Claims Filing Instructions

Claim Filing

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

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

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

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

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification for electronic claims against 837 edits
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan"
  provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to the Plan.
- All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN and Location Numbers).
- All 837 claims with Claim Attachments should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field # 80 for UB-04 Claim Form.

Important: Rejected claims are defined as claims with invalid or required missing data elements, such as the provider tax identification number, member ID number, that are returned to the provider or Electronic Data Interchange, or EDI, source without registration in the claim processing system.

- **Rejected claims** are not registered in the claim processing system and can be resubmitted as a new claim.

Important: Denied claims are registered in the claim processing system but do not meet requirements for payment under Plan guidelines. They should be resubmitted as a corrected claim.

- Denied claims must be re-submitted as corrected claims within 365 calendar days from the date of service.

- Set claim frequency code correctly and send the original claim number. These are required elements and the claim will be rejected if not coded correctly.

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

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

Claim Mailing Instructions

Submit claims to the Plan at the following address:

Blue Cross Complete Claims
P.O. Box 7355
London, KY 40742

The Plan encourages all providers to submit claims electronically. Before filing electronically, providers should call Optum/Change Healthcare at 1-800-527-8133 or Availity Client Services at 1-800-282-4548. An agent will help each provider navigate the process and confirm that the provider's software vendor is approved to bill Blue Cross electronically.

Claim Filing Deadlines

All claims must be resolved with 365 calendar days from the date of service or discharge date.This applies to capitated and fee-for-service claims.

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

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

Exceptions

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 120 days of the date of the primary insurer's EOB (claim adjudication).

Important: Requests for adjustments may be submitted by telephone to Provider Claims Services at 1-800-521-6007.

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

If you are submitting a corrected claim, please be sure to enter a "7" along with the original claim number in box 22 of the 1500. Or use the bill type ending in 7 for a UB.

Blue Cross Complete Claims
P.O. Box 7355
London, KY 40742

Refunds for Claims Overpayments or Errors

Blue Cross Complete of Michigan encourages providers to conduct regular self-audits to ensure receipt of accurate payment(s) from Blue Cross Complete. Medicaid program funds must be returned when identified as improperly paid or overpaid. If a provider identifies improper payment or overpayment of claims from Blue Cross Complete, the improperly paid or overpaid funds must be returned to Blue Cross Complete within 60 days from the date of discovery of the overpayment. Providers may return improper or overpaid funds to Blue Cross Complete by:

1. Completing page one of the *Provider Claim Refund Form* at mibluecrosscomplete.com.

2. Using page two of the form or attaching your spreadsheet with the pertinent fields from the form, as needed, to list multiple claims connected to the return payment.
3. Submitting the completed form, attachments and refund check by mail to the claims processing department:

   Blue Cross Complete of Michigan
   Attn: Provider Refunds
   P.O. Box 7355
   London, KY 40742

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

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

PHYSICIAN OR SUPPLIER INFORMATION

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

Claim Form Field Requirements

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

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. **All claims must be submitted within the required filing deadline of 365 days from the date of service**.

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

Required Fields (CMS 1500 Claim Form):

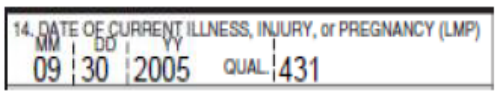
*Required [R] fields must be completed on all claims. Conditional [C] fields must be completed if the information applies to the situation, or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
N/A	**Carrier Block**			2010BB	NM103 N301 N302 N401 N402 N403	
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R	2000B	SBR09	Titled Claim Filing Indicator code in 837P.
1a	**Insured I.D. Number**	Health Plan's member identification number. If the member is a newborn, the provider must wait until the newborn's member ID is issued before submitting a claim. Enter the member's ID number exactly the way it appears on their Plan-issued ID card. Or the member's MDHHS Medicaid ID can be used in place of the plan ID number.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan I.D. card.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	**Patient's Birth Date / Sex**	MMDDYY / M or F	R	2010CA or 2010BA	DMG02 DMG03	Titled Gender in 837P.
4	**Insured's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan I.D. card..	R	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in 837P.
5	**Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	
6	**Patient Relationship To Insured**	Always indicate self .	R	2000B 2000C	SBR02 PAT01	Titled Individual Relationship code in 837P.
7	**Insured's Address (Number, Street, City, State, Zip+4 Code) Telephone (Include Area Code)**	Always indicate "Same".	C	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in 837P.
8	**Patient Status**		Not Required			Patient Status does not exist in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
9	**Other Insured's Name (Last, First, Middle Initial)**	Refers to someone other than the patient. **Completion of fields 9a through 9d is Required** if patient is covered by another insurance plan. Enter the complete name of the insured. **Note:** "COB claims that require attached EOBs must be submitted on paper."	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique member ID then the patient is the subscriber and identified in this loop. Titled Other Subscriber Name in 837P.
9a	**Other Insured's Policy Or Group #**	**Required** if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P.
9b	**Reserved for NUCC use**		Not Required	N/A	N/A	Does not exist in 837P.
9c	**Reserved for NUCC use**		Not Required	N/A	N/A	Does not exist in 837P.
9d	**Insurance Plan Name Or Program Name**	**Required** if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other Medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other insurance group in 837P.
10a, b,c	**Is Patient's Condition Related To:**	Indicate Yes or No for each category. Is condition related to: a) Employment	R	2300	CLM11	Titled related causes

