delaware first health

2024 Provider Billing Manual

www.DelawareFirstHealth.com

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Introductory Billing Information

Welcome to Delaware First Health! Thank you for being a part of our network of participating physicians, hospitals, and other healthcare professionals. This guide provides information to support your claims billing needs and can be used in conjunction with the Delaware First Health Provider Manual located in the "For Providers" section of our website at www.delawarefirsthealth.com.

Billing Instructions

Delaware First Health follows Centers for Medicare & Medicaid Services (CMS) rules and regulations, specifically the Federal requirements set forth in 42 USC § 1396a(a)(37)(A), 42 CFR § 447.45 and 42 CFR § 447.46; and in accordance with State laws and regulations, as applicable.

General Billing Guidelines

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with Delaware First Health for payment of covered services. Provider participation agreements are executed only for providers validated by Delaware First Health as enrolled with Delaware Medical Assistance Program (DMAP).

It is important that providers ensure Delaware First Health has accurate billing information on file. Please confirm with our Provider Relations department that the following information is current in our files:

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

Providers must bill with their NPI number in box 24Jb. We require providers to also bill their taxonomy code in box 24Ja and the Member's Medicaid number in box 1a on the CMS-1500 form (also known as the HCFA), to avoid possible delays in processing. Claims missing the required data will be returned, and a notice sent to the provider, creating payment delays; such claims are not considered "clean" and therefore cannot be accepted into our system.

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

Providers must notify Delaware First Health in writing at least 30 days in advance of his/her inability to accept additional Medicaid covered persons under Delaware First Health agreements.

Within 10 days of enrollment, Delaware First Health must send new members a letter encouraging them to select a PCP.

Claims eligible for payment must meet the following requirements:

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

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

When submitting your claim, you need to identify the member using the Medicaid ID number found on the member's Delaware First Health ID card or on the provider portal. Capitation payments may only be made by the State and retained by Delaware First Health for Medicaid-eligible members. Delaware First Health will not use funds paid by DHSS/DMMA, for services, administrative costs or populations not covered under Delaware First Health contract with DHSS/DMMA related to non-Title XIX or non-Title XXI members. 42 C.F.R. § 438.3(c)(2).

Submitting Claims

Providers are required to submit either an encounter or a claim for each service rendered to a Delaware First Health member.

Paper Claims Submission

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

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

Delaware First Health
1-877-236-1341

For Delaware First Health members, all paper claims and encounters should be submitted to:

Delaware First Health
Attn: Claims Department
P.O. Box 8001,
Farmington MO 63640-8001

Requirements for Paper Claims Submission

Delaware First Health uses an imaging process for paper claims retrieval. Please see Appendix IV and V for required fields. To ensure accurate and timely claims capture, please observe the following paper claims submission rules:

Do's

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

Note: Delaware First Health is able to receive primary insurance carrier EOP [electronically]

- Do submit on a proper original form - CMS-1500 or CMS-1450 (UB-04)

Don'ts

- Don't submit handwritten claim forms
- Don't use red ink on claim forms
- Don't circle any data on claim forms
- Don't add extraneous information to any claim form field
- Don't use highlighter on any claim form field
- Don't submit photocopied claim forms (no black and white claim forms)
- Don't submit carbon copied claim forms
- Don't submit claim forms via fax
- Don't use staples for attachments or multi-page documents

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

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

Common Causes of Claims Processing Delays and Denials

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

Delaware First Health will send providers written notification via the EOP for each claim that is denied, which will include the reason(s) for the denial.

Common Causes of Up-Front Rejections

- Unreadable Information
- Missing Member Date of Birth
- Missing Member Name or Identification Number
- Missing Provider Name, Tax ID, or NPI Number
- Missing Medicaid Number
- The Date of Service on the Claim is Not Prior to Receipt Date of the Claim

- Dates Are Missing from Required Fields
- Invalid or Missing Type of Bill
- Missing, Invalid or Incomplete Diagnosis Code
- Missing Service Line Detail
- Member Not Effective on The Date of Service
- Admission Type is Missing
- Missing Patient Status
- Missing or Invalid Occurrence Code or Date
- Missing or Invalid Revenue Code
- Missing or Invalid CPT/Procedure Code
- Incorrect Form Type
- Claims submitted with handwritten data or black and white forms

Delaware First Health will send providers a detailed letter for each claim that is rejected explaining the reason for the rejection.

Electronic Claims Submission

Network providers are encouraged to participate in the Delaware First Health electronic claims/encounter filing program. Delaware First Health supports ANSI X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats for professional, institution, or encounter transactions. In addition, Delaware First Health can generate an ANSI X12N 835 electronic remittance advice known as an EOP. Providers that bill electronically have the same timely filing requirements as providers filing paper claims.

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

The Delaware First Health Payor ID is 68069. The preferred clearinghouse vendor is Availity, but providers may use their own contracted clearinghouse to submit claims to Delaware First Health. Please visit the website listed below for the electronic Companion Guide which offers more instructions. For questions or more information on electronic filing please contact:

Delaware First Health
c/o Centene EDI Department
1-800-225-2573 ext. 6075525
or by e-mail (best method of contact) at EDIBA@centene.com

Billing Codes

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

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

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Delaware First Health.

CPT® Category II Codes

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

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

Encounters versus Claims

An **encounter** is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services, he/she provided to a Delaware First Health member. For example, if you are the primary medical provider for a member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a "proxy claim") on a CMS-1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or "proxy claim" is paid at zero-dollar amounts. It is mandatory that your office submits encounter data. Delaware First Health uses the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by Delaware DHSS/DMMA and by CMS. Encounters do not generate an Explanation of Payment (EOP).

A **claim** is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form; either the CMS-1500 or the UB-04 (CMS-1450). A claim will be paid or

denied with an explanation for the denial. For each claim processed, the provider who submitted the claim will receive a Remittance Advice (RA) either by mail or electronically. When registering to receive payment, the provider selects how RAs will be delivered. Claims submitted electronically are processed as described in the Electronic Claims Submission section of this manual. Each clean claim will generate an EOP.

Clean Claim Definition

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

Non-Clean Claim Definition

Non-clean claims are submitted claims that require further documentation or development beyond the information contained therein. Errors or omissions in claims result in:

- a request for additional information from the provider or other external sources to resolve or correct data omitted from the bill;
- review of additional medical records; and/or,
- the need for other information necessary to resolve discrepancies.

In addition, non-clean claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Rejection versus Denial

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

REJECTION: A list of common upfront rejections can be found in the Common Causes of Up-Front Rejections section of this manual. Rejections will not enter our claims adjudication system, so there will be no EOP. A rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. The provider will receive a letter, or a rejection report if the claim was submitted electronically.

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

Contact Information

Plan Address / Administrative Office
Delaware First Health 750 Prides Crossing Suite 200 Newark, DE 19713
Provider Services
Delaware First Health 1-877-236-1341 www.delawarefirsthealth.com Open Monday through Friday from 8:00 AM to 5:00 PM (Central Time) Please do not submit paper claims via fax.
Address for Submitting Paper Claims and Provider Claims Related Correspondence
Delaware First Health Attn: Claims P.O. Box 8001 Farmington, MO 63640-8001

Claims Payment Information

Systems Used to Pay Claims

Delaware First Health uses three main systems to process reimbursement on a claim. Those systems are:

- Amisys
- DST Pricer
- Rate Manager

AMISYS

All claims are processed from this core system and structures are maintained to meet the needs of our provider contracts. However, Delaware First Health is not limited within the bounds of this one system. The health plan utilizes multiple systems to expand its universe of possibilities and better meet the needs of its business partners.

