Provider Claims & Billing Guide

Molina Healthcare of Iowa, Inc. - 2025

Last Updated: April 2025

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Claims Submission Information

Claim Submission

Participating providers are required to submit claims to Molina with appropriate documentation. Molina will accept 275 unsolicited transactions — additional information to support a health care claim or Encounter — through our clearinghouse. Providers must follow the appropriate State and CMS provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional claims, 837P for professional claims, and 837D for dental claims). For members assigned to a delegated medical group/IPA that processes its own claims, please verify the Claim Submission instructions on the member's Molina ID card.

Molina has configured our system to drive payment accuracy to the correct fee schedule based on provider type, and the 9-digit zip on the state's PMF is what we use to determine provider type. Please note: Molina is asking the Provider to use zip codes that they used when enrolling with Iowa Medicaid. If those zip codes now need to be updated, that would need to be done through Provider enrollment.

Providers must bill Molina for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge.

Required Elements

Electronic submitters should use the Implementation Guide and Molina Companion Guide for format and code set information when submitting or receiving files directly with Molina. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Molina website under Claims & Authorizations for regularly updated information regarding Molina's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Molina Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Molina website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic claim submissions will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- Total billed charges

- Place and type of service code
- Days or units as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Specialty Type/Taxonomy (as applicable)
- Rendering provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), HCPCS/CPT Code and the unit of measure and quantity for all drug claims
- E-signature
- Service Facility Location information
- Any other state-required data

Provider and member data will be verified for accuracy and active status. Be sure to validate this data in advance of claims submission. This validation will apply to all provider data submitted and also applies to atypical and out-of-state providers. Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Molina. Encounters must be corrected and resubmitted within 15 days from the rejection/denial. Molina created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to providers.

When Encounters are filed electronically providers should receive two types of responses:

- First, Molina will provide a 999 acknowledgement of the transmission.
- Second, Molina will provide a 277CA response file for each transaction.

Molina is partnered with March Vision Network for vision services. Please contact March Vision regarding questions related to claims or claims payments at (844) 496-2724 or visit online: March Vision Care.

Molina is partnered with Access 2 Care (an MTM Company) as our Non-Emergency Medical Transportation (NEMT) vendor. Visit A2C | MTM to learn more. Members will call (844) 544-1389 to schedule a ride.

Pharmacy point of sale claims must be submitted to CVS. Prior Authorization is required as noted on the PDL or for FDA approved drugs not found on the PDL (excluding non-covered drug categories). Completed prior authorization forms and supporting documentation should be faxed to Molina at (877) 733-3195.

Dental claims must be submitted to the dental payer on the back of the member ID card. Please contact the dental plan on the back of the member's ID card for questions regarding claims and payments.

Submitting a Prior Authorization Request

Molina Healthcare of Iowa will only process completed PA request forms; the following information MUST be included for the request form to be considered complete:

- Member first name, last name, date of birth and identification number.
- Prescriber first name, last name, NPI, phone number and fax number
- Drug name, strength, quantity and directions of use.
- Diagnosis.

Molina's decisions are based upon the information included with the PA request. Clinical notes are recommended. If clinical information and/or medical justification is missing, Molina will either fax or call your office to request clinical information be sent in to complete the review. To avoid delays in decisions, be sure to complete the PA form in its entirety, including medical justification and/or supporting clinical notes.

The preferred method for submitting prior authorizations is through the Availity Essentials Portal.

In the event you are unable to use the Availity Essentials Portal, you may fax a completed Medication PA Request form to Molina at (877) 319-6828 (limit 100 pages). A blank Medication PA Request Form may be obtained by accessing MolinaHealthcare.com or by calling (844) 236-1464.

CLAIMS PAYMENT INFORMATION

Payment Frequency

Molina performs check runs each day for Iowa claims. If you are signed up for EFT, you should expect to see deposits into your account 5 business days from the date of our check runs. Please note: providers must wait until they receive their first paper check from Molina to sign up for EFT with ECHO. If you are on checks, they will be mailed two business days after the check run date.

Claim Payment

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

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

Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) is technology used to verify and document that authorized HCBS visits occur. EVV ensures that services are delivered to the Members needing services, and that billing is correct. Molina contracts with CareBridge for EVV. To learn more about the EVV requirement, visit the HHS' EVV website. Services that are required to use EVV include, but may not be limited to:

Personal Care Services:

Code + Mod	Service Description	Program Type	Unit of Measure	Auth Issuance Type	Claim Type	Revenue Code
S5125	Attendant Care Services	n/a	15 min	Always	837p	n/a
S5125 U3	Attendant Care Services - Skilled	n/a	15 min	Always	837p	n/a
S5130	Homemaker NOS	n/a	15 min	Always	837p	n/a
T1019	Personal Care Services,	n/a	15 min	Always	837p	n/a
T1019 U3	Personal Care Services - Skilled	n/a	15 min	Always	837p	n/a

Home Health Services:

Code + Mod	Service Description	Program Type	Unit of Measure	Auth Issuance Type	Claim Type	Revenue Code
S9122	Home Health Aide	Waiver	Per Hour	Always	837p	n/a
S9123	Skilled Nursing (RN)	Waiver	Per Hour	Always	837p	n/a
S9124	Skilled Nursing (LPN)	Waiver	Per Hour	Always	837p	n/a
T1002	Nursing Care, RN, IMMT, home	n/a	Per 15 Min	Always	837p	n/a
T1003	Nursing Care, LPN, IMMT, home	n/a	Per 15 Min	Always	837p	n/a
T1004	Home Health Aide, IMMT	n/a	Per 15 Min	Always	837p	n/a
T1004 U3	Home Health Aide	n/a	Per 15 Min	Always	837p	n/a
T1021	Home Health Aide	n/a	Per Hour (2 hr.)	Always	837p	n/a
T1030	Nursing Care, RN, home	n/a	Per Hour (2 hr.)	Always	837p	n/a
T1031	Nursing Care, LPN, home	n/a	Per Hour (2 hr.)	Always	837p	n/a
S9122	Home Health Aide	Non-Waiver	Per Hour	Sometimes	837i	0572
S9123	Skilled Nursing (RN)	Non-Waiver	Per Visit	Sometimes	837i	0551
S9124	Skilled Nursing (LPN)	Non-Waiver	Per Visit	Sometimes	837i	0551
G0151	Physical Therapist (PT), home health setting or hospice	n/a	Per Visit	Sometimes	837i	0421
G0152	Occupational Therapist (OT), home health setting or hospice	n/a	Per Visit	Sometimes	837i	0431
G0153	Speech Language Pathologist (SLP or ST), home health setting or hospice	n/a	Per Visit	Sometimes	837i	0441
G0156	Home Health Aide, home health or hospice setting	n/a	Per Visit	Sometimes	837i	0571
G0158	OT Assistant, home health setting or hospice	n/a	Per Visit	Sometimes	837i	0431
G0159	PT, home health setting	n/a	Per Visit	Sometimes	837i	0421
G0160	OT, home health setting	n/a	Per Visit	Sometimes	837i	0431
G0161	SLP, home health setting	n/a	Per Visit	Sometimes	837i	0441
G0299	RN Direct Care, home health or hospice setting	n/a	Per Visit	Sometimes	837i	0551
G0300	LPN Direct Care, home health setting or hospice	n/a	Per Visit	Sometimes	837i	0551

CareBridge Contact Information

Training Resources: https://www.carebridgehealth.com/states/iowa
Request for Login Information: http://evv.carebridgehealth.com/loginrequest
Email: iaevv@carebridgehealth.com
Technical Support Center: (844) 343-3653

Electronic Claims Submission

Molina requires participating providers to submit claims electronically, including secondary claims. Electronic claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and claims reach Molina faster.

Molina offers the following electronic claims submission options:

- Submit claims directly to Molina via the Availity Essentials portal
- Submit claims to Molina via your regular EDI clearinghouse

Molina's payer ID is MLNIA. Our preferred Clearinghouse is SSI. Please see our Provider Manual by clicking here: Molina Healthcare of Iowa | Provider Manual 2025. You may also visit our website to see our EDI Submitter Companion Guide, which offers more instructions.

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

Participating providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow providers to reduce paperwork, provides searchable ERAs, and providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the provider for EFT enrollment, and providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery.

ECHO Health

Molina contracts with our payment vendor, Change Healthcare, who has partnered with ECHO Health, Inc. By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via Virtual Card. This method may include a fee that is established between you and your merchant agreement and is not charged by Molina or ECHO. You may opt out of this payment preference and request payment be reissued at any time by following the instructions on your Explanation of Payment and contacting ECHO Customer Service at (888) 834-3511 or edi@echohealthinc.com. Once your payment preference has been updated, all payments will go out in the method requested. If you would like to opt-out of receiving a Virtual Card prior to your first payment, you may contact ECHO Customer Service at (888)834-3511 or edi@echohealthinc.com and request that your Tax ID for payer Molina Healthcare of Iowa be opted out of Virtual Cards. Additional instructions on how to register are here: ECHO Health Inc.

Common Causes of Claims Processing Delays and Denials

- Missing or incomplete information;
- Diagnosis Code missing digits;
- Explanation of Benefits from the Primary Carrier is Missing or Incomplete;
- Provider TIN and NPI Do Not Match;
- Group NPI Taxonomy Code Missing or Invalid; and/or
- Dates of Service Span Do Not Match Listed Days/Units.

Common Causes of Up-Front Rejections

- Missing or Incomplete member Information;
- Missing Provider Name, Tax ID, NPI Number, missing taxonomy code or one that does not match records on file;
- Member Not Effective on the Date of Service;
- Missing or Invalid Occurrence Code or Date, or CPT/Procedure Code; and/or
- Institutional Claim (UB-04) exceeded the maximum 97 service line limit/Professional Claim (CMS-1500) exceeded the maximum 50 service line limit.

