



AmeriHealth Caritas[™]
Louisiana



Claim Filing Instructions

For AmeriHealth Caritas Louisiana Providers

March 10, 2020



AmeriHealth Caritas Louisiana

Claim Filing Instructions

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Claim Filing

Procedures for Claim Submission

AmeriHealth Caritas Louisiana, hereinafter referred to as the 'Plan' or 'AmeriHealth Caritas Louisiana' is required by state and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

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

Claims for billable services provided to AmeriHealth Caritas Louisiana members must be submitted by the provider who performed the services.

Claims filed with AmeriHealth Caritas Louisiana are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification of member eligibility for services under AmeriHealth Caritas Louisiana during the time period in which services were provided
- Verification for electronic claims against 837 edits at Change Healthcare.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
- Verification that the provider is eligible to participate with the Medicaid Program at the time of service.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- Verification of whether there is Medicare coverage or any other third-party resource and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to the Plan.

IMPORTANT:

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

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

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

- Denied claims must be resubmitted within 365 calendar days from the date of service as a new claim if the error is a repairable edit.

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

* For more information on EDI, review the section titled Electronic Data Interchange (EDI) for Medical and Hospital Claims in this booklet.

Claim Mailing Instructions

Submit claims to AmeriHealth Caritas Louisiana at the following address:

AmeriHealth Caritas Louisiana
Claims Processing Department
P.O. Box 7322
London, KY 40742

The Plan encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or **Change Healthcare's Provider Support Line at 877-363-3666** to arrange transmission.

Any additional questions may be directed to the AmeriHealth Caritas Louisiana EDI Technical Support Hotline at **866-428-7419** or by e-mail at edi@amerihealthcaritasla.com.

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 365 calendar days from the date services were rendered or compensable items were provided.

Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

Claims with Explanation of Benefits (EOBs) from primary insurers must also be submitted within 365 days of the date of service.

Refunds for Claims Overpayments or Errors

It is the provider's responsibility to return any Medicaid Program funds that were improperly paid. If a provider identifies improper payment or overpayment of claims from AmeriHealth Caritas Louisiana, the improperly paid or overpaid funds must be returned to AmeriHealth Caritas Louisiana within 60 days from the date of discovery of the overpayment.

Please follow the process listed below to return overpayments:

For all **overpayments**, please submit a check in the correct amount to:

AmeriHealth Caritas Louisiana
P.O. Box 7322
London, KY 40742

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

Important: Requests for adjustments may be submitted electronically or on paper.

On Paper:

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

Claims Processing Department AmeriHealth Caritas Louisiana
P.O. 7322
London, KY 40742

Refer to the Provider Handbook or look online at the Provider Center of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com for complete instructions on submitting appeals. An appeal is a written or oral request from a member, or a provider acting on behalf of the member with member consent.

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 365 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 1.) **Note:** AmeriHealth Caritas Louisiana EDI Payer ID# 27357

Clean Claim Interest Payment

AmeriHealth Caritas Louisiana shall pay providers interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable clean claim remains unpaid beyond the thirty (30) day claims processing deadline. Interest owed is paid the same date that the claim is adjudicated..

Weekly Check Cycles

AmeriHealth Caritas Louisiana runs two (2) provider payment cycles per week, (Mondays and Wednesdays). On occasion, there may be one check run for the week due to an AmeriHealth Caritas Louisiana recognized holiday.

Claims System Updates

AmeriHealth Caritas Louisiana updates its Claims Adjudication system within 30 days of receiving new fee schedules from the Louisiana Department of Health and claims are recycled within 15 days after the system updates.

CMS 1500 Claim Form



HEALTH INSURANCE CLAIM FORM

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

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA/BULKING <input type="checkbox"/> OTHER <small>(Medicare) (Medicaid) (ID#(DODM)) (Member/ID#) (ID#) (ID#)</small>										FICA <input type="checkbox"/> <input type="checkbox"/>	
1. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		1s. INSURED'S I.D. NUMBER (For Program in Item 1)			
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		6. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? (Include State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indorse the release of any medical or other information necessary to process this claim. Also request payment of government benefits, either to nurse 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 _____ DATE _____		14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL.		15. OTHER DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer back to service line below (24E) ICD Impl.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE		C. PROCEDURE(S), SERVICE(S), OR SUPPLIES (Explain unusual circumstances) MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES	
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$	
29. AMOUNT PAID \$				30. Rsvd for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) 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. _____ B. _____ C. _____		33. BILLING PROVIDER INFO & PH # () A. _____ B. _____	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

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

CMS 1500 Claim Form Field & EDI Requirements

The CMS 1500 claim form must be completed for all services that have requirements on the CMS 1500 claim form. **All claims must be submitted within the required filing deadline of 365 days from the date of service.** Claim data requirements apply to all claim submissions, regardless of the method of submission electronic or paper.

CMS-1500 Claim Form & EDI Requirements					
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
N/A	Carrier Block			2010BB	NM103 N301 N302 N401 N402 N403
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R	2000B	SBR09
1a	Insured's I.D. Number (Enter the Member ID Number)	Enter the Member ID number as it appears on the AmeriHealth Caritas Louisiana Member ID card. For electronic submissions, this ID must be less than 17 alphanumeric characters.	R	2010BA	NM109
2	Patient's Name (Last, First, Middle Initial)	Enter the patient's name as it appears on the member's AmeriHealth Caritas Louisiana Member ID card or enter the newborn's name when the patient is a newborn.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107
3	Patient's Birth Date/Sex	MMDDYY / M or F Enter the patient's birth date and select the appropriate gender.	R	2010CA or 2010BA	DMG02 DMG03

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
4	Insured's Name (Last, First, Middle Initial)	Enter the patient's name as it appears on the AmeriHealth Caritas Louisiana Member ID card, or enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105 NM107
5	Patient's Address (Number, Street, City, State, Zip) Telephone (with Area Code)	Enter the patient's complete address and telephone number. (Do not punctuate the address or telephone number.)	R	2010CA	N301 N401 N402 N403 N404
6	Patient Relationship To Insured	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01
7	Insured's Address (Number, Street, City, State, Zip Code) Telephone (with Area Code)	If same as the patient, enter "Same". Otherwise, enter insured's information.	R	2010BA	N301 N302 N401 N402 N403
8	Patient Status	Not used.	Not Required		
9	Other Insured's Name (Last, First, Middle Initial)	Refers to someone other than the patient. Completion of fields 9a through 9d is required if the patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107
9a	Other Insured's Policy Or Group #	Required if # 9 is completed.	C	2320	SBR03

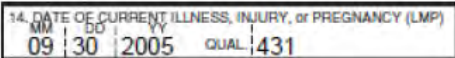
CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
9b	Reserved for NUCC use	To be determined.	Not Required	N/A	N/A
9c	Reserved for NUCC use	To be determined.	Not Required	N/A	N/A
9d	Insurance Plan Name Or Program Name	Required if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other Medical insurance is available or if 9a is completed.	C	2320	SBR04
10 a,b,c	Is Patient's Condition Related to:	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident (Including Place/State) c) Other Accident	R	2300	CLM11
10d	Claim Codes (Designated by NUCC)	Enter new Condition Codes as appropriate. Available 2-digit Condition Codes include nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include: <ul style="list-style-type: none"> • AD – Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or Exacerbated by the Pregnancy Itself • W3 – Level 1 Appeal 	C	2300	K3 use K3 Segment with HIPAA Compliant codes
11	Insured's Policy Group Or FECA #	Required when other insurance is available. Complete if more than one other Medical insurance is available or if “yes” to 10 a, b,	C	2000B	SBR03

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		c. Enter the policy group or FECA number.			
11a	Insured's Birth Date / Sex	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03
11b	Other Claim ID	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: <ul style="list-style-type: none"> Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line; identifier to the right of the vertical, dotted line.	C	2010BA	REF01 REF02
11c	Insurance Plan Name or Program Name	Enter name of the health plan. Required if 11 is completed.	C	2000B	SBR04
11d	Is There Another Health Benefit Plan?	Indicate Yes or No by checking the box. If Yes, complete # 9 a-d.	R	2320	
12	Patient's or Authorized Person's Signature	On the 837, the following values are addressed as follows at Change Healthcare: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	R	2300	CLM09
13	Insured's or Authorized Person's Signature		C	2300	CLM08
14	Date of Current Illness Injury, Pregnancy (LMP)	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include:	C	2300	DTP01 DTP03

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		<ul style="list-style-type: none"> 431 – Onset of Current Symptoms or Illness 439 – Accident Date 484 – Last Menstrual Period (LMP) <p>Use the LMP for pregnancy.</p> <p>Example:</p> 			
15	Other Date	<p>MMDDYY or MMDDYYYY</p> <p>Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include:</p> <ul style="list-style-type: none"> 454 – Initial Treatment 304 – Latest Visit or Consultation 453 – Acute Manifestation of a Chronic Condition 439 – Accident 455 – Last X-Ray 471 – Prescription 090 – Report Start (Assumed Care Date) 091 – Report End (Relinquished Care Date) 444 – First Visit or Consultation 	C	2300	DTP01 DTP03

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment												
		Example: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <table style="font-size: small; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black;">15. OTHER DATE</td> <td style="border-right: 1px solid black;">QUAL</td> <td style="border-right: 1px solid black;">454</td> <td style="border-right: 1px solid black;">MM</td> <td style="border-right: 1px solid black;">DD</td> <td>YY</td> </tr> <tr> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;"></td> <td style="border-right: 1px solid black;">09</td> <td style="border-right: 1px solid black;">25</td> <td>2005</td> </tr> </table> </div>	15. OTHER DATE	QUAL	454	MM	DD	YY				09	25	2005			
15. OTHER DATE	QUAL	454	MM	DD	YY												
			09	25	2005												
16	Dates Patient Unable to Work in Current Occupation		C	2300	DTP03												
17	Name of Referring Physician or Other Source	<p>Required if a provider other than the member's primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order:</p> <ol style="list-style-type: none"> 1. Referring Provider 2. Ordering Provider 3. Supervising Provider <p>Qualifiers include:</p> <ul style="list-style-type: none"> • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider <p>Example:</p> <div style="border: 1px solid black; padding: 2px; width: fit-content;"> <table style="font-size: small; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black;">17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td> <td>DN Jane A Smith MD</td> </tr> </table> </div>	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	DN Jane A Smith MD	R	2310A (Referring) 2310D (Supervising) 2420 (Ordering)	NM101 NM103 NM104 NM105 NM107										
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	DN Jane A Smith MD																
17a	Other ID Number of Referring Physician (AmeriHealth Caritas	Enter the AmeriHealth Caritas Louisiana Provider ID Number for the referring physician. The qualifier indicating what the	C	2310A (Referring) 2010D (Supervising)	REF01 REF02												

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
	Louisiana Provider ID#)	number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the AmeriHealth Caritas Louisiana ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. Required if #17 is completed.		2420E (Ordering)	
17b	National Provider Identifier (NPI)	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310D	NM109
18	Hospitalization Dates Related to Current Services	Required when place of service is in-patient. MMDDYY (indicate from and to date).	C	2300	DTP03
19	Additional Claim Information (Designated by NUCC)	Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and data combination. FQHC/RHC – Multispecialty providers billing under a FQHC/RHC must put Taxonomy in field 19. The NUCC qualifier for Taxonomy is ‘ZZ’.	Not Required R	2300	NTE PWK
20	Outside Lab	Conditional	C	2400	PS102

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
21	Diagnosis or Nature of Illness or Injury. (Relate To 24E)	<ul style="list-style-type: none"> • 0 - ICD-10-CM <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD 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.</p> <p>Note: Claims with invalid diagnosis codes will be denied for payment. ICD-10 codes are required for dates of service on or after October 1, 2015.</p> <p>"E" codes are not acceptable as a primary diagnosis.</p>	R	2300	HIXX-02 Where XX = 01,02,03,04,05,06,07, 08,09,10,11,12
22	Resubmission Code and/or Original Ref. No.	<p>This field is Required for resubmissions or adjustments/corrected claims. For resubmissions or adjustments, enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field. Additionally, stamp “resubmitted” or “corrected” on the claim</p> <ul style="list-style-type: none"> • 7 – Replacement of Prior Claim • 8 – Void/cancel of Prior Claim 	C	2300 2300	CLM05-3 REF02 Where REF01 = F8

