



**western sky
community care™**

Provider Billing Manual

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Introductory Billing Information

A claim is a request for reimbursement for any health-care service provided. The claims process begins when a member's eligibility for coverage is determined and Western Sky Community Care (WSCC) provides benefits for specific services. Western Sky providers are encouraged to submit a claim or encounter for each service rendered to a Western Sky member. However, Western Sky will not accept claims submitted to an address or through a method not described in this manual.

All providers whose NPI is required to appear on a claim must be enrolled via a provider agreement with New Mexico HSD/MAD. This includes billing, rendering, ordering, attending, referring, and prescribing providers unless the provider's "type" is ineligible for enrollment under New Mexico's State Plan (for example, a radiology technician or a Medical School Resident at UNM). For additional information regarding provider Medicaid enrollment, please see the section of this manual titled "Provider Registration with the New Mexico Medicaid Program."

Billing Instructions

Western Sky Community Care follows CMS rules and regulations, specifically the Federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR § 447.45 and 42 CFR § 447.46; and in accordance with State laws and regulations, as applicable.

General Billing Guidelines

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

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

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

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

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

Claims eligible for payment must meet the following requirements:

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

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

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

- The Western Sky Community Care enrollee number found on the enrollee ID card or the provider portal.
- The Medicaid Number provided by the State and found on the enrollee ID card or the provider portal.

Claim Forms

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

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

844-543-8996 (TTY:711) Monday through Friday, 8am to 5pm MST

Billing Codes

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

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

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Western Sky Community Care.

CPT® Category II Codes

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

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

Encounters vs Claim

An encounter is a claim that is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our enrollees. For example; if you are the PMP for an enrollee and receive a monthly capitation amount for services, you must file an encounter (also referred to as a “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. It is mandatory that your office submits encounter data. Western Sky Community Care utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by DHS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an Explanation of Payment (EOP).

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

You are required to submit either an encounter or a claim for each service that you render to a Western Sky Community Care enrollee.

Clean Claim Definition

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

Non-Clean Claim Definition

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

Rejection versus Denial

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

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

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

Claim Payment

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

- From I/T/Us, day activity Providers, assisted living Providers, Nursing Facilities and home care agencies, including Community Benefit Providers:
 - 95% within 15 Calendar Days of receipt
 - 99% within 30 Calendar Days of receipt
- For all other Claims:
 - 90% within 30 Calendar Days of receipt
 - 99% within 90 Calendar Days of receipt;

Contact Information

Plan Address / Administrative Office

Western Sky Community Care
5300 Homestead Rd NE
Albuquerque, NM 87110

Claims Submission Address

Western Sky Community Care
Attn: Claims
PO Box 8010,
Farmington, MO 63640-8010

Customer Service:

844-543-8996, TTY Users: 711
Monday through Friday from 8:00 AM to 5:00 PM.

Claims Payment Information

Systems Used to Pay Claims

Western Sky Community Care uses three main systems to process reimbursement on a claim. Those systems are:

- Amisys
- DST Pricer
- Rate Manager

AMISYS

Our core system; All claims are processed from this system and structures are maintained to meet the needs of our provider contracts. However, we are not limited within the bounds of this one system. We utilize multiple systems to expand our universe of possibilities and better meet the needs of our business partners.

DST PRICER

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

RATE MANAGER

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

$$\text{(Provider Base Amount x DRG Weight) x Contract \% + pass through amount = DRG Amount}$$

The payment can be effected by discharge status, length of stay and other allowed charges.

Outpatient facilities claims are based on APC pricing. APC stands for Ambulatory Payment Classification system. This is a prospective payment system for outpatient services based on HCPCS and CPT codes. APCs are groups or CPT/HCPCS which make up groups of common types of services or delivery methods... Weights are assigned like with DRGs, but unlike DRGs, more than one APC can be assigned per claim.

Electronic Claims Submission

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

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

Western Sky Community Care's Payor ID is 68069. Our Clearinghouse vendors include Change Healthcare (formerly Emdeon), Envoy, WebMD, Availity and Gateway EDI. Please visit our website for our electronic Companion Guide, which offers more instructions. For questions or more information on electronic filing, please contact:

WESTERN SKY COMMUNITY CARE
c/o CENTENE EDI DEPARTMENT
PO Box 8010,
Farmington, MO 63640-8010
1-800-225-2573, extension 25525
Or by e-mail at EDIBA@centene.com

Paper Claim Submission

For Western Sky Community Care enrollees, all claims and encounters should be submitted to:

WESTERN SKY COMMUNITY CARE
ATTN: CLAIMS DEPARTMENT
PO Box 8010,
Farmington MO 63640-8010

REQUIREMENTS

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

Do's

- Do use the correct P.O. Box number
- Do submit all claims in a 9" x 12" or larger envelope
- Do type all fields completely and correctly
- Do use typed black or blue ink only at 10 to 12 point font
- Do include all other insurance information (policy holder, carrier name, ID number and address) when applicable
- Do include the EOP from the primary insurance carrier when applicable

Note: Western Sky Community Care is able to receive primary insurance carrier EOP [electronically]

- Do submit on a proper original form - CMS 1500 or UB 04

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms (no black and white claim forms)

- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't utilize staples for attachments or multi page documents

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

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

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

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

1. Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
2. Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
3. Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
4. Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information on our EFT and ERA services, please contact our Provider Services Department at

WESTERN SKY COMMUNITY CARE
 5300 Homestead Rd NE
 Albuquerque, NM 87110
 844-543-8996
 TTY: 711
 MONDAY THROUGH FRIDAY
 8:00AM TO 5:00PM

Common Causes of Claims Processing Delays and Denials

- Incorrect Form Type
- Diagnosis Code Missing Digits

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

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

Common Causes of Up Front Rejections

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

Western Sky Community Care will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

CLIA Accreditation

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

How to Submit a CLIA Claim

Via Paper

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

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

Via EDI

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

-Or-

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

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

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

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

the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

All claim requests for reconsideration, corrected claims or claim disputes must be received within 90 calendar days from the date of the Explanation of Payment (EOP).