Clinical Laboratory Improvement Amendment (CLIA) Accreditation

All laboratory testing performed on humans in the U.S. is regulated by the Centers for Medicare & Medicaid Services (CMS) through the Clinical Laboratory Improvement Amendments (CLIA). Laboratory services for Molina must be provided through a CLIA certified lab in accordance with CLIA law. The CLIA ID should be indicated in field 23 on CMS-1500.

Any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code and/or does not have complete servicing provider demographic information will be considered incomplete and rejected. Types of CLIA Certificates:

- Certificate of Waiver
- Certificate of Registration
- Certificate of Accreditation
- Certificate for Physician-Performed Microscopy
- Certificate of Compliance

All lab claims must include the Clinical Laboratory Improvement Amendments (CLIA) certification number except for single line claims with one of the following procedures:

36415	36416	36600

Timely Filing

- In-network providers: 180 calendar days after the discharge for inpatient services or the Date of Service for outpatient services.
- Out-of-network providers: 365 calendar days after discharge or from the Date of Service.
- Coordination of Benefit/Third Party Liability: 365 days from last date of EOB from primary carrier.
- Corrected Claims: 365 calendar days from the last adjudication date for up to 2 years from Date of Service.

Third Party Liability / Coordination of Benefits

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

Medicaid is always the payer of last resort and providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Molina members. If third party liability can be established, providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Molina for secondary claim processing. If coordination of benefits occurs, provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the claim submission. Providers can submit claims with attachments, including EOB and other required documents. Molina will pay claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the provider requesting a refund including third party policy information required for billing.

Subrogation: Molina retains the right to recover benefits paid for a member's health care services when a third party is responsible for the member's injury or illness to the extent permitted under State and Federal law and the member's benefit plan. If third party liability is suspected or known, please refer pertinent case information to Molina's vendor at:

Crossover / COBA

Molina's policies and processes align with the CMS-developed national contract, the COBA, which standardizes how eligibility and Medicare claims payment information within an exchanged claim's crossover. Our affiliates have also passed multiple, rigorous readiness reviews with state regulators and CMS, demonstrating the ability to properly administer authorizations and adjudicate pharmacy and acute claims, and apply appropriate cost sharing with holding members harmless.

Under COBA, Medicaid providers submit claims for dually eligible members to the Medicare FFS claims system for processing. Medicare will:

1. Process the claims
2. Apply any deductible/coinsurance or copay amount
3. Forward the claim to Molina for further claims processing

Overpayments related to TPL/COB

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For members with Commercial COB, Molina will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. A provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. Molina will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A provider shall pay a claim for an Overpayment made by Molina which the provider does not contest or dispute within the specified number of days on the refund request letter mailed to the provider. If a provider does not repay or dispute the overpaid amount within the timeframe allowed Molina may offset the overpayment amount(s) against future payments made to the provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Molina, or the date that the provider receives a payment from Molina that reduces or deducts the overpayment.

"Lesser of" Logic

Secondary payment will be determined by paying the lesser of:

1) the difference between the amounts paid as if the Medicaid plan was primary and the actual payment was made from the primary plan; or
2) the amount reflected as the member's responsibility by the primary payer.

- Example 1 – Code 15845 – Billed $800. Negotiated Rate is $600. MCO pays $600 negotiated rate.
- Example 2 – Code 15845 – Billed $300. Negotiated Rate is $500. MCO pays $300 billed rate.

Optum Pause and Pay

Molina Healthcare is committed to continuously improving its overall payment integrity program and administers payment rules based on generally accepted principles of correct coding. Molina has partnered with Optum to implement best practices to reduce waste, abuse and error in medical claim billing through a pre-payment review. The intent of this payment integrity solution is to ensure that claims submitted to Molina Healthcare are coded and billed properly for accurate reimbursement. This program is designed to identify practices inconsistent with acceptable fiscal, business or medical practices that unnecessarily increase costs as well as overutilization of resources and inaccurate payments for service. Depending on the type of review, Optum may require medical records for review to support the services submitted on the claim and prior to payment determination. Medical records will be reviewed to verify the extent and nature of the services rendered for the patient's condition and that the claim is coded correctly for the services provided. This review does not include a determination of medical necessity. Referrals of aberrant billing patterns or behavior that may be potentially fraudulent may be made to the Special Investigations Unit (SIU). SIU may then pursue an internal investigation using established processes. This program will support Molina Healthcare's contractual obligations related to FWA contract language.

The submission of medical records is not a guarantee of payment, and Molina edits apply. Optum will review medical records within ten (10) business days of receipt. If the claim is supported, a letter will be mailed and the claim will be reprocessed. If the claim is partially supported, a letter will be mailed with the rationale for the denial and the claim will be reprocessed. If the claim is unsupported, a letter will be mailed with the rationale for the denial. If records are not received, the review is performed based on available information and a technical denial letter will be issued. Instructions for submitting a reconsideration or a first level dispute are included in the letter.

Reconsiderations and First Level Disputes

If a provider disagrees with a denial, a reconsideration if applicable and/or a dispute may be submitted to Optum for review. The communication must include an explanation of the disagreement of the denial as well as supporting documentation such as additional medical records and source information within applicable HHS filing guidelines. Upon review, if it is determined that a coding and/or payment adjustment is applicable, the healthcare provider will receive a letter from Optum with the review outcome and Molina will perform the appropriate claim adjudication.

Second Level Disputes

Instructions for submitting a second level dispute if applicable are included in the Optum first level dispute findings letter. Optum does not perform second level disputes. All communications sent by Optum are shared with Molina Healthcare for record retention.

Provider Inquiries/Support

Optum's Provider Inquiry Response Team (PIRT) is dedicated specifically to answering questions. Optum's provider inquiry team is equipped to educate providers on submitting medical records for review, case status,

understanding review outcome, etc. Providers can contact the Optum PIRT team at (877) 244-0403. Operational hours are Monday through Friday 8:00 a.m. to 6:30 p.m. CST, excluding holidays.

PROVIDER CLAIM DISPUTE PROCESS

Claims payment appeal or claims dispute is the initial request to investigate the outcome of a finalized claim. First level claim payment disputes are accepted electronically and in writing within 180 days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA). Second level disputes must be submitted within 30 days from original decision date. Disputes submitted after the specified timelines will be considered untimely and will be denied unless good cause can be validated.

Providers are encouraged to submit claim disputes electronically, using the Availity Essentials portal. Alternatively, claim disputes may be submitted using the form located on the MolinaHealthcare.com website.

The item(s) being resubmitted should be clearly marked as an appeal and must include the following documentation:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
- The Claim number clearly marked on all supporting documents

Molina will not take any punitive actions against any provider who files a Grievance or Claims Dispute.

*Please Note: Providers may submit a Claims Inquiry/Reconsideration in Availity, but only when no documentation needs review. A Reconsideration is useful if you suspect a minor error that can easily be remediated. Examples include retro-eligibility issues, coordination of benefit updates, Claims denied as a duplicate in error and Claims denied for no authorization when authorization is not required or when an approved authorization is on file. You **cannot** submit supporting documentation with a Claim payment inquiry. A payment reconsideration may result in a Claims adjustment or the outcome may direct you to submit a Corrected Claim or initiate the Claim Payment Dispute/Appeal process (including documentation).

Provider Claims Dispute

Claims disputes are the initial request to investigate the outcome of a finalized claim. First level claim payment disputes are accepted in electronically and writing within 180 days from the date on the Explanation of Payment (EOP) or the Provider Remittance Advice (PRA). Second level disputes must be submitted within 30 days from the decision on the original dispute. Disputes submitted after the specified timelines will be considered untimely and will be denied unless good cause can be validated.

The provider will be notified of Molina's decision in writing within 60 calendar days of receipt of the Claims Dispute/Adjustment request.

Claim reconsiderations shall be submitted at:

Availity Essentials portal: https://availity.com/molinahealthcare

Email: Iowaproviderinquiry@molinahealthcare.com
Fax: (855) 275-3082

Overpayment Disputes

If you disagree with an overpayment determination, please dispute via the Availity Provider Portal, with supporting documentation, within 45 days of the overpayment notification. You may submit a dispute, including any supporting documentation, along with a copy of the notification, via fax (712) 560-3821
or mail to the following address:

Molina Healthcare of Iowa, Inc.
Attn: Corporate Claims Recovery - Disputes
PO Box 2470
Spokane, WA 99210-2470

MODIFIERS

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books. Please see the HHS Procedure Code Modifiers List for more information: HHS | Procedure Code Modifiers.

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Molina uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same

provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

Modifier 59

Modifier 59 is defined as a Distinct Procedural Service and is used to identify procedures/services not normally reported together, but appropriately billable under the circumstances. Effective for dates of service on and after January 1, 2015, CMS established four HCPCS modifiers that are a subset of modifier 59 to provide more precise coding options. They are:

- XE – "Separate Encounter, a service that is distinct because it occurred during a separate encounter." Only use XE to describe separate encounters on the same date of service.
- XS – "Separate Structure, a service that is distinct because it was performed on a separate organ/structure"
- XP – "Separate Practitioner, a service that is distinct because it was performed by a different practitioner"
- XU – "Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service"

Modifier 25

"The use of modifier 25: Consistent with the general NCCI policy approach for the CPT instruction around these codes, the new edits are established to permit payment of both codes, if a significant, separately identifiable E&M service is provided on the same day as an administration code and a PTP associated modifier (i.e., modifier 25) is appended to the E&M code. All of the edits have a Correct Coding Modifier Indicator (CCMI) of "1", which permits the edit to be bypassed based on a correctly appended modifier. Providers should ensure they report E&M codes with immunization administration codes only if the E&M service is significant and separately identifiable and append modifier 25 with an E&M service code in order to bypass the PTP edits as appropriate."

Source: *HHS Informational Letter No.1219*

EMERGENCY ROOM SERVICES

Emergency Services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act.
- Needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, if a pregnant woman, the health the woman or her unborn child) in serious jeopardy; or
- Serious impairment to bodily organ or part. See 42 CFR §438.114(a).