DST PRICER

The DST Pricer is a system outside the core system with flexibility on addressing provider contractual needs. It allows Delaware First Health to be more responsive to the market demands. It houses both Fee Schedules and procedure codes, and it mirrors the Amisys system, but with a more attention to detail.

RATE MANAGER

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

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

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

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

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

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

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

Delaware First Health

1-877-236-1341

Open Monday through Friday from 8:00 AM to 5:00 PM (Central Time)

Prompt Pay

Claim Payment

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

- 90% of all non-pharmacy clean claims will be adjudicated (paid or denied) within 14 calendar days of receipt.
- 99% of all non-pharmacy clean claims will be adjudicated (paid or denied) within 60 calendar days of receipt. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

For the purpose of actions which must be taken by Delaware First Health, if the referenced calendar day falls on a weekend or a holiday, the first business day following that day will be considered the date the required action must be taken.

Timely Filing

Timely filing guidelines described in this section apply to both participating and non-participating providers.

Providers must submit all first-time claims for reimbursement no more than one hundred twenty (120) calendar days from the Date of Service. Exceptions are provided when:

- The provider is pursuing payment from a Third Party. In this situation, the maximum timeframe for filing a claim begins on the date that the Third Party documented resolution of the claim.

- A member is enrolled in Delaware First Health with a retroactive eligibility date. In this situation, the timeframe for filing a claim begins on the date that Delaware First Health receives notification from the state of the member's eligibility/enrollment.

Claim Denials

Within seven (7) calendar days of receiving a medical claim, Delaware First Health may notify the provider and request from the provider all additional information needed to timely process the claim. If a claim is pended or denied because more information is required to process it, the claim denial notice will specifically describe all information and supporting documentation needed to evaluate the claim for processing.

Overpayment

Delaware First Health, to the extent required by Contract, promptly reports overpayments, specifying overpayments due to potential fraud in accordance with 42 C.F.R. §438.608(a)(2). Delaware First Health administers recovery of overpayment in accordance with 42 C.F.R. §438.608(a)(2).

Cost-Sharing

Delaware First Health imposes any cost-sharing in accordance with the State of Delaware and 42 C.F.R. § 438.910. Plan members are not required to pay for any covered services other than the co-payment amounts required under the state plans. Delaware First Health tracks cost-sharing obligations of each member.

Cost-sharing does not apply to:

Cost Sharing Exempt Populations:

- Health Plan members under age 21;
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in Foster Care and individuals receiving benefits under Part E of that title, without regard to age;
- Pregnant women, during the pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends;
- Any Health Plan member whose medical assistance for services furnished in an institution, is reduced by amounts reflecting available income other than required for personal needs;
- Health Plan members receiving hospice care, as defined in section 1905(o) of the Act;
- An Indian Health Plan member who is eligible to receive or has received an item or service furnished by an IHCP or through referral under purchase and referred care is exempt from premiums. Indian Health Plan members who are currently receiving or have ever received an

item or service furnished by an IHCP or through referral under purchase and referred care are exempt from all Cost Sharing; and

- Health Plan members who are receiving Medicaid due to a diagnosis of breast or cervical cancer in accordance with 42 C.F.R. § 435.213.

Cost Sharing Exempt Services:

- Emergency Services;
- Family Planning Services and Supplies;
- Preventive Services, at a minimum the services specified at 42 C.F.R. § 457.520 of Chapter D, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well-child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics;
- Pregnancy-Related Services; and
- Provider-Preventable Services.

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, commercial carrier, automobile insurance, or worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member. Any other insurance, including Medicare, is always primary to Medicaid coverage.

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

If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform the health plan that efforts have been unsuccessful. Delaware First Health will make every effort to work with the provider to determine liability coverage.

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

Billing the Member / Member Acknowledgement Statement

Delaware First Health reimburses only services that are medically necessary and covered through the program. Providers are not allowed to "balance bill" for covered services if the provider's usually and customary charge for covered services is greater than our fee schedule.

Providers may bill members for services NOT covered by either Medicaid or Delaware First Health or for applicable copayments, deductibles or coinsurance as defined by the State of Delaware.

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

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

CLIA Accreditation

Labs that participate in the Medicare or Medicaid sector with Delaware First Health must be CLIA accredited. Requirements for laboratory accreditation are contained in the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB) located at the following link: http://www.jcrinc.com/store/publications/manuals/

How to Submit a CLIA Claim

Via Paper

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

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

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

Via EDI

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

-Or-

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

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

Via AHA Provider Portal

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

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

Delaware First Health Code Auditing and Editing

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

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

Moreover, Delaware First Health may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

CPT and HCPCS Coding Structure

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

1. ***Level I HCPCS Codes (CPT):*** This code set is comprised of CPT codes that are maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a member. These codes are then used to bill health insurance companies.
2. ***Level II HCPCS:*** The Level II subset of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, and prosthetics, etc.). Level II codes are an alphabetical coding system and are maintained by CMS. Level II HCPCS codes are updated on an annual basis.
3. ***Miscellaneous/Unlisted Codes:*** The codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous codes are subject to a manual review. To

facilitate the manual review, providers are required to submit medical records with the initial claim submission. If the records are not received, the provider will receive a denial indicating that medical records are required. Providers billing miscellaneous codes must submit medical documentation that clearly defines the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a registered nurse reviews the medical records to determine if there was a more specific code(s) that should have been billed for the service or procedure rendered. Clinical validation also includes identifying other procedures and services billed on the claim for correct coding that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. ***Temporary National* Codes:** These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H, and T code ranges.
5. ***HCPCS Code Modifiers:*** Modifiers are used by providers to include additional information about the HCPCS code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a member was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

International Classification of Diseases (ICD 10)

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

Revenue Codes

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

Edit Sources

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

The software applies edits that are based on the following sources:

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

Code Auditing and the Claims Adjudication Cycle

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

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

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

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

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

Code Auditing Principles

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

Unbundling

CMS National Correct Coding Initiative -

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

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

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

PTP Practitioner and Hospital Edits

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

Medically Unlikely Edits (MUEs) for Practitioners, DME Providers and Facilities

MUE's reflect the maximum number of units that a provider would bill for a single member, on a single date of service. These edits are based on CPT/HCPCs code descriptions, anatomic specifications, the nature of the service/procedure, the nature of the analyst, equipment prescribing information and clinical judgment.

Code Bundling Rules not sourced to CMS NCCI Edit Tables

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

Procedure Code Unbundling

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

Mutually Exclusive Editing

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

Incidental Procedures

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

Global Surgical Period Editing/Medical Visit Editing

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

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

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

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

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

Global Maternity Editing

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

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

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

Multiple Code Rebundling

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

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. There are also codes that are allowed a limited number of times on a single date of service, over a given period of time or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period of time or during a member's lifetime; Code editing will fire a frequency edit when the procedure code is billed in excess of these guidelines.

Duplicate Edits

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

National Coverage Determination Edits

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

Anesthesia Edits

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

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

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

Co-Surgeon/Team Surgeon Edits

CMS guidelines define whether an assistant, co-surgeon, or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co- or team surgeon.