If a provider has a question or is not satisfied with the information they have received related to a claim, contact a Western Sky Community Care Service Representative at:

WESTERN SKY COMMUNITY CARE

Attn: Claims

PO Box 8010,

Farmington, MO 63640-8010

844-543-8996

TTY: 711

MONDAY THROUGH FRIDAY

8:00AM TO 5:00PM

Third Party Liability / Coordination of Benefits

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

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

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

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

party liability.

Billing the Enrollee / Enrollee Acknowledgement Statement

Western Sky Community Care reimburses only services that are medically necessary and covered through the program. Providers are not allowed to “balance bill” for covered services if the provider’s usually and customary charge for covered services is greater than our fee schedule.

Providers may bill enrollees for services NOT covered by either Medicaid or Western Sky Community Care or for applicable copayments, deductibles or coinsurance as defined by the State of New Mexico.

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

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

Western Sky Community Care Code Auditing and Editing

Western Sky Community Care uses HIPAA compliant clinical claims auditing software for physician and outpatient facility coding verification. The software will detect, correct, and document coding errors on provider claim submissions prior to payment. The software contains clinical logic which evaluates medical claims against principles of correct coding utilizing industry standards and government sources. These principles are aligned with a correct coding “rule.” When the software audits a claim that does not adhere to a coding rule, a recommendation known as an “edit” is applied to the claim. When an edit is applied to the claim, a claim adjustment should be made.

While code auditing software is a useful tool to ensure provider compliance with correct coding, a fully automated code auditing software application will not wholly evaluate all clinical patient scenarios. Consequently, the health plan uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. For example, clinicians review all claims billed with modifiers -25 and -59 for clinical scenarios which justify payment above and beyond the basic service performed.

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

CPT and HCPCS Coding Structure

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

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

International Classification of Diseases (ICD 10)

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

Revenue Codes

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

Edit Sources

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

The software applies edits that are based on the following sources

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

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

Code Auditing and the Claims Adjudication Cycle

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

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

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

Deny: Code auditing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.

Pend: Code auditing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The appropriate decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions

Replace and Pay: Code auditing recommends the denial of a service line and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the enrollee's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing as the original billing remains on the claim.

Code Auditing Principles

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

Unbundling:

CMS National Correct Coding Initiative-

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

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

for the comprehensive code. The column I code is considered an integral component of the column II code.

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

PTP Practitioner and Hospital Edits

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

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

Code Bundling Rules not sourced to CMS NCCI Edit Tables

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

Procedure Code Unbundling

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

Mutually Exclusive Editing

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

Incidental Procedures

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

Global Surgical Period Editing/Medical Visit Editing

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

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

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

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

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

Global Maternity Editing

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

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a enrollee within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility; they are considered bundled into the inpatient admission, and therefore, are not separately reimbursable.

Multiple Code Rebundling

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

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a enrollee’s lifetime. State fee schedules also delineate the number of times a

procedure can be billed over a given period of time or during an enrollee's lifetime. Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Duplicate Edits

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

National Coverage Determination Edits

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

Anesthesia Edits

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

Invalid revenue to procedure code editing:

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

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

Co-Surgeon/Team Surgeon Edits:

CMS guidelines define whether or not an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co or team surgeon.

Add-on and Base Code Edits

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

Bilateral Edits

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

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, the same provider bills more than one outpatient consultation

code for the same enrollee in the enrollee's history. This rule will deny the office consultation code and replace it with a more appropriate evaluation and management service, established patient or subsequent hospital care code. Another example, the rule will evaluate if a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. This rule will replace the second submission with the appropriate established patient visit. This rule uses a crosswalk to determine the appropriate code to add.

Missing Modifier Edits

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

Administrative and Consistency Rules

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

Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes

Deleted Codes: Evaluates claims for procedure codes which have been deleted

Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.

Age Rules: Identifies procedures inconsistent with enrollee's age

Gender Procedure: Identifies procedures inconsistent with enrollee's gender

Gender Diagnosis: Identifies diagnosis codes inconsistent with enrollee's gender

Incomplete/invalid diagnosis codes: Identifies diagnosis codes incomplete or invalid

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Western Sky Community Care's clinical validation services is modifier -25 and -59 review. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1." Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion or separate injury (modifier -59). Western Sky Community Care's clinical validation team uses the information on the prospective claim and claims history to

determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for an enrollee on a given date of service.