Urgent care means those services rendered for an urgent medical condition or the protection of the public health. An urgent medical condition means a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, would reasonably expect the illness or injury to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in jeopardy
- Impairment to bodily functions, or
- Dysfunction of any bodily organ or part.

Emergent and urgent care Services are covered by Molina without an authorization. Screening and examination services conducted to determine if an emergency medical condition exists are also covered by Molina. This includes non-contracted Providers inside or outside of Molina's service area. Emergency services are available 24 hours per day, 7 days per week. Molina will process and adjudicate claims for non-contracted/non-Iowa Medicaid enrolled providers at the same amount that would have been paid if the service had been provided under Iowa's fee for service Medicaid program.

Consideration for Emergency Medical Services

Molina Healthcare of Iowa wants to ensure that each member has access to timely and appropriate care for emergency related conditions. To this end, the Molina Healthcare of Iowa will not:

- Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms
- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCO, or applicable State entity of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.
- Members will not be held liable for payment of subsequent screening and treatment need to diagnose the specific condition or stabilize the member.

The attending emergency physician, or the provider treating the member, is responsible or determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Molina Healthcare of Iowa.

The HHS Website has a detailed list of diagnosis codes used to determine emergency room payment. Click here to download.

Emergency Room Co-payments

In accordance with state requirements, there is an $8 copayment for Iowa Health and Wellness Plan Enrolled Members' non-emergency use of an ER and a $25 copayment for Hawki enrolled members' non-emergency use of an ER. A copayment shall not be imposed on Hawki enrolled members whose family income is less than 181%

of the federal poverty level or Iowa Health and Wellness Plan enrolled members whose family income is at or below 50% of the federal poverty level.

Before providing non-emergency services and imposing cost-sharing for such services on an individual, the hospital must:

- Inform the individual of the amount of their cost-sharing obligation for non-emergency services provided in the emergency department;
- Provide the individual with the name and location of an available and accessible alternative non-emergency services provider. If geographical or other circumstances prevent the hospital from meeting this requirement, cost-sharing may not be imposed;
- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost-sharing amount. The assessment of access to timely services shall be based on the medical needs of the enrolled member; and
- Provide a referral to coordinate scheduling for treatment by the alternative provider.

HOSPITAL READMISSIONS

The Medicaid National Correct Coding Initiative (NCCI) program was made to help states reduce improper payments in Medicaid and Children's Health Insurance Programs (CHIP).

The Medicaid NCCI contains two types of edits:

1. Procedure-to-Procedure (PTP) edits define pairs of Healthcare Common Procedure Coding System (HCPCS) /Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The PTP edits prevent improper payments when incorrect code combinations are reported.
2. Medically Unlikely Edits (MUEs) define, for each HCPCS/CPT code, the maximum Units of Service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

Please visit the CMS National Correct Coding Initiative (NCCI) website for more information.

OTHER RELEVANT INFORMATION

Interim Billing

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

Balance Billing / Member Acknowledgment Statement

Providers may not balance bill Molina members for any reason for covered services. Detailed information regarding the billing requirements for non-covered services is available in the Provider Manual. Providers must inform the member of their responsibility for payment of non-covered services prior to services being rendered.

The provider must obtain a written acknowledgment from the member to bill the member for non-covered services. Please have the member sign the following Member Acknowledgment Statement:

I understand that the services or items that I have requested to be provided to me on [dates of service] may not be covered by Molina Healthcare of Iowa, and in the opinion of [Provider's Name] they are reasonable and medically necessary for my care. I understand that Molina, through its contract with Iowa Medicaid determines medical necessity for the services and items that I receive. The cost of services to be rendered are estimated to be [price]. I understand that I am responsible for the payment of non-covered services and items that I request and receive if those services are not medically necessary or reasonable.

Newborn Billing

Providers should submit newborn claims with the newborn's Medicaid ID number. Providers should also complete the Newborn Notification Form and return to Molina within 12 hours of birth.

Atypical Providers

Atypical Providers are service providers that do not meet the definition of health care provider. Examples include taxi services, home and vehicle modifications, insect control, habilitation and respite services, etc. Although they are not required to register for an NPI, these providers perform services that are reimbursed by Molina. Atypical Providers are required to use the state assigned atypical NPI number given to them by the state of Iowa to take the place of the NPI. Providers should report the full atypical provider identification number in addition to the outlining requirement for the G2 qualifier.

HCBS Programs

Long-Term Care and Support Services (LTSS) and Home and Community Base Services (HCBS) are benefits that help members stay safe and independent in their home or community. Members can receive LTSS services if they need help with daily healthcare and living needs and meet the level of care eligibility standards.

Iowa has eight LTSS/HCBS programs:

- AIDS/HIV Waiver
- Brain Injury Waiver
- Children's Mental Health Waiver
- Elderly Waiver
- Health and Disability Waiver
- Intellectual Disability Waiver
- Physical Disability Waiver
- HCBS Habilitation Services

HCBS Habitation Services is an additional State plan amendment included with these programs. The HHS Home and Community Based Services (HCBS) Provider Manual has more information on HCBS programs and billing.

Behavioral Health and Substance Abuse Services

Behavioral Health and Substance Abuse services may be billed by Community Mental Health Centers and other Behavioral Health Service providers. More information can be found on the web site at Medicaid Provider Policy Manuals | Health & Human Services.

Behavioral Health Intervention Services (BHIS)

There will not be a Dx restriction placed on BHIS services. Covered services are available in a variety of settings and depending on the member's age and diagnosis, specific services offered may vary. Settings include:

- Community-based behavioral health intervention is available to a member living in a community-based environment.
- Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1)

Covered billing codes for intervention services can be found on the Iowa Medicaid fee schedule 6. The health plan would like to apply the denial of BHIS services from N1 when billed in the following places of service:

- 21,
- 32,
- 51, and/or
- 56.

B3 and Substance Use Disorder Services

Iowa Medicaid members enrolled with a Managed Care Plan (MCP) have access to an expanded array of mental health and substance use disorder services. These services are often referred to as "B3" services because they are authorized as a 1915(b)(3) waiver exemption by the Centers for Medicare and Medicaid Services (CMS) but require no additional HCBS eligibility like with Waivers or Habilitation State Plan Amendment (SPA).

IHAWP members are not eligible to receive B3 services, unless they are determined medically exempt. Provider eligibility to participate varies by service, but all require contract specific language to determine which B3 services and the corresponding rates (no state driven fee schedule or provider type).

- Providers of substance use disorder services must be licensed by the Iowa Department of Health and Human Services in accordance with Iowa Code Chapter 125.
- Providers of intensive psychiatric rehabilitation services and community support services must be provided by an accredited CMHC or a Chapter 24 accredited mental health service provider.
- Providers of peer support services and family peer support services must be certified through a state-recognized training program.
- Respite and integrated services and supports can be delivered by any MCO-contracted provider.

Common HCPCS Codes for B3:

- ASAM Level III.1 Clinically Managed Low Intensity Residential SUD Treatment (aka Transitional Residential Tx) - H2034
- ASAM Level III.3 and III.5 Clinically Managed Medium/High Intensity Residential SUD Treatment (aka Inpatient Rehab) – H0018 TF or H0017 TF
- ASAM Level III.7 Community-Based SUD Treatment (aka Detox) – H0018 TG
- Intensive Psychiatric Rehabilitation – H2017 U1-U5
- Community Support Services (CSS) – H0037 or H0037 TF
- Peer Support and Parent Peer Support – H0038
    - H0038 U4 – For children in Therapeutic Foster Care, ages 11-15
    - H0038 U5 – For children in Therapeutic Foster Care, ages 12-15
- Integrated Services and Supports (aka Wraparound Services) – H2022
    - H2022 X1 – increased supervision for 1 - 8 hours per day (1:1 Supervision)
    - H2022 X2 – increased supervision for 8.25 - 16 hours per day (1:1 Supervision)
    - H2022 X3 – increased supervision for 16.25 - 24 hours per day (1:1 Supervision)
    - H2022 X4 – Mentoring
    - H2022 X5 – Other Supports and Services
- Respite – H0045
    - H0045 U4 – Respite for members in Therapeutic Foster Care, ages 6-11
    - H0045 U5 – Respite for members in Therapeutic Foster Care, ages 12-15

Community Mental Health Centers (CMHC)

- Community Mental Health Centers (CMHCs) and the catchment area processes are defined by Chapter 230A.
- CMHCs are then accredited by standards in Iowa Admin Code Chapter 24 and designated for various catchment areas by the state (formerly IDPH, now Disability and Behavioral Health division).
- There can be more than one designated CMHC per catchment area depending on special circumstances
- CMHCs are eligible for block grants directly through the state to support infrastructure and community awareness efforts (not to compensate for service delivery).
- CMHCs have a specific Fee Schedule and Provider Type (21) that drives their billing and reimbursements.

Crisis Services

- Crisis providers in Iowa are accredited by the state under Iowa Admin Code Chapter 24 and then approved for Fee Schedule/Provider Type 80 or 81.
- The following crisis services are available for Medicaid billing:

Service	Procedure Code	Revenue Code	Unit of Service
Mobile Crisis Counseling	H2011	NA	15 min
Crisis Evaluation	90791	NA	Encounter

24 hr Access to Crisis	90839	NA	60 min
24 hr Access to Crisis	90840	NA	30 min
23 Crisis Observation & Holding	S0201	762	Per Diem – 8 to 23 hr
Crisis Stabilization Community or Residential	S9484	NA	60 min
Crisis Stabilization Community or Residential	S9485	761	Per Diem – 8 to 24 hr
Sub-Acute Crisis	H2013	190	Per Diem – 8 to 24 hr

State Resources

For additional information regarding Iowa Medicaid resources and requirements, please see the resources below.

