Keystone First

Community HealthChoices

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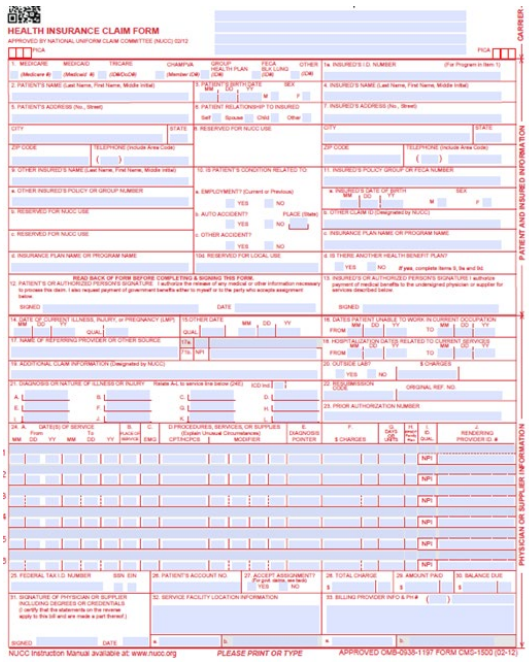
HEALTH INSURANCE CLAIM FORM

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

PLEASE PRINT OR TYPE

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

Claims Filing Instructions

Home- and Community-Based Services (HCBS) Providers

April 2025

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Keystone First Community Health Choices (CHC), hereafter referred to as the Plan (where appropriate), is required by state and federal regulations to capture specific data regarding services rendered to its Participants. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

Section 6401 of the Affordable Care Act (ACA) requires that all providers must be enrolled in Medicaid in order to be paid by Medicaid. This means all providers must enroll and meet all requirements of the Pennsylvania Department of Human Services (DHS) which then issues a Medicaid identification number called Promise Provider Identification (PPID). The enrollment requirements include registering every service location with the state and having a different service location extension for each location.

Additionally, DHS has implemented the requirement that all providers must revalidate their Medical Assistance enrollment every five (5) years. (ACA) (§42 CFR 455.414). Claims from Providers who have not accurately updated their enrollment information cannot be paid. Providers should log into PROMISe™ to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

Reimbursement for all rendering network providers for claims subject to the ordering/referring/prescribing (ORP) requirement is determined by validating that participating ordering/referring/prescribing practitioners have a valid PPID. Claims subject to the ORP requirement will be denied when billed with the NPI of a network ordering/referring/prescribing provider that is not enrolled in Medicaid.

Claim Filing

Keystone First Community Health Choices (Keystone First CHC) is required by state and federal regulations to capture specific data regarding services rendered to its Participants. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

Important: To comply with provisions of the Affordable Care Act (ACA) regarding enrollment and screening of providers (Code of Federal Regulations: 42CFR, §455.410), Providers participating with Keystone First CHC must participate in the Pennsylvania Medical Assistance Program.

All providers must be enrolled in the Pennsylvania State Medicaid program before a payment of a Medicaid claim can be made.

Important note: This applies to non-participating out-of-state providers as well.
This means all providers must enroll and meet applicable Medical Assistance provider requirements of DHS and receive a Pennsylvania Promise ID (PPID). The enrollment requirements for facilities, physicians and practitioners include registering every service location with DHS and having a different service location extension for each location.

DHS fully intends to terminate Medical Assistance enrollment of all non-compliant providers. Keystone First CHC will comply with DHS's expectation that non-compliant providers will also be terminated from out network, since medical assistance enrollment is a requirement for participation with Keystone First CHC. Enroll by visiting: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994.

For providers other than Type 59, DHS also requires that Providers obtain an NPI and share it with them. Further information on DHS's requirements can be found at https://www.dhs.pa.gov/providers/Providers/Pages/NPI.aspx.

When required data elements are missing or are invalid, claims will be rejected by the Plan for correction and re-submission.
Claims for billable and capitated services provided to Plan Participants must be submitted by the provider who performed the services.

Claims filed with the Plan are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 form.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification for electronic claims against 837 edits at Optum/Change Healthcare™, Availity, or other clearinghouse.
- Verification of Participant eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible Participant.
- Verification that the provider participated with the Medical Assistance program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to the Plan.
- **All 837 claims should be compliant with SNIP level 4 standards, with exception to provider secondary identification numbers (Provider legacy, Commercial, State ID, UPIN, and Location Numbers).**
- **All 837 claims with Claim Attachments should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field # 80 for UB-04 Claim Form.**

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

- **Rejected claims** are not registered in the claim processing system and can be resubmitted as a new claim.
- **Rejected claims are considered original claims and timely filing limits must be followed.**

Important: **Denied claims** are registered in the claim processing system but do not meet requirements for payment under Plan guidelines. They should be resubmitted as a corrected claim.

