2020 Provider Billing Manual

IowaTotalCare.com

012020

INTRODUCTORY BILLING INFORMATION

Billing Instructions

Iowa Total 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 Iowa Total Care for payment of covered services.

It is important that providers ensure Iowa Total 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 CMS 1500, 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 Iowa Total 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 Member must be effective on the date of service (see information below on identifying the Member,
- The service provided must be a covered benefit under the Member'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 Member via the Medicaid Number provided by the State and found on the Member ID card or the provider portal.

Claim Forms

Iowa Total Care only accepts the CMS 1500 (2/12), CMS 1450 (UB-04), and Targeted Medical Care (TMC) Form 470-2486 paper claim forms. Additionally, Iowa Total Care utilizes a web portal for claim submission. This web portal can be found at iowatotalcare.com.

Handwritten claims are not accepted, except for the TMC Form 470-2486 used for Consumer-Directed Attendant Care (CDAC) found on the Iowa Medicaid Enterprise (IME) website at https://dhs.iowa.gov/ime/Providers/claims-and-billing/ClaimsPage. Claim Form Instructions can also be found at this location. 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. Iowa Total 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, except for the TMC Form 470-2486 (noted in paragraph above).

If you have questions regarding what type of form to complete, contact Iowa Total Care at our Toll Free number: 1-833-404-1061

Billing Codes

Iowa Total 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, as per correct coding guidelines. 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 Member
- 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 Iowa Total 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 which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided Iowa Total Care Members. For example; if you are the Primary Medical Professional (PMP) for a Member 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. Iowa Total Care utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HSD 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 an Iowa Total Care Member. The encounter or claim file structure and content definition requirements shall adhere to those standards defined by the Iowa Department of Human Services as revised from time-to-time.

Clean Claim Definition

A clean claim means a claim received by Iowa Total 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 Iowa Total 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 office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

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

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

Claim Payment

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

- 90% within 30 Calendar Days of receipt
- 95% within 45 Calendar Days of receipt
- 99% within 90 Calendar Days of receipt

Contact Information

Plan Address / Administrative Office:
Iowa Total Care
1080 Jordan Creek Parkway, Suite 100 South
West Des Moines, IA 50266

Claims Submission Address:
Iowa Total Care
Attn: Claims
PO Box 8030
Farmington MO 63640

Customer Service:
833-404-1061, Iowa Total Care
ITC Duals: 833-765-8507
ITC Foster Care: 833-222-4832

TYY Users 1-833-404-1061; Open Monday through Friday from 8:00 a.m. to 5:00 p.m.

CLAIMS PAYMENT INFORMATION

Systems Used to Pay Claims

Iowa Total 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:

Hospital Base Rate x DRG Relative weight

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

Outpatient hospital claims, other than Critical Access Hospitals, 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 similar to DRGs, but unlike DRGs, more than one APC can be assigned per claim. Outpatient claims for Critical Access Hospitals are paid on a Cost-to-Charge Ratio basis (CCR).

Electronic Claims Submission

Network providers are encouraged to participate in Iowa Total Care's electronic claims/encounter filing program. Iowa Total Care can receive ANSI X12N 837 professional, institutional 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.

Iowa Total Care's payer ID 68069. Our preferred Clearinghouse is Availity. Please visit our website for our electronic Companion Guide, which offers more instructions. For questions or more information on electronic filing please contact:

Iowa Total Care
c/o Centene EDI Department
1-800-225-2573, extension 25525

Or by e-mail at EDIBA@centene.com

Paper Claim Submission

For Iowa Total Care Members, all claims and encounters should be submitted to:

Iowa Total Care
Attn: Claims Department
PO Box 8030, Farmington MO 63640

Requirements

Iowa Total 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

- 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:*** Iowa Total Care is able to receive primary insurance carrier EOP [electronically]
- Do submit on a proper original form - CMS 1500 or UB 04.

Don't

- Don't submit handwritten claim forms (Other than the TMC 470-2486).
- 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 Member.
- 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 Member, 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)

Iowa Total 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:

Iowa Total Care
1080 Jordan Creek Parkway, Suite 100 South
West Des Moines, IA 50266
833-404-1061

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 Member 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.
- Missing or incomplete consent forms.
- Missing or incomplete CPT/HCPCS Codes.
- Missing, invalid or invalid POA/HAC Codes.
- Missing or incomplete Type of Bill.

Iowa Total 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 - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), or the font is too small.
- Missing Member Date of Birth.
- Missing or Incomplete Member Name or Identification Number.
- Missing Provider Name, Tax ID, or NPI Number, or one that does not match records on file.
- Missing Medicaid Number if required.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 76 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service is prior to Member's effective date.
- Date of Service or Date Span is missing from required fields.
- Invalid or Missing Type of Bill.
- Missing, Invalid or Incomplete Diagnosis Code.
- Missing Service Line Detail.
- Member 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.
- Modifiers are missing or invalid.
- Institutional Claim (UB-04) exceeded the maximum 97 service line limit.
- Professional Claim (CMS-1500) exceeded the maximum 50 service line limit.

Iowa Total Care will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection. See Appendix I for a complete list.

Clinical Laboratory Improvement Amendment (CLIA) Accreditation

The Centers for Medicare and Medicaid (CMS) regulates all laboratory testing on humans through the CLIA program, which ensures quality lab testing through established laboratory standards. Labs that participate in Medicare or Medicaid with Iowa Total Care must be CLIA accredited and registered with CMS. Requirements for laboratory accreditation are contained in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB),which may be accessed on the web site at: http://www.jcrinc.com/store/publications/manuals/.

How to Submit a CLIA Claim

Via Paper

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

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

Via EDI

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

-Or-

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

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

Via AHA Provider Portal

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

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

Timely Filing

Providers must submit all claims and encounters within 180 calendar days of the date of service. All retroactive eligibility claims need to be received at Iowa Total Care within 365 days of the notice date. When Iowa Total Care is the secondary payer, claims must be received within 365 calendar days of the final determination of the primary payer.

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 Member. Any other insurance, including Medicare, is always primary to Medicaid coverage.

Iowa Total 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 Iowa Total Care Members. If a Member has other insurance that is primary, providers must submit the 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 a Member with insurance primary to Medicaid, the claim will pend and/or deny until this information is received. If a Member 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 a Member to identify potential third party resources, the provider shall inform the health plan that efforts have been unsuccessful. Iowa Total Care will make every effort to work with the provider to determine liability coverage.

Iowa Total Care will pay the Member's coinsurance, deductibles, co-payments and other cost-sharing expenses up to the allowed amount.

Iowa Total Care will pay and chase for pediatric preventative services and prenatal services.