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

MODIFIER -59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier 59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier -59 as follows: “Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

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

Western Sky Community Care uses the following guidelines to determine if modifier -59 was used correctly:

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

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

MODIFIER -59—Behavioral Health Billing for Individual, Family, and Group Therapy on the Same Day

Modifier 59 should not be used when billing individual, family or group therapy on the same day. For these services, the following modifiers should be used:

- **XE** Separate Encounter, a Service That Is Distinct Because It Occurred During a Separate Encounter
- **XS** Separate Structure, a Service That Is Distinct Because It Was Performed On a Separate Organ/Structure
- **XP** Separate Practitioner, a Service That Is Distinct Because It Was Performed By a Different Practitioner
- **XU** Unusual Non-Overlapping Service, the Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of the Main Service

MODIFIER -25

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

The NCCI policy manual states that “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Western Sky Community Care uses the following guidelines to determine whether or not modifier 25 was used appropriately.

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

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

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

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

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

Payment and Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits. These policies are posted on each health plan's provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Reconsiderations Related to Code Auditing and Editing

Claims appeals resulting from claim-editing are handled per the provider claims appeals process outlined in this manual. When submitting claims appeals, please submit medical records, invoices and all related information to assist with the appeals review.

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

Viewing Claim Coding Edits

Code Editing Assistant

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

This tool offers many benefits:

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

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

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

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

Disclaimer

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

Other Important Information

Health Care Acquired Conditions (HCAC) – Inpatient Hospital

Western Sky Community Care follows Medicare’s policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare’s most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim. POA is defined as “present” at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses. Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

Reporting and Non Payment for Provider Preventable Conditions (PPCS)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by Western Sky Community Care for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are

required to report the occurrence of a PPC and are prohibited from payment.

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

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

Other Provider Preventable Conditions (OPPCS) – Outpatient

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

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

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

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

Lesser of Language

Unless specifically contracted otherwise, Western Sky Community Care's policy is to pay the lesser of billed charges and negotiated rate.

- Example 1 – Code 12345 – Billed \$600. Negotiated Rate is \$500. RCO pays \$500 negotiated rate.
- Example 2 – Code 12345 – Billed \$500. Negotiated Rate is \$600. RCO pays \$500 billed rate.

Timely Filing

Providers must submit all claims and encounters so WSCC receives them within 180 calendar days of the date of service, except for IHS providers, who have 24 months. The filing limit may be extended where the eligibility has been retroactively received by Western Sky Community Care up to a maximum of 120 days from the date eligibility was updated. When Western Sky Community Care is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer (not to exceed 210 days from the date of service).

All claim requests for reconsideration, corrected claims or claim disputes must be received within 90 calendar days from the date of notification of payment or denial is issued.

Indian Health Services (IHS) providers have 24 months from the date of service to submit claims.

School based healthcare providers have 120 calendar days from the date of service to submit claims.

Use of Assistant Surgeons

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

Hospital medical staff bylaws that require an Assistant Surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity. Nor is reimbursement guaranteed when the patient or family requests an Assistant Surgeon be present for the surgery. Coverage and subsequent reimbursement for an Assistant Surgeon's service is based on the medical necessity of the procedure itself and the Assistant Surgeon's presence at the procedure.

Billing for Anesthesia Services Units

- Units of service for anesthesia are calculated at 1 unit for every 15 minutes of time.
- Neuraxial labor analgesia, CPT 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery), is billed at 1 unit for each hour of neuraxial analgesia management.
- When an emergency cesarean is required, the provider bills 1 unit for each hour of neuraxial analgesia time using CPT 01967 and also bills the CPT add-on code for the cesarean, CPT 01968 (Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia).
- Time for the cesarean is calculated at 1 unit for each 15 minutes of time.

CPT and HCPCS Codes That Require an NDC

The federal Deficit Reduction Act of 2005 (signed in 2006) requires Medicaid providers to report the 11-digit National Drug Code (NDC) on the CMS1500 and UB04 claim forms as well as on the 837 electronic transactions when billing for injections and other drug items administered in outpatient offices, hospitals, and other clinical settings.

For a complete list of the CPT and HCPCS codes that require the use of an NDC code, please visit the New Mexico HSD website: <http://www.hsd.state.nm.us>

For more information regarding billing NDCs, please see the section in this manual titled "Appendix III: Instructions for Submitting NDC Information."

Telehealth

Western Sky Community Care supports innovative technologies such as telehealth. For a telehealth claim to be payable, the interactive telehealth communication system must include both audio and video delivered on a real-time basis at the originating and distant sites. Services rendered through telehealth are covered just as they would be when rendered in person. In addition, reimbursement is made to the originating site for a telehealth system fee.

The “originating site” is the location of the member at the time the service is furnished via telehealth. The “distant site” is the location where the physician or practitioner is physically located at time of the telehealth service.

Per New Mexico HSD guidance, if the originating site is in New Mexico and the distant site is outside of New Mexico, the provider at the distant site must be licensed for telehealth to the extent required by New Mexico state law and regulations or meet federal requirements for providing services to Indian health service facilities or tribal contract facilities.

Things to remember when billing for telehealth:

- The code for the originating site telehealth system fee is Q3014.
- The codes for the distant site provider’s services should include the GT modifier.
- The location code for telehealth is 02.

Provider Registration with the New Mexico Medicaid Program

All providers whose NPI is required to appear on a claim must be enrolled via a provider agreement with New Mexico HSD/MAD. This includes billing, rendering, ordering, attending, referring, and prescribing providers unless the provider’s “type” is ineligible for enrollment under New Mexico’s State Plan (for example, a radiology technician or a Medical School Resident at UNM).

