PADS WITH HARDWARE, PAIR
K0108	Wheelchair component or accessory, not otherwise specified	W4141	KNEE BLOCKS WITH HARDWARE, PAIR
K0108	Wheelchair component or accessory, not otherwise specified	W4143	SHOE HOLDERS WITH HARDWARE, PAIR
K0108	Wheelchair component or accessory, not otherwise specified	W4144	FOOT/LEGREST CRADLE, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4145	MANUAL TILT-IN-SPACE OPTION, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4150	MULTI-ADJUSTABLE TRAY, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4152	GROWTH KIT, EACH
E1399	Durable medical equipment, miscellaneous	W4153	TRACHEOSTOMY TIES, TWILL, EACH
K0108	Wheelchair component or accessory, not otherwise specified	W4155	ADDUCTOR PADS WITH HARDWARE, PAIR
B9998	NOC for enteral supplies	W4211	LOW PROFILE GASTROSTOMY EXTENSION/REPLACEMENT KIT FOR CONTINUOUS FEEDING, EACH

B9998	NOC for enteral supplies	W4212	LOW PROFILE GASTROSTOMY EXTENSION/REPLACEMENT KIT FOR BOLUS FEEDING, EACH
E1399	Durable medical equipment, miscellaneous	W4670	STERILE SALINE, 3 CC VIAL, EACH
E1399	Durable medical equipment, miscellaneous	W4678	REPLACEMENT BATTERY FOR PORTABLE SUCTION PUMP ADAPTIC AND TRANSPARENT TYPE SUCH AS TEGADERM OR OPSITE for use with external insulin pump, EACH
E1399	Durable medical equipment, miscellaneous	W4688	SINGLE POINT CANE FOR WEIGHTS 251# TO 500#
E1399	Durable medical equipment, miscellaneous	W4689	QUAD CANE FOR WEIGHTS 251# TO 500#
E1399	Durable medical equipment, miscellaneous	W4690	UNDERARM CRUTCHES FOR WEIGHTS 251# TO 500#
E1399	Durable medical equipment, miscellaneous	W4691	FIXED-HEIGHT FOREARM CRUTCHES FOR WEIGHTS TO 600#
E1399	Durable medical equipment, miscellaneous	W4695	GLIDES/SKIS FOR USE WITH WALKER
K0108	Wheelchair component or accessory, not otherwise specified	W4713	OVERSIZED FOOTPLATES FOR WEIGHTS 301# AND GREATER, PAIR
K0108	Wheelchair component or accessory, not otherwise specified	W4714	SWINGAWAY SPECIAL CONSTRUCTION FOOTRESTS FOR WEIGHTS 401# AND GREATER, PAIR
K0108	Wheelchair component or accessory, not otherwise specified	W4715	SWINGAWAY REINFORCED LEGREST, ELEVATING, FOR WEIGHTS 301# TO 400#, PAIR
K0108	Wheelchair component or accessory, not otherwise specified	W4716	SWINGAWAY SPECIAL CONSTRUCTION LEGRESTS, ELEVATING, FOR WEIGHTS 401# AND GREATER, PAIR
K0108	Wheelchair component or accessory, not otherwise specified	W4717	OVERSIZED CALF PADS, PAIR

K0108	Wheelchair component or accessory, not otherwise specified	W4718	OVERSIZED SOLID SEAT
K0108	Wheelchair component or accessory, not otherwise specified	W4719	OVERSIZED SOLID BACK
K0108	Wheelchair component or accessory, not otherwise specified	W4722	OVERSIZED FULL SUPPORT FOOTBOARD
K0108	Wheelchair component or accessory, not otherwise specified	W4723	OVERSIZED FULL SUPPORT CALFBOARD
E1399	Durable medical equipment, miscellaneous	W4733	REPLACEMENT OVERSIZED INNERSPRING MATTRESS FOR HOSPITAL BED W/ WIDTH TO 39"
L8499	Unlisted procedure for miscellaneous prosthetic services	N/A	N/A

Emergency Services

CCH shall not require referral or prior authorization for Emergency services. CCH shall cover and pay for emergency services regardless of whether the provider that furnishes the services is in CCH's network.