Add-on and Base Code Edits

Rules look for claims where the add-on CPT code was billed without the primary service CPT code; or if the primary service code was denied, then the add-on code is also denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one (1), when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

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

Missing Modifier Edits

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

Administrative and Consistency Rules

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

- **Procedure code invalid rules:** Evaluates claims for invalid procedure and revenue or diagnosis codes.
- **Deleted Codes:** Evaluates claims for procedure codes which have been deleted.
- **Modifier to procedure code validation:** Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers -24, -25, -26, -57, -58 and -59.
- **Age Rules:** Identifies procedures inconsistent with member's age.
- **Gender Procedure:** Identifies procedures inconsistent with member's gender.
- **Gender Diagnosis:** Identifies diagnosis codes inconsistent with member's gender.
- **Incomplete/invalid diagnosis codes:** Identifies diagnosis codes incomplete or invalid.

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. Examples of Delaware First Health clinical validation services are modifiers -25 and -59 reviews. Some code pairs within the CMS NCCI edit tables are allowed for modifier override when they have a correct coding modifier indicator of "1." Furthermore, public-domain specialty organization edits may also be considered for override when they are billed with these modifiers. When these modifiers are billed, the provider's billing should support a separately identifiable service (from the primary service billed, modifier -25) or a different session, site or organ system, surgery, incision/excision, lesion, or separate injury (modifier -59). Delaware First Health clinical validation team uses the information on the prospective claim and claims history to determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

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

MODIFIER -59

The NCCI (National Correct Coding Initiative) states the primary purpose of modifier -59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify

procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

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

Delaware First Health uses the following guidelines to determine if modifier -59 was used correctly:

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

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

MODIFIER -25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service."

Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra-, and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant

and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply; The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Delaware First Health uses the following guidelines to determine whether modifier -25 was used appropriately:

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

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

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

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

Payment and Coverage Policy Edits

Payment and Coverage policy edits are developed to increase claims processing effectiveness, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers regarding these policies. It encompasses the development of payment policies based on coding and

reimbursement rules and clinical policies based on medical necessity criteria, both to be implemented through claims edits or retrospective audits. These policies are posted on each health plan's provider portal when appropriate. These policies are highly customizable and may not be applicable to all health plans.

Claim Complaints related to Code Auditing and Editing

Claims complaints resulting from claim-editing are handled per the provider claims complaint process outlined in your Provider Manual. When submitting claims processing complaints, please submit medical records, invoices, and all related information to assist with the complaint review.

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

Viewing Claim Coding Edits

Code Editing Assistant

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

This tool offers many benefits:

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

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

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

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

Disclaimer

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

Other Important Information

Health Care Acquired Conditions (HCAC) – Inpatient Hospital

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

Reporting and Non-Payment for Provider Preventable Conditions (PPCS)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by Delaware First Health for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment. Delaware First Health will comply with 42 C.F.R. § 438.3(g) which mandates provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. §§ 434.6(a)(12) and 447.26. Delaware First Health submits all identified Provider Preventable Conditions utilizing a quarterly log report.

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

Delaware First Health follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported. If covered services/procedures are also provided during the same stay, the health plan follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient

hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no pay TOB claim. Delaware First Health follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

Other Provider Preventable Conditions (OPPCS) – Outpatient

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

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

Non-Payment and Reporting Requirements

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

POA Indicator

All claims involving inpatient admissions to general acute care hospitals using the UB-04/CMS-1450 claim form or 837U claim transaction must file their discharge claims with POA/HAC indicators for all primary and secondary diagnoses. The POA/HAC indicator is placed adjacent to the principle and secondary diagnoses after the ICD10-CM diagnosis code.

The codes that are acceptable as POA/HAC indicators are:

- Y = Yes – Present at the time of inpatient admission.
- N = No – Not present at the time of inpatient admission.
- U = Unknown – The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
- W = Clinically Undetermined – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.
- Unreported/Not used – Exempt from POA reporting

The ICD10-CM Official Guidelines for Coding and Reporting includes a list of diagnosis codes that are exempt from POA reporting.

Hospitals will not receive additional payments for cases in which the selected condition was not present on admission. In other words, the DRG will be paid excluding any code that has a character of N or U; an indicator of "1" will be paid as though the secondary diagnosis were not present; only diagnosis codes with a character of Y will be considered in the DRG calculations.

Types of providers that are **EXEMPT** from POA/HAC indicator reporting are listed on the CMS website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/AffectedHospitals

Other Relevant Billing Information

Electronic Visit Verification (EVV)

Rules for Billing Unit (add a reference to Page 50 – Units).

Visits are to be rounded to the nearest 15-minute or hourly increment based on the code being billed. The following chart is to be used to assist in determining the number of units to be billed:

Counting of 15-Minute Increments

Units	Time Range in Minutes
1 Unit	<23 minutes
2 Units	>23 minutes to <38 minutes
3 Units	>38 minutes to <53 minutes
4 Units	>53 minutes to <68 minutes
5 Units	>68 minutes to <83 minutes
6 Units	>83 minutes to <98 minutes
7 Units	>98 minutes to <113 minutes
8 Units	>113 minutes to <128 minutes

Counting of Hourly Increments

Units	Time Range in Minutes
1 Unit	>53 minutes and <113 minutes
2 Units	>113 minutes and <173 minutes
3 Units	>173 minutes and <233 minutes
4 Units	>233 minutes and <293 minutes
5 Units	>293 minutes and <353 minutes
6 Units	>353 minutes and <413 minutes
7 Units	>413 minutes and <473 minutes
8 Units	>473 minutes and <533 minutes

Emergency Services

- Emergency Services are available 24 hours a day, seven days a week and provided in accordance with 42 CFR 438.114.
- Delaware First Health has policies that address emergency and non-emergency use of services provided in an outpatient emergency setting.
- Delaware First Health reviews and approves or disapproves claims for Emergency Services based on whether the member had an Emergency Medical Condition.
- Delaware First Health will not deny payment for treatment obtained when a representative of Delaware First Health instructed the member to seek Emergency Services.
- Delaware First Health bases coverage decisions for Emergency Services on the severity of symptoms at the time of presentation and covers Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. Delaware First Health will not impose restrictions on the coverage of Emergency Services that are more restrictive than those permitted by the prudent layperson standard.
- Delaware First Health provides coverage for inpatient and outpatient Emergency Services that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard and are furnished by a qualified provider, regardless of whether the member obtains the services from a participating provider. These services are provided without prior authorization in accordance with 42 CFR 438.114.
- Delaware First Health and/or its authorized representative may not:

- Refuse to cover Emergency Services based on the emergency room physician, hospital, or Fiscal Agent not notifying the member's PCP, Delaware First Health, or applicable State entity of the member's screening and treatment within ten calendar days of presentation for Emergency Services;
- Deny payment for treatment obtained when a member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition;
- Hold a member who has had an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member;
- Disagree with the judgement of the attending emergency physician, or the provider actually treating the member in determining when the member is sufficiently stabilized for transfer or discharge; that determination is binding on Delaware First Health with respect to coverage and payment; or
- Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnosis or symptoms.