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
23	CLIA Certificate ID	Enter the CLIA number relevant to the location the provider is performing on site lab testing when applicable. The number must include the “X4” qualifier, the two-digit state code, followed by the letter “D” and then the assigned CLIA number. EXAMPLE: of valid CLIA number formatting: X419DXXXXXXX	R	2300	
24A	Date(s) of Service See page 43 for supplemental guidance on the shaded portions of fields 24 A – J.	“From” date: MMDDYY. If the service was performed on one day there is no need to complete the “to” date. See page 43 for additional instructions on completing the shaded portion of field 24.	R	2400	DTP03
24B	Place of Service	Enter the CMS standard place of service code. “00” for place of service is not acceptable. 50 (FQHC) 72 (RHC) 99 (PDHC)	R	2300 2400	CLM05-1 SV105
24C	EMG	This is an emergency indicator field. Enter Y for “Yes” or leave blank for “No” in the bottom (unshaded area of the field).	C	2400	SV109
24D	Procedures, Services or Supplies CPT/HCPCS/ Modifier	Enter the CPT or HCPCS code(s) and modifier (if applicable). Procedure codes (5 digits) and modifiers (2 digits) must be	R	2400	SV101 (2-6)

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		valid for date of service. Note: Modifiers affecting reimbursement must be placed in the first modifier position.			
24E	Diagnosis Pointer	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (A-L). Note: AmeriHealth Caritas Louisiana can accept up to eight (8) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service. (ICD-9 codes are valid for dates of service up to and including September 30, 2015. ICD-10 codes are valid for dates of service on or after October 1, 2015.)	R	2400	SV107(1-4)
24F	Charges	Enter charges. A value must be entered. Enter zero (\$0.00) or actual charged amount. (This includes capitated services.)	R	2400	SV102
24G	Days or Units	Enter quantity. Value entered must be greater than zero. (Field allows up to 3 digits.)	R	2400	SV104
24H	Child HealthCheck (EPSDT) Services	<u>In shaded area of field:</u> <u>AV</u> - Patient refused referral; <u>S2</u> - Patient is currently under treatment for referred diagnostic or corrective health problems; <u>NU</u> - No referral given; or <u>ST</u> - Referral to another provider for diagnostic or corrective treatment.	C	2300 2400	CRC SV111 SV112

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		<p><u>In unshaded area of field:</u></p> <p>“Y” for Yes – if service relates to a pregnancy or family planning;</p> <p>“N” for No – if service does not relate to pregnancy or family planning.</p>			
24I	ID Qualifier	<p>If using taxonomy code in field 24J, enter the qualifier “ZZ”.</p> <p>If using a Louisiana Medicaid provider ID for an atypical provider, enter the qualifier “1D”.</p> <p>If the Other ID number is the AmeriHealth Caritas Louisiana ID number, enter G2.</p> <p>If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier.</p>	R	2310B	REF01 NM108
24J	Rendering Provider ID NPI in the bottom (unshaded) portion. Enter the AmeriHealth Caritas Louisiana Provider ID number in the top (shaded) portion.	<p>The individual rendering the service is reported in 24J. Enter the AmeriHealth Caritas Louisiana ID number in the shaded area of the field.</p> <p>Enter the NPI number in the unshaded area of the field. (Except for Behavioral Health, DME, Ambulance, Independent Lab and Home Health claims).</p>	R	2310B	REF02 NM109
25	Federal Tax ID Number SSN/EIN	Physician or Supplier's Federal Tax ID number.	R	2010AA	REF01 REF02

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
26	Patient's Account No.	Enter the patient's account number assigned by the provider	R	2300	CLM01
27	Accept Assignment	Yes or No must be checked.	R	2300	CLM07
28	Total Charge	Enter the total of all charges listed on the claim.	R	2300	CLM02
29	Amount Paid	Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02
30	Reserved for NUCC Use	To be determined.	Not Required		
31	Signature of Physician or Supplier Including Degrees or Credentials / Date	Signature on file, signature stamp, computer-generated or actual signature is acceptable. (Except for Behavioral Health Claims and DME).	R	2300	CLM06
32	Name and Address of Facility Where Services Were Rendered	Enter Name, address, and ZIP Code (ZIP+4) of the service location. Required when it is a physician performing on site lab testing. Ambulance providers are required to enter the following: The complete address of origin of services, the time of departure from origina (including a.m. or p.m.), the complete address of destination, and the time of	C	2310C	NM103 N301 N401 N402 N403

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
		arrival at destination (including a.m. or p.m.) P O Boxes are not acceptable here.			
32a.	NPI number	Required unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109
32b.	Other ID# (AmeriHealth Caritas Louisiana issued Provider Identification Number)	Enter the AmeriHealth Caritas Louisiana Provider ID # (strongly recommended). Enter the G2 qualifier followed by the Louisiana Medicaid ID #. Required when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	C Recommended	2310C	REF01 REF02
33	Billing Provider Info & Ph #	Required – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. P.O. Boxes are accepted.	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04

CMS-1500 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment
33a.	NPI Number	Required unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2010AA	NN109
33b.	Other ID# (AmeriHealth Caritas Louisiana issued Provider Identification Number)	Enter the AmeriHealth Caritas Louisiana Provider ID # (strongly recommended). Required when the Billing Provider is an Atypical Provider and does not have an NPI number. For atypical providers that do not have an NPI, enter the G2 qualifier followed by the Louisiana Medicaid ID #. Do not enter a space, hyphen, or other separator between the qualifier and number.	C Recommended	2000A 2010AA	PRV03 REF02 where REF01=G2

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

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

UB-04 Claim Form

1		2		3a PAT. CNTL. # 3b MISC. REC. #		4 TYPE OF BILL	
5 PATIENT NAME		6 PATIENT ADDRESS		7 FED. TAX NO.		8 STATEMENT COVERED PERIOD FROM THROUGH	
9 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION 13a ICD 14 TYPE 15 SRC	16 CHRG	17 STAT	18 19 20 21	22 OCCURRENCE CODES 22 23 24 25 26 27 28 29 ACCT STATE
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE FROM THROUGH	37 CODE	38 OCCURRENCE FROM THROUGH
39				40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT	42 VALUE CODES AMOUNT	43 VALUE CODES AMOUNT
44 ICD	45 DESCRIPTION	46 HCPCS / ICDL / ICDPS CODE	47 SERV DATE	48 SERV UNITS	49 TOTAL CHARGES	50 NON-COVERED CHARGES	51
PAGE OF		CREATION DATE		TOTALS			
52 PAYER NAME		53 HEALTH PLAN ID		54 PER. REC.	55 GROUP NO.	56 FUND PAYMENTS	57 EST. AMOUNT DUE
58 INSURED'S NAME		59 PER. NO. INSURED'S UNIQUE ID		60 GROUP NAME		61 INSURANCE GROUP NO.	
62 TREATMENT AUTHORIZATION CODES		63 DOCUMENT CONTROL NUMBER		64 EMPLOYER NAME			
65 ADMIT. DTK	66 ADMISSION REASON CODE	67 OTHER PROCEDURE DATE	68 OTHER PROCEDURE DATE	69 OTHER PROCEDURE DATE	70 OTHER PROCEDURE DATE	71 ATTENDING NPI	72 QUAL
73 OTHER PROCEDURE CODE	74 OTHER PROCEDURE DATE	75 OTHER PROCEDURE CODE	76 OTHER PROCEDURE DATE	77 OTHER PROCEDURE CODE	78 OTHER PROCEDURE DATE	79 OTHER NPI	80 QUAL
81 REMARKS		82 INDC	83	84	85	86	87
88		89	90	91	92	93	94

UB04 Claim Form & EDI Requirements

The UB-04 claim form must be completed for all services requiring submission on the UB04 claim form. **All claims must be submitted within the required filing deadline of 365 days from the date of service.** Claim data requirements apply to all claim submissions, regardless of the method of submission electronic or paper.

UB04 Claim Form & EDI Requirements						
			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
1	Unlabeled Field Billing Provider Name, Address and Telephone Number	Service Location, no P.O. Boxes Left justified Line a: Enter the complete provider name. Line b: Enter the complete street information. Line c: City, State, and Zip Code (Zip Codes should include Zip + 4 for a total of 9 digits). Line d: Enter the area code and telephone number.	R	R	2010AA	NM1/85 N3 N4
2	Unlabeled Field Billing Provider's Designated Pay-To Name and Address	Enter Remit Address Billing Provider's designated pay-to address. (Zip Codes should include Zip + 4 for a total of 9 digits).	R	R	2010AB	NM1/87 N3 N4

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		Enter the AmeriHealth Caritas Louisiana Facility Provider ID number. Left justified.				
3a	Patient Control No.	Provider's patient account/control number.	R	R	2300	CLM
3b	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider.	R	R	2300	REF02 where REF01 = EA
4	Type of Bill	Enter the appropriate three or four-digit code. First position is a leading zero. Do not include the leading zero on electronic claims. Second position indicates type of facility. Third position indicates type of care. Fourth position indicates billing sequence. Use one of the following codes:	R	R	2300	CLM05 1/2/3

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		1 = Admission through discharge 2 = Interim-first claim 3 = Interim-continuing 4 = Interim-last claim 7 = Replacement of prior claim 8 = Void of prior claim				
5	Fed. Tax No.	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010AA	REF02 Where REF01=EI
6	Statement Covers Period From/Through	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434
7	Unlabeled Field	No entry required				
8a	Patient Identifier	Patient AmeriHealth Caritas Louisiana ID is conditional if number is different from field 60.	C	C	2010BA 2010CA	NM109 where NM101 = IL NM109 where NM101 = QC

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
8b	Patient Name	<p>Patient name is required.</p> <p>Last name, first name, and middle initial. Enter the patient name as it appears on the AmeriHealth Caritas Louisiana ID card.</p> <p>Use a comma or space to separate the last and first names.</p> <p><u>Titles</u> (Mr., Mrs., etc.) should not be reported in this field.</p> <p><u>Prefix</u>: No space should be left after the prefix of a name e.g., McKendrick.</p> <p><u>Hyphenated names</u>: Both names should be capitalized and separated by a hyphen (no space).</p> <p><u>Suffix</u>: A space should separate a last name and suffix.</p>	R	R	2010BA 2010CA	<p>NM103, NM104, NM107 where NM101=IL</p> <p>NM103, NM104, NM107 where NM101 = QC</p>
9a-e	Patient Address	The mailing address of the patient	R	R	2010BA	N301, N302 N401, 02, 03, 04

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		9a. Street Address 9b. City 9c. State 9d. Zip Code 9e. Country Code (report if other than U.S.A.)			2010CA	N301, N302 N401, 02, 03, 04
10	Patient Birth Date	The date of birth of the patient. Right-justified: MMDDYYYY	R	R	2010BA 2010CA	DMG02 DMG02
11	Patient Sex	The sex of the patient recorded at admission, outpatient service, or start of care.	R	R	2010BA 2010CA	DMG03 DMG03
12	Admission Date	The start date for this episode of care. For inpatient services, this is the date of admission. Right-justified.	R	R	2300	DTP03 where DTP01=435
13	Admission Hour	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left-justified.	R For bill types other than 21X.	Not Required.	2300	DTP03 where DTP01=435

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
14	Admission Type	A code indicating the priority of this admission/visit.	R	R	2300	CL101
15	Point of Origin for Admission or Visit	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102
16	Discharge Hour	Code indicating the discharge hour of the patient from inpatient care.	R	Not Required	2300	DTP/096/03
17	Patient Discharge Status	A code indicating the disposition or discharge status of the patient at the end of the service for the period covered on this bill, as reported in Field 6.	R	R	2300	CL103
18 - 28	Condition Codes	A code used to identify conditions or events relating to the bill that may affect processing. Please see NUCC Specifications Manual Instructions for condition codes and descriptions to complete fields 18 – 28.	C	C	2300	HIXX-2
29	Accident State	The accident state field contains the two-digit state	C	C	2300	REF02

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		abbreviation where the accident occurred. Required when applicable.				
30	Unlabeled Field	Leave Blank.				
31a,b – 34a,b	Occurrence Codes and Dates	Enter the appropriate occurrence code and date. Required when applicable.	C	C	2300	HIXX-1 = BH
35a,b – 36a,b	Occurrence Span Codes and Dates	A code and the related dates that identify an event that relates to the payment of the claim. Required when applicable.	C	C	2300	
37a,b	EPSDT Referral Code	Required when applicable. Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YD – Dental *(Required for Age 3 and Above) YO – Other YV – Vision YH – Hearing YB – Behavioral	C	C	2300	K3