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		b) Auto Accident c) Other Accident				code in 873P.
10d	**Claim Codes (Designated by NUCC)**		C	2300	K3	Use K3 with HIPAA Compliant codes.
11	**Insured's Policy Group Or FECA #**	Required when other insurance is available. Complete if more than one other Medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P.
11a	**Insured's Birth Date / Sex**	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P.
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line; identifier to the right of the vertical, dotted line.	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P.
11c	**Insurance Plan Name Or Program Name**	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.
11d	**Is There Another Health Benefit Plan?**	Y or N by check box. If yes, complete # 9 a-d.	R	2320		If yes, indicates Y for yes.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
12	**Patient's or Authorized Person's Signature**	Enter “Signature on File,” “SOF,” or legal signature. When legal signature, enter date signed in 6-digit (MM|DD|YY) or 8-digit format (MM|DD|YYYY) format. If there is no signature on file, leave blank or enter “No Signature on File.”	R	2300	CLM09	Titled Release of Information code in 837P.
13	**Insured's or Authorized Person's Signature**	Enter “Signature on File,” “SOF,” or legal signature. If there is no signature on file, leave blank or enter “No Signature on File.”	C	2300	CLM08	Titled Benefit Assignment Indicator in 837P.
14	**Date of Current Illness Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: • 431 – Onset of Current Symptoms or Illness • • 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy. Example: 	C	2300	DTP01 DTP03	
15	**Other Date**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription	C	2300	DTP01 DTP03	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		• 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) • 444 – First Visit or Consultation Example:  				
16	**Dates Patient Unable To Work In Current Occupation**	If the patient is employed and is unable to work in current occupation, a 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.	C	2300	DTP03	Titled Disability from Date and Work Return Date in 837P.
17	**Name Of Referring Physician Or Other Source**	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported. DN Referring Provider DK Ordering Provider DQ Supervising Provider Enter the qualifier to the left of the  vertical, dotted line. Example:	C	2310A (Refer-ring) 2310D (Super-vising) 2420 (Ordering)	NM 101 NM103 NM104 NM105 NM107	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
17a	**Other I.D. Number Of Referring Physician**	The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.)	C	2310A (Referring) 2010D Supervising 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P.
17b	**National Provider Identifier (NPI)**	Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.	R	2310D	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P.
18	**Hospitalization Dates Related To Current Services**	Enter the inpatient 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.	C	2300	DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
19	**Additional Claim Information (Designated by NUCC)**	Please refer to the most current instructions from the public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field. If identifiers are reported in this field, enter the appropriate qualifiers describing the identifier. Do not enter a space, hyphen, or other separator between the qualifier code and the number. The NUCC defines the following qualifiers used in 5010A1: • 0B State License Number • 1G Provider UPIN Number • G2 Provider Commercial Number • LU Location Number (This qualifier is used for Supervising Provider only.) • N5 Provider Plan Network Identification Number • SY Social Security Number (The social security number may not be used for Medicare.) • X5 State Industrial Accident Provider Number • ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.) • Claim Attachment Report Type codes in 837P defines the following qualifiers 03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice	Not Required Required	2300 2300	NTE PWK PWK01	 Claim Attachment Report Type codes in 837P

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet				
20	**Outside Lab**		C	2400	PS102	
21	**Diagnosis Or Nature of Illness or Injury. (Relate To 24E)**	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. 9 ICD-9-CM 0 ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand area of the field. Enter the codes left justified on each line to identify the patient's diagnosis or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than 12 ICD-10-CM or ICD-9-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field.	R	2300	HIXX-02 Where XX = 01,02,03,04,05,06,07,08,09,10,11,12	
22	**Resubmission Code and/or Original Ref. No**	List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field. When resubmitting a claim, enter the appropriate bill frequency code left	C **Required** for resubmitted or adjusted claims.	2300 2300	CLM05-3 REF02 Where REF01 = F8	Send the original claim if this field is used.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		justified in the left-hand side of the field. 7 Replacement of prior claim 8 Void/cancel of prior claim • This Item Number is not intended for use for original claim submissions.				
23	**Prior Authorization Number**	Enter the referral or authorization number. Refer to the Provider Manual to determine if services rendered require an authorization.	C	2300 2300	REF02 Where REF01 – G1 REF02 Where REF01 = 9F	Titled Prior Authorization Number in 837P. Titled Referral Number in 837P.
24A	**Date(s) Of Service**	"From" date: MMDDYY. If the service was performed on one day leave "To" blank or re-enter "From" Date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R	2400	DTP03	Titled Service Date in 837P.
24B	**Place Of Service**	In 24B, enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed. The Place of Service Codes are available at: www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.	R	2300 2400	CLM05-1 SV105	Titled Facility Code Value in 837P. Titled Place of Service Code in 837P.
24C	**EMG**	Check with payer to determine if this information (emergency indicator) is necessary. If required, enter Y for "YES" or leave blank if "NO" in the bottom, unshaded area of the field. The definition of emergency would be either defined by federal or state regulations or programs, payer contracts, or as defined in 5010A1.	C	2400	SV109	Titled Emergency Indicator in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
24D	**Procedures, Services Or Supplies CPT/HCPCS Modifier**	Enter the CPT or HCPCS code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. This field accommodates the entry of up to four 2-character modifiers. The specific procedure code(s) must be shown without a narrative description.	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P.
24E	**Diagnosis Pointer**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service, and must be entered in field 21. Do not enter diagnosis codes in 24E. Note: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107(1-4)	Titled Diagnostic Code Pointer in 837P.
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount. (This includes capitated services.)	R	2400	SV102	Titled Line Item Charge Amount in 837P.
24G	**Days Or Units**	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a	R	2400	SV104	Titled Service Unit Count in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		time period (such as “daily management”).				
24H	**EPSDT Family Plan**	**In Shaded area of field:** AV - Patient refused referral; S2 - Patient is currently under treatment for referred diagnostic or corrective health problems; NU - No referral given; or ST - Referral to another provider for diagnostic or corrective treatment. **In unshaded area of field:** “Y” for Yes – if service relates to a pregnancy or family planning “N” for No – if service does not relate to pregnancy or family planning	C	2300 2400	CRC SV111 SV112	
24I	**ID Qualifier**	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. The NUCC defines the following qualifiers used in 5010A1: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number ZZ Provider Taxonomy (The qualifier in the 5010A1 for Provider Taxonomy is PXC, but ZZ will remain the qualifier for the 1500 Claim Form.) The above list contains both provider identifiers, as well as the provider taxonomy code. The provider identifiers are assigned to the	R	2310B	REF(01) NM108	Titled Reference Identification Qualifier in 837P. XX required for NPI in NM109.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		provider either by a specific payer or by a third party in order to uniquely identify the provider. The taxonomy code is designated by the provider in order to identify his/her provider grouping, classification, or area of specialization. Both, provider identifiers and provider taxonomy may be used in this field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.				
24J	**Rendering Provider ID**	The individual rendering the service is reported in 24J. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b.	R	2310B	REF02 NM109	Change HealthCare will pass this ID on the claim when present. NPI
25	**Federal Tax I.D. Number SSN/EIN**	Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider identified in Item Number 33. This is the tax ID number intended to be used for 1099 reporting purposes. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.	R	2010AA	REF01 **REF02**	EI Tax /SY SSN