Doula Billing

When billing for Doula services, use the professional claim format (CMS1500) and the codes and modifiers listed below based on the State doula benefit:

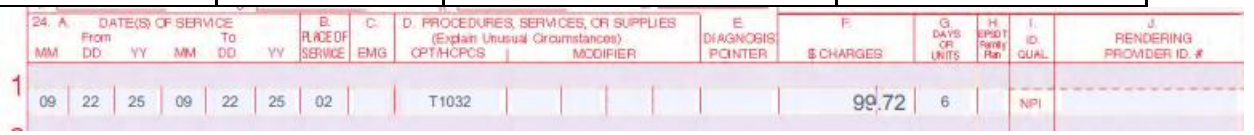
State Doula Benefit:

- **Max of three (3) prenatal visits** up to 90 minutes (15 minutes per unit or up to 6 units per visit) – **HPCPS CODE = T1032**
- **Max of three (3) postpartum visits** up to 90 minutes (15 minutes per unit or up to 6 units per visit) – **HCPCS Code & Modifier = T1032 HD**
- **DFH Added Value Benefit – Max of two (2) additional postpartum visits** up to 90 minutes with doctors' approval (15 minutes per unit or up to 6 units per visit) – **HCPCS Code & Modifier = T1032 U1**
- **Attendance through labor and birth** – **HCPCS Code = T1033**
- **Doula Incentive Payment – HCPCS Code & Modifier = T5999 HD**. *Important Note: The incentive payment is payable when the prenatal, postpartum and attendance to delivery is performed by the same doula. In addition, there must be a paid claim for a prenatal visit, postpartum visit, and attendance to delivery on file before the incentive payment is payable.*

Billing Guide:

Prenatal Visit Billing Example

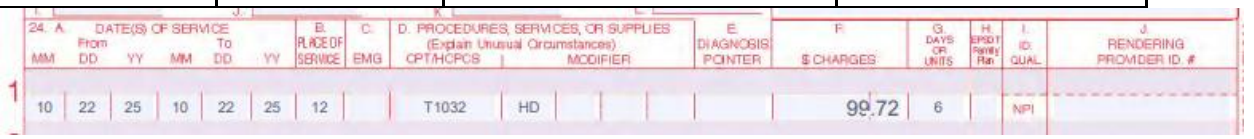
Code	Modifier	Description	Rate
T1032		Prenatal Doula Visit	$16.62 Per Unit



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 09	22	25	09	22	25	02		T1032			99.72	6		NPI	

Postpartum Visit Billing Example

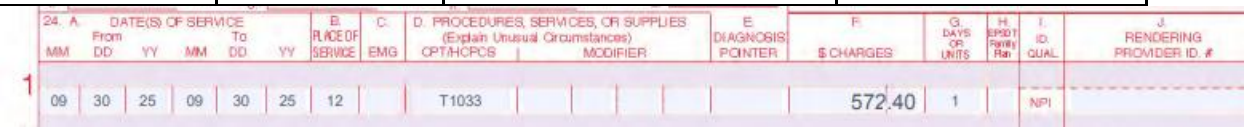
Code	Modifier	Description	Rate
T1032	HD	Postpartum Doula Visit	$16.62 Per Unit



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 10	22	25	10	22	25	12		T1032	HD		99.72	6		NPI	

Attendance to Delivery Visit Billing Example

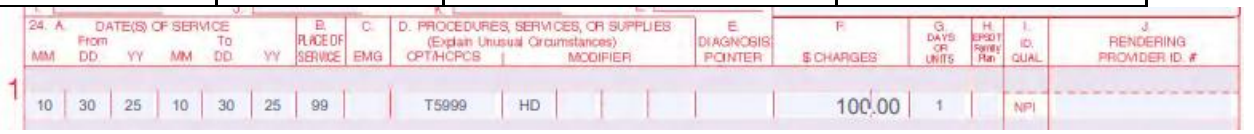
Code	Modifier	Description	Rate
T1033		Attendance to Delivery	$572.40 Flat Rate



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 09	30	25	09	30	25	12		T1033			572.40	1		NPI	

***Incentive Payment Billing Example**

Code	Modifier	Description	Rate
T5999	HD	Incentive Payment	$100.00 Flat Rate



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 10	30	25	10	30	25	99		T5999	HD		100.00	1		NPI	

*Incentive payment is payable after at least 1 prenatal visit, 1 postpartum visit, and attendance to delivery claim is paid.

Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

FQHC Providers must bill on a CMS-1500 claim form and must bill with appropriate encounter codes and CPT codes for core services. When billing non-core services only CPT code should be billed, and the appropriate fee schedule rates will be paid as appropriate.

RHC Providers must bill on a UB-04 claim form and must bill appropriate encounter REV codes and CPT codes for core services. Combine all fees for all "core" services provided during an encounter. When billing, a non-core service provider must itemize separately from encounter using the appropriate revenue, HCPC, and/or CPT codes.

Hospice (Non-Hospital Based)

Covered for Health Plan members with a life expectancy of six months or less. Hospice Service providers must bill using the UB-04/CMS-1450 claim form, with the appropriate Rev/HCPCS codes.

Hospital Claims

Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

Multiple Surgeries

When multiple surgeries are performed the second through fifth surgery is reimbursed at 50%. If six or more procedures are billed on the same day medical records are required form manual review and payment. If additional procedures are determined medically necessary, each subsequent procedure is reimbursed at 50%.

National Drug Code (NDC) Requirements

If the provider is billing drug-related revenue, HCPCS or CPT codes, the claim must indicate the drug's national drug code (NDC), quantity and unit of measure. National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. The NDC is not required for G codes and P codes, or routine childhood and adult immunization drug codes. The NDC must be 11 digits (5 digits-4 digits-2 digits) to be accepted; however, there are times when the NDC on the container does not contain 11 digits. In this case, add preceding zeroes to the section of the NDC that does not follow the 5-4-2 format. Providers must include the NDC units to report the units being administered. Both are required on the claim for accurate reimbursement. To bill NDC units, the unit of measurement and the quantity (including decimals) are required. Acceptable units of measurement are GR for gram, ML for milliliter, UN for unit, and F2 for international unit.

Newborn Billing

Providers are to notify the Delaware First Health Medical Management department of all newborn deliveries within 2 business days of the delivery. Newborns born to mothers who are DSHP or DSHP Plus members at the time of the child's birth will be Enrolled in their mother's MCO. If the mother is a client but not Enrolled with an MCO, but the newborn is eligible for Medicaid or the Children's Health Insurance Program (CHIP), the birth is covered by fee-for-service Medicaid or CHIP, and the child and the mother will be Enrolled in the same MCO.