- **Denied claims** must be re-submitted as corrected claims within 365 calendar days from the date of service.
- Set claim frequency code correctly and send the original claim number.

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

Claim Mailing Instructions

Submit claims to the Plan at the following address:

Keystone First CHC w/o Medicare	**Keystone First CHC (with aligned Keystone First VIP Choice Medicare)**
Claims Processing Department	Claims Processing Department
P.O. Box 7146	**P.O. Box 7143**
London, KY 40742	London, KY 40742

The Plan encourages all providers to submit claims electronically. Providers may submit electronic claims via Optum/Change Healthcare or Availity clearinghouses. Hereafter throughout this document we will use "Clearinghouse" to mean either Optum/Change Healthcare or Availity. For those interested in electronic claim filing, contact your EDI software vendor or Optum/**Change Healthcare's Provider Support Line at 1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 AM to 8 PM ET.

Any additional questions may be directed to the EDI Technical Support Hotline at 1-877-234-2460 or by email at edi.support@amerihealthcaritas.com.

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.
Re-submission of previously denied claims with corrections and requests for adjustments must be submitted within 365 calendar days from the date services were rendered or compensable items were provided.

Please allow for normal processing time before re-submitting a claim either through the EDI or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or Participant data.

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

Exceptions

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB (claim adjudication).

Important: Claims **originally rejected for missing or invalid data elements** must be corrected and re-submitted **within 180 calendar days from the date of service**. Rejected claims are not registered as received in the claim processing system.

Important: Requests for adjustments may be submitted by telephone to Provider Claims Services at **1-800-521-6007**.

(Select the prompts for the correct Plan, and then, select the prompt for claim issues.) If submitting via paper or EDI, please include the original claim number.

If you prefer to resubmit claims by mail or by EDI, please refer to instructions under "Resubmitted Professional Corrected Claims".

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

Keystone First CHC (No Medicare)	**Keystone First CHC (with aligned Medicare)**
Claims Processing Department	Claims Processing Department
P.O. Box 7146	**P.O. Box 7143**
London, KY 40742	London, KY 40742

Electronically:
Mark claim frequency code "7" and use CLM05-3 to report claims adjustments electronically. Include the original claim number.

A Dispute is a verbal or written expression of dissatisfaction by a Network Provider regarding a Plan decision that directly impacts the Network Provider. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.

An **appeal** is a written request from a Health Care Provider for the reversal of a denial by Keystone First, through its Formal Provider Appeals Process, with regard to two (2) major types of issues. The two (2) types of issues that may be addressed through the Plan's Formal Provider Appeals Process are:

- Disputes involving medical necessity and not resolved to the Network Provider's satisfaction through the Plan's Informal Provider Dispute Process

- Denials for services already rendered by the Health Care Provider to a Participant including, denials that do not clearly state the Health Care Provider is filing a Participant Complaint or Grievance on behalf of a Participant (even if the materials submitted with the Appeal contain a Participant consent)

<u>Clinical provider medical appeals</u> must be submitted in writing to:
Clinical Provider Appeals Department
Keystone First CHC
P.O. Box 8011
London, KY 40742-0113

<u>Written Disputes</u> should be mailed to:
Informal Provider Disputes
Keystone First CHC
P.O. Box 7146
London, KY 40742-7146

Refer to the Provider Manual for complete instructions on submitting appeals.
Note: **Keystone First CHC's EDI Payer ID # is 42344**

Refunds for Claims Overpayments or Errors

The Plan and the Pennsylvania Department of Human Services encourage providers to conduct regular self-audits to ensure accurate payment.

Medicaid program funds that were improperly paid or overpaid must be returned. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make immediate arrangements to return the funds to the Plan or follow the DHS protocols for returning improper payments or overpayment.