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		Do not enter hyphens with numbers. Enter numbers left justified in the field.				
26	**Patient's Account No.**	Enter the patient's account number assigned by the provider of service's or supplier's accounting system. Do not enter hyphens with numbers. Enter numbers left justified in the field.	R	2300	CLM01	Titled Patient Control Number in 837P.
27	**Accept Assignment**	Always indicate **Yes**. Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participatio n Code in 837P.
28	**Total Charge**	Enter charges. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated services. Blank is not acceptable.	R	2300	CLM02	May be $0.
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	**Reserved for NUCC Use**		Not Required			
31	**Signature Of Physician Or Supplier Including Degrees Or Credentials / Date**	"Signature of Physician or Supplier Including Degrees or Credential" does not exist in 5010A1. Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM|DD|YY), 8-digit date (MM|DD|YYYY), or alphanumeric	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		date (e.g., January 1, 2003) the form was signed.				
32	**Name and Address of Facility Where Services Were Rendered (If other than Home or Office)**	Enter the name, address, city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP code Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.	R	2310C	NM103 N301 N401 N402 N403	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
32a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	
32b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers used in 5010A1: 0B State License Number G2 Provider Commercial Number LU Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	C Recommended	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility secondary Identifier in 837P.
33	**Billing Provider Info & Ph. #**	Enter the provider's or supplier's billing name, address, ZIP code, and phone number. The phone number is to be entered in the area to the right of the field title. Enter the name and address information in the following format: 1st Line – Name 2nd Line – Address 3rd Line – City, State and ZIP code Item 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use punctuation (i.e., commas, periods) or other symbols in the address (e.g., 123 N Main Street	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Report a 9-digit ZIP code. Enter the 9-digit ZIP code without the hyphen.				
33a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.
33b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers: 0B State License Number G2 Provider Commercial Number ZZ Provider Taxonomy **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	C Recommended	2000A 2010AA	PRV03 REF02 where REF01 = G2	Titled Provider Taxonomy Code in 837P. Titled Reference Identification Qualifier and Billing Provider Additional Identifier in 837P.

Required Fields (UB-04 Claim Form):

UB-04 Claim Form							
Field #	**Field Description**	Instructions and	Required or	Required or	Loop	Segment	Notes
1							
2							
3a							
3b							
4		1st position is a leading zero – Do not include the					

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		leading zero on electronic claims. 2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates billing sequence.					
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010AA	REF02 Where REF01 = EI	Pay to provider = Billing Prov use 2010AA
6	**Statement Covers Period From/Through**	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434	MMDDCCYY
7	**Unlabeled Field**	Not Used. Leave Blank.					
8a	**Patient Identifier**	Patient Health Plan ID is conditional if number is different from field 60	R	R	2010BA 2010CA	NM109 where NM101 = IL NM109 where NM101 = QC	Patient =Subscriber Use 2010BA
8b	**Patient Name**	Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the	R	R	2010BA 2010CA	NM103,NM104,NM107 where NM101=IL NM103,NM104,NM107	Patient =Subscriber Use 2010BA

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		Health Plan ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should **not** be reported in this field. Prefix: No space should be left after the prefix of a name e.g., McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix. Newborns and Multiple Births: If submitting a claim for a newborn that does not have an identification number, enter “Baby Girl” or “Baby Boy” and last name. Refer to page 42 for additional newborn billing information, including Multiple Births.				where NM101 = QC	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
9a-e	**Patient Address**	The mailing address of the patient 9a. Street Address 9b. City 9c. State 9d. ZIP Code + 4 9e. Country Code (report if other than USA)	R	R	2010BA 2010CA	N301, N302 N401, 02, 03, 04 N301, N302 N401, 02, 03, 04	
10	**Patient Birth Date**	The date of birth of the patient Right-justified; MMDDYYYY	R	R	2010BA 2010CA	DMG02 DMG02	
11	**Patient Sex**	The sex of the patient recorded at admission, outpatient service, or start of care.	R	R	2010BA 2010CA	DMG03 DMG03	
12	**Admission Date**	The start date for this episode of care. For inpatient services, this is the date of admission. Right-justified	R	R	2300	DTP03 where DTP01=435	Required on inpatient.
13	**Admission Hour**	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R for bill types other than 21X.	R	2300	DTP03 where DTP01=435	Required on inpatient.

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
14	**Admission Type**	A code indicating the priority of this admission/visit.	R	R	2300	CL101	
15	**Point of Origin for Admission or Visit**	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102	
16	**Discharge Hour**	Code indicating the discharge hour of the patient from inpatient care.	R	R	2300	DTP03 where DTP01=096	
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6.	R	R	2300	CL103	
18 - 28	**Condition Codes** **The following is unique to Medicare eligible Nursing Facilities. Condition codes should be billed when Medicare Part A does not cover Nursing Facility Services** **Applicable Condition Codes:**	When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed: Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service for which you are billing:	C	C	2300	HIXX-2	HIXX-1=BG

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
	X2 – Medicare EOMB on File **X4 – Medicare Denial on File**	• There was no 3-day prior hospital stay • The resident was not transferred within 30 days of a hospital discharge • The resident's 100 benefit days are exhausted • There was no 60-day break in daily skilled care • Medical Necessity Requirements are not met • Daily skilled care requirements are not met All other fields must be completed as per the appropriate billing guide					
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. **Required when applicable.**	C	C	2300	REF02	
30	**Unlabeled Field**	Leave Blank					