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		YM – medical				
38	Responsible Party Name and Address	The name and address of the party responsible for the bill.	C	C		
39a,b,c,d – 41a,b,c,d	Value Codes and Amounts	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Codes and amounts. If more than one value code applies, list in alphanumeric order. Required when applicable. Note: If value code is populated then value amount must also be	C	C	2300	HIXX-2 HIXX-5

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		<p>populated and vice versa. 02 = Hospital has no semi-private rooms. Entering the code requires \$0.00 amount to be shown. 06 = Medicare blood deductible 08 = Medicare lifetime reserve first CY 09 = Medicare coinsurance first CY 10 = Medicare lifetime reserve second year 11 = Coinsurance amount second year 12 = Working aged recipient/spouse with employer group health plan 13 = ESRD (end stage renal disease) recipient in the 12-month coordination period with an employer's group health plan 14 = Automobile, no fault or any liability insurance 15 = Worker's compensation including Black Lung</p>				

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		<p>16 = VA, PHS, or other federal agency 30 = Pre-admission testing - this code reflects charges for pre-admission outpatient diagnostic services in preparation for a previously scheduled admission. 37 = Pints blood furnished 38 = Blood not replaced - deductible is patient's responsibility 39 = Blood pints replaced *80 = Covered days *81 = Non-covered days *82 = Co-insurance days (required only for Medicare crossover claims) *83 = Lifetime reserve days (required only for Medicare crossover claims)</p> <p>Hospice providers should enter the value code 61 in the "code" section of the field; and then the appropriate Core Based Statistical Area (CBSA)</p>				

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		<p>code (formerly MSA code) in the "Dollar" portion and the "00" in the "Cents" field for each service line billed on the UB-04 even if it is multiple occurrences of the same service in the same month.</p> <p>A1,B1,C1 = Deductible A2,B2,C2 = Co-insurance</p> <p><u>*Enter the appropriate value code in the code portion of the field and the number of days in the "Dollar" portion of the "Amount" section of the field. Enter "00" in the "Cents" portion of the "Amount" section of the field.</u></p> <p><u>The dollars/cents data must be entered accurately to prevent claim denials.</u></p>				

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
42	Revenue Code	<p>Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. On the last line, enter 0001 for the total. Refer to the Uniform Billing Manual for a list of revenue codes.</p> <p>Hospice Providers billing revenue code 655 for Respite Care and 656 for General Inpatient Care may only bill with these codes for the first 5 days per admission. After the 5 days, then it should be billed with revenue code 651 routine home care.</p>	R	R	2400	SV201
43	Revenue Description	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field	R	R	N/A	N/A

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		42 for description of each revenue code category.				
44	HCPCS/Accommodation Rates	<ol style="list-style-type: none"> 1. The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills. 2. The accommodation rate for inpatient bills. 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. <p>Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are</p>	R	R	2400	SV202-2

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		required for all Outpatient Claims. (Note: NDC numbers are required for all administered or supplied drugs.)				
45	Serv. Date	Report line item dates of service for each revenue code or HCPCS code.	R	R	2400	03DTP03 where DTP01=472
46	Serv. Units	Report units of service. A quantitative measure of services rendered by revenue category or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, observation hours etc. Note: for drugs, service units must be consistent with the NDC code and it's unit of measure. NDC unit of measure must be a valid HIPAA UOM code or claim should be rejected.	R	R	2400	SV205
47	Total Charges	Total charges for the primary payer pertaining to	R	R	2300	SV203

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non-covered charges. Report grand total of submitted charges at the bottom of this field to be associated with revenue code 001. Value entered must be greater than zero (\$0.00).				
48	Non-Covered Charges	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code. Required when Medicare is Primary. If there is more than one other private payer, lump all amounts together in Field 48 and attach each company's EOB or RA.	C	C	2400	SV207
49	Unlabeled Field		Not required	Not required		

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
50	Payer	Enter the name for each payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; Line B refers to the, secondary; and Line C refers to the tertiary.	R	R	2330B	NM103 where NM101=PR
51	AmeriHealth Caritas Louisiana Identification Number	The number used by the health plan to identify itself. AmeriHealth Caritas Louisiana's Payer ID is #27357.	R	R	2330B	NM109 where NM101=PR
52	Rel. Info	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary. It is expected that the provider have all necessary release information on file. It is expected that all	R	R	2300	CLM09

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		released invoices contain "Y".				
53	Asg. Ben.	Assignment of Benefits Certification Indicator is required. The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	R	R	2300	CLM08
54	Prior Payments	The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01=D
55	Est. Amount Due	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage).	C	C	2300	AMT02 where AMT01 =EAF
56	National Provider Identifier – Billing Provider	The unique NPI identification number assigned to the provider submitting the bill; NPI is	R	R	2010AA	NM109 where NM101 = 85

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		the national provider identifier. Required if the health care provider is a Covered Entity as defined in HIPAA Regulations.				
57 A,B,C	Other (Billing) Provider Identifier AmeriHealth Caritas Louisiana issued Provider Identification Number (strongly recommended)	A unique identification number assigned to the provider submitting the bill to AmeriHealth Caritas Louisiana. The UB-04 does not use a qualifier to specify the type of Other (Billing) Provider Identifier. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A, B and C.	C	C	2010AA 2010BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U
58	Insured's Name	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the insured is indicated here.	R	R	2010BA 2330A	NM103,NM104, NM105 where NM101 = IL NM103,NM104, NM105 where NM101 = IL

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
59	Patient Rel	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured. Code 18: Self.	R	R	2000B	SBR02
60	Insured's Unique Identifier AmeriHealth Caritas Louisiana Member ID Number	Enter the patient's Member ID on the appropriate line, exactly as it appears on the patient's AmeriHealth Caritas Louisiana ID card on line B or C. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2010BA	NM109 where NM101= IL REF02 where REF01 = SY
61	Group Name	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000B	SBR04

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
62	Insurance Group No.	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C	2000B	SBR03
63	Treatment Authorization Codes	Enter the AmeriHealth Caritas Louisiana prior authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary. Field 63A is required.	R	R	2300	REF02 where REF01 = G1
64	DCN	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Note: This field is required for resubmitted claims and must contain the original claim ID.	C	C	2300	REF02 where REF01 = F8

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
65	Employer Name	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim.	C	C	2320	SBR04
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. A value of 9 indicates ICD-9, a value of 0 indicates ICD-10. Note: Claims with invalid codes will be denied for payment. ICD-9 codes are valid for dates of service up to and including September 30, 2015. ICD-10 codes are valid for dates of service on or after October 1, 2015.	Not Required	Not Required	2300	Determined by the qualifier submitted on the claim
67	Prin. Diag. Cd. and Present on Admission (POA) Indicator	The appropriate ICD codes describing the principal diagnosis (i.e., the condition established after study to be	R	R	2300	HIXX-2 HIXX-9

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		<p>chiefly responsible for causing the use of hospital services that exists at the time of services or develops subsequently to the service that has an effect on the length of stay.</p> <p>Y=Present at the time of inpatient admission</p> <ul style="list-style-type: none"> • N=Not present at the time of inpatient admission • U=Documentation is insufficient to determine if condition is present on admission • W=Provider is unable to clinically determine whether condition was present on admission or not 				Where HI01-1 = BK or ABK
67 A - Q	Other Diagnosis Codes	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, that develop subsequently, or that affect the treatment received	C	C	2300	HIXX-2 HIXX-9 Where HI01-1 = BF or ABF

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital service.				
68	Unlabeled Field					
69	Admitting Diagnosis Code	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician. Required for inpatient and outpatient admissions.	R	R	2300	HI02-2
70	Patient's Reason for Visit	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2
71	Prospective Payment System (PPS) Code	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary	C	C	2300	HI01-2 Where HI01-1 = DR

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
		payer. Required when the Health Plan/Provider contract requires this information. Up to 4 digits.				
72a-c	External Cause of Injury (ECI) Code	ICD-10 Diagnosis Codes beginning with V, W, X, and Y and ICD-9 diagnosis codes beginning with E are not acceptable in the primary or first field and/or the admitting diagnosis.	C	C	2300	HIXX-2
73	Unlabeled Field	No entry required				
74	Principal Procedure Code and Date	The appropriate ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corresponding date. Inpatient facility – Surgical procedure code is required if the operating room was used. Outpatient Facility - ICD code is required when a surgical procedure is	C R	C R	2300	HI01-2 HI01-4 Where HI01-1 = BR or BBR

UB04 Claim Form & EDI Requirements

Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X	Loop	Segment
		performed.				
74a-e	Other Procedure Codes and Dates	<p>The appropriate ICD code(s) identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed.</p> <p>Inpatient facility – Surgical procedure code is required if the operating room was used.</p> <p>Outpatient facility - ICD code is required when a surgical procedure is performed.</p>	C R	C R	2300	HIXX-2 Where HI01-1 = BQ or BBQ
75	Unlabeled Field	No entry required				
76	Attending Provider Name and Identifiers NPI#/Qualifier/Other ID# Enter the NPI number of the attending physician	Enter the NPI of the physician who has primary responsibility for the patient’s medical care or treatment in the upper line, and their name in the lower	R	R	2310A 2310A	NM109 where NM101 = 71 REF02

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
	<p>Enter the AmeriHealth Caritas Louisiana issued Provider ID number</p> <p>Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number</p>	<p>line, last name first. If the Attending Physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.</p>			2310A	NM103 where NM101 = 71
					2301A	NM104 where NM101 = 71
77	<p>Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#</p> <p>Enter the NPI number of the physician who performed surgery</p> <p>Enter the AmeriHealth Caritas Louisiana issued Provider ID number</p> <p>Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued</p>	<p>Enter the NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.</p> <p>Required when a surgical procedure code is listed.</p>	C	C	2310B	NM109 where NM101 = 72
					2310B	NM103 where NM101 = 72
					2310B	NM104 where NM101 = 72
			R	R	2310b	REF02

UB04 Claim Form & EDI Requirements

			Inpatient, Bill Types 11X, 12X, 18X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X		
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment
	Provider ID number					
78 – 79	Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID# Enter the NPI number of another attending physician Enter the AmeriHealth Caritas Louisiana issued Provider ID number Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient’s medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#.	R	R	2310C 2310C 2310C 2310C	NM109 where NM101 = ZZ NM103 where NM101 = ZZ NM104 where NM101 = ZZ REF02
80	Remarks Field	Leave Blank	C	C	2300	NTE02
81CC,a-d	Code-Code Field	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C	2000A	PRV01 PRV02

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

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

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

I. Supplemental Information

A. CMS 1500 Paper Claims – Field 24:

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

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

- Anesthesia duration in hours and/or minutes with start and end times.
- Narrative description of unspecified codes.
- National Drug Codes (NDC) for drugs.
- Vendor Product Number – Health Industry Business Communications Council (HIBCC).
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) formerly Universal Product Code (UPC) for products.
- Contract rate.

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

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

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

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

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

1. NDC on CMS 1500

- NDC must be entered in the shaded sections of items 24A through 24G
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information
 - Do not enter a space between the qualifier and the 11 digit NDC number
 - Enter the 11 digit NDC number in the 5-4-2 format (no hyphens)
 - Do not use 9999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC

- "Enter a space between the 11 digit NDC number and the NDC unit qualifier with one of the following unit qualifiers":
 - F2-International Unit
 - GR-Gram
 - ME-Milligram
 - ML-Milliliter
 - UN-Unit
- Enter the NDC quantity
 - Do not use a space between the NDC quantity unit qualifier and the NDC quantity
 - Note: The NDC quantity is frequently different than the HCPC code quantity

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

24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS		F. CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From	To					(Explain Unusual Circumstances)			DD	DI	DD									
MM	DD	YY	MM	DD	YY															
N4	59	14	80	16	65	UN											N	G2	12345678901	
10	01	05	10	01	05	11		J0400				1		250	00	40	N	NPI	0123456789	

Labels in image: N4 qualifier (points to 'N4'), NDC Unit Qualifier (points to 'UN'), 11 digit NDC (points to '5914801665'), NDC Quantity (points to 'UN1')

EXCEPTION: Only the 11 digit NDC number is required for DME enterals (in the shaded area of 24A).