Claims from providers who are not currently enrolled with New Mexico Medicaid will be denied. Once the provider has enrolled with New Mexico Medicaid, the claim can be resubmitted for reconsideration. In such cases, the provider has 90 calendar days from the date the provider is enrolled to submit the claim, not to exceed 210 calendar days from the date of service.

A provider who is already enrolled in NM Medicaid as a participating provider does not need to submit a separate application to enroll as an ordering, referring, or prescribing provider. Providers who only perform as an ordering, referring or prescribing provider are not required to become rendering providers and may enroll using provider type 411-Ordering/Referring/Prescribing or Community Health Worker.

Per New Mexico HSD guidance, the attending provider must be reported on UB claims for the following:

- Inpatient hospital claims
- Hospice claims
- Home health agency claims (referring or order provider in the attending field)
- Nursing facility and ICF-IID claims (referring or order provider in the attending field)
- Residential facility claims (ARTC, RTC, group homes) (referring or order provider in the attending field)

The rendering provider must be reported at the claim header level or on all lines of an outpatient hospital claim.

A referring or ordering provider must be reported on an outpatient hospital claim when the service is the result of a referral or an order.

For more information regarding this requirement, please review Supplement 17-07 on the New Mexico

HSD website by following the link below.

[http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/Supplement%2017-07%20\(3\).pdf](http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/Supplement%2017-07%20(3).pdf)

Per New Mexico HSD guidance, referring or ordering providers must be reported on claims when the service or item is the result of a referral or an order. For more information regarding this requirement, please review Supplement 17-08 on the New Mexico HSD website by following the link below.

<http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/Supplement%2017-08.pdf>

Per New Mexico HSD guidance, rendering providers must be reported on claims for professional services. This requirement includes claims for laboratory, radiology, injections, supplies and virtually all other services report on a CMS 1500 claims form. For more information regarding this requirement, please review Supplement 17-09 on the New Mexico HSD website by following the link below.

<http://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/Supplements%20for%20MAD%20NMAC%20Program%20Rules/Supplement%2017-09.pdf>

To submit an electronic application for New Medicaid enrollment, please visit

<https://nmmedicaid.portal.conduent.com/webportal/enrollOnline>.

For additional information or assistance regarding the New Mexico Medicaid program enrollment process, providers may contact the Conduent Provider Relations Help Desk at: 1-800-299-7304.

Behavioral Health

Western Sky Community Care fully integrates behavioral health and physical health claims processing. Billing for behavioral health services should follow a nationally accepted claims format in compliance with standard coding guidelines. Please access our online provider portal to determine whether a service requires prior authorization.

Supervising Providers—Using the U7 Modifier

Please use the U7 modifier to communicate on a claim that the rendering provider is really a supervising provider. This means the NPI listed in the rendering provider field is to be interpreted as the supervisor of the rendering provider.

Except under specific, limited circumstances, evaluations and therapy can only be billed by practitioners independently licensed to perform the services. For example, a psychologist in a private or group practice cannot have an independent or non-independent practitioner actually provide the services and then bill as if the psychologist had actually performed the services.

However, special provisions apply when the billing provider is one of the following agencies:

1. A Community mental health center (CMHC)
2. A Federally Qualified Health Center (FQHC);
3. An Indian Health Services (IHS) hospital and clinic;
4. A PL 93-638 tribally operated hospital and clinic;
5. The Children, Youth and Families Department (CYFD);
6. A hospital and its outpatient facility; or
7. A Core Service Agency (CSA).

When the service is provided in one of these settings, the service may be provided by a licensed practitioner whose license does not include practicing independently when the service is within the scope of the practitioner's license and all clinical supervision requirements under the law are met. The supervisory requirements include those required under state law, by licensing boards, and Medical Assistance Division and Behavioral Health Service Division guidelines. The supervisor of the service must meet all requirements related to supervision including having a license for which the scope includes the ability to supervise and for which the scope includes the service being supervised.

Providers authorized under the Supervisory Protocol are also able to bill for non-independently licensed practitioner's services when all requirements described above related to supervision are met. When program rules or service definitions for specific behavioral health services indicate that the services may be performed by a specific level of practitioner or individual, that individual or practitioner may render the service when all requirements for supervision are met.

Providers specifically certified for specific services may bill for the services as allowed by the certification, providing all requirements by the certifying agency are met. For example, if a provider is certified for Day Treatment, then practitioners rendering the Day Treatment services must meet the requirements of the certifying agency for staffing and supervisory requirements.

Otherwise, only when specifically allowed by program rules and program service definitions, is a provider able to bill for the service of a non-independently licensed practitioner.

Behavioral Health Billing for Individual, Family, and Group Therapy on the Same Day

Modifier 59 should not be used when billing individual, family or group therapy on the same day.

For these services, the following modifiers should be used:

- **XE** Separate Encounter, a Service That Is Distinct Because It Occurred During a Separate Encounter
- **XS** Separate Structure, a Service That Is Distinct Because It Was Performed On a Separate Organ/Structure
- **XP** Separate Practitioner, a Service That Is Distinct Because It Was Performed By a Different Practitioner
- **XU** Unusual Non-Overlapping Service, the Use of a Service That Is Distinct Because It Does Not Overlap Usual Components of the Main Service

Agency Based Community Benefits (ABCB) and Self-Directed Community Benefits (SDCB)

Environmental Modifications

Environmental Modification providers must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on a project basis, one (1) unit per Environmental Modification project. Prior authorization is required.

