AmeriHealth Caritas Louisiana

Revenue Code

Reimbursement Policy ID: RPC.0082.2100

Recent review date: 02/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

The policy addresses the requirement to include revenue codes when billing facility services on the UB-04 form, also known as the CMS-1450 form.

Exceptions

N/A

Reimbursement Guidelines

The Official UB-04 Data Specifications Manual is the only official source of UB-04 billing information adopted by the National Uniform Billing Committee (NUBC). The health plan considers no other publication - governmental or private/commercial — to be authoritative. As defined by NUBC, revenue codes are codes that

identify specific accommodations, ancillary services, or unique billing calculations or arrangements relevant to the claim. Revenue codes are represented by four digits and are used to indicate the department or place in which a procedure or treatment is performed, such as the emergency room, operating room, or some other department.

Example:
Intensive Care Unit (020X)
0200 — General
0201 — Surgical
0202 — Medical
0203 — Pediatric
0204 — Psychiatric
0206 — Intermediate ICU
0207 — Burn care
0208 — Trauma
0209 — Other

Valid procedure codes must be accompanied by an appropriate revenue code for the claim to be reimbursable. Without the required revenue code (missing or ineligible), the claim will not be reimbursed. Revenue codes must be accompanied by a valid CPT code with the exception of revenue codes which are exempt from this requirement.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Applicable Medicaid Fee Schedule(s).
V. https://www.amerihealthcaritasla.com/pdf/provider/billing/claim-filing-instructions.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

10/2026	• Removed the next review date • Replaced the plan name with “the health plan”
02/2026	Reimbursement Policy Committee Approval
02/2026	Annual review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble

07/2024	Reimbursement Policy Committee Approval
	Precedes Act 319