2. NDC on UB-04

- Do not report NDC codes with revenue codes 100-249, 260-629, 640-999
- NDC must be entered in Form Locator 43 in the Revenue Description Field
- Report the N4 qualifier in the first two (2) positions, left-justified
 - Do not enter spaces
 - Enter the 11 character NDC number in the 5-4-2 format (no hyphens)
 - Do not use 9999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier
 - F2 – International Unit
 - GR – Gram
 - ME - Milligram
 - ML – Milliliter
 - UN – Unit
- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal)
 - Any unused spaces for the quantity are left blank

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

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

3. NDC via EDI

The NDC is used to report prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes.

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

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

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

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

- Federal Tax ID on UB04:
Federal Tax ID on UB04 (Box# 5) will come from Loop 2010AA, REF02.
- Condition codes
Condition codes (Box number 18 thru 29) will come from 2300 CRC01 – CRC07
- Patient reason DX
Patient reason DX (Box 70) qualifier will be PR qualifier from 2300, HI01.

C. EDI – Field 24D (Professional)

Details pertaining to Anesthesia Minutes and corrected claims may be sent in Notes (NTE) or Remarks (NSF format).

- Details sent in NTE that will be included in claim processing:
- Please include L1, L2, etc. to show line numbers related to the details. Please include these letters AFTER those specified below:
 - Anesthesia Minutes need to begin with the letters ANES followed by the specific times
 - Corrected claims need to begin with the letters RPC followed by the details of the original claim (as per contract instructions)
 - DME Claims requiring specific instructions should begin with DME followed by specific details

D. EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=G2, REF02 + Plan's Provider Network Number. Less than 13 Digits Alphanumeric. Field is required. **Note:** Do not send the provider on the 2400 loop.

E. EDI – Field 45 and 51 (Institutional)

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

Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – Health Plan ID – the number used by the Health Plan to identify itself. AmeriHealth Caritas Louisiana's Health Plan EDI Payer ID# is 27357

F. EDI – Reporting DME

DME Claims requiring specific instructions should begin with DME followed by specific details.

Example: NTE* DME AEROSOL MASK, USED W/DME NEBULIZER

Example: NTE*ADD* NO LIABILITY, PATIENT FELL AT HOME~

G. **Split-Billing or Interim Billing** is permitted/required by the Medicaid Program in the following circumstances.

- Hospitals must split-bill claims at the hospital's fiscal year end.
- Hospitals must split-bill claims when the hospital changes ownership.
- Hospitals must split-bill claims if the charges exceed \$999,999.99.
- Hospitals must split-bill claims with more than one revenue code that utilizes specialized per diem pricing (PICU, NICU, etc.). Hospitals have discretion to split bill claims as warranted by other situations that may arise.

Split-Billing Procedures Specific instructions for split-billing on the UB-04 claim form are provided below. In the *Type of Bill* block (form locator 4), the hospital must enter code 112, 113, or 114 to indicate the specific type of facility, the bill classification, and the frequency for both the first part and the split-billing interim and any subsequent part of the split-billing interim. In the *Patient Status* block (form locator 17), the hospital must enter a 30 to show that the recipient is "still a patient." **NOTE:** When split-billing, the hospital should never code the first claim as a discharge.

In the *Remarks* section of the claim form, the hospital must write in the part of stay for which it is split-billing. For example, the hospital should write in "Split-billing for Part 1," if it *is* billing for Part 1. Providers submitting a hospital claim which crosses the date for the fiscal year end, should complete the claim in two parts: (1) through the date of the fiscal year end and (2) for the first day of the new fiscal year.

Common Causes of Claim Processing Delays, Rejections or Denials

Authorization Number Invalid or Missing – A valid authorization number must be included on the claim form for all services requiring prior authorization from AmeriHealth Caritas Louisiana.

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

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

Diagnosis Code Missing 4th or 5th Digit – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-9-CM or ICD-10-CM manual for the 4th and 5th digit extensions. Look for the ✓4th or ✓5th symbols in the coding manual to determine when additional digits are required.

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-9-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages. AmeriHealth Caritas Louisiana accepts EOBs via paper or electronic format.

External Cause of Injury Codes – ICD-10 Diagnosis Codes Beginning with V, W, X, and Y and ICD-9 diagnosis codes beginning with E are not acceptable in the primary or first field and/or the admitting diagnosis. ICD-10 codes beginning with V, W, X, and Y are equivalent to diagnoses that begin with E in the ICD-9 code set.

Important: Include all primary and secondary diagnosis codes on the claim.

Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.

Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.

All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.

State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.

The services billed on the claim form should match the services and charges detailed on the accompanying EOB exactly. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.

EPSDT services may be submitted electronically or on paper.

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

Handwritten Claims – Completely handwritten claims will be rejected. Legible handwritten claims are acceptable on resubmitted claims. (See Illegible Claim Information)

Highlighted Claim Fields – (See Illegible Claim Information)

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

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

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

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

National Drug Code (NDC) data is missing/incomplete/invalid. The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.

Newborn Claim Information Missing or Invalid – Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert “Baby Girl” or “Baby Boy” in front of the mother’s last name as the baby’s first name. Verify that the appropriate last name is recorded for the mother and baby.

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

Submitting the original copy of the claim form will assist in assuring claim information is legible.

The *individual provider name* and NPI number as opposed to the group NPI number must be indicated on the claim form.

Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.

Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.

Submit newborn’s facility bill for child at the time of delivery using the baby’s Medicaid ID. The newborn’s Medicaid ID is to be used on well babies, babies with extended stays (sick babies) past the mother’s stay and on all aftercare and professional bills. The facility or provider should obtain the newborn’s Medicaid ID# from LDH’s Newborn Eligibility System before submitting the claim to AmeriHealth Caritas Louisiana.

The claim for baby *must* include the *baby’s date of birth* as opposed to the mother’s date of birth.

Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.

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

Provider Name Missing – The name of the provider performing the service must

Provider Services 1-888-922-0007

be present on the claim form and must match the service provider name and NPI/TIN on file with the Plan. For claims with COB, the adjudication date of the other payer is required for EDI and paper claims

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

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

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

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

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

Type of Bill – A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, adjustments, voids, etc). The first digit is a leading zero. Do not include the leading zero on electronic claims.

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

The individual service provider name and NPI number must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.

When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI numbers results in inaccurate payments or denials.

When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in

rejection. Please review the rejection report from the EDI software vendor each day.

Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 365 calendar days from the date of service.

Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 365 calendar days from the date of service.

Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to AmeriHealth Caritas Louisiana immediately. Contact your Network Management Representative to assist in updating the AmeriHealth Caritas Louisiana's records.

Electronic Data Interchange (EDI) for Medical and Hospital Claims

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

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 15 days of their receipt.

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

Important:

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

In order to verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare Acceptance report, and the R059 Plan Claim Status Report.

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

Electronic Claims Submission (EDI)

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

Hardware/Software Requirements

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

Contracting with Change Healthcare and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Change Healthcare EDI capabilities, you can contact the Change Healthcare Provider Support Line at **877-363-3666**.

You may also choose to contract with another EDI clearinghouse or vendor who already has Change Healthcare capabilities.

Contacting the EDI Technical Support Group

Providers interested in sending claims electronically may contact the EDI Technical Support Group for information and assistance in beginning electronic submissions.

When ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your EDI software vendor and/or Change Healthcare to inform them you wish to initiate electronic submissions to the Plan.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

Important:

Change Healthcare is the largest clearinghouse for EDI Healthcare transactions in the world. It has the capability to accept electronic data from numerous providers in several standardized EDI formats and then forward accepted information to carriers in an agreed upon format.

Contact AmeriHealth Caritas Louisiana's EDI Technical Support at: **1-866-428-7419** or by e-mail at edi@amerihealthcaritasla.com.

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

The Payer ID for AmeriHealth Caritas Louisiana is **27357**

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the EDI Claim Filing sections of this booklet. EDI guidance for Professional Medical Services claims can be found beginning on page 4. EDI guidance for Facility Claims can be found beginning on page 17. Change Healthcare or any other EDI clearing-house or vendor may require additional data record requirements.

Electronic Claim Flow Description

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

Once Change Healthcare receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits as described in Exhibit 99 at Change Healthcare. Claims not meeting the requirements are immediately rejected and returned to the sender via an Change Healthcare error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or Change Healthcare.

Accepted claims are passed to the Plan and Change Healthcare returns an acceptance report to the sender immediately.

Claims forwarded to the Plan by Change Healthcare are immediately validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to Change Healthcare, which also forwards this rejection to its trading partner – the intermediate EDI vendor or provider. Claims passing eligibility requirements are then passed to the claim processing queues. **Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.**

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

Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare are not transmitted to the Plan.

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Change Healthcare Provider Support Line at 1-800-845-6592.

If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the AmeriHealth Caritas Louisiana EDI Technical Support Hotline at 1-866-428-7419 or by e-mail at edi@amerihealthcaritasla.com

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

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

* An Acceptance report verifies acceptance of each claim at Change Healthcare.

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

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

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

Invalid Electronic Claim Record Rejections/Denials

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

Plan Specific Electronic Edit Requirements

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

837P – 005010X098A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

837I – 005010X096A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

- Member Number must be less than 17 digits.
- Statement date must not be earlier than the date of Service.
- Plan Provider ID is strongly encouraged.

Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups:

These exclusions apply to inpatient and outpatient claim types.

Excluded Claim Categories At this time, these claim records must be submitted on paper.

- Claim records requiring supportive documentation.
- Claim records for medical, administrative or claim appeals.

Excluded Provider Categories Claims issued on behalf of the following providers must be submitted on paper

- Providers not transmitting through Change Healthcare *or providers sending to Vendors that are not transmitting (through Change Healthcare) NCPDP Claims.*

- Pharmacy (through Change Healthcare).

Important: Requests for adjustments may be submitted electronically or on paper.

On Paper:

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

**Claims Processing Department
AmeriHealth Caritas Louisiana
P.O. 7322
London, KY 40742**

Administrative or medical appeals must be submitted in writing to:

**Provider Appeals Department
AmeriHealth Caritas Louisiana
PO Box 7324
London, KY 40742**

Refer to the Provider Handbook or the Provider Center online at www.amerihealthcaritasla.com for complete instructions on submitting administrative or medical appeals.

Contact Change Healthcare Provider Support Line at 1-800-845-6592

Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI software vendor or Change Healthcare to verify you receive the reports necessary to obtain this information.

When you receive the Rejection report from Change Healthcare or your EDI vendor, the plan does not receive a record of the rejected claim.

Common Rejections:

Invalid Electronic Claim Records – Common Rejections from Change Healthcare

- Claims with missing or invalid batch level records.
- Claim records with missing or invalid required fields.
- Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-9 or ICD-10, etc.).
- Claims without member numbers.

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)

- Claims received with invalid provider numbers.
- Claims received with invalid member numbers.
- Claims received with invalid member date of birth.

Resubmitted Professional Corrected Claims

Providers using electronic data interchange (EDI) can submit “professional” corrected claims* electronically rather than via paper to AmeriHealth Caritas Louisiana.

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

Your EDI clearinghouse or vendor needs to:

- ✓ Use frequency code “6” for replacement of a prior claim, frequency code “7” for adjustment of prior claims, or frequency code “8” for a voided claim utilizing bill type in loop 2300, CLM05-03 (837P)
- ✓ Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- ✓ **Do** include the plan’s claim number in order to submit your claim with the 6 or 7
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
 - For more information, please contact the AmeriHealth Caritas Louisiana EDI Hotline at 1-866-428-7419 or edi.AmeriHealthCaritasLouisiana@amerihealthcaritas.com
 - Providers using our NaviNet portal (www.navinet.net) can view their corrected claims

faster than available with paper submission processing.

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

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

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

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

**Claims Processing Department
AmeriHealth Caritas Louisiana
P.O. Box 7322
London, KY 40742**

Corrected Institutional and Professional claims may be resubmitted electronically using the appropriate bill type to indicate that it is a corrected claim. Adjusted claims must be identified in the bill type.