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
31a,b – 34a,b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code and date. **Required** when applicable.	C	C	2300	HIXX-2	HIXX-1 = BH
35a,b – 36a,b	**Occurrence Span Codes And Dates**	A code and the related dates that identify an event that relates to the payment of the claim. **Required** when applicable.	C	C	2300	HIXX-2	HIXX-1 = BI
37a,b	**EPSDT Referral Code**	**Required** when applicable. Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YD – Dental *(Required for Age 3 and Above) YO – Other YV – Vision YH – Hearing YB – Behavioral YM – medical	C C C C C C C	C C C C C C	2300	K3	Use K3 with HIPAA Compliant codes.
38	**Responsible Party Name and Address**	The name and address of the party responsible for the bill.	C	C			Not required Not mapped 837I
39a,b,c,d – 41a,b,c,d	**Value Codes and Amounts**	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by	C	C	2300	HIXX-2 HIXX-5	HIXX-1 = BE

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		the payer organization. Value Codes and amounts. If more than one value code applies, list in alphanumeric order. **Required** when applicable. **Note: If value code is populated then value amount must also be populated and vice versa.** Please see NUCC Specifications Manual Instructions for value codes and descriptions. **Documenting covered and non-covered days**: Value Code 81 – non-covered days; 82 to report co-insurance days; 83- Lifetime reserve days. Code in the code portion and the Number of Days in the "Dollar" portion of the "Amount" section. Enter "00" in the "Cents" field.					
42	**Rev. Cd.**	Codes that identify specific accommodation, ancillary service or unique billing	R	R	2400	SV201	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		calculations or arrangements.					
43	**Revenue Description**	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category.	R	R	N/A	N/A	Not mapped 837I
44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	1. The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills. 2. The accommodation rate for inpatient bills. 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several	R	R	2400	SV202-2	SV202-1=HC/HP

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		prospective payment systems. Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all Outpatient Claims. (Note: NDC numbers are required for all administered or supplied drugs.)					
45	**Serv. Date**	Report line item dates of service for each revenue code or HCPCS/HIPPS code.	R	R	2400	DTP03 where DTP01=472	
46	**Serv. Units**	Report units of service. A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Note: for drugs, service units must be consistent with the NDC code and its unit of	R	R	2400	SV205	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		measure. NDC unit of measure must be a valid HIPAA UOM code or claim may be rejected.					
47	**Total Charges**	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and non-covered charges. Report grand total of submitted charges. Enter a zero ($0.00) or actual charged amount.	R	R	2300	SV203	
48	**Non-Covered Charges**	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code. **Required** when Medicare is Primary.	C	C	2400	SV207	
49	**Unlabeled Field**		Not required	Not required			
50	**Payer**	Enter the name for each Payer being invoiced. When the patient has other coverage, list the payers as	R	R	2330B	NM103 where NM101= PR	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.					
51	**Health Plan Identification Number**	The number used by the health plan to identify itself. The Blue Cross Complete facility payer ID is 00210	R	R	2330B	NM109 where NM101= PR	
52	**Rel. Info**	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the provider have all necessary release information on file. It is expected that all released invoices contain "Y"	R	R	2300	CLM09	
53	**Asg. Ben.**	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary;	R	R	2300	CLM08	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		and Line C refers to the tertiary.					
54	**Prior Payments**	The A, B, C indicators refer to the information in Field 50. The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01= D	
55	**Est. Amount Due**	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage). The amount up to two decimal places.	C	C	2300	AMT02 where AMT01 =EAF	
56	**National Provider Identifier – Billing Provider**	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. **Required** if the health care provider is a Covered Entity as defined in HIPAA Regulations.	R	R	2010AA	NM109 where NM101 = 85	
57 A,B,C	**Other (Billing) Provider Identifier**	A unique identification number assigned to the provider submitting the bill	C	C	2010AA 2010BB	REF02 where REF01 = EI	Tax ID

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		by the health plan. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A, B and C.				REF02 where REF01 = G2 REF02 where REF01 = 2U	Only sent if need to determine the Plan ID Legacy ID
58	**Insured's Name**	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the insured is indicated here.	R	R	2010BA 2330A	NM103,NM104,NM105 where NM101 = IL NM103,NM104,NM105 where NM101 = IL	Use 2010BA is insured is subscriber
59	**P. Rel**	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured Code 18: Self	R	R	2000B	SBR02	
60	**Insured's Unique Identifier**	Enter the patient's Health Plan ID on the appropriate line, exactly as it appears on the patient's ID card on line B or C.	R	R	2010BA	NM109 where NM101= IL REF02 where	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		Line A refers to the primary payer; B, secondary; and C, tertiary.				REF01 = SY	
61	**Group Name**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000B	SBR04	
62	**Insurance Group No.**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000B	SBR03	
63	**Treatment Authorization Codes**	Enter the Health Plan referral or authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2300	REF02 where REF01 = G1	
64	**DCN**	Document Control Number. New field. The control number assigned to the	C	C	2320	REF02 where REF01 = F8	Original Claim Number

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code. The ESC field has been eliminated. **Note:** Resubmitted claims must contain the original claim ID					
65	**Employer Name**	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2320	SBR04	
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. **Note:** Claims with invalid codes will be denied for payment.	Not Required	Not Required	2300	Determined by the qualifier submitted on the claim	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
67	**Prin. Diag. Cd. and Present on Admission (POA) Indicator**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	R	R	2300	HIXX-2 HIXX-9 Where HI01-1 = BK or ABK	POA
67 A - Q	**Other Diagnosis Codes**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.	C	C	2300	HIXX-2 HIXX-9 Where HI01-1 = BF or ABF	POA
68	**Unlabeled Field**						
69	**Admitting Diagnosis Code**	The appropriate ICD code describing the patient's diagnosis at the time of admission	R	R	2300	HI02-2	HI01-1=BJ or ABJ

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		as stated by the physician. **Required** for inpatient and outpatient					
70	**Patient's Reason for Visit**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2	HI01-1=PR or APR
71	**Prospective Payment System (PPS) Code**	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.	C	C	2300	HI01-2 Where HI01-1 = DR	
72a-c	**External Cause of Injury (ECI) Code**	The appropriate ICD code(s) pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis.	C	C	2300	HIXX-2	HIXX-1=BN or ABN