CCH shall not hold a Member with an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

CCH shall not deny payment for treatment obtained due to an emergency medical condition or as a result of the member having been instructed by a representative of CCH to seek emergency services.

Non-emergency services are all services or care not considered Emergency Services as determined by the attending physician when an enrollee visits the emergency department. Definition of non - emergency care is defined as any health care services provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. Hospitals will operationalize this process by performing the required screening on the patient and if they determine the condition non-emergent (determined by medical professionals at the hospital), the ER staff (either a nurse, doctor, or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic), call their managed care organization when they are open, or locating an urgent care clinic that may be available.

Emergency medical conditions are medical or behavioral health conditions, regardless of diagnoses or symptoms, that manifest in acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual (or, with

respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or others, or with respect to a pregnant woman who is having contractions that there is that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child. The hospital may not impose limits on what constitutes an emergency medical condition.

Psychiatric emergency condition are symptoms characterized by an alteration in the perception of reality, feelings, emotions, actions, or behavior requiring immediate therapeutic intervention in order to avoid immediate damage to the patient, other persons, or property. A psychiatric emergency shall not be defined on the basis of lists of diagnoses or symptoms. Hospitals should utilize the admit type of PY when submitting claims that meet the psychiatric emergency condition described.

Outpatient (claim type O)

When revenue code billed is 450, 451, 452, 456, or 459, and admit type = 1 or 5, copay is $0

When revenue code billed is 450, 451, 452, 456, or 459, and admit type NOT 1 or 5, copay applies

Electronic Visit Verification (EVV)

The 21st Century Cures Act requires NC Medicaid to begin using an Electronic Visit Verification (EVV) system for Home Health Care Services (HHCS) and Personal Care Services (PCS).

To ensure that the provider community complies with the Cures Act mandate requirements, Carolina Complete Health partners with HHAeXchange as its EVV solution.

All PCS and HHCS providers are expected to be fully compliant with EVV requirements. EVV data must be validated prior to claims adjudication. Claims without required EVV criteria will deny.

View our Home Health and Personal Care Services page for more information regarding EVV requirements and HHAeXchange.

Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

Providers must bill on a CMS 1500 claim form and must bill with appropriate encounter codes and CPT codes for core services. When billing non-core services only CPT code should be billed and the appropriate fee schedule rates will be paid as appropriate.

Hospital Interim Claims

Interim hospital claims are allowed if the length of stay is greater than 61 days. However, second, third, fourth, final interim encounters must be submitted as a correction to the original claim and must contain all dates of service from admission through to the last service date included on the claim. Only one interim claim is allowed, the remaining must be corrected on the original claim.

Laboratory

For Contract Years 1-3, in instances where a LHD submits a communicable disease test, as defined by the Department, to the North Carolina State Laboratory of Public Health, CCH shall reimburse the Lab

according to applicable Medicaid Fee-For service fee schedule, unless CCH and North Carolina State Laboratory of Public Health have mutually agreed to an alternative reimbursement arrangement.

National Drug Code (NDC) Requirements

CCH has mirrored the NDC requirements NC DHHS currently has in place. CCH utilizes the NDC/procedure code crosswalk file from the CMS and Reimbursmentcodes.com website monthly and updates configuration accordingly.

Newborn Billing

Providers do not have to wait to bill claims until the newborn is issued a Medicaid State ID. If the baby has not been assigned a beneficiary number by the time the claim is billed, it should be submitted using the Newborn's name and date of birth.

Newborn services are considered procedure codes that specifically state "newborn" in the code description according to the CPT manual or revenue codes 170-179. These services must be billed with a newborn diagnosis code to receive payment.

Hospice

Hospice reimbursement is based on Core Based Statistical Area (CBSA) of the provider as outlined by North Carolina DHHS.

When Hospice care is provided within a Nursing Facility the facility NPI must be submitted in the attending provider field on the claim for proper payment consideration.