1. Contact Provider Claim Services at 1-800-521-6007 to arrange the repayment. There are two ways to return overpayments to the Plan:
    - Have the Plan deduct the overpayment/improper payment amount from future claims payments.
    - Submit a check for the overpayment/improper amount directly to:

Keystone First CHC (No Medicare)	**Keystone First CHC (with aligned Medicare)**
Claims Processing Department	Claims Processing Department
P.O. Box 7146	**P.O. Box 7143**
London, KY 40742	London, KY 40742

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

2. Providers may follow the "Pennsylvania Medical Assistance (MA) Provider Self-audit Protocol" to return improper payments or overpayments. Access the DHS voluntary

protocol process via the following link: https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx.

Submit a 275 claim attachment transaction

Keystone First CHC is accepting ANSI 5010 ASC X12 275 unsolicited attachments via Optum/Change Healthcare, Availity, or other clearinghouse. Please contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic 275 attachment submissions via the Keystone First CHC EDI payer ID: 42344.

There are three ways that 275 attachments can be submitted.

- Batch: you may either connect to Optum/Change Healthcare or Availity directly or submit via your EDI clearinghouse.
- API via JSON: you may use Optum/Change Healthcare to submit an attachment for a single claim.
- Portal: individual providers can register at Optum/Change Healthcare or Availity https://www.availity.com/documents/learning/LP_AP_GetStarted_Atypical/index.html#/ to submit attachments.

The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, xml, doc, and txt.

In addition, the following 275 claims attachment report codes have been added effective August 1, 2023. When submitting an attachment, use the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04, as documented in the Claims Filing Instructions.

Attachment Type	**Claim assignment attachment report code**
Itemized Bill	03
Medical Records for HAC review	M1
Single Case Agreement (SCA)/LOA	04
Advanced Beneficiary Notice (ABN)	05
Consent Form	CK
Manufacturer Suggested Retail Price /Invoice	06
Electric Breast Pump Request Form	07
CME Checklist consent forms (Child Medical Eval)	08
EOBs — for 275 attachments should only be used for non-covered or exhausted benefit letter	EB
Certification of the Decision to Terminate Pregnancy	CT
Ambulance Trip Notes/Run Sheet	AM

HEALTH INSURANCE CLAIM FORM

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PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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

Claim Form Field Requirements

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

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. All claims must be submitted within the required filing deadline of 180 days from the date of service.
Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

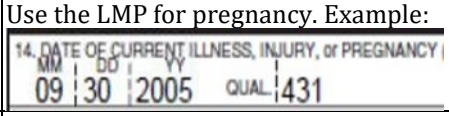
Required Fields (CMS 1500 Claim Form):

*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. Refer to the NUCC or NUBC Reference Manuals for additional information.

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
N/A	**Carrier Block**			2010BB	NM103 N301 N302 N401 N402 N403	N/A
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim	R	2000B	SBR09	Titled Claim Filing Indicator code 837P
1a	**Insured Medicaid I.D. Number**	Health Plan's Participant identification number. If submitting a claim for a newborn that does not have an identification number, enter the mother's Medicaid ID number. Enter the Participant's Medicaid ID number exactly the way it appears on their Plan-issued ID card.	R	2010BA	NM109	Titled Subscriber Primary Identifier in 837P
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the Participant's Health Plan ID card. If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name.	R	2010CA or 2010BA	NM103 NM104 NM105 NM107	
3	**Patient's Birth Date/Sex**	MMDDYY / M or F If submitting a claim for a newborn, enter "newborn" and DOB/Sex.	R	2010CA or 2010BA	DMG02 DMG03	Titled Gender in 837P.

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
4	**Insured's Name (Last, First, Middle**	Enter the patient's name as it appears on the Participant's Health Plan ID card or enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105	2010BA
5	**Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	
6	**Patient Relationship to Insured**	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01	Titled individual Relationship code in 837P.
7	**Insured's Address (Number, Street, City, State, Zip+4 Code)**	If same as the patient, enter "Same." Otherwise, enter insured's information.	C	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in 837P.
8	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	N/A
9	**Other Insured's Name (Last, First, Middle initial)**	Refers to someone other than the patient. **Completion of fields 9a through 9d is Required** if patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique Participant ID, then the patient is the subscriber and identified in this loop. Titled Other Subscriber Name in 837P.
9a	**Other Insured's policy or Group#**	**Required** if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P.
9b	**Reserved for NUCC use**	N/A	Not required	N/A	N/A	Does not exist in 837P
9c	**Reserved for NUCC use**	N/A	Not required	N/A	N/A	Does not exist in 837P
9d	**Insurance Plan Name or Program Name**	**Required** if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other insurance group 837P
10a, b,c	**Is Patient's Condition related to**	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident c) Other Accident	R	2300	CLM11	Titled related causes code in 837P
10d	**Claim Codes (designated by NUCC)**	Enter new Condition Codes as appropriate. Available 2-digit Condition Codes includes nine codes for abortion services and four	C	2300	NTE	NTE 01 position – input "ADD" Upper case/capital format.