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.

Iowa Total Care will not coordinate benefits when the primary insurer denies for the following administrative reasons:

- No Authorization
- Untimely Filing
- Duplicate Denial

If the primary insurer denies for non-administrative reasons, the provider would be required to obtain an authorization for any service Iowa Total Care would require an authorization for if we were the primary payer. The provider is encouraged to obtain an authorization for the following potential denials:

- Noncovered Service
- Benefits Exhausted

Tertiary medical claims must be billed on paper claim forms and both the primary and secondary EOBs must be attached. Paper submissions should be mailed to:

Iowa Total Care
Attn: Claims Department
PO Box 8030, Farmington MO 63640

Medicare with Other Insurance

If a Member has Medicare coverage and other insurance, bill the other sources before submitting a bill to Medicaid.

You may submit the bill to Medicaid for consideration if the payment is not made within 60 days of the Explanation of Benefits (EOB).

Crossover / COBA

Iowa Total Care processes crossover claims for members enrolled in both its Medicare and Medicaid plans. It also participates in coordination of benefits agreement (COBA) to process claims received directly from Centers for Medicare and Medicaid Services (CMS). With either process, claim crossover between Medicare and Medicaid is automatic and providers can submit a clean claim once for adjudication by both services.

Receiving a TPL Payment after Iowa Total Care Payment

If a provider receives payment from a third party after Iowa Total Care has made payment to the provider, the provider must reimburse Iowa Total Care. The provider needs to adjust the claim and indicate the TPL payment.

No Response from Other Insurance

If a provider bills a third-party insurer and, after 30 days, has not received a written or electronic response to the claim from the third-party insurer, the provider can submit the claim within 12 months of the service date to the Iowa Total Care as a denial from the insurance company.

- If submitting a paper claim, any documentation sent to the third-party insurer must be attached with the claim.
- If submitting electronically, the documentation must be kept on file as proof of prior billing to the third-party insurer and available upon request.

This 30-day stipulation does not apply to:

- Self-insured employer plans.
- Medicare/Medicare supplement policies.
- Other Medicaid MCOs.

- Workers' compensation.
- Federal employee plans.
- Vision or drug plans.
- Disability income.
- Medical claims paid by auto or homeowners insurance.

If the third-party insurer sends any requests to the provider for additional information, the provider must respond appropriately. If the provider complies with the requests for additional information and, after 90 days from the date of the original claim to the third-party insurer has not received payment or denial from the third-party insurer, then the provider can submit the claim within 12 months of the service date to Iowa Total Care as a denial from the insurance company.

Note: This does not apply to the insurance plan types listed above.

If submitting a paper claim, any documentation sent to the third-party insurer must be attached with the claim. When submitting a claim electronically, the documentation must be kept on file and available upon request.

Documentation Requirements

Adequate documentation is important for claims with TPL. Attachment of acceptable proof of payment or denial is required for paper claim submissions. Providers are not required to submit paper documentation for claims billed using electronic submissions, but documentation must be retained in the patient's file and is subject to request and review by the state.

The only acceptable forms of documentation proving that another insurer was billed first are an RA or EOB from the other insurer. The provider can use a copy of the claim filed with the insurance company by the provider or the policyholder as proof of billing, if the other insurance company never responded.

If a Member has other insurance that applies and providers are submitting paper claims, providers need to attach a copy of the EOB from the other insurance company for all affected services.

Acceptable Proof of Payment or Denial

Documentation of proper payment or denial of TPL is considered acceptable if it corresponds with the Member name, dates of service, charges, and TPL payment listed on the Iowa Total Care claim. Exception: If there is a reason why the charges do not match (such as another insurer requires another code to be billed, which generates a different charge), the provider should note this on the EOB.

Acceptable documentation:

- Insurance carrier's EOB.

- Insurance carrier's RA.
- Correspondence from insurance carrier indicating payment.
- Copy of provider's ledger account.

Client Participation / Aggregate Share of Cost

Generally, Iowa Total Care, their providers, contractors and subcontractors shall not require cost sharing for covered services. However, Members may be subject to client participation such as the following: (i) Members in an institutional setting and (ii) 1915(c) HCBS Waiver Member. Iowa Total Care will implement a mechanism to inform providers about the liability amount, and will delegate the collection of that liability to the providers.

Client participation is the amount of income the Member must pay before Medicaid reimbursement for services is available. The Iowa Department of Human Services (DHS) has the responsibility of determining the Member liability amount. Through the DHS eligibility and enrollment files, the state will notify Iowa Total Care of any applicable Member liability amounts. This information will be made available to Providers. Providers will be required to collect this amount from the Member and bill gross/full charges. Iowa Total Care will adjudicate the claim and deduct the patient liability amount. In the event the sum of any applicable third-party payment and a Member's client participation equals or exceeds the reimbursement amount established for services, Iowa Total Care will make no payment to the provider.

Some Iowa Total Care Members are subject to a co-payment for certain services (see Emergency Care Co-payments below), which are tracked by Iowa Total Care (Aggregate Share of Cost). This will be indicated on their ID card. Member co-payments are capped at 5% of household income, and may not be collected after Members have paid/reached that amount. Prior to collecting co-payments from any Member, and in conjunction with eligibility verification, providers should verify a Member's co-payment status before collecting any co-payments.

Emergency Care Co-payments

An eight dollar ($8) copayment for Iowa Total Care Plan Members and a twenty-five dollar ($25) copayment for Hawki Members will be applied for use of a hospital Emergency Department (ED) to treat non-emergent conditions. A copayment shall not be imposed on Hawki Members whose family income is less than 182 percent of the federal poverty level.

Before providing non-emergency services and imposing co-payments, the hospital providing care must:

- Conduct an appropriate medical screening to determine that the Member does not need emergency services.
- Inform the Member of the amount of his or her co-payment obligation for non-emergency services provided in the hospital ED.

- Provide the Member with the name and location of an available and accessible alternative non-emergency services provider.
- Determine that the alternative provider can provide services to the Member in a timely manner with the imposition of a lesser or no co-payment.
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

If the Member has been advised of the available alternative provider and of the amount of the co-payment, and chooses to continue to receive treatment for a non-emergency condition at the hospital ED, the hospital will assess the co-payment.

Emergency services rendered for emergent conditions are exempt from any copayment.

Missed Appointments

Providers are prohibited from billing Members for missed appointments.

Billing the Member / Member Acknowledgement Statement

Iowa Total 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 Members for services NOT covered by either Medicaid or Iowa Total Care or for applicable copayments, deductibles or coinsurance as defined by the State of Iowa.