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		Required if applicable.					
73	**Unlabeled Field**						
74	**Principal Procedure code and Date**	The appropriate ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corresponding date. **Inpatient facility** – Surgical procedure code is required if the operating room was used. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C R	C R	2300	HI01-2 HI01-4 Where HI01-1 = BR or BBR	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
74a-e	**Other Procedure Codes and Dates**	The appropriate ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. **Inpatient facility** – Surgical procedure code is required when a surgical procedure is performed. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C C	C C	2300	HIXX-2 Where HI01-1 = BQ or BBQ	
75	**Unlabeled Field**						
76	**Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#**	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the attending physician has another unique ID#, enter the appropriate	R	R	2310A 2310A	NM109 where NM101 = 71 REF02	REF01/0B/1G/LU/G2 (Do not send the Provider's Plan ID)

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician. Note: If a qualifier is entered, a secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will reject.			2310A 2301A	NM103 where NM101 = 71 NM104 where NM101 = 71	
77	**Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#**	**Enter the** NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician. Required when a surgical procedure code is listed.	C R	C R	2310B 2310B 2310B 2310B	NM109 where NM101 = 72 NM103 where NM101 = 72 NM104 where NM101 = 72 REF02	

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
78 – 79	**Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID#**	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#	R	R	2310C 2310C 2310C 2310C	NM109 where NM101 = ZZ NM103 where NM101 = ZZ NM104 where NM101 = ZZ REF02	
80	**Remarks Field**	Area to capture additional information necessary to adjudicate the claim. Claim Attachment Report Type codes in 837I defines the following qualifiers 03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice	C Required	C	2300 2300	NTE02 PWK01	NTE01=ADD Claim Attachment Report Type codes in 837I

UB-04 Claim Form							
Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional *	Loop	Segment	Notes
		07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet					
81CC, a-d	**Code-Code Field**	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C	2000A	PRV01 PRV03	

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

Supplemental Information

A. CMS 1500 Paper Claims – Field 24:

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

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

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) formerly Universal Product Code (UPC) for products
- Contract rate

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

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

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

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

B. EDI – Field 24D (Professional)

C. EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=G2, REF02+ Plan's Provider Network Number. Less than 13 Digits Alphanumeric. Field is required. **Note:** do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims **D. EDI – Field 45 and 51 (Institutional)**

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

Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – **Health Plan ID** – the number used by the health plan to identify itself. Blue Cross Complete's facility payer ID is 00210; the Blue Cross Complete professional payer ID is 00710.

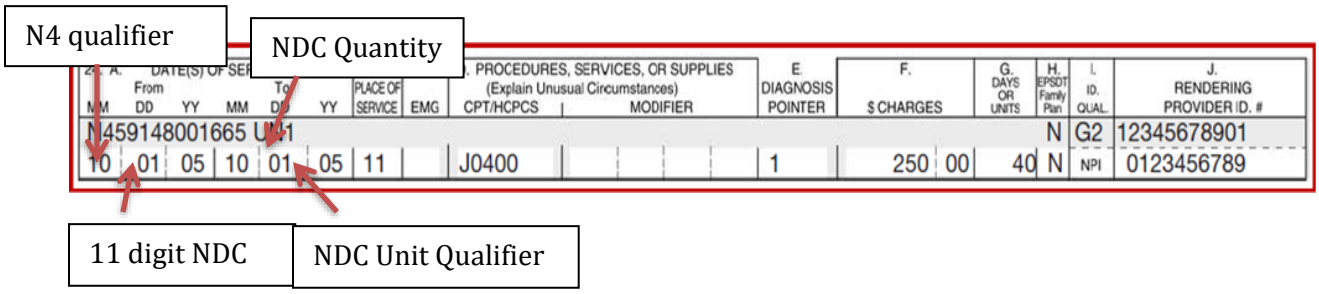
E. Reporting NDC on CMS-1500 and UB-04 and EDI

1. NDC on CMS 1500

- NDC must be entered in the shaded sections of item 24A through 24G.
- Do not submit any other information on the line with the NDC; drug name and drug strength should not be included on the line with the NDC.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information.
    - Do not enter a space between the qualifier and the 11 digit NDC number.
    - Enter the 11 digit NDC number in the 5-4-2 format (no hyphens).
    - Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Enter the NDC quantity unit qualifier
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN – Unit
- Enter the NDC quantity
    - Do not use a space between the NDC quantity unit qualifier and the NDC quantity

Note: The NDC quantity is frequently different than the HCPC code quantity

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



2. NDC on UB-04

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

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

  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal). Any unused spaces for the quantity are left blank.

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

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

3. NDC via EDI

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

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

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

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

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

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

Which events must be reported?
Never events and other preventable serious adverse events must be reported on claims for all Blue Cross Complete products.

What are these events?
A never event is a serious, preventable condition that results from health care management and that should never have occurred. A never event is defined as follows:

- A surgical or other invasive procedure performed on the wrong body part or the wrong site
- A surgical or other invasive procedure performed on the wrong member

- The wrong surgical or other invasive procedure performed on a member

A preventable serious adverse event other than a never event is one that meets all of the following criteria:

- It is reasonably preventable through the use of evidence-based guidelines or criteria.
- It is within the control of the facility or the providers practicing within the facility.
- It is the result of an error made in the facility. (That is, the condition was not present when the member entered the facility.)
- It results in serious or significant harm.
- It is clearly, unambiguously and precisely identified, reportable and measurable.

Note: In the terminology of government programs, never events and other preventable serious adverse events are known as provider-preventable conditions. Those PPCs that occur in an inpatient hospital setting are called health care-acquired conditions. Those that occur elsewhere are called other provider-preventable conditions. The list of hospital-acquired conditions published by CMS is available at **cms.gov** > Medicare > Hospital-Acquired Conditions (Present on Admission Indicator) > Hospital-Acquired Conditions (on the left navigation bar) > **FY 2013, FY 2014, and FY 2015 Final Hac List (no changes have been made during the past 3 years)**. This document is a list of hospital-acquired conditions with ICD-9 codes.