Resource	Link
Fee Schedules	HHS | Fee Schedule
Sign up for Informational Letters	HHS | Informational Letters
HHS Procedure Codes Modifiers List	HHS | Procedure Code Modifiers
Habilitation Services Guide	HHS | Habilitation Services
Home and Community Based Services (HCBS)	HHS | HCBS
Medicaid Provider Manuals	HHS | Medicaid Provider Policy Manuals
Emergency Room Diagnosis Codes	HHS | ER Diagnostic Codes

General Resources

Resource	Link
March Vision	MARCH Vision Care | Join Our Network
Access 2 Care (An MTM Company)	A2C | Non-Emergency Medical Transportation
CareBridge Login	CareBridge | EVV Provider Log In
Sign up for EFT/ERA	ECHO | Provider EFT/ERA Enrollment
CMS National Correct Coding Initiative (NCCI)	CMS | The National Correct Coding Initiative (NCCI)
Centers For Medicare & Medicaid Services	CMS | Centers for Medicare & Medicaid Services

APPENDIX I

Date Span Billing with Examples (Waivers)

WAIVER BILLING

Span billing means you can bill for services over a range of dates within the same month (CMS 1500 only). The number of units billed for these dates do have to be an exact match. Examples of the correct way to bill with date spans are below: (Example – H2016 has a max of 31 units a month)

Dates of Service	Procedure Code	Billed Units
7/1/23 – 7/31/23	H2016	31 units
7/1/23 – 7/5/23	H2016	5 units
7/1/23 – 7/1/23	H2016	1 unit
7/6/23 – 7/8/23	H2016	3 units
7/1/23 – 7/27/23	H2016	27 units

You must bill within the same calendar month, and you cannot overlap any given calendar month, e.g., 07/15/23 through 08/10/23 – this would be two claims, one for July and one for August.

LONG TERM CARE FACILITY AND PSYCHIATRIC MEDICAL INSTITUTION FOR CHILDREN BILLING

When billing for inpatient room and board, claims should be submitted once per month at the end of the month unless the member is discharged prior. Note: Do NOT span calendar months.

INPATIENT HOSPITAL BILLING

Inpatient Hospital claim should not span across calendar years. These claims should be split billed. For example, member is admitted 12/15/23 and discharged 1/10/24, you should bill two separate claims: one for December and one for January.

DURABLE MEDICAL EQUIPMENT BILLING

Rental Items

- Codes paid at a monthly rental rate should be billed as one unit per line with a date span of one month.
- Codes paid at a daily rental rate should be billed with from/to dates of service that reflect the beginning and end of the rental period. The number of units billed should reflect the total number of days within that rental period.
    - Daily rental date spans should not include more than 31 days.
    - In the event that a member's month-to-month eligibility changes in the middle of a date span for daily rental the claim line should then be split consistent with eligibility dates.

Purchase Items

With the exception of codes for diabetic supplies, infusion pumps and enteral/parenteral nutrition supplies, purchased items should not be billed with a date span.

- When date span billing purchase items, bill the total number of units supplied, and span the number of days that the supply is for.

FQHC/RHC

FQHC and RHC providers are reimbursed at the Benefits Improvement and Protection Act of 2000 (BIPA) rate or the interim rate if a BIPA rate has not been determined. Note: bill with correct place of service (50 – FQHC; 72– RHC), and bill with appropriate encounter codes T1015 and CPT Codes (T1015 must be billed on the first claim line for all encounters). Rendering box/loop can be left BLANK for FQHC/RHC. If rendering provider NPI is billed, it should be the billing group NPI. The rendering 24J & Billing 33b NPI should match if both are submitted. If not, the claim will reject.

Hospice

Medicaid provides a daily reimbursement for every day that a member is hospice eligible. The daily rate is one of the four categories of care:

- Routine Home Hospice Care (Revenue Code 651): The hospice will be paid the Routine Home Care (RHC) rate for each day the member is at home, under the care of the hospice, and not receiving continuous home care.
- Continuous Home Hospice Care (Revenue Code 652): Continuous home care is covered when it is provided to maintain a member at home during a period of medical crisis. A period of crisis is a period of time when a member requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.
- Inpatient Respite Care (Revenue Code 655): Respite inpatient care is short-term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the member at home. Respite care is not paid when the hospice member is residing in a nursing facility.
- General Inpatient Care (Revenue Code 656): General inpatient care is provided in periods of acute medical crisis when the member is hospitalized for pain control or acute or chronic symptom management.

The additional claim requirements will apply to all hospice services billed to the HHS for the following revenue codes:

- 651 - Routine Home Care
- 652 - Continuous Home Care
- 655 - Inpatient Respite Care
- 656 - General Inpatient Care
- 657 - Direct Physician Care
- 658 – Nursing facility daily rate (95%)

The hospice claim will deny if:

- The begin date of the applicable hospice election period is missing,
- the date of service billed is not within the election period, and/or
- the Occurrence Code 27 is not present on the claim.

Hospice claims for Service Intensity Add-On services can only be reimbursed if the following conditions are met:

- Bill type = 81X OR 82X;
- Revenue code 0651 is present on the claim;
- Revenue code 0551 + procedure code G0299 are both present AND discharge status is 40, 41 or 42; or
- Revenue code 0561 + procedure code G0155 are both present AND discharge status is 40, 41 or 42.

If the previous conditions are not met, the claim will be rejected.

Observation Room

Code G0378 should be used to bill for outpatient services. This code replaces 99218ET.

In addition, at least 8 units of G0378 (Observation services, per hour) *up to* 72 hours must be reported and no procedure with a status indicator of T (significant procedure subject to multiple procedure discounting).

Out of Network Providers

With the exception of single case agreements and other arrangements established with Out-of-Network Providers, Molina shall pay Out-of-Network Providers no less than 80% of the rate of reimbursement to in-Network Providers unless otherwise required by law or regulatory requirement. Molina will pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program. Additionally, Out-of-Network providers must obtain a prior authorization.

POA Indicator

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1. Foreign Object Retained After Surgery
2. Air Embolism
3. Blood Incompatibility
4. Stage III and IV Pressure Ulcers

5. Falls and Trauma
    a. Fractures
    b. Dislocations
    c. Intracranial Injuries
    d. Crushing Injuries
    e. Burn
    f. Other Injuries
6. Manifestations of Poor Glycemic Control
    a. Hypoglycemic Coma
    b. Diabetic Ketoacidosis
    c. Non-Ketotic Hyperosmolar Coma
    d. Secondary Diabetes with Ketoacidosis
    e. Secondary Diabetes with Hyperosmolarity
7. Catheter-Associated Urinary Tract Infection (UTI)
8. Vascular Catheter-Associated Infection
9. Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10. Surgical Site Infection Following Certain Orthopedic Procedures:
    a. Spine
    b. Neck
    c. Shoulder
    d. Elbow
11. Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a. Laparoscopic Gastric Restrictive Surgery
    b. Laparoscopic Gastric Bypass
    c. Gastroenterostomy
12. Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13. Iatrogenic Pneumothorax with Venous Catheterization
14. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a. Total Knee Replacement
    b. Hip Replacement

What this means to Providers:

- Acute Inpatient Prospective Payment System (IPPS) Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: https://www.cms.gov/ .

POA Indicator Codes:

- Y: The condition was present or developing at the time of the order for inpatient admission.
- N: The condition was not present or developing at the time of the order for inpatient admission.
- U: Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
- W: Clinically undetermined. The provider is unable to clinically determine whether the condition was present or developing at the time of the order for inpatient admission.
- Leave the POA indicator field blank if the ICD-10 diagnosis is excluded from reporting the POA indicator.

Swing Bed Nursing Facility

Swing-bed placement is only intended to be short-term in nature. Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission.

- For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.
- A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

APPENDIX II: PHYSICIAN ADMINISTERED DRUG BILLING INFORMATION

1. Medicaid Drug Rebate Program (MDRP) Requirement:
    a. Only be covered if drug qualifies for rebate from the Medicaid Drug Rebate Program (MDRP) (Medicaid.gov).
    b. Iowa Medicaid will determine the rebate eligibility of drugs using the labeler code that identifies the manufacturer; the labeler code is the first 5 digits of the (11-digit) NDC code.

2. 340B
    a. All 340B CEs (providers) that use 340B drugs and serve Medicaid (FFS and MCO) members must do one of the following:
        i. 340B Medicaid CARVE-OUT
            1. Medicaid CARVE-OUT all prescriptions, physician-administered drugs, and other products from the 340B program
            2. Use non-340B drugs for all Medicaid (FFS or managed care) members you serve.
            3. Bill only for drugs, vaccines and diabetic supplies purchased outside the 340B program billed in accordance with existing Medicaid (FFS or managed care) reimbursement methodologies, allowing rebates to be collected where appropriate.
            4. Do not list the 340B entity's NPI on the HRSA Medicaid Exclusion File. This allows rebates to be collected where appropriate
        ii. 340B Medicaid CARVE-IN
            1. Use 340B drugs for all Medicaid (FFS or MC) members you serve.
            2. Inform OPA at the time of 340B enrollment that you intend to purchase and dispense 340B drugs for Medicaid (FFS or MC) members.
            3. Do not bill Medicaid (FFS or MC) for 340B acquired drugs and products if your NPI is not listed on the HRSA Medicaid Exclusion File.
            4. Purchase all drugs and other products billed to Medicaid (FFS or MC) on the CE's NPI under 340B unless the product is not eligible for 340B pricing.
            5. This ensures these claims are excluded from Medicaid rebate.
            6. Carved in entities should append the appropriate modifier to indicate that the drug was obtained through the 340B program at a discounted price (UD, TB and JG).
    b. Non-340B Claims: If the product is not eligible for 340B pricing do not include a modifier and bill at the regular Medicaid rate.