Nursing Facility

Nursing facility providers must bill using the UB-04 claim form. Room and board is not billable by the nursing facility when a member elect's hospice benefits, room and board in this case would be billed by the hospice provider. Per diem rate for Nursing Facility is based on NPI.

Swing Bed Nursing Facility

Room and board must be billed on a UB-04 claim form. Per diem rate based on NPI.

Patient Monthly Liability

Patient Monthly Liability will be deducted from claim payment when applicable. It is the provider's responsibility to collect this payment from the member.

Out of Network Providers

- Out of Network Providers may be subject to a reduced reimbursement rate of 90% of Medicaid Fee Schedule rate.
- Out of Network Indian Health Providers are reimbursed 100% of Medicaid Fee Schedule rate.
- Family planning and Emergency services are reimbursed at 100% of Medicaid Fee Schedule regardless of in or out of network status.

Out of State Reimbursement

Out of state inpatient and outpatient hospital services are reimbursed based on Out of State Hospital Inpatient and Outpatient Fee Schedule published on the North Carolina DHHS state website. Out of state

providers must be credentialed with NC Medicaid and active on the Provider Enrollment File to be eligible for reimbursement of Medicaid covered services.

Prosthetic and Orthotic Supplies

Providers must bill on a CMS-1500 claim form. Providers shall report the appropriate codes used to determine billing units.

- Units of services for Purchased Equipment: 1 unit for each device purchased
- Units of service for Service and Repair: 1 unit of service for each approved service or repair unit in 15-minute increments.

Therapies

PT, OT, and ST visits from therapy providers in any outpatient setting, if multiple disciplines treat on the same date of service, each count separately.

Tribal Claims

CCH allows any Tribal member eligible to receive services from an Indian Health Care Provider (IHCP) to choose the IHCP as the Tribal member's primary care provider (PCP), if the IHCP has the capacity to provide PCP services at all times. CCH considers any referral from such IHCP acting as

the Member's PCP to a network provider as satisfying any coordination of care or referral requirement of the Contract.

CCH permits IHCPs to refer a Tribal member to any provider within the IHCP Purchased/Referred Care (PRC) network, even if the provider is not a contracted provider, without having to obtain prior authorization or a referral from a contracted provider. CCH will refer Tribal members to IHCPs and other sources of culturally competent care as determined by the DHHS. As an enroller of Tribal populations, the Plan additionally provides training for culturally competent care among contracted providers.

Consistent with 42 C.F.R. Part 457, Subpart E, CCH does not impose any enrollment fee, premium, deductible, copayment or similar cost-sharing on any North Carolina Medicaid or North Carolina Health Choice member who is a Tribal member, or on any Tribal member who receives services from an Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization or through referral under contract health services.

In accordance with 42 C.F.R. §438.14(c) and consistent with 42 C.F.R. §438.14(b), CCH reimburses IHCPs as follows:

- Those IHCPs that are not enrolled as a Federally Qualified Health Center (FQHC), regardless of whether they participate in CCH's network, are reimbursed:
    - at the applicable encounter rate published annually in the Federal Register by the Indian Health Service; OR
    - for services that do not have an applicable encounter rate, at the Medicaid Fee- for-Services rate.
- IHCPs enrolled as FQHCs, but not participating in CCH's network, are reimbursed at an amount equal to the amount CCH would pay a network FQHC that is not an IHCP.

Unlisted CPT Codes

Providers are required to bill the CPT that most accurately describes the service or procedure provided. If such a code does not exist, the provider should bill with the unlisted CPT from the appropriate section of the CPT book. Providers to follow the instructions for submission of these codes as described in the current CPT manual, published by the American Medical Association.

Vaccines for Children (VFC) Program

CCH shall encourage primary care providers, who serve Members under age 19, to participate in the Vaccines for Children (VFC) program that allows providers to receive vaccines at no cost for children eligible for Medicaid who are under age nineteen (19).

Vaccines provided for children enrolled in NC Health Choice excluding American Indian/Alaskan Native members are not covered by the VFC program.

CCH shall reimburse the provider for both the vaccine and administration fee for NC Health Choice Members. CCH shall adhere to additional VFC requirements as defined in Section V.C.7. Prevention and Population Management Health Programs.