Environmental Modification services are limited to five thousand dollars (\$5,000.00) every five (5) years, beginning from the first date of service. Additional services may be requested if the member's health and safety needs exceed the specified limit. The \$5,000.00 – five (5) year time limit applies across all Community Benefit packages where Environmental Modifications are a covered service. Example: an Agency Based Community Benefit (ABCB) member receives an Environmental Modification of \$2,300 leaving a \$2,700 available balance for future Environmental Modification. Six (6) months later the ABCB member transitions to the Self-Directed Community Benefit (SDCB), the member now has \$2,700 available for Environmental Modifications.

Environmental Modifications excludes those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member, such as carpeting, fences, roof repair, storage sheds or other outbuildings, furnace replacement, insulation, and other general household repairs. Adaptations that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an adaptation related to the SDCB member's medical condition.

Agency Based Community Benefits (ABCB)

ABCB service codes and units:

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Adult Day Health	S5100	15 minutes
Assisted Living	T2031	Day
Community Transition Services	T2038	Per service
Emergency Response	S5161	Month
Emergency Response High Need	S5161 U1	Month
Environmental Modifications	S5165	1 unit per project
Behavior Support Consultation	H2019	15 minutes
Behavior Support Consultation, Clinic Based	H2019TT	15 minutes
Employment Supports	H2024	Day
Home Health Aide	S9122	Hour
Personal Care-Consumer Directed	99509	Hour
Personal Care-Consumer Delegated	T1019	15 minutes
Personal Care-Directed training	S5110	15 minutes
Personal Care-Directed-Administrative Fee	G9006	1 unit + 1 month

Private Duty Nursing for Adults – RN	T1002	15 minutes
Private Duty Nursing for Adults – LPN	T1003	15 minutes
Respite RN	T1002 U1	15 minutes
Private Duty Nursing for Adults – LPN	T1003 U1	15 min
Respite	99509 U1	Hour
Physical Therapy for Adults	G0151	15 minutes
Occupational Therapy for Adults	G0152	15 minutes
Speech Language Therapy for Adults	G0153	15 minutes

Nursing Facilities

Hospice

When a member who resides in a nursing facility receives hospice care, only the hospice provider should submit claims to Western Sky Community Care. The hospice provider will reimburse the nursing facility per the hospice provider’s agreement with the nursing facility.

- The revenue codes for hospice rendered in a nursing facility are 0658 and 0659.
- The nursing facility NPI should be included in box 80 on the UB claim form.
- Do not include the nursing facility name.

Medical Care Credit (MCC)

Members who reside in residential facilities, such as nursing facilities, may be required to pay a patient liability each month. The patient liability is called the Medical Care Credit (MCC).

- The MCC is paid directly to the facility.
- The nursing facility should report the amount collected in value code 23.

Appeals and Grievances

Important Information about Your Appeal Rights

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

Western Sky Community Care maintains written policies and procedures for the filing of provider Grievances and Appeals. A provider has the right to file a Grievance or an Appeal with us. Provider Grievances or Appeals shall be resolved within thirty (30) Calendar Days. If the provider Grievance or Appeal is not resolved within thirty (30) Calendar Days, we shall request a fourteen (14) Calendar Day extension from the provider. If the provider requests the extension, the extension shall be approved by us. A provider shall have the right to file an Appeal with us regarding provider payment issues and/or Utilization Management decisions.

Providers may file a Provider grievance regarding WSCC policies, procedures, or any aspect of WSCC administrative functions other than administrative review matters, including the process by which WSCC handles Notice of Proposed Actions and EOPs in addition to dissatisfaction with the resolution of the Provider’s informal claims adjustment/claim grievance. Provider grievances may be filed

verbally/telephonically, or in writing. Administrative review matters should be addressed following the procedures outlined in the Member Appeals section of this manual.

Western Sky Community Care wants to resolve provider concerns. We will not hold it against the provider if he/she files a grievance. We will not treat providers differently.

How to File a Grievance

A provider can file a grievance in any way that works best for them. They can:

- Call Provider Services. The phone number is 844-738-5019 (TDD/TTY: 711).
- Send a fax. The fax number is 844-235-6065.
- Give it to us in person or by mail:

Western Sky Community Care

ATTN: Grievances

5300 Homestead Road NE

Albuquerque, NM 87110

How to file an Appeal

A Provider Appeal is the request for review of a claim (Post Service) or any adverse determination prior to rendering a requested service or procedure (Pre-Service).

Examples include but are not limited to:

- Incorrect amount of claim payed
- Authorization related claim denial
- Contract related claim denial
- Partial payment of a claim

Provider Appeals must be received no later than 90 days from the Notice of Action or Explanation of Payment (EOP) or the appeal will be denied for timely filing.

Provider Appeals can be received by Mail, Fax, or Online Portal. An "Appeal Request" form [NM Provider Appeal Form](#) must be accompanied by any request for appeal. Send all appeal requests to:

Western Sky Community Care Healthplan

Attn: Appeals

P.O. Box 5090

Farmington, MO 63640-5090

Provider Appeals will be resolved as soon as possible but no later than 30 calendar days from the day Western Sky Community Care receives the initial appeal request.