3. Injections

a. Are not covered when they are not specific or an effective treatment for the condition for which they are administered. We will look to the fee schedule for covered and non-covered codes.
b. Injected Medication Covered Services The following information must be provided when billing for injections:
    i. HCPCS code
    ii. NDC
        1. Must consist of 11 digits in a 5-4-2 format
    iii. Units of service
        1. Unit qualifier and the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. The Unite Qualifiers are:

F2	International Unit
GR	Gram
ML	Milliliter
ME	Milligram
UN	Unit

    iv. Charge for each injection*
        1. *When billing an "unlisted" J code (otherwise known as a "dump" code), in addition to the three bulleted items directly above, the provider should also indicate the charge for the injection.
c. Allergenic Extract
    i. injections used for self-administration are allowed. We will look to the fee schedule for covered and non-covered codes.

4. Vaccines
    a. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90472, 90473, and 90474, or their successor codes.
    b. COVID 19 Administration fees-****may need to change (see COVID 19 Administration fees)
    c. Not covered-immunizations for travel
        i. 90476, 90665, 90717, 90477, 90690, 90725, 90581, 90691, 90727, 90585, 90692, 90735, 90586, 90693, 90738
    d. Vaccine for Children (VFC) Program
        i. Payment for vaccines available through the VFC Program will be approved only if the VFC program stock has been depleted.
        ii. In order to be paid for the administration of a vaccine covered under the VFC Program, a physician must enroll in the VFC program.

iii. HAWKI children's vaccines are NOT covered through VFC. HAWKI children are considered to be insured and therefore do not meet the criteria for VFC. Payment for both the administration and the vaccine are covered through the benefit plan and reimbursement based off of the appropriate fee schedule.

e. Bill the appropriate vaccine administration codes for the vaccine administration in addition to the CPT code for the vaccine. Basis of reimbursement is Physician fee schedule and upper limit is physician fee schedule rate.

f. The following information must be provided when billing for injections:
   i. HCPCS code
   ii. NDC
   iii. Units of service

g. All vaccines are excluded from rebate program

5. Electronic Loops and Segments for Reporting

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

APPENDIX III: COMMON EDI REJECTION CODES AND DESCRIPTIONS

These are common rejection codes and their descriptions for EDI submissions from SSI. All errors indicated must be corrected before the claim is resubmitted:

Current Error Message(s)	New edit number	HAG	New Edit desc	Claim Status Category	Claim Status	Entity
01a. MISSING OR INVALID INSURED ID	195016	131850	Policy Number (2010BA/2330B*NM109) cannot be blank, must be at least 2 characters in length and must be a valid string.	A6	153	IL
02. MISSING OR INVALID PATIENT FIRST NAME	195018	77532	Patient First Name (2010CA*NM104) can not be blank and must be a valid string.	A6	125	QC
02. MISSING OR INVALID PATIENT LAST NAME	195022	10680	Patient Last Name (2010CA*NM103) Must Begin With an Alpha Character.	A6	125	QC
03 MISSING OR INVALID PATIENT SEX CODE	195023	57540	Patient Gender (2010BA/2010CA*DMG03) must be M, F, or U.	A7	157	QC
03. PATIENT BIRTHDATE REQUIRED	195024	55106	Patient Birth Date (2010BA*DMG02) must be a valid date and cannot be later than the submission date.	A6	158	QC

04. INSURED FIRST NAME INVALID	195026	70681	Primary Insured's First Name (2010BA*NM104) cannot be blank if Insured's Entity (2010BA*NM102) is "1" (Person).	A6	125	IL
04. INSURED FIRST NAME INVALID	195244	70681	If Insureds Entity (2010BA*NM102) is '2' (Non-person) then the Insured's First Name (2010BA*NM104), Middle initial/Middle Name(2010CA*NM105) and Generation (2010BA*NM07) must be blank.	A6	125	IL
04. INSURED FIRST NAME INVALID	195245	70681	Secondary Insured's First Name (2010BA*NM104) cannot be blank if Insured's Entity (2010BA*NM102) is "1" (Person).	A6	125	IL
04. INSURED FIRST NAME INVALID	195246	70681	If Insureds Entity (2010BA*NM102) is '2' (Non-person) then the Insured's First Name (2010BA*NM104), Middle initial/Middle Name(2010CA*NM105) and Generation (2010BA*NM07) must be blank.	A6	125	IL

04. INSURED LAST NAME INVALID	195029	74080	INSURED'S LAST NAME (2010BA*NM103) CANNOT BE BLANK. COLONS ARE NOT ALLOWED.	A6	125	IL
05. PATIENT'S ADDRESS INVALID	195031	75150	PATIENT STREET ADDRESS (2010BA*N301) can only contain valid characters A-Z 0-9 ! & ' , + ( ) - . / ; ? = NOTE: : COLON *ASTERISK ^ CARAT : COLON and ~ TILDE are not valid.	A6	126	QC
05. PATIENT CITY INVALID	195053	75161	PATIENT CITY (2010BA*N401) MUST BE AT LEAST TWO CHARACTERS AND MUST BE VALID STRING.	A6	502	QC
05. PATIENT STATE INVALID	195077	75196	Patient State (2010BA*N402) must be at least two characters in length.	A7	501	QC
05. Patient zip invalid for state	195078	75168	Patient Zip Code (2010BA*N403) must be at least 3 characters.	A7	500	QC
05. PATIENT ZIP INVALID	195197	72517	Patient Zip Code (2010BA/2010CA*N403) must be 5 or 9 numerics and must be a valid us zip code.	A7	500	QC

06. PATIENT RELATION INVALID	195079	130058	Relationship To Insured (2000C/2320*SBR02) must be:01 = SPOUSE, 18 = SELF, 19 = CHILD, 20 = EMPLOYEE, 21 = UNKNOWN, 39 = ORGAN DONOR, 40 = CADAVER DONOR, 53 = LIFE PARTNER, G8 = OTHER RELATIONS	A7	156	
Insured zip code not valid for insured state or is not 5 or 9 numeric characters.	195198	72525	Primary Insureds Zip (2010BA*N403) must be 5 or 9 numerics and must be a valid zip code.	A7	500	IL
<Various messages depending on particular missing data>			No Edit	A7	448	
09. Other insured date of birth same as patient, but other insured name does not match patient			No Edit	A7	125	GB
09. OTHER INS. FIRST NAME INVALID	199264		Other Subscriber First Name (2010CA*NM104) cannot be blank if Other Payer Name (2330B*NM103) is submitted.	A6	125	GB
09. OTHER INS. FIRST NAME INVALID	199265		Other Subscriber First Name (2010CA*NM104) cannot be blank if Other Payer Name (2330B*NM103) is submitted.	A6	125	GB

09. OTHER INS. BIRTHDATE INVALID			No Edit	A6	158	GB
09. OTHER INS. SEX INVALID			No Edit	A7	157	GB
11. PRIMARY PAYOR ID INVALID	195344	34590	Primary Payor Name (2010BB*NM103/2330B*NM103) cannot be blank and must be a valid string.	A7	26	PR
15. DATE OF SIMILAR ILLNESS INVALID	195345		SIMILAR SYMPTOM DATE (2300*DTP*438) must be after submission date.	A7	192	
20. LAB CHARGES INVALID			No Edit	A6	179	
21.1 DIAGNOSIS CODE INVALID			No Edit	A7	255	
21.2 DIAGNOSIS CODE INVALID			No Edit	A7	255	
21.3 DIAGNOSIS CODE INVALID			No Edit	A7	255	
21.4 DIAGNOSIS CODE INVALID			No Edit	A7	255	
24a. FROM DATE OF SERVICE MUST BE PRESENT AND CANNOT BE PRIOR TO ONSET OR ACCIDENT DATE	195080	3876	Service From Date (2400*DTP*472) cannot be blank.	A7	448	

P.O.S. INVALID	195081	131822	Place of Service (2400*Sv105) must be valid.	A7	249
Modifier 1 must be 2 characters	195082	5733	Modifier (2400*SV101-3) must be two alphanumerics.	A7	453
Modifier 2 must be 2 characters	195083	5735	Modifier (2400*SV101-4) must be two alphanumerics.	A7	453
Modifier 3 must be 2 characters	195084	49186	Modifier (2400*SV101-5) must be two alphanumerics.	A7	453
24d. PROCEDURE CODE INVALID	195085	25320	Procedure Code (2400*SV101-2) must be a valid CPT or HCPCS code.	A7	454
24e INVALID DIAGNOSIS POINTER 1	195187	71133	Diagnosis pointer 1 (2400*Sv107-1) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.	A7	477
24e INVALID DIAGNOSIS POINTER 2	195188	132694	Diagnosis pointer 2 (2400*Sv107-2) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.	A7	477
24e INVALID DIAGNOSIS POINTER 3	195189	132696	Diagnosis pointer 3 (2400*Sv107-3) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.	A7	477
24e INVALID DIAGNOSIS POINTER 4	195190	132697	Diagnosis pointer 4 (2400*Sv107-4) must be 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 or 12.	A7	477
24e. MISSING DIAGNOSIS POINTER	195086	67887	Diagnosis Code Pointer (2400*SV107-1) cannot be blank.	A7	477

8 possible messages: (1) No adjustment segments present for prior adjudication. One or more CAS segments are required in LOOP 2430 when SVD segment is present	195106	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Primary Adjustment Group Code (2320/2430*CAS01) is required and must be CO, CR, OA or PR.	A7	448
8 possible messages: (2) Missing or invalid claim paid date for prior adjudication. DTP segment required in LOOP 2430 when SVD segment is present. Date reported cannot be greater than current date.	195107	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Adjudication Date (2330B*DTP*573) is required.	A7	448
8 possible messages: (3) Service adjustments and payments do not balance. Sum of adjustments and payments must equal service charge	195108	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Claim level Adjustments (2320*CAS) are required when COB Total Paid Amount (2320*AMT*D) does not equal the Total Charges(CLM02).	A7	448
8 possible messages: (4) Claim adjustments and payments do not balance. Sum of adjustments and payments must equal claim charge	195108	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Claim level Adjustments (2320*CAS) are required when COB Total Paid Amount (2320*AMT*D) does not equal the Total Charges(CLM02).	A7	448