Information on hospital-acquired conditions with ICD-10 codes is available at **cms.gov.**

How to report never events

Providers must comply with the following guidelines when reporting never events:

- **Facility services.** Hospitals are required to submit a no-pay claim (TOB 110) when an erroneous surgery related to a never event is reported. If there are covered services or procedures provided during the same stay as the erroneous surgery, hospitals are required to submit two claims:
- One claim with covered services or procedures unrelated to the erroneous surgery(s) on a TOB 11X (with the exception of 110)
- The other claim with the noncovered services or procedures related to the erroneous surgery or surgeries on a TOB 110 (no-pay claim). Within the first five diagnosis codes listed on the claim, the TOB 110 claim should also contain one of the diagnosis codes to indicate the type of preventable serious adverse event: E876.5 (wrong surgery), E876.6 (wrong patient) or E876.7 (wrong body part).

Note: Both the covered and the noncovered claim must have Statement Covers Periods that match.

- **Professional services.** Any claim for an erroneous surgery or procedure rendered by a practitioner should be submitted using the CMS-1500 claim form or an 837P claim transaction. The claim must include the appropriate modifier appended to all lines that relate to the erroneous surgery or procedure using one of the following applicable National Coverage Determination modifiers:
    - PA – surgery wrong body part
    - PB – surgery wrong patient
    - PC – wrong surgery on patient

Note: Physician claims associated with these events should be submitted with a charge of 1 cent.

Never events are not reimbursed
Blue Cross Complete will not reimburse a hospital or physician in the hospital setting for costs associated with direct actions that result in a never event.
In addition, all services provided in the operating room when an error occurs are considered related and are therefore not covered. No providers who are in the operating room when the preventable serious adverse event occurs and who could bill individually for their services are eligible for payment. All related services provided during the same hospitalization in which the error occurred are noncovered.
Note: Related services do not include performance of the correct procedure.

Policy is administered using APR-DRG Grouper
For DRG-reimbursed hospitals, Blue Cross Complete uses the most current version of the All Patient Refined Diagnosis-Related Groups (APR-DRG) Grouper to administer the policy, incorporating the POA indicator into the DRG assignment.

Note: Blue Cross Complete continues to require authorization for all inpatient services. Authorizations do not change any of the payment guidelines stated here.

Common causes of claim processing delays, rejections and denials

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

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

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

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

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

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

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

qualifier 573. COB pertains to the other payer found in 2330B. For COB, the plan is considered the payer of last resort.

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

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

Handwritten Claims – Handwritten claims are no longer accepted. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity, therefore handwritten claims will be rejected.

Highlighted Claim Fields (See Illegible Claim Information)

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

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

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

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

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

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

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

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

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

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

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

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

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

Taxonomy –The provider's taxonomy number is required wherever requested in claim submissions.

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

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

IMPORTANT BILLING REMINDERS:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- EPSDT services may be submitted electronically or on paper.
- Submitting the original copy of the claim form will assist in assuring claim information is legible.
- The individual provider name and NPI number as opposed to the group NPI number must be indicated on the claim form.
- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.
- Although the newborn claim is submitted under the mother's ID, the claim must be processed under the baby's ID. The claim will not be paid until the state confirms eligibility and enrollment in the plan.

- The claim for baby *must* include the *baby's date of birth* as opposed to the mother's date of birth. Claim must also include *baby's birth weight (value code 54)*.
- Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- The *individual service provider name and NPI number* must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.
- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI number's results in inaccurate payments or denials.
- When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.
- Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 365 calendar days from the date of service.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 365 calendar days from the date of service.
- Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately. Contact your Provider Account Executive to assist in updating the Plan's records.

Electronic Data Interchange (EDI) for medical and hospital claims

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

The benefits of billing electronically include:

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

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

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

Important: Change Healthcare, a health care technology company is a part of Optum. In order to verify satisfactory receipt and acceptance of submitted records, please review both the Optum/Change Healthcare (formerly Change Healthcare) Acceptance report, and the R059 Plan Claim Status Report.

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

Electronic Claim Submission

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

Hardware/Software Requirements

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

Blue Cross Complete providers have the option of submitting electronic claims via:

Availity

- Providers or clearinghouses not currently using Availity to submit claims, must register at: availity.com/intelligent-gateway/.
- Providers who are currently registered with Availity for another payer, or using another clearinghouse, must request to have electronic claims for Blue Cross Complete routed to Availity.
- For registration process assistance, submit the Provider Inquiry form at the bottom of the Availity webpage or contact Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday from 8 a.m. to 8 p.m. ET.

Optum/Change Healthcare

- Blue Cross Complete has re-established connectivity with Optum/Change Healthcare.
- Providers who have a software vendor or use another clearinghouse to submit claims to Optum/Change Healthcare will need to consult with their vendor/clearinghouse to see if there have been changes in their process for claims submission.
- For questions contact Optum/Change Healthcare's call center at: 1-800-527-8133, Monday through Friday from 8 a.m. to 8 p.m. CT.

Contracting with Optum/Change Healthcare, Availity and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Optum/Change Healthcare EDI capabilities, you can contact Optum/Change Healthcare at 1-800-527-8133 or Availity Client Services at 1-800-282-4548.

When ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.

- Contact your EDI software vendor, Optum/Change Healthcare or Availity to inform them you wish to initiate electronic submissions to the Plan.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

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

I**mportant: the Payer ID for Blue Cross Complete facility payer ID is 00210; the Blue Cross Complete professional payer ID is 00710**

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

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

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

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

Since your EDI clearinghouse or vendor returns acceptance reports directly to the sender, submitted claims not accepted are not transmitted to the Plan.

If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact Optum/Change Healthcare at 1-800-527-8133or Availity Client Services at 1-800-282-4548.

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

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

*An Acceptance report verifies acceptance of each claim at Optum/Change Healthcare, and Availity.

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

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

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

Important: Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI clearinghouse or vendor to verify you receive the reports necessary to obtain this information. When you receive the Rejection report from your EDI clearinghouse or vendor, the plan does not receive a record of the rejected claim.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass Optum/Change Healthcare HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 365 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Optum/Change Healthcare, Availity or your EDI software vendor in order to identify and re-submit these claims accurately.