Other Relevant Billing Information

Interim Claims

Interim hospital encounters are allowed as long as the length of stay is greater than 30 days. However, second, third, fourth, final interim encounters must be submitted as an adjustment to the original claim and must contain all dates of service from admission through to the last service date included on the claim. Only one interim claim is allowed, the remaining must be adjusted to the original claim.

APPENDIX I: COMMON HIPAA COMPLIANT EDI REJECTION CODES

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

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

APPENDIX II: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

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

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

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

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

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

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

- F2 International Unit
- GR Gram
- ML Milliliter
- UN Unit

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

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

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

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

Unspecified/Miscellaneous/Unlisted Codes

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPD01 Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To									
MM DD YY	MM DD YY									
ZZ	Laparoscopic Ventral Hernia Repair Op Note Attached									
									NPI	

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPD01 Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To									
MM DD YY	MM DD YY									
ZZ	Kaye Walker									
10	01	05	10	01	05	11		E1399	12	165 00
							1	N	NPI	123456789

NDC Codes

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPD01 Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To									
MM DD YY	MM DD YY									
N459148001665	UN1									
10	01	05	10	01	05	11		J0400	1	250 00
							40	N	NPI	0123456789

APPENDIX III: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION

Instructions for Entering the NDC:

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

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

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

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

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

Paper Claim Type	Field
CMS 1500(02/12)	24 A (shaded claim line)
UB04	43

Facility

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

Physician

- Paper, use the red shaded detail of 24A on the CMS1500 line detail.
- Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.
- The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size.
 - If you are given an NDC that is less than 11 digits, add the missing digits as follows:
 - For a 4-4-2 digit number, add a 0 to the beginning
 - For a 5-3-2 digit number, add a 0 as the sixth digit.
 - For a 5-4-1 digit number, add a 0 as the tenth digit.

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

F2 - International Unit
GR - Gram
ML - Milliliter
ME - Milligram
UN – Unit

APPENDIX IV: CLAIMS FORM INSTRUCTIONS CMS 1500

CMS 1500 (2/12) Claim Form Instructions



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>										FICA <input type="checkbox"/> <input type="checkbox"/>				
1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (DDA/DCD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)				
CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()					8. RESERVED FOR NUCC USE					CITY STATE ZIP CODE TELEPHONE (Include Area Code) () ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>					11. INSURED'S POLICY GROUP OR FECA NUMBER				
6. OTHER INSURED'S POLICY OR GROUP NUMBER					10a. CLAIM CODES (Designated by NUCC)					11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				
7. RESERVED FOR NUCC USE					10b. PLACE (State)					12. OTHER CLAIM ID (Designated by NUCC)				
8. RESERVED FOR NUCC USE					10c. CLAIM CODES (Designated by NUCC)					13. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete Items 9, 9a, and 9d.				
9. INSURANCE PLAN NAME OR PROGRAM NAME					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.)					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 _____ DATE _____					SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.					15. OTHER DATE MM DD YY QUAL.					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES					21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY (Refer to ICD-9-CM to service line below (24E)) ICD Incl.				
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____					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 (Specify Unusual Circumstances) E. DIAGNOSIS POINTER					F. \$ CHARGES G. DAYS OR UNIT H. FROSTING I. BL. QUAL. J. RENDERING PROVIDER ID. #									
1					2					3				
4					5					6				
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				
28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. (Rev. 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.)					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ()				
SIGNED _____ DATE _____					NPI					NPI				

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.
NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

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

Field#	FieldDescription	Instruction or Comments	Required or Conditional
6	PATIENT'S RELATIONTO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	<p>Enter the patient's complete address and telephone number, including area code on the appropriate line.</p> <p>First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).</p> <p>Second line – In the designated block, enter the city and state.</p> <p>Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).</p> <p>Note: Does not exist in the electronic 837P.</p>	C
8	RESERVEDFOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVEDFOR NUCC USE		Not Required

Field#	FieldDescription	Instruction or Comments	Required or Conditional
9c	RESERVEDFOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM DD YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIMID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY: Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R

Field#	FieldDescription	Instruction or Comments	Required or Conditional
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the enrollee's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C

Field#	FieldDescription	Instruction or Comments	Required or Conditional
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	OUTSIDE LAB/ CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF. NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization.	If auth = C If CLIA = R

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

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

Field#	FieldDescription	Instruction or Comments	Required or Conditional
Unshaded			
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy,. Use 1D qualifier for ID, if an Atypical Provider.	R
<u>Typical Providers:</u>			
24 J Shaded	NON-NPI PROVIDER ID#	Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code.	R
<u>Atypical Providers:</u>			
Enter the Provider ID number.			
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a enrollee of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Health Plan recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C

Field#	FieldDescription	Instruction or Comments	Required or Conditional
28	TOTAL CHARGES	<p>Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</p> <p>REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Health Plan. Medicaid programs are always the payers of last resort.</p>	R
29	AMOUNT PAID	<p>Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</p> <p>REQUIRED when field 29 is completed.</p> <p>Enter the balance due (total charges minus the amount of payment received from the primary payer).</p>	C
30	BALANCE DUE	<p>Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign (\$). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</p>	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	<p>If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed.</p> <p>Note: Does not exist in the electronic 837P.</p>	R

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

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

APPENDIX V – CLAIMS FORM INSTRUCTIONS – UB

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

Completing a UB-04 Claim Form

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

Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

Professional fees and ambulatory surgical center claims must be billed on a CMS 1500 claim form.