CCH shall require that primary care providers administer vaccines consistent with the AAP/Bright Future periodicity schedule. CCH shall only pay for the vaccine administration fee for VFC eligible children. Vaccines provided for children enrolled in Medicaid outside of VFC are not an allowed expense.

Appeals and Grievances

Refer to your Provider Manual for details on your appeals rights.

Provider Claim Corrections, Reconsiderations, and Claim Grievances

Claim Correction

Claim Correction refers to the process for providers to make a correction to the initial claim submission.

- Contracted Providers: submitters have 365 calendar days from the date of service to file a timely corrected claim. Request may be submitted via EDI, provider secure web portal or to the address below.
- Non-Contracted Providers: submitters have 180 calendar days from the date of service to file a timely corrected claim. Request may be submitted via EDI, provider secure web portal or to the address below.

Medicaid Claims Department
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

NOTE: View our Claims and Billing Provider Guide on Duplicate Submissions and Correcting Claims

Claim Reconsideration

A Claim Reconsideration is a formal expression by a Provider, which indicates dissatisfaction or dispute with Carolina Complete Health claim adjudication, to include the amount reimbursed or regarding denial of a particular service. Contracted providers must submit requests for claim reconsideration within 365

calendar days from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA). Non-Contracted providers must submit claim reconsiderations within 180 calendar days from the date of the EOP or ERA. Providers must complete a claim reconsideration prior to submitting a claim grievance.

Claim reconsiderations may be submitted via provider secure web portal or to the address below.

Medicaid Claims Reconsiderations/Disputes Department
Carolina Complete Health
PO Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms

Claim Grievance

A Claim Grievance is the mechanism following the exhaustion of the claim reconsideration process that allows providers the right to express dissatisfaction regarding the amount reimbursed or the denial of a particular service. All claim grievances must be submitted from the provider within thirty (30) calendar days from the date of the EOP or ERA.

NOTE: Claim grievances do not include decisions related to prior authorization and adverse medical necessity determinations. For those concerns, Provider must follow the applicable retrospective review or beneficiary appeal process:

- If services were provided to a beneficiary but for which authorization and/or timely notification to Carolina Complete Health was not obtained due to extenuating circumstances, the request may be reviewed retrospectively.
- The Beneficiary Appeal process allows the Provider acting on the beneficiary's behalf with the beneficiary's written consent, to file an appeal either orally or in writing, within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination.
- Additional Information about the retrospective review and beneficiary appeals process can be found on the Prior Authorization Guide and Provider Manual online at: network.carolinacompletehealth.com/guides.
- Administrative Rules for Retrospective Review and Beneficiary Appeals apply.

Please submit eligible claim grievances via provider secure web portal or to the address below:

Claim Grievances
Carolina Complete Health
P.O. Box 8040
Farmington, MO 63640-8040

NOTE: If submitting a claim reconsideration or grievance through the mail, please complete the Claim Reconsideration and Grievance form located online at: network.carolinacompletehealth.com/forms.

A decision will be made, and appropriate notification of the decision must be received by the Provider within 30 calendar days of Carolina Complete Health's receipt of the request.

Providers must exhaust the Claim Reconsideration Process prior to pursing the Claim Grievances Process.

APPENDIX I: COMMON HIPAA COMPLIANT EDI REJECTION CODES

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

Code	Description
1	Invalid Mbr DOB
2	Invalid Mbr
6	Invalid Prv
7	Invalid Mbr DOB & Prv
8	Invalid Mbr & Prv
9	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
23	Invalid Prv; Invalid Diag
34	Invalid Proc
35	Invalid Mbr DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
38	Mbr not valid at DOS; Prov not valid at DOS; Invalid Diag
39	Invalid Mbr DOB;Mbr not valid at DOS; Prov not valid at DOS; Invalid Diag
40	Invalid Prov; Invalid proc
41	Invalid Mbr DOB; Invalid Prov; Invalid Proc
42	Invalid Mbr; Invalid Prov; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prov not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS; Invalid Proc
49	Mbr not valid at DOS; Invalid Prov; Invalid Proc
51	Invalid Diag; Invalid Proc
74	Services Performed prior to Contract Effective Date
75	Invalid units of service

APPENDIX II: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS-1500 (2/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (2/12) form field 24A-G:

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

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

ZZ	Narrative description of unspecified/miscellaneous/unlisted codes
N4	National Drug Codes (NDC)
CTR	Contract Rate

The following qualifiers are to be used when reporting NDC units:

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

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.