In order for a provider to bill a Member 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 Member 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 Iowa Total Care through its contract with the Iowa Medicaid Enterprise 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.

EMERGENCY ROOM SERVICES

Iowa Total Care follows the Iowa Medicaid policy to modify the reimbursement methodology to either reduce or deny payment for nonemergency services rendered in a hospital emergency room. Status Indicator V, clinic or emergency department visit, if covered by Iowa Medicaid, is paid under Outpatient Prospective Payment System Ambulatory Payment Classifications (OPPS APC) with separate APC payment, subject to limits on nonemergency services provided in an emergency room as described below:

Payment to a hospital for assessment of any Medicaid Member in an emergency room shall be made pursuant to fee schedule. ITC will cover and pay for emergency services regardless of if provider is in network. Payment for treatment of an Iowa Total Care Member in an emergency room shall be made as follows:

- If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided. Critical access hospitals (CAH) are exempt from this requirement.
- If the emergency room visit does not result in an inpatient hospital admission but involved emergency services as defined by the IA Emergency Room Diagnosis list, payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided. CAH payment is based on a cost to charge ratio.
- If the emergency room visit does not result in an inpatient hospital admission and did not involve emergency services as defined by the IA Emergency Room Diagnosis List, payment for treatment provided in the emergency room depends on whether the Member had a referral to the emergency room from the Member's primary care provider (PCP):
    - For Members who were referred to the emergency room by either their primary care physician or other appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent (75%) of the APC payment for the treatment provided.
    - For Members who were not referred to the emergency room by their primary care physician or appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent (50%) of the APC payment for the treatment provided.

Diagnosis codes used to determine emergency room payment are located on the IME Website (https://dhs.iowa.gov/sites/default/files/ICD-10_Emergency_Dx_3.pdf?022720191902)

Iowa Total Care will cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with us.

Iowa Total Care shall not deny payment for treatment obtained under either of the following circumstances:

i. A member has an emergency medical condition, including cases in which the absence of immediate medical attention will not result in:

    a. Placing the health of the individual in serious jeopardy; for a pregnant women, the health of the women or unborn child.

    b. Serious impairment to bodily functions.

    c. Serious dysfunction of any bodily organ or part.

ii. A representative of Iowa Total Care instructs the Member to seek emergency care.

THIRTY (30) DAY HOSPITAL READMISSIONS

Iowa Total Care follows the Iowa Medicaid 30-day readmission policy to exclude readmissions that are planned for repetitive or staged treatments and to clarify that the policy does not apply to critical access hospitals. We may review hospital admissions on a specific Member if it appears that two or more admissions are related based on same or similar conditions. The claim review, which includes a review of medical records if requested from the provider, may result in necessary adjustments. If so, Iowa Total Care will make all necessary adjustments to the claim (including recovery of payments) not supported by the medical record. Providers who do not submit the requested medical records or who do not remit the overpayment amount identified by us may be subject to a recoupment.

IOWA TOTAL CARE CODE AUDITING AND EDITING

Iowa Total 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, Iowa Total 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.

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.

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.

Miscellaneous/Unlisted Codes

The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claims submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

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.

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 Member/provider eligibility review), the claim is ready for analysis.

Code Auditing Rules

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 Member/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.

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 Member, 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 Member 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 Member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a Member'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 Member 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 Member 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 Member 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.

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. These claims will deny if a required modifier is absent from the claim.

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 member's age.
- **Gender Procedure:** Identifies procedures inconsistent with member's gender.
- **Gender Diagnosis:** Identifies diagnosis codes inconsistent with member'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 Iowa Total 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). Iowa Total Care's clinical validation team uses the information on the prospective claim and claims history to determine whether or not it is likely that a modifier was used correctly based on the unique clinical scenario for a member 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 are routinely assigning modifier 59 when billing a combination of codes that will result in a denial due to unbundling. We commonly find misuse of modifier 59 related to the portion of the definition that allows its use to describe "different procedure or surgery". NCCI guidelines state that providers should not use modifier 59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier 59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

Iowa Total 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 -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.

Iowa Total 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 member on or around the same date of the procedure support that an E/M service would have been required to determine the member'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 (excluding planned 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 Disputes related to Code Auditing and Editing

Claims disputes resulting from claim-editing are handled per the provider claims dispute process outlined in this manual. When submitting a claim dispute, please submit medical records, invoices and all related information to assist with the claim dispute review (reconsideration). Refer to the Provider Claims Dispute Process section within this Manual

If you disagree with a code audit or edit and request a claim reconsideration, you must submit medical documentation (medical record) related to the dispute. 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

Iowa Total 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 Iowa Total 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

Iowa Total 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. Iowa Total 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.

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, Iowa Total Care's policy is to pay the lesser of billed charges and negotiated rate.

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

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.

Dual Eligible Member Payments When Not Covered by Medicare

When a Member is a dual eligible with Medicaid and Medicare, and they require services that are covered under Medicaid but not Medicare, and the services are ordered by a Medicare provider, Iowa Total Care shall pay for the ordered, medically necessary service if it is provided by a contract provider.

PROVIDER CLAIM DISPUTE PROCESS

All requests for claim payment disputes must be submitted within 180 days (or as required by law or your participation agreement) from the date of the Explanation of Payment (EOP) or Provider Remittance Advice (PRA) utilizing the Provider Dispute Form (The paper Provider Dispute Form can be downloaded from iowatotalcare.com.

A **Claim Payment Dispute** is defined as a finalized claim in which the provider disagrees with the outcome. Claim payment disputes are submitted for numerous reasons, including, but not limited to:

- Contractual payment Issues.
- Reduced or Zero-Paid claims disagreements.
- Post-service authorizations.
- Claim code-editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Timely filing issues (Iowa Total Care will consider reimbursement of a claim that has been denied due to meeting timely filing guidelines if provided documentation that the claim was submitted within the timely filing guidelines or can validate good cause).

Claim related issues that are ***NOT*** considered for claim disputes are as follows:

- Claim Inquiry - a question related to a claim but not requesting a change to the claim payment.
- Claim Correspondence - if Iowa Total Care requests further information to finalize a claim (i.e. medical records, itemized bills, or information about other insurance Member may have).
- Medical Necessity Appeals - a pre-service appeal for a denied service for which a claim has not yet been submitted.

Claim Payment Reconsideration is the initial request to investigate the outcome of the finalized claim. The process is described as follows:

- Reconsiderations are accepted in writing within 180 days from the date on the EOP or PRA.
- Any reconsideration submitted after the 180 days will be considered as untimely and denied unless good cause can be validated.
- Iowa Total Care can understand why the claim payment is being disputed together with the Provider Dispute Form.