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

1. Plan ID, Tax ID and NPI number
 2. If no single match is found, the Service Location’s zip code (ZIP+4) is used
 3. If no service location is include, the billing address
- Provider Services 1-888-922-0007

- zip code (ZIP+4) will be used
4. If no single match is found, the Taxonomy is used
 5. If no single match is found, the claim is sent to the Invalid Provider queue (IPQ) for processing
 6. If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim
 7. If you have submitted a claim and you have not received a rejection report but are unable to locate your claim via NaviNet, it is possible that your claim is in review by AmeriHealth Caritas Louisiana. Please check with provider services and update your NPI data as needed, by using the Provider Change form located at:
<http://www.amerihealthcaritasla.com/provider/resources/forms/index.aspx>. It is essential that the service location of the claim match the NPI information sent on the claim in order to have your claim processed effectively.

Contact the Change Healthcare Provider Support Line at: 1-800-845-6592

Contact AmeriHealth Caritas Louisiana EDI Technical Support at: 1-866-428-7419

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

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

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2[PIN]

Supplemental Information

Ambulance

Ambulatory Surgical Centers

Anesthesia

Audiology

Behavioral Health

Claims that include HCPCS H0036 and H2017

Submitting Claims During Month of CSOC Referral

Submitting Claims During Months of CSOC Enrollment

Submitting Claims During Month of Discharge

Exclusions

Billing for Non-CSOC members

- I. Professional Claims (non-emergency)
- II. Facility Claims (non-emergency)
- III. Lab and Radiology Claims
- IV. Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) Claims
- V. Emergency Department (ED) Claims
- VI. Inpatient Acute Detox Claims
- VII. Current Procedural Terminology Codes for Neuropsychological Testing and Behavioral Assessment Claims
- VIII. Non-Emergency Medical Transportation Cost
- IX. Pharmacy Claims

Chemotherapy

Chiropractic Care

Dental Services

Diabetic Self-Management

Dialysis

Durable Medical Equipment (DME)

EPSDT

Medical Screening

Vision Screening

Hearing Screening

Interperiodic Screening

FQHC/RHC EPSDT

Family Planning

FQHC/RHC Non-EPSDT

Home Health Care (HHC)

Family Planning

Immunization

Infusion Therapy

Injectable Drugs

Maternity

Observation

Outpatient Hospital Services

Ambulance

Ground and Air Ambulance Services are billed on CMS 1500 or 837 Format.

When billing procedure codes A0425-A0429 and A0433-A0434 for ambulance transportation services, the provider must enter a valid 2-digit modifier at the end of the associated 5-digit procedure code. Different modifiers may be used for the same procedure code.

- Providers must bill the transport procedure codes with the appropriate modifier.
- Ground mileage must be billed with the appropriate transport procedure code and the appropriate modifier.
- Providers who submit a claim for transport procedure codes without a modifier will be denied for invalid/missing modifier.
- Providers who bill mileage alone will be denied for invalid/inappropriate billing.
- Mileage will only be paid when billed in conjunction with a paid transport procedure code.
- A second trip may be reimbursed if the member is transferred from the first hospital to another hospital on the same day in order to receive appropriate treatment. The second trip must be billed with the appropriate "hospital to hospital" modifier.
- Providers must complete box 32 of the CMS 1500 claim form. This includes the full address for the origin and destination for all ambulance services. The time of departure from origin and arrival time at the destination must also be reported in box 32.
- Procedure codes for rotary wing trips, A0431 and A0436 must be billed with a "TN" modifier if the trip originated in a rural area in order to be paid the appropriate rural rate.
- Air Ambulance should not bill supplies separately.
- Only "R" codes from the ICD-10 manual should be used. This includes emergency medical technicians (EMTs). EMTs are to report observed signs and symptoms utilizing the ICD-10 "R" codes. Any historical diagnosis information reported by a member, the member's family, or a caregiver to the EMT should be recorded in the chart notes.

Refer to the Ambulance Fee Schedule located on the Louisiana Medicaid website at:

https://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm for Emergency Ground, Emergency Air and Non-Emergency Ambulance fees, regions, billable codes and modifier for rural area.

Ambulatory Surgical Centers

- Ambulatory Surgical Centers (ASC) are required to bill on CMS 1500 or 837 Format.
- Providers are to bill only one surgical procedure (the highest compensable surgical code) per outpatient surgical session.
- If providers are looking to perform a service in the Ambulatory Surgical Center that is not on the Louisiana Medicaid Fee Schedule, provider must obtain prior authorization and rate negotiation prior to service being rendered. Failure to obtain prior authorization for procedures not on Ambulatory Surgical Fee Schedule will result in claim denial.

Anesthesia

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

- Reimbursement for moderate sedation and maternity-related procedures, other than general anesthesia for vaginal delivery, will be a flat fee.

- Reimbursement for surgical anesthesia procedures will be based on formulas utilizing base units, time units (1= 15 min) and a conversion factor.
- Minutes must be reported on all anesthesia claims except where policy states otherwise.

The following modifiers are to be used to bill for surgical anesthesia services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction of one CRNA
QK	Anesthesiologist	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction by an anesthesiologist
QZ	CRNA	CRNA service without medical direction by an anesthesiologist

The following is an explanation of billable modifiers:

- Modifiers which can stand alone: AA and QZ
- Modifiers which need a partner QK, QX, and QY
- Valid modifier combinations: QK and QX, or QY and QX
- All American Society of Anesthesiologists, ASA codes still require a valid ASA modifier to be billed in first position in conjunction with the ASA code.

Behavioral Health

- AmeriHealth Caritas Louisiana covers basic behavioral health services, which include but are not limited to screening, prevention, early intervention, medication, and referral services as defined the Medicaid State Plan.
- Basic behavioral health services may further be defined as those provided in the member’s PCP or medical office by the member’s (non-specialist) physician (i.e., DO, MD, ARNP) as part of routine physician evaluation and management activities (e.g., CPT codes 99201 through 99204), and all behavioral health services provided at FQHCs/RHCs).
- Behavioral health services performed in a FQHC/RHC are reimbursed as encounters. The encounter reimbursement includes all services provided to the recipient on that date of service. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service provided on subsequent lines.
- Effective with dates of service April 1, 2019, Behavioral Health Services performed by the following providers at an FQHC or RHC will use HCPCS Code H2020 for reimbursement of the Behavioral Health Alternative Payment Methodology (APM) rate:
 - Physicians with a psychiatric specialty.
 - Nurse practitioners or clinical nurse specialists with a psychiatric specialty.
 - Licensed clinical social workers.

- o Clinical psychologists.

Going forward these RHC and FQHC providers can bill the T1015, D0999 and H2020 on the same day of service and be reimbursed for all three HCPCS codes at the PPS rate on file for the date of service. Providers must submit the HCPCS Code H2020 on the first line of the claim submission and include detailed lines for all services rendered along with the usual or customary charges or zero.

- Behavioral Health services are billed on the CMS-1500 claim form or electronically in the 837 format.
- Behavioral Health diagnosis code must be billed in the primary diagnosis code position to be considered a Behavioral Health claim.
- Coordinated System of Care (CSoc) Behavioral Health Claims (ages 5-20) should be submitted to Magellan Healthcare. For information call 1-800-424-4489 or TTY 1-800-846-5277.
- Effective for dates of service December 1, 2015, and forward follow LDH [Informational Bulletin 16-3](#) when billing specialized Behavioral Health Services for AmeriHealth Caritas Louisiana members.

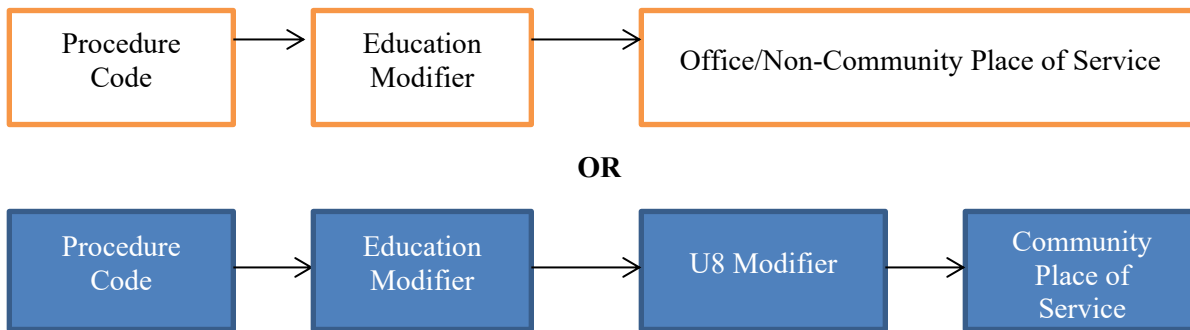
Mental Health Rehabilitation Providers billing for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

Claims that include HCPCS H0036 and H2017:

- The Education Modifier must be billed and should always come first before any other modifiers.
- The Place of Service (POS) must be billed. (Defined below.)
 - o “Office/Non-Community” Place of Service codes are 11, 20, 49, 50, 71, or 72 and cannot be billed with the U8 Modifier.
 - o “Community” Place of Service codes are 03, 04, 05, 07, 12, 14, 15, 52, 53, 57, or 99 and must be billed with the U8 modifier on each service line.

H0036 and H2017 Coding Model:

To be billed as appropriate for services rendered



Office/Non-Community Place of Service Codes	
11	Office
20	Urgent Care Facility
49	Independent Clinic
50	FQHC

71	State of Local Public Health Clinic
72	Rural Health Clinic

Community Place of Service Codes	
03	School
04	Homeless Shelter
05	Indian Health Service, Free-Standing Facility
07	Tribal 638, Free-Standing Facility
12	Home
14	Group Home
15	Mobile Unit
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
57	Non-Resident Substance Abuse Treatment Facility
99	Other Place of Service, Other Unlisted Facility

Modifiers that may be used with CPST and PSR:

U8 modifier for services provided in the natural environment

HK modifier for Homebuilders

HE modifier for Functional Family Therapy

HQ modifier for Group Setting

TG modifier for Permanent Supportive Housing (PSH)

HM modifier for less than bachelor’s degree level

HN modifier for bachelor's degree level

HO modifier for master's degree level

HA modifier for Child/Adolescent Program (0-20 years old). Note: If this modifier is in the first position, the claim will deny.

HB modifier for Adult Program (21 years and older). Note: If this modifier is in the first position, the claim will deny.

For AmeriHealth Caritas, it is requested that age modifiers be used per the fee schedule. But claims will not deny if age modifiers are omitted. However, claims will be denied if age modifiers are put in the first position. Education modifiers should always come first.

Submitting Claims During Month of CSOC Referral

If an AmeriHealth Caritas Louisiana member is receiving behavioral health services and a referral is made for CSOC services after the **FIRST** calendar day of the month, the provider (excluding CSOC service providers) should submit service claims to AmeriHealth Caritas Louisiana until the end of the month.

If the member remains in the CSOC eligibility/assessment process, or has been determined eligible, by the first calendar day of the following month, all behavioral health service claims should be submitted to the CSOC contractor. (Providers should check the Electronic Medicaid Eligibility Verification System [eMEVS] to determine if AmeriHealth Caritas Louisiana is responsible for the payment of claims.) Providers are encouraged to check eMEVS on every date of service to verify a member's eligibility and to identify if AmeriHealth Caritas Louisiana is responsible for the date of service. A member's eligibility does not routinely change during the middle of the month. There are retroactive corrections that can occur that may impact claims and responsibility.

Submitting Claims During Months of CSOC Enrollment

For any month that a recipient is enrolled in CSOC on the **first** calendar day of the month, the CSOC Contractor shall be responsible for paying providers for specialized behavioral health services rendered during the entire month.

Submitting Claims During Month of Discharge

During the month that a member is discharged from CSOC, all specialized behavioral health service providers will submit claims to CSOC contractor through the end of that month. AmeriHealth Caritas Louisiana will assume responsibility for payment of all specialized behavioral health services on the **first** calendar day of the following month.

Exclusions

Payment to providers for the provision of one of the five CSOC waiver services (i.e., Parent Support and Training, Youth Support and Training, Independent Living/Skills Building, Crisis Stabilization or Respite Care) shall be the responsibility of the CSOC contractor for any date of service upon which a child/youth is enrolled in CSOC. AmeriHealth Caritas Louisiana will not be responsible for payment to providers for the provision of waiver services to CSOC enrolled recipients.