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

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

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

Unspecified/Miscellaneous/Unlisted Codes

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

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

NDC Codes

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1									N	G2	12345678901
10 01 05	10 01 05	11		J0400		1	250 00	40	N	NPI	0123456789

APPENDIX III: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION

Instructions for Entering the NDC:

(Use the guidelines noted below for all claim types including Web Portal submission)

CMS requires the 11-digit National Drug Code (NDC), therefore, providers are required to submit claims with the exact NDC that appears on the actual product administered, which can be found on the vial of medication. The NDC must include the NDC Unit of Measure and NDC quantity/units.

When reporting a drug, enter identifier N4, the eleven-digit NDC code, Unit Qualifier, and number of units from the package of the dispensed drug.

837I/837P		
Data Element	**Loop**	**Segment/Element**
NDC	2410	LIN03
Unit of Measure	2410	CTP05-01
Unit Price	2410	CTP03
Quantity	2410	CTP04

For Electronic submissions, this is highly recommended and will enhance claim reporting/adjudication processes, report in the LIN segment of Loop ID-2410.

Paper Claim Type Field

CMS 1500 (02/12)	24 A (shaded claim line)
UB04	43

<u>Facility</u>

Paper, use Form Locator 43 of the CMS1450 and UB04 (with the corresponding HCPCS code in Locator 44) for Outpatient and Facility Dialysis Revenue Codes 250 – 259 and 634 -636.

<u>Physician</u>

Paper, use the red shaded detail of 24A on the CMS1500 line detail.

Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size.

If you are given an NDC that is less than 11 digits, add the missing digits as follows:

- For a 4-4-2 digit number, add a 0 to the beginning
- For a 5-3-2 digit number, add a 0 as the sixth digit.
- For a 5-4-1 digit number, add a 0 as the tenth digit.

Enter the Unit Qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unit Qualifiers are:

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

APPENDIX IV: TAXONOMY CODE PLACEMENT ON CLAIMS

CMS 1500 Paper Submission

- Rendering – Box 24i should contain the qualifier “ZZ”. Box 24j (shaded area) should contain the taxonomy code.
- Billing – Box 33b should contain the qualifier “ZZ” along with the taxonomy code.
- Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code in the next column.

837 Professional Submission

- Billing –Loop 2000A PRV01=“BI” PRV02 = “PXC” qualifier PRV03 = 10 character taxonomy.
- Rendering – Loop 2310B PRV01=“PE” PRV02 = “PXC” qualifier PRV03 = 10 character taxonomy code002E.
- Please note that “PXC” is the correct qualifier and that there is no taxonomy number needed for referring physician.

UB-04 Paper Submission

- Billing – Box 81CCa should contain the qualifier of “B3” in the left column and the taxonomy code in the middle column.

837I Electronic Submission

- Billing - Loop 2000A PRV01 = “BI” PRV02 = “PXC” qualifier; PRV03 = 10 character taxonomy code.

*Please also advise your Clearinghouse to make sure the changes made to taxonomy placement are permanent on your account going forward.