Include the appropriate CPT code next to each revenue code.

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

UB-04 Claim Form Example

1 PATIENT NAME		2 PATIENT ADDRESS		3A FID #		3B STATE		3C COUNTY		3D ZIP		3E FID TAX NO.		3F STATEMENT COVERED PERIOD FROM		3G STATEMENT COVERED PERIOD THROUGH		3H TYPE OF BILL																							
10 ICD-9-CM DATE		11 SEX		12 DATE		13 ADMISSION 13-1-14 TYPE		14 TYPE		15 SEC		16 ICD-9-CM		17 STATE		18		19		20		21		22		23		24		25		26		27		28		29 ACCT STATE		30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		37 OCCURRENCE SPAN THROUGH		38 OCCURRENCE SPAN FROM		39 OCCURRENCE SPAN THROUGH		40 OCCURRENCE SPAN FROM		41 OCCURRENCE SPAN THROUGH		42 OCCURRENCE SPAN FROM		43 OCCURRENCE SPAN THROUGH		44 OCCURRENCE SPAN FROM		45 OCCURRENCE SPAN THROUGH		46 OCCURRENCE SPAN FROM		47 OCCURRENCE SPAN THROUGH		48 OCCURRENCE SPAN FROM		49 OCCURRENCE SPAN THROUGH					
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42 VALUE CODES AMOUNT		43 VALUE CODES AMOUNT		44 VALUE CODES AMOUNT		45 VALUE CODES AMOUNT		46 VALUE CODES AMOUNT		47 VALUE CODES AMOUNT		48 VALUE CODES AMOUNT		49 VALUE CODES AMOUNT		50 VALUE CODES AMOUNT		51 VALUE CODES AMOUNT		52 VALUE CODES AMOUNT		53 VALUE CODES AMOUNT		54 VALUE CODES AMOUNT		55 VALUE CODES AMOUNT		56 VALUE CODES AMOUNT					
42 REV. CD		43 DESCRIPTION		44 HPCS / RATE / HPCS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		50		51		52		53		54		55		56		57		58		59		60					
PAGE		OF		CREATION DATE		TOTALS																																			
50 PRIOR NAME		51 HEALTH PLAN ID		52 PRIOR ICD-9-CM		53 PRIOR ICD-9-CM		54 PRIOR ICD-9-CM		55 EST. AMOUNT DUE		56 NPI		57 OTHER PRIOR ID		58		59		60		61		62		63		64		65		66		67		68					
59 INSURED'S NAME		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.		63		64		65		66		67		68		69		70		71		72		73		74		75		76		77					
69 TREATMENT AUTHORIZATION CODES		70 DOCUMENT CONTROL NUMBER		71 EMPLOYER NAME		72		73		74		75		76		77		78		79		80		81		82		83		84		85		86		87					
88		89		90		91		92		93		94		95		96		97		98		99		100		101		102		103		104		105		106					
99 ALMT DX		100 TREATMENT REASON DX		101 OTHER PROCEDURE CODE		102 OTHER PROCEDURE DATE		103 OTHER PROCEDURE CODE		104 OTHER PROCEDURE DATE		105 OTHER PROCEDURE CODE		106 OTHER PROCEDURE DATE		107 OTHER PROCEDURE CODE		108 OTHER PROCEDURE DATE		109 OTHER PROCEDURE CODE		110 OTHER PROCEDURE DATE		111 OTHER PROCEDURE CODE		112 OTHER PROCEDURE DATE		113 OTHER PROCEDURE CODE		114 OTHER PROCEDURE DATE		115 OTHER PROCEDURE CODE		116 OTHER PROCEDURE DATE		117 OTHER PROCEDURE CODE		118 OTHER PROCEDURE DATE			
119		120		121		122		123		124		125		126		127		128		129		130		131		132		133		134		135		136		137					
119 REMARKS		120		121		122		123		124		125		126		127		128		129		130		131		132		133		134		135		136		137					

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.
 NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

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

Field#	FieldDescription	Instruction orComments	Required or Conditional
8a-8b		8a – Enter the first 9 digits of the identification number on the enrollee's Health Plan I.D. card	Not Required
	PATIENT NAME	8b – Enter the patient's lastname, first name, and middle initial as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names. <u>Titles:</u> (Mr., Mrs., etc.) should not be reported in this field. <u>Prefix:</u> No space should be left after the prefix of a name (e.g. McKendrick. H). <u>Hyphenated names:</u> Both names should be capitalized and separated by a hyphen (no space). <u>Suffix:</u> a space should separate a last name and suffix. Enter the patient's complete mailing address of the patient. Enter the patient's complete mailing address of the patient. Line a: Street address	R
9	PATIENT ADDRESS	Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	(except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY).	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R