Payment to providers for the provision of residential treatment, including Psychiatric Residential Treatment Facilities (PRTF), Therapeutic Group Homes (TGH) and Substance Use Residential treatment shall not be the responsibility of the CSOC contractor for any date of service. AmeriHealth Caritas Louisiana will retain responsibility for the payment of providers for the provision of these services to CSOC enrolled recipients.

Payment to providers for the provision of Inpatient Psychiatric Treatment will be determined based upon which Plan was responsible (per the above guidance) as of the recipient's admission date. The Plan will maintain responsibility for payment throughout the period that was prior authorized, or through the date of discharge, whichever occurs first.

Members enrolled with the CSOC contractor will continue to receive their physical health services from AmeriHealth Caritas Louisiana or fee for service Medicaid.

Billing for Non-CSOC Members

Please refer to the electronic Medicaid Eligibility Verification System (eMEVS) to identify whether the recipient has (1) physical health, specialized behavioral health services, and non-emergency medical transportation (NEMT) through a Healthy Louisiana Plan (*Example 1* below), or (2) specialized behavioral health and NEMT benefits only through a Healthy Louisiana Plan (*Example 2* below). For these recipients, all non-specialized behavioral health claims should be directed to traditional Medicaid or the primary payer, such as Medicare, if Medicaid is secondary.

Example 1 – Physical Health, Specialized Behavioral Health and NEMT

Health Benefit Plan Coverage

Benefit	Service Type Code	Insurance Type	Plan Coverage Description
Active Coverage	Health Benefit Plan Coverage	Medicaid	Eligible for Medicaid on Plan Date. Plan Begin Date 02/01/2015
Deductible	Health Benefit Plan Coverage	Medicaid	Health Plan Base Deductible is \$0 for In Plan Network and Out of Plan Network.
Benefit Description	Health Benefit Plan Coverage	Medicaid	PREFERRED LANGUAGE: ENGLISH
Managed Care Coordinator	Medical Care	Medicaid	BAYOU HEALTH PLAN PHARMACY PBM IS PERFORMRX Managed Care Organization Name of Bayou Health Plan Telephone Phone Number for Bayou Health Plan
Managed Care Coordinator	Specialized Behavioral Health Care	Medicaid	BAYOU HEALTH PLAN Managed Care Organization Name of Bayou Health Plan Telephone Phone Number for Bayou Health Plan
Managed Care Coordinator	Dental Care	Medicaid	DENTAL BENEFITS PLAN MANAGER Payer MCNA INSURANCE COMPANY Telephone (855) 701-6262 URL https://portal.MCNA.net

Example 2 – Specialized Behavioral Health and NEMT Only

Health Benefit Plan Coverage

Benefit	Service Type Code	Insurance Type	Plan Coverage Description
Active Coverage	Health Benefit Plan Coverage	Medicaid	Eligible for Medicaid on Plan Date. Plan Begin Date 02/01/2015
Deductible	Health Benefit Plan Coverage	Medicaid	Health Plan Base Deductible is \$0 for In Plan Network and Out of Plan Network.
Benefit Description	Health Benefit Plan Coverage	Medicaid	PREFERRED LANGUAGE: ENGLISH
Managed Care Coordinator	Specialized Behavioral Health Care	Medicaid	BAYOU HEALTH PLAN Managed Care Organization Name of Bayou Health Plan Telephone Phone Number for Bayou Health Plan
Managed Care Coordinator	Dental Care	Medicaid	DENTAL BENEFITS PLAN MANAGER Payer MCNA INSURANCE COMPANY Telephone (855) 701-6262 URL https://portal.MCNA.net

Professional Claims (non-emergency)

Licensed Mental Health Professionals (LMHPs)

Professional claims for LMHPs should be submitted to AmeriHealth Caritas Louisiana (for both types of examples from eMEVS listed above) or the primary payer if Medicaid is secondary. LMHPs include the following providers:

- Psychiatrists.
- Doctor of Osteopathy (DO) (psychiatric specialty only).
- Medical or Licensed Psychologist.
- Licensed Clinical Social Worker (LCSW).
- Licensed Professional Counselors (LPC).
- Licensed Marriage and Family Therapist (LMFT).
- Licensed Addiction Counselors (LAC).
- Nurse Practitioner and Nurse Practitioner Group (psychiatric specialty only).
- Clinical Nurse Specialist (psychiatric specialty only).
- Physician Assistant (psychiatric specialty only).

Non-Licensed Mental Health Licensed Professionals

Professional claims for providers who are not Licensed Mental Health Professionals (LMHPs) should be submitted to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients enrolled in AmeriHealth Caritas Louisiana for specialized behavioral health services only (Example 2 from eMEVS).

Facility Claims (non-emergency)

General Hospital

Facility claims, inclusive of all ancillary charges, for general hospitals, should be billed to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) regardless of rendering provider, or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS.

Freestanding Mental Health Hospital or Distinct Part Psychiatric Unit (DPPU)

Facility claims, inclusive of all ancillary charges, for freestanding mental health hospitals and DPPU should be billed to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) regardless of rendering provider. This distinction makes it imperative that DPPU claims are not billed using the coding for the associated general hospital. The DPPU unique coding must be submitted on the claim.

Lab and Radiology Claims

General Hospital or Free Standing Lab

All lab and radiology services provided in a general hospital (inpatient or outpatient) or in a free standing lab should be submitted to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS.

Freestanding Mental Health Hospital or DPPU

Claims that include lab and radiology services should be submitted to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) **only** when billed as part of an inpatient psychiatric hospital stay (freestanding or DPPU).

Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) Claims

Note: Currently FQHCs and RHCs are paid an established daily encounter rate for services that include all services except dental. An individual encounter may include both specialized behavioral health services and physical health services.

LMHP Rendering Provider

FQHC and RHC providers should submit claims to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) **only** if a behavioral health service was provided during the encounter **and** an LMHP is indicated as the rendering provider on the claim. If a recipient is seen by an LMHP and non-LMHP during the same encounter, the LMHP should be indicated as the rendering provider on the claim, and it should be sent to AmeriHealth Caritas Louisiana (both eMEVS examples listed above).

Non-LMHP Rendering Provider

FQHC and RHC providers should submit any claim **without** an LMHP listed as the rendering provider on the claim to the AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS.

Emergency Department (ED) Claims

LMHP Rendering Provider

Only professional claims for an LMHP for services provided as part of an ED stay should be submitted to AmeriHealth Caritas Louisiana (both eMEVS examples listed above).

Non-LMHP Rendering Provider

Hospitals should submit ED facility claims to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS.

All professional claims associated with an ED stay should be submitted to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS, **except** when the rendering provider is an LMHP.

Inpatient Acute Detox Claims

Note: Revenue codes of 116, 126, 136, 146, 156 as well as 202 and 204 with Delirium Tremens (DT) diagnoses to accommodate for DT are utilized in billing for Acute Detox.

General Hospital

Providers should submit claims for acute detox to AmeriHealth Caritas Louisiana (Example 1 from eMEVS) or traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS if the service is performed in a general hospital.

Freestanding Mental Health Hospital or DPPU

Providers should submit claims for acute detox to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) if services were performed in a freestanding mental health hospital or DPPU.

Current Procedural Terminology Codes for Neuropsychological Testing and Behavioral Assessment Claims

Procedure codes 96118, 96150-96155 are payable to AmeriHealth Caritas Louisiana (both eMEVS examples listed above) when rendered by an LMHP and where applicable prior authorization or pre-certification requirements are met.

Non-Emergency Medical Transportation Cost

Upon referral by a provider, all non-emergency medical transportation (NEMT) for members to and from a contracted provider (or providers operating under an approved single/ad hoc case agreement) shall be reimbursed through AmeriHealth Caritas Louisiana regardless of indicator type (both eMEVS examples listed above). All Medicaid-eligible NEMT shall be coordinated in conjunction with state Medicaid fee-for-service/legacy Medicaid recipients (i.e., single state broker, state contractor) or AmeriHealth Caritas Louisiana, as applicable.

Pharmacy Claims

All Pharmacy Services including behavioral health medications will be provided through AmeriHealth Caritas Louisiana (Example 1 from eMEVS), traditional Medicaid for recipients with only Specialized Behavioral Health listed in eMEVS, or the primary payer if Medicaid is secondary.

Chemotherapy

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

Chiropractic Care (covered for ages 0-20)

- Claims for chiropractic services are billed on a CMS 1500 or via 837 format.
- Chiropractors are to bill for services using the appropriate, CPT code for the service provided. HCPCS modifier “AT” (Acute Treatment) may be appended.

Dental Services

- Dental Services for members under 21 are handled by LDH through MCNA.
- Dental Services for members over 21 are limited to the following, which should be submitted to the dental vendor:
 - Two exams with cleaning and one set of x-rays per year. Limited filings and/or extractions. (Package value - **\$500 per year**)
 - Submit on an ADA Dental Claim form to:
Avesis
Attn: Dental Claims
P. O. Box 38300
Phoenix, AZ 85069-8300
 - Claims may be submitted electronically as follows:
 - Change Healthcare (formerly Emdeon)
Payer ID 87098
<http://www.changehealthcare.com>
615-932-3000
 - Trizetto
Payer ID 86098
<http://www.trizetto.com/>
1-800-569-1222

Diabetic Self-Management Training

- Services are billed using G0108 – individual session; and G0109 – group session.
- Services may be billed on either a HCFA1500 or UB04 or via 837 Format.
- Services billed on UB04 should be billed with revenue code 0942.
- Services for pregnant members must be billed with a “TH” modifier, if the services are performed by an OB/GYN provider.

Dialysis

- Reimbursement for dialysis services must be billed using the UB-04 claim form or using the electronic submission 837I.
- Epogen must be reported using procedure code Q4081 in conjunction with revenue code 0634 and revenue code 0635.
- The following formula is used in calculating Epogen units of service: (Total number of Epogen units/100) = units of services.
- The units of service field for Epogen must be reported based on the HCPCS code dosage description as is done with all other physician administered drugs. For example: The HCPCS code description for Q4081 is Injection, Epogen. If the provider administers 12,400 units of Epogen on that date of service, then 124 should be entered as unit of service. Standard rounding should be applied to the nearest whole number.

Durable Medical Equipment

- Services are billed on a CMS 1500 claim form.
- An “NU” modifier is used for all purchases.
- An “RR” modifier is required for all rentals.

- Repair codes on the DME Fee Schedule require the submission of procedure code “K0739” in conjunction with “RP” modifier for payment consideration.
- HCPCS codes for enterals will require the submission of an NDC number and NDC units.
 - The NDC billed must be on the Louisiana Medicaid DME Enteral Nutrition Fee Schedule. Prescriptions for enteral feedings must be for an average of at least 750 calories per day over the prescribed period and must constitute at least 70 percent of the daily caloric intake. Nutritional supplements given between meals to boost daily protein-caloric intake or as the mainstay of a daily nutritional plan may be covered for members under age 21 where medical necessity is established. Nutritional supplements will not be covered as described above for members age 21 years or older unless the member has a permanently inoperative internal body organ or function which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with his/her general condition.
 - Date span should be billed as a full month (example: 01/25 – 02/25).
 - Submits bills based on a 30 day monthly cycle.
 - Do not bill in cases, must bill in units only.
 - Bill appropriate units – (1) can is equal to a quantity of “1”.
- An Electric Breast Pump Request form must be completed and attached to claims billed for breast pumps. The form is located on <http://www.lamedicaid.com> under Forms, Files, and User Manuals.
- DME billed charges under \$750 do not require an authorization. The provider must be credentialed to provide DME services with an exception for Podiatrists. AmeriHealth Caritas Louisiana will only cover the following codes billed by Podiatrists unless the podiatrist is credentialed as a DME provider:

DME Codes for Podiatrists	
HCPCS Code	Description
A4208	3 Cc Sterile Syringe Needle
A4570	Splint
A6250	Skin Seal Protect Moisturizer
A6402	Sterile Gauze <= 16 Sq. In
E0114-NU	Crutch Underarm Pair No Wood
L3260	Ambulatory Surgical Boot Each
L3260-LT	Ambulatory Surgical Boot Each
L3260-RT	Ambulatory Surgical Boot Each
L3265-RT	Plastazote Sandal Each
L4360-KT	Pneumatic Walking Splint
L4360-KX	Pneumatic Walking Splint
L4360-LT	Pneumatic Walking Splint
L4360-RT	Pneumatic Walking Splint
L4361-KX	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-th

DME Codes for Podiatrists	
HCPCS Code	Description
L4361-LT	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-th
L4361-NU	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-th
L4361-RT	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-th
L4386-KX	Non-Pneumatic Walking Splint, With Or Without Joints, Prefabricated, I
L4386-LT	Non-Pneumatic Walking Splint, With Or Without Joints, Prefabricated, I
L4387-LT	Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off-the-shelf
L4387-NU	Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off-the-shelf

EPSDT

EPSDT Medical Screening:

Billing for these screenings should be completed on the CMS 1500 Claim Form or electronically with the 837P claim transaction. Providers must use the age appropriate code in order to avoid claim denial. Billing may not be submitted for a medical screening unless all of the following components are administered:

COMPONENTS OF THE MEDICAL SCREENING
1. Comprehensive health and developmental history (including assessment of both physical and mental health and development).
2. Comprehensive unclothed physical exam or assessment.
3. Appropriate immunizations according to age and health history (unless medically contraindicated or parents or guardians refuse at the time).
4. Laboratory tests (including appropriate neonatal, iron deficiency anemia, urine, and blood lead screening).
5. Health education (including anticipatory guidance).