Plan Specific Electronic Edit Requirements

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

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

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

Exclusions

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

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

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

Important: Requests for adjustments may be submitted by telephone to:

Provider Services: 1-800-521-6007

If you prefer to write, please be sure to stamp each claim submitted “corrected” or “resubmission” and address the letter to:

Blue Cross Complete
P.O. Box 7355
London, KY 40742

Appeals for disputes related to a Utilization Management determination must be submitted in writing to:

Appeals Coordinator
Blue Cross Complete
PO Box 41789
Charleston, SC 29423
Fax: 855-737-9879

Appeals for disputes that are not related to a Utilization Management determination must be submitted in writing to:

Blue Cross Complete Claims Disputes
PO Box 7355
London, KY 40742

Refer to the Provider Manual on the Blue Cross Complete provider website online at: mibluecrosscomplete.com for complete instructions on submitting administrative or medical appeals.

Common Rejections

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

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

Resubmitted Professional Corrected Claims

Providers using EDI can submit "professional" corrected claims* electronically rather than via paper to the Plan.

*A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.

Your EDI clearinghouse or vendor needs to:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)
- ✓ Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
    - If you need assistance in resolving submission issues, Optum/Change Healthcare at **1-800-527-8133** or Availity Client Services at **1-800-282-4548**.
    - Providers using our NaviNet portal, (navinet.net) can view their corrected claims faster than available with paper submission processing.

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 365 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 1.)

Important: Before resubmitting claims, check the status of your submitted claims online at navinet.net

Important: Corrected Professional Claims may be sent in on paper via CMS 1500 or via EDI.

If sending paper, please stamp each claim submitted "corrected" or "resubmission" and send all corrected or resubmitted claims to:

Claim Processing Department

Blue Cross Complete Claims
P.O. Box 7355
London, KY 40742-7355

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

- Contact Optum/Change Healthcare at 1-800-527-8133 or Availity Client Services at 1-800-282-4548.

If you need assistance in resolving submission issues, please contact Availity at Availity.com.

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

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

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2 [PIN]

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

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

Electronic Billing Inquiries

Action	Contact
If you would like to transmit claims electronically…	Optum/Change Healthcare at 1-800-527-8133 Availity Client Services at 1-800-282-4548
If you have general EDI questions …	If you need assistance in resolving submission issues, please contact Optum/Change Healthcare, Availity or your EDI clearinghouse or vendor.
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports…	Contact your EDI clearninghouse or vendor
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	Contact Provider Services at-1-800-521-6007
If you have questions about claims that are reported on the Remittance Advice….	Contact Provider Services at 1-800-521-6007

If you need to know your provider NPI number…	Contact Provider Services at 1-800-521-6007
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information… For questions about changing or verifying provider information…	Notify Provider Network Management in writing at: Blue Cross Complete 200 Stevens Drive Philadelphia, PA 19113 Or by fax at: 215-937-5343
If you would like information on the 835 Remittance Advice:	Contact your EDI Vendor
Check the status of your claim:	Review the status of your submitted claims on NaviNet a navinet.net
Sign up for NaviNet	register.navinet.net NaviNet Customer Service: 1-888-482-8057

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

What is the Risk Score Adjustment Model?

Michigan Department of Health and Human Services (MDHHS) utilizes medical encounter data supplied by the Plan to evaluate disease severity and risk of increased medical expenditures. MDHHS employs the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, to support health-based capitation payments to the Plan. Accurate payments from MDHHS help us ensure that providers are reimbursed appropriately for services provided to our members.

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

Why are retrospective chart reviews necessary?

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

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

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

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

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

Have you coded for all chronic conditions for the member?

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

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

What are your responsibilities?

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

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:
    - E11.40 Diabetes with neurological manifestations and E08.40 for diabetic polyneuropathy

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

Documentation Guidelines

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

Physician Documentation Tips

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

Physician Communication Tips

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

SOAP stands for:

Subjective: How the patients describe their problems or illnesses.

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

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

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

Supplemental Information:

Ambulance
Ground and Air Ambulance Services are billed on CMS 1500 or UB-04 or 837 Format

When billing for Procedure Codes A0425 – A0429 and A0433 – A0434 for Ambulance Transportation services, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit Procedure Code. Different modifiers may be used for the same Procedure Code.

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

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

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

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

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

H - Hospital

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

J - Non hospital-based dialysis facility

N - Skilled nursing facility

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

R - Residence

S - Scene of accident or acute event

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

Anesthesia

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

- Anesthesia claims must be submitted using anesthesia (ASA) procedure codes only (base plus time units);
- All services must be billed in minutes;15 minute time increments will be used to determine payment.

Audiology

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

Chemotherapy

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

Chiropractic Care

- Claims for chiropractic services are billed on a CMS 1500 or via 837 electronic format..
- Must bill appropriate CPT code and modifiers.

Dialysis

- Reimbursement for dialysis services must be billed using the UB-04 claim form or via 837I electronic format.
- Epogen must be reported with revenue code 634 and revenue code 635.

Durable Medical Equipment

- Services are billed on a CMS 1500 claim form.
- An “RR” modifier is required for all rentals.
- Repair codes on the DME Fee Schedule require the submission of procedure code K0739.
- Refer to the Provider Manual for DME authorization rules and guidelines.
- Benefit Exceptions – items/services not listed on the Plan’s DME fee schedule will be reviewed on an individual basis based on coverage, benefit guidelines, and medical necessity.
- Miscellaneous codes will not be used if an appropriate code is on the Plan’s First DME fee

schedule.

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

EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions

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

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

- Use Z76.1, Z76.2, Z00.121 or Z00.129 as the primary diagnosis code
- Accurate payment of EPSDT claims will be determined solely by the presence of EPSDT modifiers to identify an EPSDT Claim. Failure to append EPSDT modifiers will cause claims to be processed as non-EPSDT related encounters
- Use one of the individual age-appropriate procedure codes outlined on the most current EPSDT Periodicity Schedule (listed below), as well as any other EPSDT related service, e.g., immunizations, etc.
- Use EPSDT Modifiers as appropriate: EP - Complete Screen; 52 - Incomplete Screen; 90 - Outpatient Lab; U1 - Autism.
    - Use U1 modifier in conjunction with CPT code 96110 for Autism screening
    - CPT code 96110 without a U1 modifier is to be used for a Developmental screening

Age Appropriate Evaluation and Management Codes

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

Newborn Care:

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

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

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

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

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

Please consult the EPSDT Program Periodicity Schedule and Coding Matrix, as well as the Recommended Childhood Immunization Schedule for screening timeframes and the services

required to bill for a complete EPSDT screen. Both are available in a printable PDF format online at the Provider Center at: www.keystonefirstpa.com