- The paper Provider Dispute Form can be downloaded from iowatotalcare.com.

- Iowa Total Care will work to resolve all reconsideration requests within 30 calendar days of receipt of all information.
- A determination letter from Iowa Total Care will be issued detailing the reconsideration decision including statement of and reason for action by Iowa Total Care, and an explanation of the provider's right to request a **Claim Payment Appeal** within the 30 days of the date of reconsideration determination letter.
- If final decision results in a claim adjustment, payment and EOP will be sent separately.

Claim Payment Appeal may be submitted by Provider if there is disagreement on the reconsideration decision. The process is described as follows:

- Claim payment appeals are accepted in writing within 30 days from the date of determination letter or EOP/PRA resulting from reconsideration action.
- Any appeal submitted after the 30 days will be considered as untimely and denied unless good cause can be validated.
- All submitted appeals should include as much information as possible so Iowa Total Care can understand why the reconsideration determination was in error.
- Iowa Total Care will work to resolve all claim payment appeals within 30 calendar days of receipt of all information.
- A determination letter from Iowa Total Care will be issued detailing the appeal decision including statement of and reason for action by Iowa Total Care.
- If final decision results in a claim adjustment, payment and EOP will be sent separately.

Important Information about Your Dispute Rights

Refer to the Provider Rights section of the ITC Provider Manual for details on your dispute rights. Disputes (Reconsiderations and Appeals) should be submitted to:

Iowa Total Care
Attn: Claim Disputes
PO Box 8030,
Farmington, MO 63640-0830

Note: All Disputes ***must be*** sent to the above address. Any Disputes sent directly to the Iowa Total Care Des Moines office will be returned to the provider for resubmission to the above address.

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.

HCBS Programs Billing Information

The Home and Community Based Services (HCBS) programs are designed to meet the needs of Members who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining overall health, socialization, independence, and community integration of those Members with the desire to live outside of an institution.

HCBS – Habilitation Services

The Medicaid Home-and Community-Based Services Habilitation program provides service funding and individualized supports to maintain eligible members in their own homes or communities who require assistance due to functional limitations typically associated with chronic mental illness. Provision of these services must be cost effective. See the Iowa Medicaid Enterprise's HCBS Habilitation Manual (http://dhs.iowa.gov/sites/default/files/Habilitation.pdf).

HCBS – Elderly Waiver

The Medicaid Home- and Community-Based Services Elderly Waiver (HCBS Elderly) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community Based Services Provider Manual (https://dhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840).

HCBS – Physical Disability (PD)

The Medicaid Home- and Community-Based Services Physical Disability Waiver (HCBS PD) provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community Based Services Provider Manual (https://dhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840).

HCBS – Brain Injury

The Medicaid Home- and Community-Based Services Brain Injury Waiver (HCBS BI) provides service funding and individualized supports to maintain eligible members in their

own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community Based Services Provider Manual (https://dhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840).

HCBS – Intellectual/Developmental Disabilities

The Medicaid Home- and Community-Based Services Intellectual Disability Waiver (HCBS ID) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community Based Services Provider Manual (https://dhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840).

HCBS - AIDS/HIV (AH) Waiver

The Medicaid Home- and Community-Based Services Acquired Immunodeficiency Syndrome/ Human Immunodeficiency Virus Waiver (HCBS AIDS/HIV) provides service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community Based Services Provider Manual (https://dhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840).

HCBS - Children's Mental Health (CMH) Waiver

The intent of the Medicaid Home- and Community-Based Services Children's Mental Health Waiver (HCBS CMH) is to identify services and supports that are not available through other mental health programs and services that can be used in conjunction with traditional services to develop a comprehensive support system for children with serious emotional disturbance. These services will allow children in this targeted population to remain in their own homes and communities. Provision of these services must be cost effective. See the Home and Community Based Services Provider Manual (https://dhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840).

HCBS - Health and Disability (HD) Waiver

The Medicaid Home- and Community-Based Services Health and Disability Waiver (HCBS HD) provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective. See the Home and Community Based Services Provider Manual (https://dhs.iowa.gov/sites/default/files/HCBS.pdf?032120191840).

Date Span Billing With Examples (Waivers)

- Span billing means you can bill for services over a range of dates within the same month (CMS 1500 only). The number of units billed for these dates do not have to be an exact match. Examples of the correct way to bill with date spans are below:

  (Example – H2016 has a max of 31 units a month)

DATES OF SERVICE	PROCEDURE CODE	BILLED UNITS
1/1/16 – 1/31/16	H2016	31 units
1/1/16 – 1/5/16	H2016	5 units
1/1/16 – 1/1/16	H2016	1 unit
1/6/15 – 1/12/16	H2016	3 units
1/1/16 – 1/31/16	H2016	27 units

- You must bill within the same calendar month, and you cannot overlap any given calendar month, e.g., 01/15/16 through 02/10/16 – this would be two claims, one for January and one for February.
- Residential Services (H2016) – Residential Supports H2016 – allows 31 days maximum per calendar month. Residential Services should not be billed on the same claim with Day Supports.
- Day and Residential Services must be billed as separate claims.
- Targeted Case Manager (H1017) – Billing must be in whole units and cannot be billed as a partial unit (1 unit = 15 minutes), with a maximum of 240 units (16 hours) per year. Prior authorization is not required within the H1017 benefit limit for TCM services for Members with I/DD. ***Note:*** Providers cannot bill for H1017 for Members in a Health Home.

Obstetrical and Gynecological Billing Guidelines

The global obstetric (OB) code should be billed whenever one practitioner or practitioners of the same group provide all components of the patient's obstetrical care, including; 4 or more antepartum visits, delivery and postpartum care. The number of antepartum visits may vary from patient to patient, however, if global OB care (more than 3 antepartum visits, delivery and postpartum care) is provided, ALL pregnancy related visits (excluding inpatient hospital visits for complications of pregnancy) should be billed under the global OB code. Individual E/M codes should NOT be billed to report pregnancy related E/M visits.

(Source: https://dhs.iowa.gov/sites/default/files/CCI_MaternityBillingGuidelines2010.pdf)

FQHC/RHC

- Bill with correct place of service (50 – FQHC; 72–HC).
- Bill with appropriate encounter codes and CPT Codes.

Hospice

- Hospice providers billing services for Members residing in a Skilled Nursing Facility, nursing facility or intermediate care facility for persons with an intellectual disability. Providers must bill Rev Code 658 on the UB-04.