Non-Participating Providers

The standard reimbursement for non-participating providers is 100% of the Medicaid Fee Schedule Rate; however, final reimbursement decisions are made on a case-by-case basis. Some facilities and services are reimbursed at Special Reimbursement rates as listed below:

- Federally Qualified Health Centers (FQHC)
    - Reimbursement includes the same service array and the same payment methodology as the State Medicaid FFS contracts with FQHCs. Delaware First Health will not pay less than the Medicaid fee-for-service (FFS) rate for FQHCs. For additional services included by Delaware First Health but which are not included in the State's Medicaid FFS contract with the FQHC, Delaware First Health must negotiate separate payment arrangements with the FQHC.
- School-Based Wellness Centers (SBWC)
    - For SBWCs that have not negotiated different payment arrangements with Delaware First Health, the plan will pay the SBWC using the State Medicaid FFS payment methodology and fee schedule.
- Long-Term Services and Supports (LTSS) Hospice
    - For Hospice services provided in a nursing facility, Delaware First Health will reimburse either the nursing facility or the hospice provider using the State's Medicaid FFS rate.
- LTSS Facilities
    - Delaware First Health reimburses Medicare/Medicaid-certified DMAP-enrolled nursing facilities using the State's Medicaid FFS rate for DSHP Plus LTSS members.
- Emergency Services and Post-Stabilization Services
    - Pursuant to Section 1932(b)(2)(D) of the Social Security Act, Delaware First Health limits payments to non-participating providers of Emergency Services to the amount of reimbursement that would have been paid if the service had been provided under the State's FFS Medicaid program.
- Behavioral Health Crisis Providers
    - Delaware First Health contracts with Behavioral Health Crisis Providers include the same service array and the same payment methodology as the State Medicaid FFS contracts with these providers. Delaware First Health will not pay these providers less than the Medicaid FFS rate for behavioral health crisis services. For additional services included by Delaware First Health but which are not included in the State's Medicaid FFS contract

with the behavioral health crisis provider, Delaware First Health must negotiate separate payment arrangements with the provider.

Tribal Claims

Delaware First Health will permit Indian Health Plan members to receive services from an IHCP primary care provider who is a participating provider and to choose that IHCP as the Indian Health Plan member's PCMH if that provider has capacity to provide the services.

Pursuant to 42 C.F.R. § 438.14(b)(4), Delaware First Health will permit Indian Health Plan members to obtain services covered under the contract from out-of-network IHCPs from whom the Indian Health Plan member is otherwise eligible to receive such services. In accordance with 42 C.F.R. § 438.14(b)(6), Delaware First Health will also permit an out-of-network IHCP to refer an Indian Health Plan member to a Participating Provider. This includes services furnished by an out-of-network IHCP or through referral under purchase and referred care.

All Delaware First Health payments to IHCPs will be made in accordance with 42 C.F.R. § 438.14. Delaware DHSS/DMMA will reimburse for services that are eligible for 100% federal reimbursement and are provided by an IHS facility to Indian Health Plan members who are eligible to receive services through an IHS facility. Encounters for Delaware First Health services billed by IHS and eligible for 100% federal reimbursement will not be accepted by DMMA or considered in capitation rate development.

Delaware First Health will make payment to Indian Health Care Providers (IHCPs) for covered services not eligible for 100% federal reimbursement and provided to Health Plan members who are eligible to receive services through the IHCP.

- **For IHCP enrolled in Delaware Medicaid as a FQHC** but who is not a Delaware First Health provider, Delaware First Health pays the IHCP an amount equal to the amount it would pay an FQHC that is a participating provider but is not an IHCP.
- **For an IHCP <u>not</u> enrolled in Delaware Medicaid as a FQHC**, and regardless of participation in the Delaware First Health provider network, Delaware First Health reimburses at the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS). In the absence of a published encounter rate, Delaware First Health will pay, at minimum, the amount the IHCP would receive if the services were provided under the State Plan FFS methodology.

Delaware First Health will timely pay all Indian/Tribal/Urban (I/T/U) participating providers in accordance with the standard timely filing requirements.

Nursing Facility

For hospice services provided in a nursing facility, Delaware First Health may either (i) pay the nursing facility and require the nursing facility to pay the hospice provider or (ii) pay the hospice provider using the State's Medicaid FFS rate.

Post Stabilization Services

Delaware First Health will cover Post Stabilization Services, pursuant to 42 CFR 438.114(e) and 42 CFR 422.113(c)(2) without requiring authorization, and regardless of whether the member obtains the services from a participating or non-participating provider if any of the following circumstances exist:

- The Post Stabilization Services were pre-approved by Delaware First Health;
- The Post Stabilization Services were not pre-approved by Delaware First Health but administered to maintain the member's stabilized condition within one hour of a request to Delaware First Health for pre-approval of further Post Stabilization Services; or
- The Post Stabilization Services were not pre-approved by Delaware First Health but administered to maintain, improve, or resolve the member's stabilized condition if:
    - Delaware First Health did not respond to the provider's request for pre-approval within one hour;
    - Delaware First Health could not be reached by the provider to request pre-approval; or
    - Delaware First Health's representative and the treating physician cannot reach an agreement concerning the member's care and a participating provider is not available for consultation. In this situation, Delaware First Health must give the treating physician the opportunity to consult with a participating provider and treating physician may continue with care of the patient until a participating provider is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.
- Delaware First Health's financial responsibility for Post Stabilization Services that have not been pre-approved shall end when: (i) a participating provider with privileges at the treating hospital assumes responsibility for the member's care; (ii) a participating provider assumes responsibility for the member's care through transfer; (iii) a representative of Delaware First Health and the treating physician reach an agreement concerning the member's care; or (iv) the member is discharged.
- Delaware First Health must limit charges to members for Post Stabilization Services received from non-participating providers to an amount no greater than what Delaware First Health would have charged the member if they obtained the services from a participating provider.

Telehealth Billing

All Telehealth charges must use Modifier 02 as the Place of Service. The member's home can be an Originating Site; however, Delaware First Health will not pay an Originating Site fee if the Originating Site is the member's home. Delaware First Health does not pay a facility fee for the Distant Site.

Transgender Related Services

To prevent inappropriate claim denials when the individual's recorded gender does not match the gender-specific procedure or services billed, the health plan will require the use of a specific billing code modifier and condition code to bypass gender-specific claim edits.

Claims Reimbursement Guidelines

The Centers for Medicare and Medicaid Services (CMS) MLN Matters #MM6638, instructs providers to report condition code 45 (Ambiguous Gender Category) on inpatient or outpatient institutional services that can be subject to gender-specific editing. Physicians and non-physician practitioners should append the modifier –KX to the gender-specific procedure code documented on the procedure code detail line.

The health plan's code editing software application will evaluate claims data to determine if an institutional claim contains the condition code 45, or for practitioner and non-physician practitioner clams, that the modifier –KX is appended to a gender-specific procedure code. When these identifiers are found on the claim or at procedure code detail level, the code editing software will bypass gender edits.

Documentation Requirements

- Practitioners and non-physician practitioners should append modifier "-KX" to the gender-specific CPT code at the service line level.
- Institutional Providers should add the condition code "45" to the appropriate claim field to indicate a gender-specific service.

Unlisted CPT Codes

Providers are required to bill the CPT that most accurately describes the service or procedure provided. If such a code does not exist, the provider should bill with the unlisted CPT from the appropriate section of the CPT book. Providers are to follow the instructions for submission of these codes as described in the current CPT manual, published by the American Medical Association.

When billing a claim with DME NOC codes (see Appendix A for the approved list of DME NOC codes):

- Submit DME NOC codes on a paper CMS 1500 claim.
- An invoice, including MSRP pricing, is required.
- Claims submitted without the invoice will be denied, EXLK – INVOICE IS MISSING/INVALID FOR PRICING.

Authorization Requirement

Refer to the Pre-Auth Check Tool on delawarefirsthealth.com for the most current information on authorization requirements. See Appendix A of DE.PP.007 Payment Policy: Billing Requirements for DME NOC and Miscellaneous Codes for DME NOC codes that require an authorization.