8 possible messages: (5) Missing claim paid amount. The segment is required in loop 2320 when the claim has been adjudicated by the payer.	195109	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	COB TOTAL PAYER PAID (2320*AMT*D) is required and must be greater than 0 (zero) if claim level Adjustments (2320*CAS) do not equalthe Total Charges (2300*CLM02).	A7	448
8 possible messages: (6) COB Payer ID Missing or Invalid. Payer ID is required in NM109 in loop 2330B. If segment SVD is present in loop 2430, SVD02 must also be present and match the loop 2330B value		(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	No Edit	A7	448
8 possible messages: (7) Adjustment data missing or payer id mismatch. CAS segments are required for each payer where prior adjudication is indicated, and the total payments for that payer do not equal the claim charges. Payer IDs in LOOP 2430 must match those in LOOP 2330B	195106	(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit (7) 182107 (8) No Edit	Primary Adjustment Group Code (2320/2430*CAS01) is required and must be CO, CR, OA or PR.	A7	448
8 possible messages: (8) Service level adjudication present using a payer ID that matches the ID for multiple payers in loop 2330B. NM109 in loop		(1) 182107 (2) 131819 (3) 137463 (4) 137463 (5) 139606 (6) No Edit	No Edit	A7	448

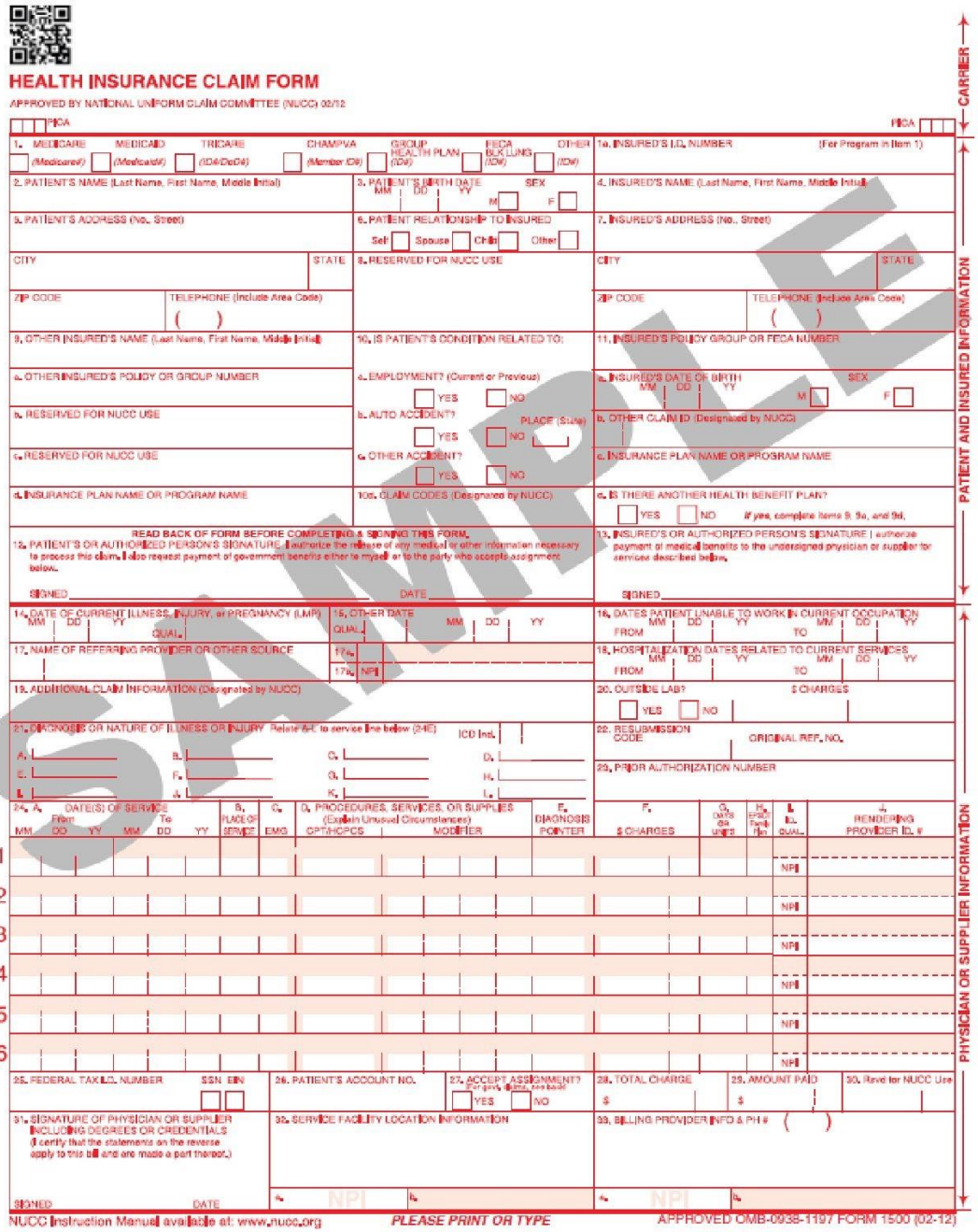
2330B must be unique across all iterations of that loop for a claim if those values are used in SVD01 in loop 2430.		(7) 182107 (8) No Edit				
Patient account number is required	195111	11489	Patient Account Number (2300*CLM*01) cannot be blank and cannot be longer than 20 characters and must be a valid string.	A6	478	
31. MISSING PHYSICIAN NAME IN THE PROVIDER TABLE When submitting claims as an individual, the physician name must be completed in the provider table of the setup tab.	195112	139608	When billing for a group the Rendering Physician (2310B*NM1) is required.	A6	125	82
31. PHYSICIAN NAME INVALID		No Edit	No Edit	A6	125	82
24g. ANESTHESIA MINUTES INVALID	195113	90056	Charge Measurement Code (2400*SV103) must be MJ for anesthesia related charges.	A6	251	
INVALID ORDERING PROVIDER PRIMARY ID QUALIFIER. It must be 24, 34, or XX.	195114	106561 133874	Ordering Provider NPI (2420*NM109) is required.	A7	745	DK

INVALID ORDERING PROVIDER PRIMARY ID QUALIFIER. It must be 24, 34, or XX.	195115	106561 133874	If Physician Identifier code 82, QB, DQ, DK, DN, or P3(2430*NM102) exist then the associated NPI (2420*NM109) is required.	A7	745	DK
Invalid Provider City, must be at least two characters. Please update in the Provider table of the Setup Tab.	195116	76452	Provider City (2010AA*N401) must be least two characters.	A7	502	85
Invalid Provider State. Please update in the Provider table of the Setup Tab.	195117	131676	Provider State (2010AA*N402) is required.	A7	501	85
Provider address must be physical address	195118	131669	PROVIDER ADDRESS LINE 1 (2010AA*N301) must be a physical address.	A7	126	85
Rendering provider primary id qualifier must be XX and primary id must be valid NPI	195119	131799	If Physician Identifier code 82, DQ, DN, or P3 (2310*NM102) exist then the associated NPI (2310*NM109) is required.	A7	562	82
2 possible messages: (1) Drug quantity is missing. CPT04 is required in loop 2410 when NDC code is submitted	195120	133626 133627	-National Drug Unit Count (2410*CTP04) is required. -National Drug Unit Count (2410*CTP04) must be blank if NDC(2410*LIN03) is blank.	A6	216	

2 possible messages: (2) Drug unit code is missing or invalid. CPT05-1 is required in loop 2410 when NDC code is submitted	195186	133626 133627	DRUG CODE QUALIFIER (2410*CTP05) MUST BE F2, GR, ME, ML, UN.	A6	216	
Claim total charges (CLM02) must equal sum of service line charges (SV102)			No Edit	A7	448	
Billing provider NPI is required	195121	130043	Billing Provider NPI (2010AA*NM109) cannot be blank.	A7	562	85
Procedure code qualifier invalid. ICD-10 qualifiers required.			No Edit	A7	448	
Claim cannot contain a mix of ICD-9 and ICD-10 procedure code qualifiers.	195122	25270	Diagnosis code must be a valid ICD9 (2300*HI*BK/BF) or ICD10(2300*HI*ABK/ABF) code.	A7	448	
Diagnosis code invalid.	195122	25270	Diagnosis code must be a valid ICD9 (2300*HI*BK/BF) or ICD10(2300*HI*ABK/ABF) code.	A7	255	

3 possible messages: (1) Service dates cannot span ICD-10 code implementation date (2) Services prior to ICD-10 implementation date must use ICD-9 diagnosis codes. (3) Services after ICD-10 implementation date must use ICD-10 diagnosis codes.	195122	25270	Diagnosis code must be a valid ICD9 (2300*HI*BK/BF) or ICD10(2300*HI*ABK/ABF) code.	A7	448
21. diagnosis code out of sequence. Codes must be present in order without skipping.			No Edit	A7	448
Primary diagnosis cannot be external cause of injury code	195191	160171	ICD-10-CM Diagnosis codes (2300*HI*ABK/ABF) in the range V00-Y999 cannot be used as Primary Diagnosis code.	A7	448
Release of benefits indicator is invalid			No Edit	A7	333
Release of information code is invalid			No Edit	A7	360
Claim does not balance. Sum of service charges does equal total charges			No Edit	A7	400

APPENDIX IV: CLAIMS FORM INSTRUCTONS CMS 1500



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

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

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Reserved for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

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

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
1	2000B	SBR09	INSURANCE PROGRAM IDENTIFICATION	Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter "X" in the box noted "Other."	R
1a	2010 BA	NM109	INSURED'S I.D. NUMBER	The 9-digit identification number on the member's Health Plan I.D. Card	R
2	2010CA OR 2010BA	NM103 (last name) NM104 (first name) NM105 (middle name) NM107 (name suffix)	PATIENTS NAME (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Health Plan I.D. card. Do not use nicknames.	R
3	2010CA or 2010BA	DMG02 (DOB) DMG03 (sex)	PATIENT'S BIRTH DATE/SEX	Enter the patient's 8 digit date of birth (MM/DD/YYYY), and mark the appropriate box to indicate the patient's sex/gender. M= Male F= Female	R
4	2010BA	N302 (2nd address line) N401 (city)	INSURED'S NAME	Enter the patient's name as it appears on the member's Health Plan I.D. Card	C