Hospitals

- For all hospitals, outpatient procedures (including, but not limited to, surgery, X- rays, and EKGs) provided within three days of a hospital admission for the same or similar diagnosis are considered content of service and must be billed on the same inpatient hospital claim. The outpatient procedure date should be changed on the claim to correspond with the actual hospital admission date. There is one exception to this policy—complications from an outpatient sterilization resulting in an inpatient admission.

In this instance, the outpatient charges and the inpatient charges should be billed on two separate claims. This is necessary in order for the service dates on the claim form to match the service dates on the Sterilization Consent Form.

- For all hospitals, the appropriate CPT/HCPCS codes are required to be billed for each service reported.
- Hospitals billing for lifeline services must use the correct NPI on the claim submission to avoid processing delays or denials.

Immunization/Vaccines/Injections

- Providers must bill the appropriate administration code in addition to the vaccine/toxoid code for each dose administered.
- In field 24D, enter the injection code, strength, and dosage.

Interim Billing

- When interim billing, be sure to enter the appropriate Type of Bill code (e.g., 112, 113, 114). A Patient Status code of 30 (still a patient) must use the appropriate Type of Bill code (e.g., 112, 113, 114). A Patient Status code of 30 (still a patient) must be indicated when Type of Bill is 112 or 113.

Modifiers

- Modifiers mirror the IME Procedure Code Modifier Listing.
    - https://dhs.iowa.gov/sites/default/files/Procedure_Code_Modifiers_9.13.18.pdf
- GN, GO, GP Modifiers – therapy modifiers required for speech, occupational and physical therapy.

Newborn Billing

- Providers should not bill claims until the newborn is issued a Medicaid State ID. EDI will reject these claims upfront.

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

NDC Requirements

- Iowa Total Care has mirrored the NDC requirements that the State of Iowa has in place. We download the NDC/procedure code crosswalk file from the Reimbursementcodes.com website monthly and update our configuration accordingly.

Nursing Facility (NF/ICF/Bed Hold)

- Nursing facility (NF) and intermediate care facility (ICF) providers must bill using the UB-04 claim form.
- Intermediate care facilities should bill with Type of Bill 65X or 66X.

Room and board is not billable by the nursing facility when a Member elects hospice benefits. The hospice provider bills for the room and board.

Observation Room

- Code G0378 should be used to bill for outpatient services. This code replaces 99218ET.
- Observation room should not be billed for the following:
    - Recovery room services following inpatient or outpatient surgery.
    - Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catheterization, etc.
- Medical supplies and injections (99070, J7030-J7130) are considered content of service of the observation room services.

Out of Network Providers

If Iowa Total Care is unable to provide medically necessary covered services to a particular Member using contract providers, Iowa Total Care shall adequately and timely cover these services using non-contract providers.

- Out-of-network providers shall be reimbursed at 80% of the rate of reimbursement to in-network providers.
- Provider will not bill Members for all or any part of the cost of treatment, except as allowed for Title XIX cost sharing and patient liability.

Physician Clinic Services

- Physician clinic services provided in a hospital location are considered content of the physician service and should not be billed to Medicaid or the member.
- The hospital can bill code G0463 for use of room and supplies, where appropriate.

POA Indicator

- All claims involving inpatient admissions to general acute care hospitals will require submission of present on admission (POA) indicator(s). 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 as POA. The POA indicator is assigned to principal and secondary or other diagnoses and the external cause of injury codes. The validity of the POA indicator will be audited, and claims are subject to denial when the POA indicator is invalid. The hospital will need to supply the correct POA indicator(s) and resubmit the claim. A POA indicator for the external cause of injury code is not required unless it is being reported as an "other diagnosis" on the UB-04.
- Definitions.
    - Y (for yes): Present at the time of inpatient admission.
    - N (for no): Not present at the time of inpatient admission.
    - U (for unknown): The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
    - W (for clinically undetermined): The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
    - Exempt from POA reporting: 5010 claim billing an exempt diagnosis code, leave the POA indicator field blank.
    - The ICD10-CM Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting.

Professional Fees

- The only physician services that can be billed by the hospital on the UB-04 claim form are those provided by hospital-based physicians assigned to the emergency department.

Prosthetic and Orthotic

- Hospitals must enroll as prosthetic and orthotic (P&O) providers and bill on the professional claim form (CMS-1500) or 837 professional transaction when providing these services.
- Prosthetic and orthotic items cannot be billed as ancillary services on the UB-04 claim form.
    - Exception: Prosthesis implanted by a surgical procedure may be billed on the hospital claim form for inpatient services.

Readmissions

- When an Iowa Medicaid Enterprise member is discharged prematurely and subsequently readmitted within 30 days with the same DRG or similar diagnosis at the same hospital, only the DRG payment for the first stay will be reimbursed (excluding planned readmissions).
- If the discharging and readmitting hospitals are not the same, only the readmitting hospital will be reimbursed.

Supplies

- Hospitals may bill code 99070 without the modifier ET for supplies. Modifier ET is no longer a valid modifier for 99070. Only one supply is allowed per day.

Swing Bed Nursing Facility

- The appropriate revenue code applicable to the patient's level of care must be entered.
- Room and board must be billed on a UB-04 claim form.
- Bill the total number of days (units).
- Indicate the total charges for the number of days billed.
- Ancillary charges cannot be billed on the Swing Bed NF facility claim. They must be billed on another UB-04 claim form with an outpatient type of bill.
- Claims must include both revenue codes and HCPCS codes.

Behavioral Health and Substance Abuse Services

Behavioral Health and Substance Abuse services may be billed by Community Mental Health Centers and other Behavioral Health Service Providers. More information can be found on the web site at: https://dhs.iowa.gov/policy-manuals/medicaid-provider.

Applied Behavioral Analysis (ABA)

- Iowa Total Care covers ABA services for Members with a diagnosis of Autism Spectrum Disorder. These services focus on increasing positive behaviors and decreasing negative or interfering behaviors in order to develop well-defined skills.

- Refer to DHS Informational Letter 1980-MC-FFS for coding and further details. Behavioral Health Intervention Services (BHIS)

- Iowa Total Care covers services for Members with a psychological disorder, and who have a need for intervention services related to their disorder. These services are supportive, directive, and teach interventions. They are provided in a community-based or residential group care environment, and are designed to improve the individual's level of functioning as it relates to a mental health diagnosis. The primary goal is to assist the Member and his or her family to learn age-appropriate skills to manage their behavior.

  Refer to DHS Informational Letter 1981-MC-FFS for coding and further details. B-3 Mental Health and Substance Abuse Services

- Iowa Total Care covers the following B-3 services for Mental Health and Substance Abuse disorders:

  - Intensive Psychiatric Rehabilitation
  - Community Support
  - Peer Support
  - Residential Substance Abuse Treatment
  - Integrated Services and Supports (including wrap around services)
  - Respite
  - Level III.1 Clinically Managed Low Intensity Residential Treatment (Halfway House) Substance Abuse.
  - Level III.3 and III.5 Clinically Managed Medium /High Intensity Residential Treatment Substance Abuse.