Reimbursement

Refer to Appendix A of Payment Policy: Billing Requirements for DME NOC and Miscellaneous Codes (DE.PP.007) for reimbursement terms for NOC and Miscellaneous codes.

Exceptions: Contractually defined reimbursement terms.

Vaccines for Children (VFC) Program

The Vaccines for Children (VFC) program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. Delaware First Health requires its participating PCPs to enroll with DPH to receive vaccines covered by the VFC program free of charge for both VFC eligible (Medicaid) children (funded by VFC) and DHCP children (paid for with State funds) and to use the free vaccine for its child members.

The cost of vaccines covered by VFC is not included in the Delaware First Health capitation payment.

Delaware First Health pays Participating Providers the regional maximum VFC vaccine administration fee (established by CMS) for both Medicaid and DHCP children. The vaccine administration fee for VFC covered vaccines for both Medicaid and DHCP children is included in the Delaware First Health's capitation rates.

Providers must report all immunization (not just vaccines covered by VFC) to the DPH Immunization Registry (also known as DelVAX).

Provider Inquiries, Claims Reconsideration, Claims Correction And Adjustments, And Appeals

A provider can inquire on the status of the claim at any time via the provider portal or calling Provider Services. For information on claims reconsiderations, corrections and adjustments, and/or appeals, please refer to the Provider Manual.

Provider Claims Complaints

A Claims Complaint is a written expression by a provider, which indicates dissatisfaction with Delaware First Health claim adjudication, to include the amount reimbursed or regarding denial of a particular service. All claims' complaints must be received from the provider in writing no later than 12 months from the date of service or 60 calendar days after the payment or denial of a timely claim submission, whichever is latest. Refer to the Provider Manual for details on filing a claims complaint.

Member Appeals and Grievances

Refer to the Provider Manual for details on member appeals and grievances.

APPENDIX I: Common HIPAA Compliant EDI Rejection Codes

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

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

APPENDIX II: Instructions for Supplemental Information

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

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

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

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

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

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

F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit

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

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

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

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

Unspecified/Miscellaneous/Unlisted Codes

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

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

NDC Codes

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

APPENDIX III: Instructions for Submitting NDC Information

Instructions for Entering the NDC:

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

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

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

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

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

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

Facility

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

Physician

- Paper, use the red shaded detail of 24A on the CMS-1500 line detail.
- Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.
- The NDC must be entered with 11 digits in a 5-4-2-digit format. The first five digits of the NDC are the manufacturer's labeler code, the middle four digits are the product code, and the last two digits are the package size.
    - If you are given an NDC that is less than 11 digits, add the missing digits as follows:

      For a 4-4-2-digit number, add a 0 to the beginning

For a 5-3-2-digit number, add a 0 as the sixth digit.

For a 5-4-1-digit number, add a 0 as the tenth digit.

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

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

Taxonomy Code Placement on Claims

CMS-1500 Paper Submission

* Rendering – Box 24i should contain the qualifier "ZZ". Box 24j (shaded area) should contain the taxonomy code.

* Billing – Box 33b should contain the qualifier "ZZ" along with the taxonomy code.

* Referring – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of "ZZ" along with the taxonomy code in the next column.

837 Professional Submission

* Billing –Loop 2000A PRV01="BI"; PRV02 = "PXC" qualifier; PRV03 = 10-character taxonomy code.

* Rendering – Loop 2310B PRV01="PE"; PRV02 = "PXC" qualifier; PRV03 = 10-character taxonomy code002E.

* Please note that "PXC" is the correct qualifier and that there is no taxonomy number needed for referring physician.

CMS-1450/UB-04 Paper Submission

* Billing – Box 81CCa should contain the qualifier of "B3" in the left column and the taxonomy code in the middle column.

837I Electronic Submission

* Billing - Loop 2000A PRV01 = "BI"; PRV02 = "PXC" qualifier; PRV03 = 10-character taxonomy code.

* Please also advise your clearinghouse to make sure the changes made to taxonomy placement are permanent on your account.

APPENDIX IV: Claims Form Instructions CMS-1500

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

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? PLACE (State) YES NO

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.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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

On the CMS-1500 form, Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided.
NOTE: Claims with missing or invalid Required (R) field information will be rejected or denied.

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

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

Field #	Field Description	Instruction or Comments	Required or Conditional
10a, b, c	IS PATIENT'S CONDITION RELATED TO	Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.	R
10d	CLAIM CODES (Designated by NUCC)	When reporting more than one code, enter three blank spaces and then the next code.	C
11	INSURED POLICY OR FECA NUMBER	REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.	C
11a	INSURED'S DATE OF BIRTH / SEX	Enter the 8-digit date of birth (MM | DD | YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.	C
11b	OTHER CLAIM ID (Designated by NUCC)	The following qualifier and accompanying identifier have been designated for use: Y4 Property Casualty Claim Number **FOR WORKERS' COMPENSATION OR PROPERTY & CASUALTY:** Required if known. Enter the claim number assigned by the payer.	C
11c	INSURANCE PLAN NAME OR PROGRAM NUMBER	Enter name of the insurance health plan or program.	C
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN	Mark Yes or No. If yes, complete fields 9a-d and 11c.	R
12	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain his/her legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	C
13	INSURED'S OR AUTHORIZED PERSONS SIGNATURE	Obtain signature if appropriate.	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
14	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	Enter the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM | DD | YY) or 8-digit (MM | DD | YYYY) format.	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).	C
17a	ID NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. Use ZZ qualifier for Taxonomy code.	C
17b	NPI NUMBER OF REFERRING PHYSICIAN	Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		C
19	RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL		C

Field #	Field Description	Instruction or Comments	Required or Conditional
	CLAIM INFORMATION		
20	OUTSIDE LAB / CHARGES		C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS A-L to ITEM 24E BY LINE). NEW FORM ALLOWS UP TO 12 DIAGNOSES, AND ICD INDICATOR	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims missing or with invalid diagnosis codes will be rejected or denied for payment.	R
22	RESUBMISSION CODE / ORIGINAL REF.NO.	For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim	C
23	PRIOR AUTHORIZATION NUMBER or CLIA NUMBER	Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services.	If auth = C If CLIA = R (If both, always submit the CLIA number)
24a-j General Information	Box 24 contains six claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each un-shaded area of a claim line, there are 10 individual fields labeled A-J. Within each shaded area of a claim line there are four individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g is for line-item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line-item detail.		