		N402 (state) N403 (zip)			
5	2010CA	N302 (2nd address line) N401 (city) N402 (state) N403 (zip)	PATIENT'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Does not exist in the electronic 837P.	C

6	**2000B** **2000C**	**SBR02** **PAT01**	**PATIENT'S RELATION TO INSURED**	**Always mark to indicate self.**	**C**

7	2010BA	N301, N302 N401, N402, N403	INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)	Enter the patient's complete address and telephone number, including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). ***Note:*** Does not exist in the electronic 837P.	C

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
8	N/A	N/A	RESERVED FOR NUCC USE		Not Required
9	2330A	NM103 (last name) NM104 (first name) NM105 (middle name) NM107 (name suffix)	OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.	C

9a	2320	SBR03	*OTHER INSURED'S POLICY OR GROUP NUMBER	REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.	C
9b	2320	DMG02 (DOB) DMG03 (sex)	RESERVED FOR NUCC USE		Not Required
9c	N/A	N/A	RESERVED FOR NUCC USE		Not Required
9d	2320	SBR04	INSURANCE PLAN NAME OR PROGRAM NAME	REQUIRED if field 9 is completed. Enter the other insured's (name of person listed in field 9) insurance plan or program name.	C
10a,b,c	2300	CLM11	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	2300	K3	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	2000B	SBR03	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C

11a	**2010BA (DOB)**	**DMG02 (DOB) DMG03 (sex)**	**INSURED'S DATE OF BIRTH / SEX**	**Enter the 8-digit date of birth (MM DD YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.**	**C**
11b	N/A	N/A	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier has been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	2000B	SBR04	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	2320		IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If Yes, complete field's 9a-d and 11c.	R
12	2300	CLM09	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	2300	CLM08	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required

14	2300	DTP03	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY	Enter the 6-digit (MM DD YY) or 8-digit (MM DD YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual	C

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
			(Accident) OR Pregnancy (LMP)	period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	
15	2300	DTP03	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6 digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format.	C
16	2300	DTP03	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	2310A	NM103 (last name) NM104 (first name) NM105 (middle name) NM107 (suffix)	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C

17a	2310A	REF02	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	2310A	NM109	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	2300	DTP03	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	2300	NTE	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION		C
20	2400	PS102	OUTSIDE LAB / CHARGES		C
21	2300	HI01-2; HI02-2;HI03-2, HI04-2	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Services requiring a diagnosis for payment (example: Emergent Diagnosis, DRG and IHAWP sleep apnea claims), the diagnosis must be in the primary diagnosis position. ***Note:*** Claims missing or with invalid diagnosis	R

				codes will be rejected or denied for payment.	
22	2300	CLM05-3 REF02	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	2300	REF02	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)

24a-j General Information	**(see below)**	**(see below)**	**Box 24 contains six claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields.** **The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number.** **Shaded boxes 24 a-g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete.** **If you are a FQHC/RHC/Indian Health Center, Chapter 24 provider or have an atypical NPI, leave box 24J blank or use your billing NPI in this box. If the provider is any of the below this field can have clinic number or be left blank. If left blank, the provider is expected to bill it in the billing provider field.** • **08 - PHARMACY** • **09 - HOME HEALTH AGENCY** • **10 - INDEPENDENT LAB** • **11 –AMBULANCE** • **12 - MEDICAL SUPPLIES** • **13 – RURAL HEALTH CLINIC** • **16-CHIROPRACTOR** • **19- REHAB AGENCY** • **21- COMMUNITY MENTAL HEALTH CENTER** • **22 – FAMILY PLANNING** • **30 - SCREENING CENTER** • **34 - ORTHOPEDIC SHOE DEALER** • **35 - MATERNAL HEALTH CENTER** • **36 - AMBULATORY SURGICAL CENTER** • **42 – TARGETED CASE MANAGEMENT** • **49 - FEDERAL QUALIFIED HEALTH** • **62-OTHER BEHAVIORAL HEALTH PROVIDERS**

			• **63 - BEHAVIORAL HLTH INTERVENTION SRVS IS)** • **64 – HABILIATION** • **71 - HEALTH HOME** • **72 - PUBLIC HEALTH AGENCIES** • **73 - INTEGRATED HEALTH HOME** • **80 – CRISIS RESPONSE SERVICES** • **81 – SUBACUTE MENTAL HEALTH** • **99 – WAIVER** **The un-shaded area of a claim line is for the entry of claim line item detail.**		
24 A-G Shaded			SUPPLEMENTAL INFORMATION	The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide.	C
24A Unshaded	2400	DTP03	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was performed (MM□DD□YYYY). If there is only one date, enter that date in the "From" field. The "To" field may be left blank or populated with the "From" date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.	R
24B Unshaded	2400	SV105	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current	R

				POS Codes may be found on the CMS website.	

24C **Unshaded**	**2400**	**SV109**	**EMG**	**Enter Y (Yes) or N (No) to indicate if the service was an emergency.**	**Not Required**
24D Unshaded	2400	SV101 (2-6)	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R

24 E Unshaded	2400	SV107 (1-4)	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM or ICD10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24 F Unshaded	2400	SV102	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
24 G	2400	SV104	DAYS OR	Enter quantity (days, visits, units). If only one	R
Unshaded			**UNITS**	**service provided, enter a numeric value of one.**	

24 H Shaded	2400	SV111 (EPSDT) SV112 (Family Planning)	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	2400	SV111 (EPSDT) SV112 (Family Planning)	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	2310B 2420A	PRV02, REF01 REF01	ID QUALIFIER	Use ZZ qualifier for Taxonomy,. Use 1D qualifier for ID, if an Atypical Provider.	R
24 J Shaded	2310B 2420A 2310B	NM109 NM109 PRV03, REF02	NON-NPI PROVIDER ID#	<u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. <u>Atypical Providers:</u> Enter the Provider ID number.	R
24 J Unshaded	2310B 2420A 2310B	NM109 NM109 PRV03, REF02	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider’s 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health,	R

					RHC/FQHC General Medical Exam, etc.).	
25		2010AA	NM109 REF02	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26		2300	CLM01	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
27	2300	CLM07	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to an Health Plan Member using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	2300	CLM02	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00),	R

				enter 00 in the area to the right of the vertical line.	
29	2300 2320	AMT02	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Health Plan. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C
30	N/A	N/A	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use	C

				commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
31	2300	CLM06	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the practitioner or practitioner's authorized representative MUST sign the form. If signature is missing or invalid, the claim will be returned unprocessed. ***Note:*** Does not exist in the electronic 837P.	R

32	2310D or 2010AA 2310D or 2010AA 2310D or 2010AA 2310D or 2010AA 2310D or 2010AA 2310D or 2010AA	NM101 (entity identifier code) NM103 (name) N301 (address) N302 (address 2) N401 (city) N402 (state) N403 (ZIP)	SERVICE FACILITY LOCATION INFORMATION	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.	C
32a	2310D	NM109	NPI – SERVICES RENDERED	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID of the facility where services were rendered.	c

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
32b	2310D	REF02	OTHER PROVIDER ID	REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers: Enter the 2-character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers: Enter the 2-character qualifier 1D (no spaces).	C
33	2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB 2010AA or 2010AB	NM103 (last name or organizational name) NM104 (first name) NM105 (middle name) NM107 (name suffix) N301 (address) N302 (address 2) N401 (city) N402 (state) N403 (ZIP) PER04 (communication number)	BILLING PROVIDER INFO & PH#	Enter the billing provider's complete name, address (include the zip + 4 code, no hyphen), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state. Fourth line- Enter the zip code and phone number. When entering a 9-digit zip code (zip+ 4 code), DO NOT include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555) 555-5555. ***Note:*** The 9-digit zip code (zip + 4 code, no hyphen) is a requirement for paper and EDI claim submission.	R

33a	2010AA	NM109	GROUP BILLING NPI	Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the 10-character NPI ID.	R

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
33b	2010AA	REF02	GROUP BILLING OTHERS ID	Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.	R