- Level III.3 and 5 Clinically Managed Medium /High Intensity Residential Treatment Substance Abuse Hospital Based.

- Level III.7 Substance Abuse Residential Community-Based

- For descriptions of services, Provider Type/Qualifications and codes, refer to the B-3 Mental Health and Substance Abuse Services document on the web site at: DHS.Iowa.gov.

837 COMPANION GUIDE (OCTOBER 2016)

Refers to the Implementation Guides based on the HIPAA Transaction ASC X12N. Standards for Electronic Data Interchange X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). Approved by IDPH.

Overview

The Companion Guide provides Iowa Total Care trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P) and ASC X12N/005010x223 Health Care Claim: Institutional (837I). The Iowa Total Care Companion Guide documents any assumptions, conventions, or data issues that may be specific to Iowa Total Care business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Iowa Total Care and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Iowa Total Care. This document provides information on Iowa Total Care-specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at http://store.x12.org.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Iowa Total Care and its trading partners. Refer to the TPA for guidelines pertaining to Iowa Total Care legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Iowa Total Care business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.

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Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Iowa Total Care.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (TA1,999). A TA1 Acknowledgment is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgment may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgment

The TA1 Interchange Acknowledgment provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgment

The 999 Functional Acknowledgment reports on all Implementation Guide edits from the Functional Group and transaction Sets.

277CA Health Care Claim Acknowledgment

The X12N005010X214 Health Care Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Iowa Total Care also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop.

Note: The STC03 – Action Code will only be a "U" if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Iowa Total Care checks five values within the ISA for redundancy:

- ISA06, ISA08, ISA09, ISA10, ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of "025" (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Iowa Total Care checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.

Note: ISA08 & GS03 could also be the Single Payer ID

New Trading Partners

New trading partners should access https://sites.edifecs.com/index.jsp?centene, register for access, and perform the steps in the Iowa Total Care trading partner program. The EDI Support Desk (EDIBA@Centene.com) will contact you with additional steps necessary upon completing your registration.

Claims Processing

Acknowledgments

Senders receive four types of Acknowledgment transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge health care claims, and the Iowa Total Care Audit Report. At the claim level of a transaction, the only Acknowledgment of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Iowa Total Care recommends that providers validate the patient's Membership Number and supplementary or primary carrier information for every claim.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3.

Data Format/Content

Iowa Total Care accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for "CC" (century) within birthdates are 18, 19, or 20.

- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient's birth date cannot be after the patient's service date.

Decimals

All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

Iowa Total Care accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Iowa Total Care are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Iowa Total Care requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Iowa Total Care will not accept more than 97 service lines per UB-04 claim.
- Iowa Total Care will not accept more than 50 service lines per CMS 1500 claim.
- Iowa Total Care will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300- REF02) is limited to 30 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Iowa Total Care sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Iowa Total Care expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Iowa Total Care will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Iowa Total Care EDI.

Payer Identifier

Single Payer IDs are used for all Health Plans. Please verify directly with the Health Plan and/or Clearinghouse the Payer ID that should be used or contact the EDI Support Desk at 800-225-2573, x6075525 or EDIBA@centene.com

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing Provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than Loop 2310B/NM1*82.

Referring Provider

Iowa Total Care has no specific requirements for Referring Provider information.

Atypical Provider

Atypical providers are not always assigned an NPI number, however, if an Atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop. ***Note: If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.***

Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber's card in the 2010BA element.

Claim Identifiers

Iowa Total Care issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. Iowa Total Care returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Iowa Total Care encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Iowa Total Care offers two options for connectivity via FTP.

- Method A – the trading partner will push transactions to the Iowa Total Care FTP server and Iowa Total Care will push outbound transactions to the Iowa Total Care FTP server.
- Method B – The Trading partner will push transactions to the Iowa Total Care FTP server and Iowa Total Care will push outbound transactions to the trading partner's FTP server.

Encryption

Iowa Total Care offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS.

(***Note:*** this method only applies with connecting to Iowa Total Care's Secure FTP. Iowa Total Care does not support retrieve files automatically via HTTPS from an external source at this time.) If PGP or SSH keys are used they will shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.

Direct Submission

Iowa Total Care also offers posting an 837 batch file directly on the Provider Portal website for processing.

APPENDIX

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.

ERROR_ID	ERROR_DESC
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS;Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS;Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date.
37	Invalid or future date.
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag

39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006
75	Invalid Unit
76	Original claim number required
77	INVALID CLAIM TYPE
81	Invalid Unit;Invalid Prv
83	Invalid Unit;Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
92	Missing or Invalid Provider NPI at any Level.
95	Operating/Purchasing provider information invalid or missing
A2	DIAGNOSIS POINTER INVALID
A3	CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT
A7	Invalid or Missing Ambulance Point of Pick Up Zip Code
AX	Invalid/missing/duplicate occurrence code
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim

B3	RENDERING OR BILLING NPI/TIN ON DOS NOT ENROLLED WITH STATE
B5	Missing/incomplete/invalid CLIA certification number
C4	Invalid COBA Member
C9	Attending Provider Required
CA	Dates of service cannot span two calendar months, please resubmit
CE	Invalid Billing Provider NPI
CF	Invalid Billing Provider Taxonomy Code
CG	Invalid Billing Provider Zip
CH	Rendering NPI/TIN on DOS not enrolled with state
CI	NPI IS REQUIRED FOR THIS PAYER
CJ	ACK/REJECT Info Entitys Medicaid Provider Id
D2	BILLING PROVIDER NOT REGISTERED PROMISe PROVIDER
D3	RENDERING PROVIDER NOT REGISTERED PROMISe PROVIDER
D4	ATTENDING PROVIDER NOT REGISTERED PROMISe PROVIDER
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
NE	Missing or Invalid Provider NPI at any Level.
R2	Payor ID Number Invalid for DOS
ZZ	Claim not processed

APPENDIX II: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

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

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

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

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

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

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

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

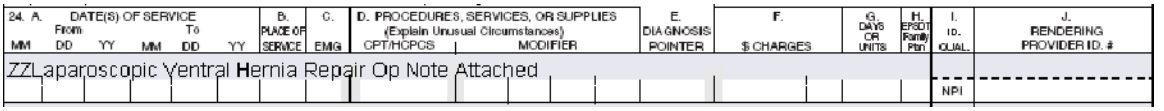
To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