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include: • AD – Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from, or Exacerbated by the pregnancy itself • W3- Level 1 Appeal				NTE 02 position – first six-character input "EPSDT=" (upper case/capital format where the sixth character will be the = sign. Input applicable referral directly after "=" For multiple code entries Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~
11	**Insured's Policy Group or FECA #**	Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	200B	SBR03	Titled Subscriber Group or Policy # in 837P
11a	**Insured's Birth date/Sex**	Same as #3. Required if 11 is Completed.	C	2010BA	DMG02 DMG03	Titled subscriber DOB and Gender of 837P
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line, identifier to the right of the vertical, dotted line.	C	2010B	REF01 REF02	Titled Other Claim ID in 837P
11c	**Insurance Plan Name or Program name**	Enter name of Health Plan. Required if 11 is completed.	C	200B	SBR04	Third Subscriber Group name in 837P
11d	**Is there Another Health Benefit Plan?**	Y or N by check box. If yes, indicate Y for yes. If yes, complete # 9 a-d.	R	2320		Presence of Loop 2320 indicates Y (yes) to the question on 837P.
12	**Patient's Or Authorized Person's Signaure**	On the 837, the following values are addressed as follows at Optum/Change Healthcare, Availity, or other clearinghouse: "A", "Y", "M", "O" or "R", then change to "Y", else send "I" (for "N" or "I").	R	2300	CLM09	Titled Release of Information code in 837P
13	**Insured's Or Authorized Person's Signature**		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P
14	**Date of Current Illness, Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: • 431 – Onset of Current Symptoms or Illness	C	2300	DTP01 DTP03	Titled in the 837P: Date-Onset of current illness or symptom date- Last Menstrual Period

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		• 439 – Accident Date • 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy. Example:  				
15	**Other Date**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date)	C	2300	DTP01 DTP03	Titled in the 837P: Date – Initial Treatment Date Date – Last Seen Date Date – Acute Manifestation Date – Accident Date – Last X-ray Date Date – Hearing and Vision Prescription Date Date – Assumed and Relinquished Care Dates Date – Property and Casualty Date of First Contact
17a	**Other ID Number of Referring Physician**	Enter the Health Plan provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The NUCC defines the following qualifiers: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) Required if # 17 is completed.	C	2310 (referring) 2010D (Supervising) 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P.
17b	**National Provider Identifier (NPI)**	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310D	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and Ordering Provider Identifier in 837P.
18	**Hospitalization Dates related to Current Services**	**Required** when place of service is in-patient. **MMDDYY** (indicate **from** and **to** date)	C	2300	DPT01 DPT03	Titled Related Hospitalization Admission and Discharge in 837P.
19	**Additional Claim Information (Designated by NUCC)**	**Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and data combination.**	R	2300	NTE PWK PRV03	