APPENDIX V – CLAIMS FORM INSTRUCTIONS – UB

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

Completing a UB-04 Claim Form

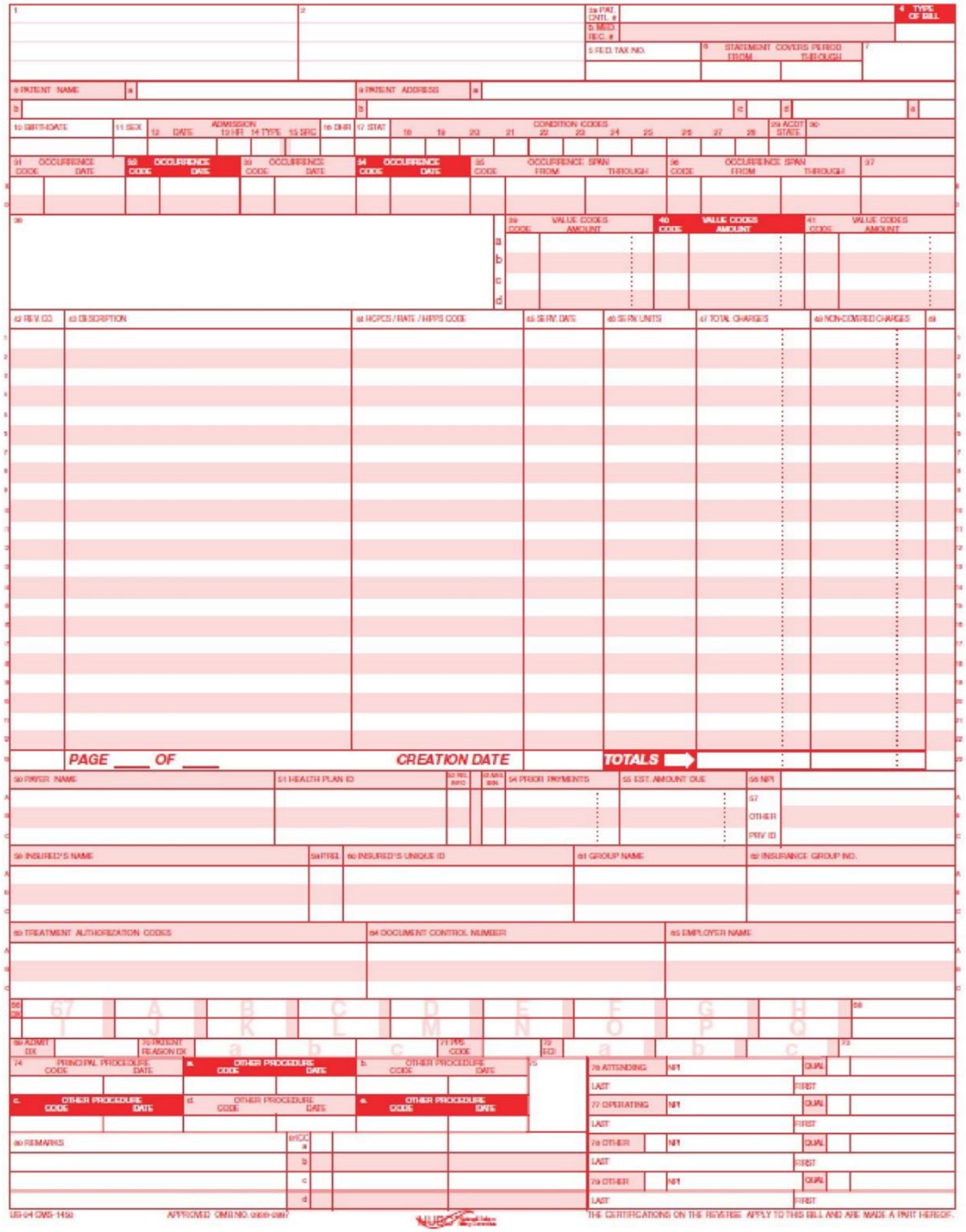
A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Molina. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services,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

UB-04 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

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

UB-04 Claim Form Example



Required Fields

Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

Field #	Loop 837I	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
1	**2010AA**	**NM1** **N3, N4**	UNLABELED FIELD	LINE 1: Enter the complete provider name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). Note: The 9 digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	**2010AB**	**NM1** **N3, N4**	UNLABELED FIELD	Enter the Pay- to Name and Address.	Not Required
3a	**2300**	**CLM**	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	**2300**	**REF**	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4			TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading “0” (zero). A leading “0” is not needed. Digits should be reflected as follows:	R

				1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	
5	**2010AA**	**REF**	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	**2300**	**DTP**	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7			UNLABELED FIELD	Not used.	Not Required

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
8a-8b	**2010BA**	**NM1**	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the enrollee's Health Plan I.D. card	Not Required
				8b – Enter the patient's last name, first name, and middle initial as it appears on the Health Plan ID card. Use a comma or space to separate the last and first names.	R

				Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name (e.g. McKendrick. H). Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: a space should separate a last name and suffix. Enter the patient's complete mailing address of the patient.	
9	**2010BA**	**N3, N4**	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: Country Code (NOT REQUIRED)	R (except line 9e)
10	**2010BA**	**DMG**	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY).	R
11	**2010BA**	DMG	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	**2300**	**DTP**	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the tHHS using 2-digit military tHHS (00-23) for the tHHS of inpatient admission or tHHS of treatment for outpatient services.	R

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional

13	**2300**	**DTP**	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02- 02:00 to 02:59 14-02:00 to 02:59 03- 03:00 to 03:39 15-03:00 to 03:59 04- 04:00 to 04:59 16-04:00 to 04:59 05- 05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R
14	**2300**	**CL1**	ADMISSION TYPE	Require for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R

15	**2300**	**CL1**	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: Physician Referral 1 Clinic Referral 2 Health Maintenance Referral (HMO) 3 Transfer from a hospital 4 Transfer from Skilled Nursing Facility 5 Transfer from another healthcare facility 6 Emergency Room	R

7 **Court/Law Enforcement** 8 **Information not available** **For Type of admission 4 (newborn):** 1 **Normal Delivery** 2 **Premature Delivery** 3 **Sick Baby** 4 **Extramural Birth** 5 **Information not available**

16	DISCHARGE HOUR	Enter the tHHS using 2 digit military tHHSs (00-23) for the tHHS of the inpatient or outpatient discharge. 0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02- 02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 -03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	C

17	**2300**	**CL1**	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2 digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice	R

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
				08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) **20** Expired or did not recover **30** Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/Transferred to a federal hospital (such as a Veteran's Administration [VA] hospital) 50 Hospice—Home 51 Hospice—Medical Facility 61 Discharged/ Transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/ Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH)	

					64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH) Additionally, please allow ALL of these patient discharge status codes: 21, 69, 70, 71, 72, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95	
18-28	**2300**	**HI**		CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29				ACCIDENT STATE		Not Required

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
30			UNLABELED FIELD	NOT USED	Not required

31-34 a-b	**2300**	**HI**	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	**2300**	**HI**	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer	C

				to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	
37			(UNLABELED FIELD)	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38			RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	**2300**	HI	VALUE CODES CODES and AMOUNTS	Code: **REQUIRED** when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a 2-character code. Codes should be entered in alphanumeric	C

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
				sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All “a” fields must be completed before using “b” fields, all “b” fields before using “c” fields, and all “c” fields before using “d” fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: **REQUIRED** when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	
General Information Fields 42-47			SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information.	

				Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	**2400**	**SV2**	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	**2400**	**SV2**	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22			DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43			PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of	C

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional

Line 23				pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e. PAGE “1” OF “1”). (Limited to 4 pages per claim)	
44	**2400**	**SV2**	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	**2400**	**DTP**	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	**2400**	**DTP**	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	**2400**	**SV2**	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the	R

				number of days for each accommodation listed.	
47 Line 1-22	**2400**	**SV2**	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	**2400**	**SV2**	TOTALS	Enter the total charges for all service lines.	R
48 Line 1-22	**2400**	**SV2**	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	**2400**	**SV2**	TOTALS	Enter the total non-covered charges for all service lines.	C
49			(UNLABELED FIELD)	Not Used	Not Required

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
50 A-C	**2000B**	**SBR**	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	**2000B**	SBR	HEALTH PLAN IDENTIFICATION NUMBER		Not Required

52 A-C	**2300**	CLM	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	**2300**	CLM	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54			PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid is listed as secondary or tertiary.	C
55	**2300**	**AMT**	EST. AMOUNT DUE		Not Required
56	**2010AA**	**NM1**	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10-character NPI ID.	R
57	**2310C**	NM1	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non - NPI number) of the billing provider.	R
58	**2010BA**	NM1	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name.	R

				Enter the name as last name, first name, middle initial.	
59	**2000B**	SBR	PATIENT RELATIONSHIP		Not Required
60	**2010BA**	REF	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61			GROUP NAME		Not Required

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
62			INSURANCE GROUP NO.		Not Required
63	**2300**	**REF**	TREATMENT AUTHORIZATION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C
64	**2300**	**REF**	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim).	C

				* Please refer to reconsider/corrected claims section.	
65	**2320**	**SBR**	EMPLOYER NAME		Not Required
66			DX VERSION QUALIFIER		Not Required
67	**2300**	**HI**	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Services requiring a diagnosis for payment (example: Emergent Diagnosis, IHAWP sleep apnea claims), the diagnosis must be in the principal diagnosis position.	R
67 A-Q	**2300**	**HI**	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the tHHS of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" and most “V” codes are **NOT**	C

				acceptable as a primary diagnosis. ***Note:*** Claims with incomplete or invalid diagnosis codes will be denied.	
68			PRESENT ON ADMISSION INDICATOR		R
69	**2300**	**HI**	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the tHHS of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or“5” digit. "E" codes	R

Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
				and most “V” are **NOT** acceptable as a primary diagnosis. ***Note:*** Claims with missing or invalid diagnosis codes will be denied.	

70	**2300**	HI	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the tHHS of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or"5". "E" codes and most "V" codes are NOT acceptable as a primary diagnosis. ***Note:*** Claims with missing or invalid diagnosis codes will be denied.	R
71	**2400**	**SV2**	PPS/DRG CODE		Not Required
72 a,b,c			EXTERNAL CAUSE CODE		Not Required
73			UNLABELED		Not Required
74	**2300**	**HI**	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C

74 a-e	2300	**HI**	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75			UNLABELED		Not Required
Field #	Loop 837P	Segment / Element	Field Description	Instruction or Comments	Required or Conditional
76	**2310A**	**NM1**	ATTENDING PHYSICIAN	Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician's last name.	R

				FIRST: Enter the attending physician's first name.	
77	**2420A**	**NM1**	OPERATING PHYSICIAN	REQUIRED when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID. Hospice Providers billing for room and board (revenue code 658) can use box 77 for the nursing facility NPI. Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code.	C

78 & 79	**2420B**	**NM1**	OTHER PHYSICIAN	Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care. (Blank Field): Enter one of the following Provider Type Qualifiers: DN – Referring Provider. ZZ – Other Operating MD. 82 – Rendering Provider. NPI: Enter the other physician 10-character NPI ID.	C
				QUAL: Enter one of the following qualifier and ID number: 0B - State license number 1G - Provider UPIN number G2 - Provider commercial number	
80	**2300**	**NTE**	REMARKS		Not Required
81	**2000A**	**PRV**	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82			Attending Physician	Enter name or 7-digit Provider number of ordering physician.	R