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

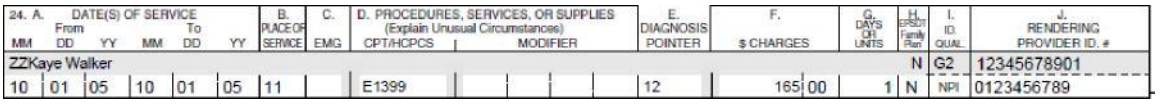
More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

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

Unspecified/Miscellaneous/Unlisted Codes

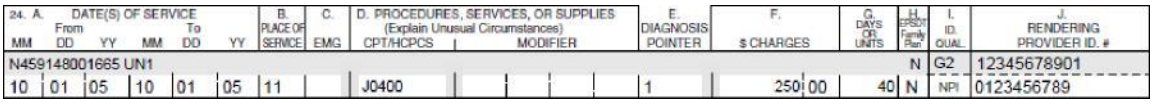


24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral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



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

NDC Codes



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

APPENDIX III: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION

Instructions for Entering the NDC

(Use the guidelines noted below for all claim types including 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:

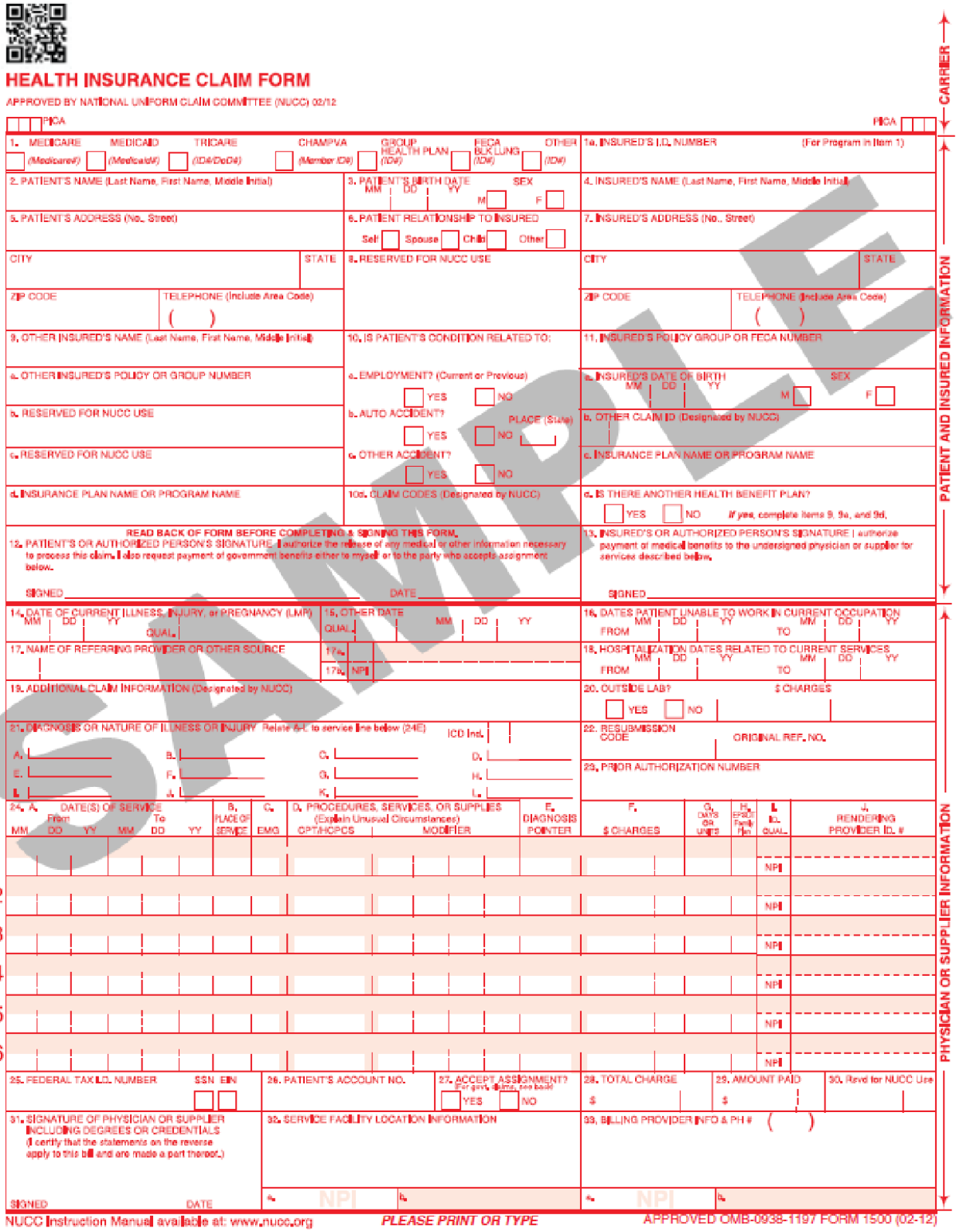
- For a 4-4-2 digit number, add a 0 to the beginning
- For a 5-3-2 digit number, add a 0 as the sixth digit.
- For a 5-4-1 digit number, add a 0 as the tenth digit

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

NDC billing information shall comply with Medicaid FFS billing requirements including, but not limited to, inclusion of the NDC for rebate and 340B purposes. The 340B billing guidelines and other guidelines can be found in Informational Letters posted on the Iowa DHS website.

CMS 1500 (2/12) Claim Form Instructions



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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 IDENTIFICATIO N	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter “X” in the box noted “Other.”	R
1a	INSURED’S I.D. NUMBER	The 9-digit identification number on the member’s Health Plan I.D. Card	R
2	PATIENTS NAME (Last Name, First Name, Middle Initial)	Enter the patient’s name as it appears on the member’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 member’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	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		telephone number (i.e. (803)5551414). ***Note:*** Does not exist in the electronic 837P.	
6	PATIENT'S RELATION TO INSURED	Always mark to indicate self.	C
7	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). ***Note:*** Does not exist in the electronic 837P.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
8	RESERVED FOR NUCC USE		Not Required
9	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	RESERVED FOR NUCC USE		Not Required
9c	RESERVED FOR NUCC USE		Not Required
9d	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the	C

Field #	Field Description	Instruction or Comments	Required or Conditional
	FECA NUMBER	other insurance. If Item Number 10abc is marked Y, this field should be populated.	
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM DD YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain 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	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	C

Field #	Field Description	Instruction or Comments	Required or Conditional
	(Accident) OR Pregnancy (LMP)	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	
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C