Field #	Field Description	Instruction or Comments	Required or Conditional
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
24 A Unshaded	DATE(S) OF SERVICE	Enter the date the service listed in field 24D was 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
24 B Unshaded	PLACE OF SERVICE	Enter the appropriate 2-digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website.	R
24 C Unshaded	EMG	Enter Y (Yes) or N (No) to indicate if the service was an emergency.	Not Required
24 D Unshaded	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER	Enter the 5-digit CPT or HCPC code and 2-character modifier, if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.	R

24 E Unshaded	DIAGNOSIS CODE	In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM or ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service, or the claim will be rejected/denied.	R
24 F Unshaded	CHARGES	Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (e.g.,199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	R
24 G Unshaded	DAYS OR UNITS	Enter quantity (days, visits, units). If only one service provided, enter a numeric value of one.	R
24 H Shaded	EPSDT (Family Planning)	Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.	C
24 H Unshaded	EPSDT (Family Planning)	Enter the appropriate qualifier for EPSDT visit.	C
24 I Shaded	ID QUALIFIER	Use ZZ qualifier for Taxonomy, Use 1D qualifier for ID if an Atypical Provider.	R
24 J Shaded	NON-NPI PROVIDER ID#	<u>Typical Providers:</u> Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code. <u>Atypical Providers:</u> Enter the Provider ID number.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
24 J Unshaded	NPI PROVIDER ID	Typical Providers ONLY: Enter the 10-character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10-character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).	R
25	FEDERAL TAX I.D. NUMBER SSN/EIN	Enter the provider or supplier 9-digit Federal Tax ID number, and mark the box labeled EIN	R
26	PATIENT'S ACCOUNT NO.	Enter the provider's billing account number.	C
27	ACCEPT ASSIGNMENT?	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Health Plan recipient using state funds indicates the provider accepts assignment. Refer to the back of the CMS-1500 (02-12) Claim Form for the section pertaining to Payments.	C
28	TOTAL CHARGES	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (e.g., 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	R
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Health Plan. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (e.g.,199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (e.g., 10.00), enter 00 in the area to the right of the vertical line.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
30	BALANCE DUE	REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e., 199999.99). Do not use 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

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

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

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

APPENDIX V - Claims Form Instructions – UB-04/CMS-1450

Completing a UB-04/CMS-1450 Claim Form

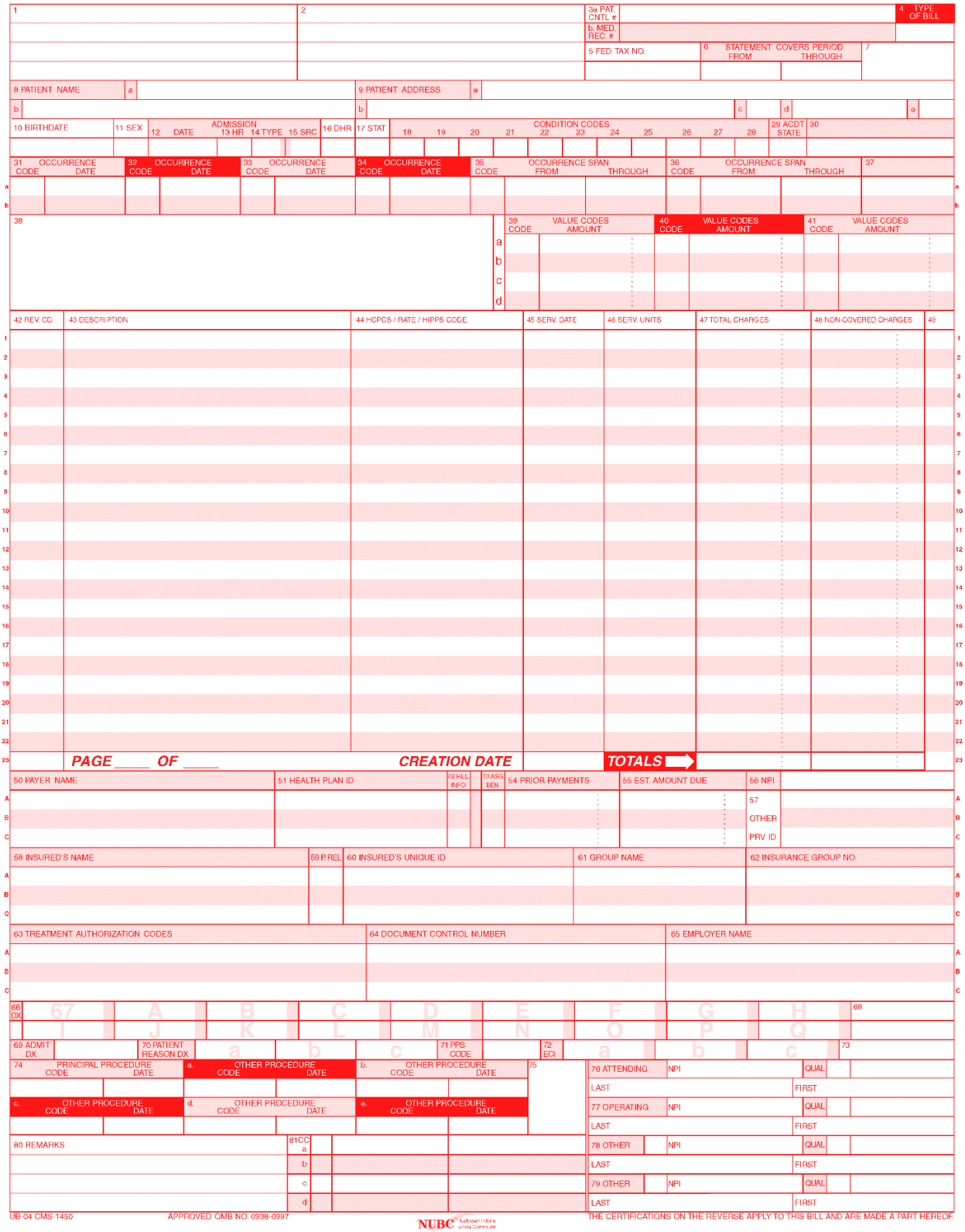
A UB-04 (also known as a CMS-1450) is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Delaware First Health. A sample of this form is depicted on the following page. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

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

UB-04 Claim Form Example:



On the CMS-1450 form, Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation, or the service provided.

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

Field #	Field Description	Instruction or Comments	Required or Conditional
1	UNLABELED FIELD	LINE 1: Enter the complete provider's name. LINE 2: Enter the complete mailing address. LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9-digit zip (zip +4 codes) is a requirement for paper and EDI claims. LINE 4: Enter the area code and phone number.	R
2	UNLABELED FIELD	Enter the Pay- to Name and Address.	Not Required
3a	PATIENT CONTROL NO.	Enter the facility patient account/control number.	Not Required
3b	MEDICAL RECORD NUMBER	Enter the facility patient medical or health record number.	R
4	TYPE OF BILL	Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows: 1st Digit – Indicating the type of facility. 2nd Digit – Indicating the type of care. 3rd Digit- Indicating the bill sequence (Frequency code).	R
5	FED. TAX NO	Enter the 9-digit number assigned by the federal government for tax reporting purposes.	R
6	STATEMENT COVERS PERIOD FROM/THROUGH	Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY).	R
7	UNLABELED FIELD	Not used.	Not Required
8a-8b	PATIENT NAME	8a – Enter the first 9 digits of the identification number on the member'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

Field #	Field Description	Instruction or Comments	Required or Conditional
		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	PATIENT ADDRESS	Enter the patient's complete mailing address of the patient. Line a: Street address Line b: City Line c: State Lined: Zip code Line e: Country Code (NOT REQUIRED)	R (Except line 9e)
10	BIRTHDATE	Enter the patient's date of birth (MMDDYYYY).	R
11	SEX	Enter the patient's sex. Only M or F is accepted.	R
12	ADMISSION DATE	Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using 2-digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.	R
13	ADMISSION HOUR	0012:00 midnight to 12:59 12-12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59	R