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		The NUCC defines the following qualifiers: • **1G** Provider UPIN Number • **G2** Provider Commercial Number • **LU** Location Number (This qualifier is used for Supervising Provider only.) • **N5** Provider Plan Network Identification Number • **SY** Social Security Number • **X5** State Industrial Accident Provider Number • **ZZ** Provider Taxonomy		2310 (rending provider taxonomy) 2310B	PRV03 PRV01 =PE	Titled Provider Taxonomy code is 837P Provider Additional Identifier in 837P.
	Additional Claim Information	**Claim Attachment Report Type codes in 837P defines the following qualifiers** **03 - Itemized Bill** **M1 - Medical Records for HAC review** **04 - Single Case Agreement (SCA)/ LOA** **05 - Advanced Beneficiary Notice (ABN)** **CK - Consent Form** **06 - Manufacturer Suggested Retail Price /Invoice** **07 - Electric Breast Pump Request Form** **08 - CME Checklist consent forms (Child Medical Eval)** **EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter** **CT - Certification of the Decision to Terminate Pregnancy** **AM - Ambulance Trip Notes/ Run Sheet**	Required	2300	PWK01	Claim Attachment Report Type codes in 837P
20	**Outside Lab**	If applicable, indicate Yes. (If patient had outside lab work completed.) Otherwise, leave blank.	C	2400	PS102	
21	**Diagnosis or Nature of Illness or Injury (Relate to 24E)**	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note**: Claims with invalid diagnosis codes will be denied for payment. External diagnosis or "E" codes are not acceptable as a primary diagnosis.	R	2300	HIXX-02 Where XX=01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
22	**Resubmission Code and/or Original Ref. No**	This field is required for resubmissions or adjustments/corrected claims. Enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field. • 7 – Replacement of Prior Claim • 8 – Void/cancel of Prior Claim	C **Required** for resubmitted or adjusted claims	2300	CLM05-3 REF02 Where REF01 =F8	Titled Claim Frequency Code in the 837P. Titled Payer Claim Control Number in the 837P. Send the original claim number if this field is used.
23	**Prior Authorization Number** **CLIA Number Locations**	Enter the referral or authorization number. Refer to the Provider Manual to determine if services rendered require an authorization. Laboratory Service Providers must enter CLIA number here for the location. EDI claims: CLIA must be represented in the 2300 loop, REF02 element.	C	2300	REF02 Where REF01-G1REF02 Where REF01-9FREF02 Where REF01 =X4	Titled Prior Authorization Number in 837P. Titled Referral Number in 837P. Titled CLIA Number in 837P.
24A	**Date(s) of Service**	"From" date: MMDDYY. If the service was performed on one day leave "To" blank or re-enter "From" Date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R	2400	DTP01 DPT03	Titled Service Date in 837P
24B	**Place of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	2300 2400	CLM05-1 SV105	Titled Facility Code Value in 837P. Titled Place of Service Code in 837P.
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	C	2400	SV109	Titled Emergency Indicator in 837P.
24D	**Procedures, Services, or Supplies CPT/HCPCS Modifier**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. **Note**: Modifiers affecting reimbursement must be placed in the 1st modifier position.	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P.
24E	**Diagnosis Pointer**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service and must be entered in field 21. Do not enter diagnosis codes in 24E. **Note**: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107 (1-4)	Titled Diagnostic Code Pointer in 837P

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount.	R	2400	SV102	Titled Line-Item Charge Amount in 837P.
24G	**Days or Units**	Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable. (Field allows up to 3 digits.)	R	2400	SV104	Titled Service Unit Count in 837P.
24H	**Family Plan**	In Shaded area of field: **AV** - Patient refused referral. **S2** - Patient is currently under treatment for referred diagnostic or corrective health problems. **NU** - No referral given; or **ST** - Referral to another provider for diagnostic or corrective treatment. **In unshaded area of field**: "Y" for Yes – if service relates to a pregnancy or family planning "N" for No – if service does not relate to pregnancy or family planning	C	2300 2400	CRC SV111 SV112	
24I	**ID Qualifier**	If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I. **0B** State License Number **1G** Provider UPIN Number **G2** Provider Commercial Number **LU** Location Number If the rendering provider does have an NPI see field 24J below. If the Other ID number is the Health Plan ID number, enter G2.	R	2310B	REF (01) NM108	Titled Reference Identification Qualifier in 837P. XX required for NPI in NM109.
24J	**Rending Provider ID**	The individual rendering the service is reported in 24J. Enter the Provider Health Plan legacy ID number in the shaded area of the field. Use Qualifier G2 for Provider Health Plan legacy ID. Enter the NPI number in the unshaded area of the field. Use qualifier. Enter Taxonomy in shaded area • ZZ Provider Taxonomy Box 19 can also be used for sending Rendering Provider taxonomy	R	2310B	REF02 NM109 PRV03	Optum/Change HealthCare, Availity, or other clearinghouse will pass this ID on the claim when present. NPI Rendering provider taxonomy
25	**Federal Tax ID Number**	Physician or Supplier's Federal Tax ID numbers.	R	2010AA	REF01 REF02	Titled Reference Identification Qualifier and Billing Provider Tax

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
	SSN/EIN					Identification Number in the 837P. Where REF01 Qualifier EI=Tax ID Where REF01 Qualifier SY=SSN
26	**Patient's Account No.**	The provider's billing account number	R	2300	CLM01	Titled Patient Control Number in 837P.
27	**Accept Assignment**	**Always indicate Yes**. Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P.
28	**Total Charge**	Enter charges. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated Services). **Blank is not acceptable.**	R	2300	CLM02	Titled Total Claim Charge Amount in the 837P May be $0.
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	**Reserved for NUCC use**		Not required			
31	**Signature of Physician or Supplier Including Degrees or Credentials/ Date**	**Actual Signature is required**	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P
32	**Name and Address of Facility Where Services Were Rendered (If other than Home or Office)**	**Required** unless #33 is the same information. Enter the physical location. **(P.O. Box #'s are not acceptable here)**	R	2301C	NM103 N301 N401 N402 N403	
32a	**NPI Number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P.
32b	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers used in 5010A1: • **0B** State License Number	C Recommended	2301C	REF01 RED02	Titled Reference Identification Qualifier and Laboratory or Facility secondary Identifier in 837P.