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

Field #	Field Description	Instruction or Comments	Required or Conditional
24a-j General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail.		
24 A-G Shaded	SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM□DD□YYYY). If there is only one date, enter that date in the “From” field. The “To” field may be left blank or populated with the “From” date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
24C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R
24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24 G	DAYS OR	Enter quantity (days, visits, units). If only one	R

Field #	Field Description	Instruction or Comments	Required or Conditional
Unshaded	UNITS	service provided, enter a numeric value of one.	
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy,. Use 1D qualifier for ID, if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	<u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. <u>Atypical Providers:</u> Enter the Provider ID number.	R
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider’s 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	PATIENT’S ACCOUNT NO.	Enter the provider’s billing account number.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Health Plan Member using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Health Plan. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. ***Note:*** Does not exist in the electronic 837P.	R
32	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	c

Field #	Field Description	Instruction or Comments	Required or Conditional
32b	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).	C
33	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). ***Note:*** The 9 digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.	R
33a	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
33b	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

APPENDIX V – CLAIMS FORM INSTRUCTIONS – UB

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

Completing a UB-04 Claim Form

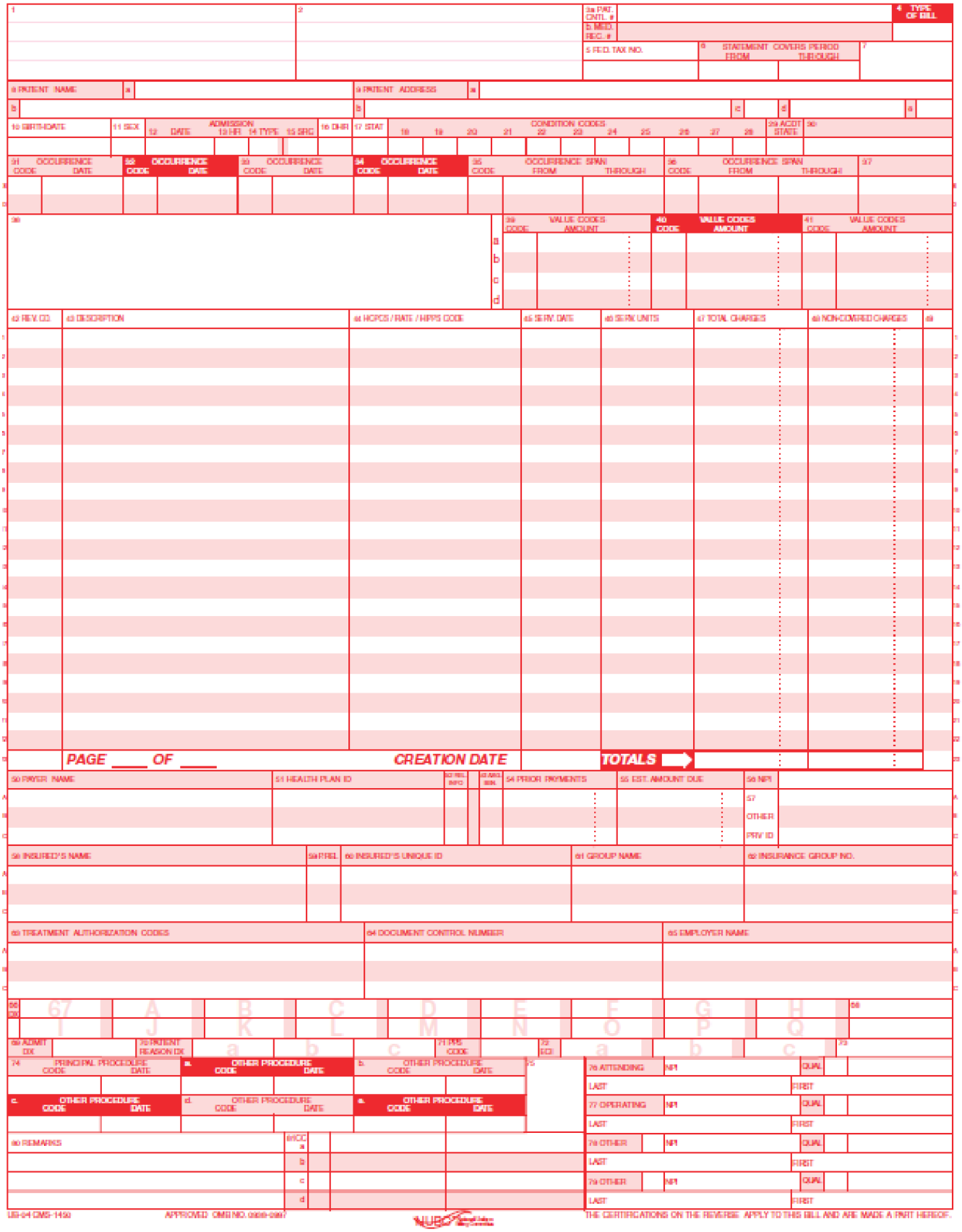
A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Iowa Total Care. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice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

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.
- Please refer to your provider contract with Iowa Total Care or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.

UB-04 Claim Form Example



Required Fields

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

Field #	Field Description	Instruction or Comments	Required or Conditional
13	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02- 02:00 to 02:59 14-02:00 to 02:59 03- 03:00 to 03:39 15-03:00 to 03:59 04- 04:00 to 04:59 16-04:00 to 04:59 05- 05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	ADMISSION TYPE	Require for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: Physician Referral 1 Clinic Referral 2 Health Maintenance Referral (HMO) 3 Transfer from a hospital 4 Transfer from Skilled Nursing Facility 5 Transfer from another health care facility 6 Emergency Room	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		7 Court/Law Enforcement 8 Information not available For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby 4 Extramural Birth 5 Information not available	
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	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	
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

Field #	Field Description	Instruction or Comments	Required or Conditional
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
37	(UNLABELED FIELD)	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: **REQUIRED** when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	
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	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of	C

Field #	Field Description	Instruction or Comments	Required or Conditional
Line 23		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)	
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
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 IDENTIFCATI O N NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHI P		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

Field #	Field Description	Instruction or Comments	Required or Conditional
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or"5" digit. "E" and most "V" codes are **NOT** acceptable as a primary diagnosis. ***Note:*** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or"5" digit. "E" codes	R

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

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

Field #	Field Description	Instruction or Comments	Required or Conditional
		QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	
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.	
Mod	Description
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event

Based on the modifiers noted above:

The following are all 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	I I	NE
HR	EJ	SH	JR	GR	DJ	NR
JH	GH	DG	NJ	HJ	EG	RJ
NG	HH	ED	RG	JD	GD	

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