- Providers must bill with the most appropriate diagnosis in the primary diagnosis position.
- These codes are billed hard copy on the CMS-1500 form or electronically using the 837P claim transaction.
- The following procedure codes are used to bill for the medical screening:

99381	Initial comprehensive preventive medicine; Infant (age under 1 year)
99382	Initial comprehensive preventive medicine; Early Childhood (ages 1-4)
99383	Initial comprehensive preventive medicine; Late Childhood (ages 5-11)
99384	Initial comprehensive preventive medicine; Adolescent (ages 12-17)
99385	Initial comprehensive preventive medicine; Adult (ages 18-20)
99391	Periodic comprehensive preventive medicine; Infant (age under 1 year)
99392	Periodic comprehensive preventive medicine; Early Childhood (ages 1-4)
99393	Periodic comprehensive preventive medicine; Late Childhood (ages 5-11)
99394	Periodic comprehensive preventive medicine; Adolescent (ages 12-17)
99395	Periodic comprehensive preventive medicine; Adult (ages 18-20)

EPSDT Vision Screening

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

EPSDT Subjective Vision Screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of:

- Any eye disorders of the child or his family.
- Any systemic diseases of the child or his family which involve the eyes or affect vision; behavior on the part of the child that may indicate the presence or risk of eye problems; and
- Medical treatment for any eye condition.

EPSDT Objective Vision Screening

EPSDT objective vision screenings (99173-EP) may be performed by trained office staff under the supervision of a LICENSED Medicaid physician, physician assistant, registered nurse, or optometrist.

Objective vision screenings begin at **age 3**. The objective vision screening must include tests of:

- Visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children).
- Color perception (must be performed at least once after the child reaches the age of 6 using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter).
- Muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

The following procedure code is used to bill for vision screening:

99173 with EP modifier	Vision Screening
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EPSDT Hearing Screening

The purpose of the hearing screening is to detect central auditory problems, sensorineural hearing loss, conductive hearing impairments, congenital abnormalities, or a history of conditions which may increase the risk of potential hearing loss.

EPSDT Subjective Hearing Screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of:

- The child's response to voices and other auditory stimuli.
- Delayed speech development.
- Chronic or current otitis media.
- Other health problems that place the child at risk for hearing loss or impairment.

EPSDT Objective Hearing Screening

EPSDT objective hearing screenings may be performed by trained office staff under the supervision of a licensed Medicaid audiologist, speech pathologist, physician, physician assistant, or registered nurse.

Objective hearing screenings begin at **age 4**. The objective hearing screening must test at 1000, 2000, and 4000 Hz at 20 decibels for each ear using the puretone audiometer, Welsh Allyn audioscope, or other approved instrument.

The following procedure code is used to bill for hearing screening:

92551	Hearing Screening
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EPSDT Interperiodic Screenings

An interperiodic screening can only be billed if recipient has received an age-appropriate medical screening. If his or her medical screening has not been performed, the provider should bill an age-appropriate medical screening. It is not acceptable to bill for an interperiodic screening if the age-appropriate medical screening had not been performed.

An interperiodic screening by an AmeriHealth Caritas Louisiana provider must include all of the components required in the periodic screening. This includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education, and other age appropriate procedures. Medically necessary laboratory, radiology, or other procedures may also be performed and should be billed separately.

There is no limit on the frequency or number of medically necessary interperiodic screenings, or on the proximity to previous screenings. Therefore, it is essential that providers document in the recipient's records:

- Who requested the interperiodic screening,
- Why the screening was requested (the concern, symptoms or condition that led to the request), and
- The outcome of the screening (any diagnosis and/or referral resulting from the screening).

Documentation must indicate that all components of the screening were completed. Medically necessary laboratory, radiology, or other procedures may also be performed and should be billed

separately. A well diagnosis is not required.

These codes are billed hard copy on the CMS-1500 form or electronically using the 837P claim transaction.

Emergency Room Services:

Hospital providers must bill revenue code 450 or 459 when submitting claims for outpatient emergency room services, along with the appropriate HCPCS code. Only one revenue code 450 or 459 may be billed on the emergency room claim.

Claims for emergency room services are not to be billed as a single line item. Claims must include all revenue codes (i.e., pharmacy, lab, x-rays and supplies) which were utilized in the member's treatment, using the appropriate revenue code and HCPCS where applicable.

When an emergency visit results in an inpatient admit, providers must bill the ER visit and all ER associated charges on the inpatient bill. This policy applies to members admitted from the ER or if the member has been seen in the ER within 24 hours either prior to admit or after the inpatient discharge. All associated charges for the emergency visit must be included by appropriate revenue codes with the total charges for the inpatient stay.

FQHC/RHC EPSDT Claim Filing Instructions

- Bill using the CMS-1500 or via 837 Format.
- EPSDT Services are billed with HCPCS Code T1015 with "EP" modifier and detail level procedure codes.
- Procedure code "T1015" cannot be billed as a single line claim. EPSDT service will deny for payment if billed as a single line item. The entire claim will be denied if the provider bills procedure code "T1015" with a valid detail procedure code and an invalid detail procedure code, or a procedure code that is not on the Louisiana Medicaid Fee-for-Service Fee schedule.
- All claim line items must be billed with a valid detail procedure code that is listed on the Louisiana Medicaid fee-for-Service Fee Schedule.
- Providers must bill with the most appropriate diagnosis in the primary diagnosis position

FQHC/RHC Non-EPSDT Claim Filing Instructions

- Require the submission of procedure code "T1015" in conjunction with detail level procedure codes, including mental/behavioral health. If detail procedure code lines are not billed with procedure code "T1015" or any of the detail procedure codes billed are not present on the Louisiana Medicaid Fee-for-Service Fee Schedule, procedure code "T1015" will be denied. Procedure code "T1015" cannot be billed as a single line claim. Claims billed with a single line item will be denied.
- The entire claim will be denied if procedure code "T1015" is billed with a valid detail procedure code and an invalid detail procedure code, or a procedure code that is not on the Louisiana Medicaid Fee-for-Service Fee Schedule. All claim line items must be billed with a valid detail procedure code that is listed on the Louisiana Medicaid Fee-for-Service Fee Schedule for payment consideration.
- RHC/FQHCs will not be reimbursed for family planning services in addition to the encounter payment.

- Maternity Care Visits – Obstetricians providing maternity care at an RHC/FQHC should append the T1015 with "TH" modifier and it must be in the first position if other modifiers are billed in addition to the "TH. RHC/FQHCs may bill for adjunct services in addition to the T1015.
- Use the correct place of service code 50 (FQHC) and code 72 (RHC) or 12 (RHC and FQCH) if the service was rendered in the member's home..

Home Health Care (HHC)

- Provider must bill on UB04 or via 837 Format.
- Bill the appropriate revenue code for the homecare service.
- Eligible revenue codes/procedure code combinations and modifiers can be found within the Home Health provider manual located at:
http://www.lamedicaid.com/provweb1/Providermanuals/HH_Main.htm.

Immunization

Single Administration

- Providers must bill administration code(s) 90471, or 90473 and the specific CPT Code for the vaccine, with \$0.00 in the “billed charges” field.
- CPT Codes 90471 and 90473 may not be billed together on the same date of service

Multiple Administrations

- Providers must bill administration codes(s) 90472 and 90474 with the appropriate number of units for the additional vaccines. The specific CPT code for the vaccine must be billed with \$0.00 in the “billed charges” field. The number of vaccines billed must equal the number of units indicated for the administration code.
- Use CPT Codes 90472 or 90474 with 90471 OR 90473 to report more than one vaccine administered.

Hard Copy Claim Filing for Greater Than Four Administrations

- When billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded, providers should bill on two CMS-1500 claim forms. The first claim should follow the instructions above for billing the single administration. The second CMS-1500 claim form should be used to bill the remaining immunizations as described above for billing multiple administrations.

Infusion Therapy

- Drugs administered by physician or outpatient hospital on the Louisiana Medicaid Fee Schedule will be reimbursed, but some are subjected to Prior Authorization. Drugs require the provider to also bill the NDC and related NDC information. Please refer to HCPCS codes requiring an authorization at <http://www.amerhealthcaritasla.com/provider/resources/priorauth/index.aspx>.
- Failure to bill the NDC required information will result in denial.
- Infusion supplies can be provided by a DME provider or home care providers; nursing services are provided by home care agency.
- Infusions/drugs provided in the home are not billed by the home care or DME provider and are not covered by the AmeriHealth Caritas Louisiana.
- Drugs would need to be obtained through the pharmacy benefit for any home infusion.
- Nursing and supplies would be covered by the AmeriHealth Caritas Louisiana.

Injectable Drugs

All drugs billed are required to be submitted with NDC information and may be submitted via CMS-1500 or 837 electronic format. Refer to NDC instructions in Supplemental Information section on pages 47-49.

The NDC number and the HCPCS code for drug products are required on both the 837 format and the CMS-1500 for reimbursable medications. Claims submitted without NDC information and a valid HCPCS code will be denied.

Inpatient Services

Inpatient services shall not be billed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. Billing outpatient services for a member who is admitted and an inpatient within 24 hours of the performance of the outpatient service is not allowed.

Only one service from the current CPT listing of "initial hospital care" procedure code range can be reimbursed per **inpatient stay** to the "admitting" provider. For initial inpatient encounters by physicians other than the admitting physician, subsequent hospital care codes or inpatient consultation codes, if appropriate, are to be used.

Maternity

Visits: Pregnancy diagnosis code must be billed in primary or secondary DX code position.

Initial prenatal and follow-up outpatient/office visit codes for services rendered by the OB/GYN must be modified with "TH" modifier in order to process correctly. The modifier must be placed in the first position after the CPT code for the visit.

The "TH" modifier is not required for observation or inpatient hospital physician services.

Postpartum Visits: The postpartum care CPT code should be billed for the postpartum care visit (which should NOT be billed with "TH" modifier).

Delivery:

The most appropriate "delivery only" CPT code should be billed by the delivering physician. Global delivery maternity procedure codes which include antepartum and/or postpartum care are only covered when the member has primary coverage that includes maternity benefits. If the primary payer is major medical without maternity benefits then a global delivery procedure code should NOT be billed.

Please use the most appropriate revenue code to bill for obstetrics (OB) room and board. Below are important requirements to remember when billing inpatient claims:

- Include the admit or primary delivery diagnosis.
- The secondary diagnosis must be the appropriate outcome of delivery.
- The surgical procedure code for the delivery and the date of the procedure must appear on the claim.
- AmeriHealth Caritas Louisiana does not require authorizations for OB room and board up to 3 days for a standard vaginal delivery and up to 5 days for a Cesarean section delivery. Failure to submit appropriate OB revenue codes will result in claim denials.