APPENDIX V: CLAIMS FORM INSTRUCTIONS CMS 1500

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	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.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

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

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

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

7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). C Note: Does not exist in the electronic 837P.	C
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C

11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM|DD|YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a- d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the enrollee's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C

15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note**: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For claim corrections, enter the original claim number of the original claim. New form – for corrections only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C

23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.		
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24 A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was date, enter that date in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24 B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24 C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required

24 D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM or ICD-10- CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy,. Use 1D qualifier for ID, if an Atypical Provider.	R

24 J Shaded	NON-NPI PROVIDER ID#	TYPICAL PROVIDERS: Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. ATYPICAL PROVIDERS: Enter the Provider ID number	R
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a enrollee of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Health Plan recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R

29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Health Plan. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. Note: Does not exist in the electronic 837P	R

32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	C
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).	C

33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). NOTE: The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

APPENDIX VI – CLAIMS FORMS INSTRUCTIONS UB

UB-04/CMS 1450 (2/12) Claim Form Instructions

Completing a UB-04 Claim Form

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

UB-04 CLAIM FORM

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

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

Please refer to your provider contract with Health Plan Name or research the Uniform Billing Editor

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		3b MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME	9 PATIENT ADDRESS			
a XXXX	a Street Address			
b	b City	c St	d Zip	e

10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															
b															

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
		a					
		b					
		c					
		d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23 0001	PAGE 1 OF 1	CREATION DATE		TOTALS			23

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

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A		XXXXXXXXXXX		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING	NPI	QUAL	
							LAST		FIRST	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	

80 REMARKS	81CC a		78 OTHER	NPI	QUAL	
	b		LAST		FIRST	
	c		79 OTHER	NPI	QUAL	
	d		LAST		FIRST	

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OMB APPROVAL PENDING

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

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

Field #	Field Description	Instructions or Comments	Required or Conditional
1	UNLABELED FIELD	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9 digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not used.	Not Required

8a-8b	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the enrollee's Health Plan I.D. card 8b – Enter the patient's last name, first name, and middle initial 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. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address of the patient.	R
9	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (Except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY).	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R

13	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: Physician Referral 1 Clinic Referral 2 Health Maintenance Referral (HMO) 3 Transfer from a hospital 4 Transfer from Skilled Nursing Facility 5 Transfer from another health care facility 6 Emergency Room 7 Court/Law Enforcement 8 Information not available For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	R

16	DISCHARGE HOUR	Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 -03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	C

17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital. 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	R

18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	UNLABELED FIELD	NOT USED	Not Required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: REQUIRED when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: REQUIRED when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C

37	(UNLABELED FIELD)	REQUIRED for claim corrections. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: REQUIRED when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: REQUIRED when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1- 22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R

42 **Line 23**	REV CD	Enter 0001 for total charges.	R
43 **Line 1- 22**	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 **Line 23**	PAGE_____ OF _____	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (i.e. PAGE "1" OF "1"). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 **Line 1-22**	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	C
45 **Line 23**	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 **Line 1-22**	TOTAL CHARGES	Enter the total charge for each service line.	R
47 **Line 23**	TOTALS	Enter the total charges for all service lines.	R
48 **Line 1-22**	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 **Line 23**	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required

50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	HEALTH PLAN IDENTIFCATION NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C

64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of “7” (Replacement of Prior Claim) or Type of Bill. Frequency of “8” (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" and most “V” codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" codes and most “V” are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.	R

70	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit –4th or"5". "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	UNLABLED		Not Required

76	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	R
77	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name. FIRST: Enter the attending physician's first name.	C
78 & 79	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider. ZZ – Other Operating MD. 82 – Rendering Provider. NPI: Enter the other physician 10-character NPI ID. QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	C

80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit Provider number of ordering physician.	R

APPENDIX VII – ORIGIN AND DESTINATION MODIFIERS FOR TRANSPORTATION

Origin and Destination Modifiers for Transportation. The first place alpha code is the origin; the second place alpha code is the destination

Mod	Description
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 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 (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event

Based on the modifiers noted above:

The following are all the valid combinations for the first modifier fields:

DN	RD	IH	EN	SI	ND	HE
EH	RN	JN	GN	DH	NN	HN
GE	DD	NH	HI	EE	RH	JE
HG	DR	RE	IN	ER	I	NE
HR	EJ	SH	JR	GR	DJ	NR
JH	GH	DG	NJ	HJ	EG	RJ
NG	HH	ED	RG	JD	GD	

For a repeat trip - Modifier TS (Follow up Service) is used in the second modifier position to indicate a repeat trip for the same recipient on the same day.