Field #	Field Description	Instruction or Comments	Required or Conditional
14	ADMISSION TYPE	Require for inpatient and outpatient admissions. Enter the 1-digit code indicating the type of the admission using the appropriate following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	R
15	ADMISSION SOURCE	Required for inpatient and outpatient admissions. Enter the 1-digit code indicating the source of the admission or outpatient service using one of the following codes. For Type of admission 1,2,3, or 5: Physician Referral 1 Clinic Referral 2 Health Maintenance Referral (HMO) 3 Transfer from a hospital 4 Transfer from Skilled Nursing Facility 5 Transfer from another health care facility 6 Emergency Room 7 Court/Law Enforcement 8 Information not available For Type of admission 4 (newborn): 1 Normal Delivery 2 Premature Delivery 3 Sick Baby	R
16	DISCHARGE HOUR	Enter the time using 2-digit military times (00-23) for the time of the inpatient or outpatient discharge. 00-12:00 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	C

Field #	Field Description	Instruction or Comments	Required or Conditional
		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	
17	PATIENT STATUS	REQUIRED for inpatient and outpatient claims. Enter the 2-digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine Discharge 02 Discharged to another short-term general hospital 03 Discharged to SNF 04 Discharged to ICF 05 Discharged to another type of institution 06 Discharged to care of home health service Organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 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	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		63 Discharged/ Transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/ Transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH)	
18-28	CONDITION CODES	REQUIRED when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.	C
29	ACCIDENT STATE		Not Required
30	UNLABELED FIELD	NOT USED	Not required
31-34 a-b	OCCURRENCE CODE and OCCURENCE DATE	Occurrence Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: **REQUIRED** when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C
35-36 a-b	OCCURRENCE SPAN CODE and OCCURRENCE DATE	Occurrence Span Code: **REQUIRED** when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: **REQUIRED** when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
37	(UNLABELED FIELD)	**REQUIRED** for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.	C
38	RESPONSIBLE PARTY NAME AND ADDRESS		Not Required
39-41 a-d	VALUE CODES 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 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 (e.g., 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (e.g.,10.00), enter 00 in the area to the right of the vertical line.	C
General Information Fields 42-47	SERVICE LINE DETAIL	The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.	
42 Line 1-22	REV CD	Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
43 Line 1-22	DESCRIPTION	Enter a brief description that corresponds to the revenue code entered in the service line of field 42.	R
43 Line 23	PAGE ___ OF ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted, enter a "1" in both fields (e.g., PAGE "1" OF "1"). (Limited to 4 pages per claim)	C
44	HCPCS/RATES	REQUIRED for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to 9 characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s), do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.	C
45 Line 1-22	SERVICE DATE	REQUIRED on all outpatient claims. Enter the date of service for each service line billed (MMDDYY). Multiple dates of service may not be combined for outpatient claims	C
45 Line 23	CREATION DATE	Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).	R
46	SERVICE UNITS	Enter the number of units, days, or visits for the service. A value of at least "1" must be entered. For inpatient room charges, enter the number of days for each accommodation listed.	R
47 Line 1-22	TOTAL CHARGES	Enter the total charge for each service line.	R
47 Line 23	TOTALS	Enter the total charges for all service lines.	R
48 Line 1- 22	NON-COVERED CHARGES	Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	TOTALS	Enter the total non-covered charges for all service lines.	C
49	(UNLABELED FIELD)	Not Used	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
50 A-C	PAYER	Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary	R
51 A-C	HEALTH PLAN IDENTIFCATIO N NUMBER		Not Required
52 A-C	REL INFO	REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter 'Y' (yes) or 'N' (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain 'Y.'	R
53	ASG. BEN.	Enter 'Y' (yes) or 'N' (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R
54	PRIOR PAYMENTS	Enter the amount received from the primary payer on the appropriate line when Medicaid is listed as secondary or tertiary.	C
55	EST. AMOUNT DUE		Not Required
56	NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID	Required: Enter providers 10- character NPI ID.	R
57	OTHER PROVIDER ID	Enter the numeric provider identification number. Enter the TPI number (non -NPI number) of the billing provider.	R
58	INSURED'S NAME	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the name as last name, first name, middle initial.	R
59	PATIENT RELATIONSHIP		Not Required
60	INSURED'S UNIQUE ID	REQUIRED: Enter the patient's Insurance ID exactly as it appears on the patient's ID card. Enter the Insurance ID in the order of liability listed in field 50.	R
61	GROUP NAME		Not Required
62	INSURANCE GROUP NO.		Not Required
63	TREATMENT AUTHORIZAT ION CODES	Enter the Prior Authorization or referral when services require pre-certification.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
64	DOCUMENT CONTROL NUMBER	Enter the 12-character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting the Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4). Frequency of "7" (Replacement of Prior Claim) or Type of Bill. Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to reconsider/corrected claims section.	C
65	EMPLOYER NAME		Not Required
66	DX VERSION QUALIFIER		Not Required
67	PRINCIPAL DIAGNOSIS CODE	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service.	R
67 A-Q	OTHER DIAGNOSIS CODE	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or "5" digit. "E" and most "V" codes are **NOT** acceptable as a primary diagnosis. **Note:** Claims with incomplete or invalid diagnosis codes will be denied.	C
68	PRESENT ON ADMISSION INDICATOR		R
69	ADMITTING DIAGNOSIS CODE	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1& 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or "5" digit. "E" codes and most "V" are **NOT** acceptable as a primary diagnosis. **Note:** Claims with missing or invalid diagnosis codes will be denied.	R
70	PATIENT REASON CODE	Enter the ICD-9/10-CM Code that reflects the patient's reason for visit at the time of outpatient registration. Field 70a requires entry; fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit –	R

Field #	Field Description	Instruction or Comments	Required or Conditional
		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.	
71	PPS/DRG CODE		Not Required
72 a, b, c	EXTERNAL CAUSE CODE		Not Required
73	UNLABLED		Not Required
74	PRINCIPAL PROCEDURE CODE/DATE	CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
74 a-e	OTHER PROCEDURE CODE DATE	REQUIRED on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9/ICD-10 procedure code(s) that identify significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-9/ICD-10 Procedure Codes may be entered. Do not enter the decimal; it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).	C
75	UNLABLED		Not Required

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

Field #	Field Description	Instruction or Comments	Required or Conditional
		G2 – Provider commercial number	
80	REMARKS		Not Required
81	CC	A: Taxonomy of billing provider. Use B3 qualifier.	R
82	Attending Physician	Enter name or 7-digit Provider number of ordering physician.	R

APPENDIX VI: Origin and Destination Modifiers for Transportation

Origin and Destination Modifiers for Transportation

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

Based on the modifiers noted above:

The following are all the valid combinations for the first modifier fields:						
DN	RD	IH	EN	SI	ND	HE
EH	RN	JN	GN	DH	NN	HN
GE	DD	NH	HI	EE	RH	JE
HG	DR	RE	IN	ER	I I	NE
HR	EJ	SH	JR	GR	DJ	NR
JH	GH	DG	NJ	HJ	EG	RJ
NG	HH	ED	RG	JD	GD	

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

Revisions

Revision Date	Page No.	Comment
12/29/2022	36	Added: Provider Inquiries, Claims Reconsideration, Claims Correction and Adjustments, and Appeals section
12/27/2024	40	Not Otherwise Classified (NOC) codes for Durable Medical Equipment (DME) Supplies
12/31/24	34	EVV Billing Guidelines
9/25/2025		