Below are the appropriate revenue codes for OB room and board to bill to prevent OB claim denials for no authorization:

Revenue Code	Description	Category
112	OB OB/PRVT	Room & Board – Private
122	OB – OB/2 BED	Room & Board – Semi-private Two Bed
132	OB – OB/3 & 4 Beds	Room & Board – Semi-Private 3 & 4 Bed
152	OB – OB/Ward	Room & Board - Ward

AmeriHealth Caritas Louisiana does not require clinical review and authorization of inpatient stays for deliveries when the length of stay is as follows:

Service Description	Labor Days	Requirement
Standard vaginal	2 inpatient	If the delivery occurs on the day after admission, up to 3 days will be allowed for payment. <u>Days exceeding this timeframe will require prior authorization.</u>
Cesarean section	4 inpatient	If the delivery occurs on the day after admission, up to 5 days will be allowed for payment. <u>Days exceeding this timeframe will require prior authorization.</u>

In cases of multiple births (twins, triplets, etc.), the diagnosis code must indicate a multiple birth.

Modifier 22 for unusual circumstances should be used with the most appropriate CPT code for a vaginal or C-Section delivery when the method of delivery is the same for all births.

If the multiple gestation results in a C-Section delivery and a vaginal delivery, the provider should bill the most appropriate CPT code for the C-Section delivery without a modifier and should also bill the most appropriate CPT code for the vaginal delivery and append modifier “51”.

AmeriHealth Caritas Louisiana will deny hospital and professional claims for the non-medically necessary delivery of a baby prior to 39 weeks. (Claims for anesthesia related to the delivery will not be impacted by this policy.) AmeriHealth Caritas Louisiana will use the Louisiana Electronic Event Registration System (LEERS) data from the Office of Public Health Vital Records to validate that the delivery was not prior to 39 weeks or, if prior to 39 weeks, that it was medically necessary.

Effective March 1, 2015, AmeriHealth Caritas Louisiana will adjudicate all professional delivery claims based on the modifier present on the claim. Professional delivery claims received without one of the designated modifiers will deny for incomplete information.

Maternity Modifiers:

Modifier	Description
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GB	Delivery is <u>39 weeks or more</u>
AT	Delivery is <i>less than 39 weeks</i> and medically indicated/spontaneous
GZ	Delivery is <i>less than 39 weeks</i> and <u>NOT</u> medically indicated
None	Claim will Deny for incomplete information

Babies admitted to NICU require prior authorization from date admitted to NICU; even if during mother’s stay. NICU services require separate authorization for baby in order to be paid.

Mother’s delivery and baby stay should be billed on two separate claims. Mother’s claim should only include mother’s room, board and ancillary charges. Baby claim should only include baby’s room, board and ancillary charges.

For rural hospitals that have general per diem only rates and border baby rates, if baby is discharged with mother and not in NICU, “well baby” is not eligible for payment on baby’s claim. Baby services are considered inclusive in mother’s stay. If baby is discharged with mother, but goes to NICU for any days prior to discharge with mother, facility must notify and receive authorization in order to receive payment for NICU days. If baby is detained and not in NICU, the facility would be eligible for reimbursement under border baby rate (if authorized by Medical Management). If baby is detained and in NICU, facility would be eligible for payment at the NICU rate (which for rural facilities is the general per diem rate) if authorized. Border baby rate is payable for detained babies only when authorized. It should not be authorized for babies discharged with mother. NICU rate is only payable for babies in NICU when NICU bed-type is authorized (authorization begins with date admitted to NICU).

Note: Well baby per diem rate is only payable to facilities that have a published well baby per diem rate. Well baby is paid to those facilities when baby is discharged with mother and stay is not in NICU; can be covered under mother’s maternity authorization.

Observation

Observation services should not exceed 48 hours. Any observation services over 48 hours requires an authorization. Any observation services paid beyond 48 hours that are not authorized are subject to recoupment.

Observation service hours must be billed in units populated in the units field of the UB-04 claim form. The total service hours (units) should be billed on one line using the appropriate revenue code and should not be billed on multiple lines.

The entire outpatient encounter should be billed including emergency department, observation, and any associated services on the same claim with the appropriate revenue codes. The admission hour and discharge hour must also be included on the claim.

Opioid Treatment Programs (OTP)

Reimbursement for members receiving methadone treatment in an Opioid Treatment Program (OTP) consists of a daily bundled rate. The bundled rate is inclusive of all services provided in the OTP including, but not limited to:

- Medication: This includes the administration, dosing, and dispensing of methadone as per the patient’s treatment plan.
- Counseling: Patients are required to participate in group or individual sessions as part of the patient’s treatment plan.
- Urine Drug Testing: This includes the urine drug testing or other laboratory tests deemed medically necessary.
- Physical examinations by a physician, advanced practice registered nurse, or physician assistant.
- Evaluation and management visits.
- Case management.
- Laboratory services.

Providers shall not bill separately for any services provided in the OTP. There is a limit of one daily bundled rate per patient per day of service. Guest dosing shall be billed by the guest facility and not the home facility. For claim submission, the billing provider number shall also be used as the rendering provider.

The HCPCS code for the daily methadone treatment bundle is H0020. On days of service where a patient is receiving a take-home dose, providers shall append the modifier U8.

Example 1: A patient is starting treatment and attends the OTP six days per week with a take-home dose for Sunday when the clinic is closed.

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020	H0020	H0020	H0020	H0020	H0020	H0020-U8

Example 2: A patient attends the OTP on Monday, Wednesday, and Friday, and receives four take-home doses weekly.

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020	H0020-U8	H0020	H0020-U8	H0020	H0020-U8	H0020-U8

Example 3: A patient attends the OTP once every two weeks and receives 13 take-home doses.

Week 1:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8

Week 2:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Code	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8	H0020-U8

Billing for members receiving buprenorphine treatment in an Opioid Treatment Program (OTP) consists of two components: the daily bundle rate for clinical care (H0047) and the ingredient cost of the medication (J-codes).

Code	Description	Unit
H0047	Alcohol and/or drug services - NOS (buprenorphine service)	Day
J0571	Buprenorphine, oral, 1 mg	1 mg

Code	Description	Unit
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	Per Dose
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	Per Dose
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	Per Dose
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	Per Dose

J-code/NDC Billing Instructions

Federal law requires that any code for a drug covered by Medicaid (billed using the appropriate J-code) must be submitted with the 11-digit NDC assigned to each drug package. The NDC specifically identifies the manufacturer, product and package size. Each NDC is an 11-digit number, sometimes including dashes in the format 5555-4444-22. When submitting claims, providers are to submit each NDC using the 11-digit NDC without dashes or spaces. The NDC included on the claim must be the exact NDC that is on the package used by the provider.

Some drug packages include a 10-digit NDC. In this case, the provider should convert the 10 digits to 11 digits when reporting this on the claim. When converting a 10-digit NDC to an 11-digit NDC, a leading zero should be added to only one segment:

- If the first segment contains only four digits, add a leading zero to the segment;
- If the second segment contains only three digits, add a leading zero to the segment;
- If the third segment contains only one digit, add a leading zero to the segment.

The NDC is required at the detail level when a claim is submitted with a J-code. In addition to the NDC number, providers must indicate the NDC units. NDC units are based upon the numeric quantity administered and the unit of measurement. "EA" (each) is used when the product is dispensed in discreet units such as films or tablets.

The Louisiana Single Preferred Drug List is located at: <http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf>
Non-preferred forms of buprenorphine and buprenorphine/naloxone require prior authorization.

Dosage Billing Guide

Buprenorphine (without naloxone) is priced per milligram. Providers bill the number of units equivalent to the number of milligrams dispensed.

For buprenorphine/naloxone, while the J-code descriptions state a range, the fee is based on a specific strength, according to the table below.

Code	Description	Priced to equal	Unit
J0571	Buprenorphine, oral, 1 mg	Per 1mg	Per mg
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	1x2mg/0.5mg film	Per Dose
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	1x4mg/1mg film	Per Dose

Code	Description	Priced to equal	Unit
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	1x8mg/2mg film	Per Dose
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	1x12mg/3mg film	Per Dose

Providers are expected to bill the dosage which most closely matches the dose administered. Billing multiple units of smaller dosages or other combinations of J-codes to maximize reimbursement is prohibited and may be subject to recoupment.

For dosages not represented above, the following combinations of J-codes are to be billed:

Total Target Dose	Code	Description	Units
16mg/4mg	J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	2
20mg/5mg	J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	1
	J0575	Buprenorphine/naloxone, oral, greater than 10 mg	1
24mg/6mg	J0575	Buprenorphine/naloxone, oral, greater than 10 mg	2

For example, for a total target dose of 16mg/4mg on a day of service (row number one), the provider must bill two units of J0574. Each unit represents one 8mg/2mg film or tablet. The corresponding NDC of the film or tablet must also be submitted with the claim.

Dosages above 24mg of buprenorphine (with or without the naloxone component) are not payable in Louisiana Medicaid.

Modifiers

For take-home doses of buprenorphine, the following modifiers must be applied:

Code	Description	Modifier
H0047	Alcohol and/or drug services - NOS (buprenorphine service)	U8
J0571	Buprenorphine, oral, 1 mg	RD
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	RD
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	RD
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	RD
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	RD

Daily Unit Limits

On any given day of service, providers may not bill more than the number of units listed below.

Code	Description	Unit	Daily Limit
J0571	Buprenorphine, oral, 1 mg	Per mg	24
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine	Per Dose	1
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine	Per Dose	1
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine	Per Dose	2
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	Per Dose	2

Outpatient Hospital Services

Providers are required to bill a revenue code on the Louisiana Medicaid FFS Hospital Outpatient Fee Schedule. Most outpatient services must be billed with a CPT or HCPCS code. Drugs are required to be billed with NDC information (valid NDC, NDC units and NDC unit of measure).

Hospitals must bill outpatient surgery for the specified surgeries using revenue code 490 on a UB-04 claim form. Revenue code 490 cannot be billed alone. All ancillary charges must be billed with appropriate revenue codes on the same claim form along with the revenue code 490. The only revenue code that will be paid will be the flat rate fee for the surgical code billed with the 490. If there are multiple procedures performed then multiple 490s can be billed; however, ACLA will only reimburse for the code generating the highest reimbursement. The procedure must be a covered procedure on the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedule.

NOTE: Minor surgeries that are medically necessary to be performed in the operating room but the associated CPT/HCPCS code is not included on the Louisiana Medicaid Outpatient Hospital Ambulatory Surgery Fee Schedule, should be billed with revenue code 361.

Policy For Papanicolaou (PAP) Test / Cervical Cancer Screenings

Routine cervical cancer screenings for recipients under the age of 21 years are no longer be covered. However, there are exceptions:

- As a value added service, AmeriHealth Caritas Louisiana will cover Pap Tests (or cervical cancer screenings) for pregnant members under 21 regardless of ACOG criteria. The claim must be submitted with a pregnancy diagnosis (O00.XX-O99.XX) or it will deny.
- Cervical cancer screenings for recipients under 21 years of age may be covered if, according to published LDH and/or American Congress of Obstetricians and Gynecologists (ACOG) criteria, the screening is medically necessary.
- Repeat cervical cancer screenings for recipients under the age of 21 may also be covered for members who are currently being treated for abnormal cervical cancer screening test results with dates of service prior to January 1, 2017. For these cases, claims filed for repeat screenings must include hard copy supporting documentation.

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically...	Contact Change Healthcare at: 877-363-3666
If you have general EDI questions...	Contact AmeriHealth Caritas Louisiana EDI Technical Support at: 1-866-428-7419 or by e-mail at: edi@amerihealthcaritasla.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports...	Contact your EDI Software Vendor or call the Change Healthcare Provider Support Line at 1-800-845-6592
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)...	Contact Provider Claim Services at 1-888-922-0007; press 2 for claim status inquiries
If you have questions about claims that are reported on the Remittance Advice...	Contact Provider Claim Services at 1-888-922-0007, press 3 for remittance advice inquiries.
If you need to know your provider NPI number...	Contact Provider Services at: 1-888-922-0007
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information... For questions about changing or verifying provider information...	Notify Provider Network Management using the Provider Change form located at: http://www.amerihealthcaritasla.com/provider/resources/forms/index.aspx Fax: 225-300-9126; Provider Services: 1-888-922-0007
If you would like information on the 835 Remittance Advice...	Contact your EDI Vendor or call Change Healthcare at 877-363-3666
Check the status of your claim...	Review the status of your submitted claims on NaviNet at: www.navinet.net
Sign up for NaviNet	www.navinet.net NaviNet Customer Service: 1-888-482-8057
Sign up for Electronic Funds Transfer	Contact Change Healthcare at 866-506-2830, Option 2

NOTES