Field#	FieldDescription	Instruction orComments	Required or Conditional
13	ADMISSION HOUR	<p>0012:00 midnight to 12:59 12-12:00 noon to 12:59</p> <p>01-01:00 to 01:59 13-01:00 to 01:59</p> <p>02-02:00 to 02:59 14-02:00 to 02:59</p> <p>03-03:00 to 03:59 15-03:00 to 03:59</p> <p>04-04:00 to 04:59 16-04:00 to 04:59</p> <p>05-05:00:00 to 05:59 17-05:00:00 to 05:59</p> <p>06-06:00 to 06:59 18-06:00 to 06:59</p> <p>07-07:00 to 07:59 19-07:00 to 07:59</p> <p>08-08:00 to 08:59 20-08:00 to 08:59</p> <p>09-09:00 to 09:59 21-09:00 to 09:59</p> <p>10-10:00 to 10:59 22-10:00 to 10:59</p> <p>11-11:00 to 11:59 23-11:00 to 11:59</p> <p>Require for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes:</p>	R
14	ADMISSION TYPE	<p>1 Emergency</p> <p>2 Urgent</p> <p>3 Elective</p> <p>4 Newborn</p> <p>5 Trauma</p>	R
15	ADMISSION SOURCE	<p>Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes.</p> <p>For Type of admission 1,2,3, or 5:</p> <p>Physician Referral</p> <p>Clinic Referral</p> <p>Health Maintenance Referral (HMO)</p> <p>Transfer from a hospital</p> <p>Transfer from Skilled Nursing Facility</p> <p>Transfer from another health care facility</p> <p>Emergency Room</p>	R

Field#	FieldDescription	Instruction orComments	Required or Conditional
		Court/Law Enforcement Information not available	
		For Type of admission 4 (newborn):	
		1 Normal Delivery	
		2 Premature Delivery	
		3 Sick Baby	
		4 Extramural Birth	
		5 Information not available	
16	DISCHARGE HOUR	Enter the time using 2 digit military times (00-23) for the time of the inpatient or outpatient discharge. 0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 -03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	C
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2 digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider	R

Field#	FieldDescription	Instruction orComments	Required or Conditional
		09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)	
		20 Expired or did not recover	
		30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)	
		40 Expired at home (hospice use only)	
		41 Expired in a medical facility (hospice use only)	
		42 Expired—place unknown (hospice use only)	
		43 Discharged/Transferred to a federal hospital (such as a Veteran’s Administration [VA] hospital)	
		50 Hospice—Home	
		51 Hospice—Medical Facility	
		61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed	
		62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital	
		63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)	
		64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare	
		65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital	
		66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: REQUIRED when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing.	C

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

Field#	FieldDescription	Instruction orComments	Required or Conditional
		(i.e. 10.00), enter 00 in the area to the right of the vertical line.	
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE ____ OF ____	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e. PAGE “1” OF “1”). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	C

Field#	FieldDescription	Instruction orComments	Required or Conditional
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1- 22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1- 22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required
50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	HEALTH PLAN IDENTIFICATION NUMBER		Not Required
52 A-C	RELINFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG.BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
56	NATIONAL PROVIDER IDENTIFIER OR	Required: Enter providers 10- character NPI ID.	Required

Field#	FieldDescription	Instruction orComments	Required or Conditional
57	PROVIDER ID OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'SNAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of	C

Field#	FieldDescription	Instruction orComments	Required or Conditional
		specificity – 4 th or “5” digit. “E” and most “V” codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied.	
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4 th or “5” digit. “E” codes and most “V” are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.	R
70	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient’s reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4 th or “5”. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis. NOTE: Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS/DRG CODE		Not Required
72 a,b,c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C

Field#	FieldDescription	Instruction orComments	Required or Conditional
74 a-e	OTHER PROCEDURE CODE DATE	<p>REQUIRED on inpatient claims when a procedure is performed during the date span of the bill.</p> <p>CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied.</p> <p>DATE: Enter the date the principal procedure was performed (MMDDYY).</p>	C
75	UNLABELED		Not Required
76	ATTENDING PHYSICIAN	<p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician’s last name. FIRST: Enter the attending physician’s first name.</p>	R
77	OPERATING PHYSICIAN	<p>REQUIRED when a surgical procedure is performed.</p> <p>Enter the NPI and name of the physician in charge of the patient care.</p> <p>NPI: Enter the attending physician 10-character NPI ID.</p> <p>Taxonomy Code: Enter valid taxonomy code.</p> <p>QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code.</p> <p>LAST: Enter the attending physician’s last name.</p>	C

Field#	FieldDescription	Instruction orComments	Required or Conditional
78 & 79	OTHER PHYSICIAN	<p>FIRST: Enter the attending physician's first name.</p> <p>Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care.</p> <p>(Blank Field): Enter one of the following Provider Type Qualifiers:</p> <p>DN – Referring Provider.</p> <p>ZZ – Other Operating MD.</p> <p>82 – Rendering Provider.</p> <p>NPI: Enter the other physician 10-character NPI ID.</p> <p>QUAL: Enter one of the following qualifier and ID number:</p> <p>0B - State license number</p> <p>1G - Provider UPIN number</p> <p>G2 - Provider commercial number</p>	C
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7 digit Provider number of ordering physician.	R

APPENDIX VI – ORIGIN AND DESTINATION MODIFIERS FOR TRANSPORTATION

Origin and Destination Modifiers for Transportation

Origin and Destination Modifiers	
The first place alpha code is the origin; the second place alpha code is the destination. The valid	
<u>Mod</u>	<u>Description</u>
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event

Based on the modifiers noted above:

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

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

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