Completing the CMS 1500 or UB-04 Claim Form

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

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

UB-04	CMS 1500	Item	Description	C/R
37	10d	Reserved for Local Use EPSDT Referrals	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YD – Dental (Required for ages 3 and over) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical * **Following an EPSDT screen, if the screening Provider suspects developmental delay and the child is not receiving services at the time of screening, he/she is required to refer the child (ages birth to age 5) through the CONNECT Helpline at 1-800-692-7288, document the referral in the child's medical record and submit the YO EPSDT referral code*.	 C C C C C C
18	N/A	Condition Codes	Enter the Condition Code A1 EPSDT	R
67	21	Diagnosis or Nature of Illness or Injury	When billing for EPSDT screening services, **diagnosis code Z76.1, Z76.2, Z00.121 or Z00.129** (Routine Infant or Child Health Check) must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2, 21.3, 21.4. **An appropriate diagnosis code must be included for each referral.** Immunization V-Codes are not required.	R
42	N/A	Revenue code	Enter Revenue **Code 510**	R

44	24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Populate the first claim line with the age appropriate E & M codes along with the EP modifier when submitting a "complete' EPSDT visit, as well as any other EPSDT related services, e.g., immunizations	R
N/A	24H	EPSDT/Family Planning	**Enter Visit Code 03** when providing EPSDT screening services.	R

Key:

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

Factor Drug Carve-Out

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

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

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

- Questions regarding status should be directed to the Nurse Case Manager at 215-937-5052.
- Upon Nurse Case Manager approval and authorization, an approval notice is sent to the Attending Physician, Member and Hospital contact.
- Upon Case Manager recommendation of denial, the case is sent to a Medical Director for review.
    - After review of the request and the Medical Director concurs with the denial recommendation, a denial notice is sent to the Attending Physician, Member and Hospital Contact.
    - Any appeal should follow the instructions and process that are provided on the denial letter.
    - After review, if the Medical Director decides to approve and authorizes the request, an approval notice is sent to the Attending Physician, Member and Hospital Contact.

Family Planning

Members are covered for Family Planning Services without a referral or Prior Authorization from the Plan. Members may self-refer for routine Family Planning Services and may go to any physician or clinic, including physicians and clinics not in the Plan's Network. Members that have questions or need help locating a Family Planning Services provider can be referred to Member Services at 1-800-521-6860.

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

A Member seeking sterilization must voluntarily give informed consent on the MDHHS form MSA-1959

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

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

Home Health Care (HHC)

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

Infusion Therapy

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

Injectable Drugs

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

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

Maternity

- Last menstrual period (LMP) is a required field to be submitted on all claim types.
- The completed ONAF form must be faxed to Bright Start (1-866-405-7946) within seven calendar days of the date of the prenatal visit as indicated on the form.

Postpartum:

- Render the postpartum visit within 21 to 56 days after delivery.
- Fax the ONAF form again to the Bright Start department (1-866-405-7946) at the post-partum visit with all post-partum information and any additional visit dates as needed.

- appropriate post-partum diagnosis codes and the appropriate post-partum visit code (59430) must be reported and billed together on the same claim form within 21-56 days after the delivery date to receive payment.

Multiple Surgical Reduction Payment Policy

The Plan adheres to the following payment procedure:

- When two or more surgical inpatient or outpatient procedures are performed by the same practitioner on the same day, the practitioner will be reimbursed at 100% for the highest allowable payment for one procedure and 50% for the second highest paying procedure, with no payment for additional procedures.

Physical/Occupational and Speech Therapies

A prior authorization is required for physical, occupational and/or speech after 36 visits.
Therapy services may be billed on a UB-04 or CMS 1500 claim form or via 837 electronic format.

Termination of Pregnancy

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest. The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider
(e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion. Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions. Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax.

Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure. This process can eliminate submitting paper attachments for abortion claims and pre-confirms the acceptability of the completed forms, as well as reduces costly claim rejections.

Prior to rendering these services, the provider must contact the Utilization Management department to receive a prior authorization and to also provide copies of the MSA-4240 and/or MSA-1550.

Most Common Claims Errors

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"**Member date of birth (DOB) is missing.**" (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	"**Member's sex is required.**" (If no box is checked, the claim will be rejected.)
4	Insured's Name	"**Insured's name missing or illegible.**" (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address(number, street, city, state, zip+4) phone	"**Patient address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"**Patient relationship to insured is required.**" (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address(number, street, city, state, zip+4) phone	**"Insured's address is missing.**" (If street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	"Diagnosis code is missing or illegible." (The claim will be rejected.)
24	Supplemental Information	"**National Drug Code** (**NDC) data is missing/incomplete/invalid.**" (The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.)
24A	Date of Service	**"Date of service (DOS) is missing or illegible.**" (The claim will be rejected if both the" From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	"Place of service is missing or illegible." (Claim will be rejected.)
24D	Procedure, Services or Supplies	"Procedure code is missing or illegible." (Claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
24E	Diagnosis Pointer	"**Diagnosis (DX) pointer is required on line ___" [lines 1-6].** (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	"**Line item charge amount is missing on line ___" [lines 1-6].** (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"**Days/units are required on line ___" [lines 1-6].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering Provider identification	"National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible." (If NPI is missing or illegible, claim will be rejected.)
26	Patient Account/Control Number	"Patient Account/Control number is missing or illegible" (If missing or illegible, claim will reject)
27	Assignment Number	"**Assignment acceptance must be indicated on the claim.**" (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	"**Total charge amount is required.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
31	Signature of physician or supplier including degrees or credentials	**"Provider name is missing or illegible."** (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)
33	Billing Provider Information and Phone number	"**Billing provider name and/or address is missing or incomplete.**" (If the name and/or street number and/or street name and/or city and/or state and/or zip+4 are missing, the claim will be rejected.)
33	Billing Provider Information and Phone number	"Field 33 of the CMS1500 claim form requires the provider's physical service address including the full 9 character ZIP code + 4." (If a PO Box is present, the claim will be rejected.)

NOTES

Updated: April 2025