CMS-1500 Claim Form						
Field #	Field Description	Instructions and Comments	Required or Conditional*	Loop ID	Segment	Notes
		• **G2** Provider Commercial Number • **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two- digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.				
33	**Billing Provider Info and Ph #**	**Required** – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location; P.O. Boxes are not acceptable	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	
33a	**NPI Number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.
33b	**Other ID #**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers: • **G2** Provider Commercial Number • **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two- digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	R Required Health Plan ID (recommended)	2010A 2010AA	PRV03 When PRV01 =B1 REF02 where REF01 =G2	Titled Provider Taxonomy Code in 837P. Titled Reference Identification Qualifier and Billing Provider Additional Identifier in 837P.

Special Instructions and Examples for CMS 1500 and EDI Claims Submissions

Supplemental Information

A. CMS 1500 Paper Claims – Field 24

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

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24 (or 2410/LIN and CTP segments when submitting via 837):

- Narrative description of unspecified codes
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) formerly Universal Product Code (UPC) for products
- Contract rate

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

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

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

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

B. CMS 1500 Paper Claims – Field 17B:

Important Note: Home- and Community-Based Services (HCBS) Provider who do not have an NPI must enter the legacy provider ID provided by the Plan.

C. EDI – Field 24D (Professional)

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

- Details sent in NTE that will be included in claim processing:
- Please include L1, L2, etc. to show line numbers related to the details. Please include these letters AFTER those specified below:

- Corrected claims need to begin with the letters RPC followed by the details of the original claim (as per contract instructions)
- DME Claims requiring specific instructions should begin with DME followed by specific details

D. EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=G2, REF02+ Plan's Provider Network Number. Less than 13 Digits Alphanumeric. Field is required. **Note:** do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims D. **EDI – Field 45 and 51 (Institutional)**

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

Service Line Loop 2400, DTP*472
Claim statement date Loop 2300, DTP*434

Field 51 – Health Plan ID – the number used by the health plan to identify itself. AmeriHealth Caritas PA CHC's EDI Payer ID# is **77062**.

E. EDI – Reporting DME

DME Claims requiring specific instructions should begin with DME followed by specific details.
Example: NTE*ADD*DME AEROSOL MASK, USED W/DME NEBULIZER

Common Causes of Claim Processing Delays, Rejections or Denials

Authorization Invalid or Missing - A valid authorization number must be included on the claim form for all services requiring prior authorization.

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

Diagnosis Code Missing Required Digits – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM or ICD-10 manual for the appropriate categories, subcategories, and extensions. Three-digit category codes are required at a minimum. Refer to the coding manuals to determine when additional alpha or numeric digits are required. Use "X" as a place holder where fewer than seven digits are required. Submit the correct ICD qualifier to match the ICD code being submitted.

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages. Payment from the previous payer may be submitted on the 837I or 837P. Besides the information supplied in this document, the line item details may be sent in the SVD segment. Include the adjudication date at the other payer in the DTP, qualifier 573. COB pertains to the other payer found in 2330B. For COB, the plan is considered the payer of last resort.

External Cause of Injury Codes – External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Include applicable POA Indicators with ECI codes.

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

Handwritten Claims – Handwritten claims are no longer accepted. Handwritten information often causes delays in processing or inaccurate payments due to reduced clarity, therefore handwritten claims will be rejected.

Highlighted Claim Fields (See Illegible Claim Information)

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

Incomplete Forms – All required information must be included on the claim forms in order to ensure prompt and accurate processing.
Participant Name Missing – The name of the Participant must be present on the claim form and must match the information on file with the Plan.

Participant Plan Identification Number Missing or Invalid – The Plan's assigned identification number must be included on the claim form or electronic claim submitted for payment.

Participant Date of Birth does not match Participant ID Submitted – a newborn claim submitted with the mother's ID number will be pended for manual processing causing delay in prompt payment.

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

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

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Plan.

Provider NPI Number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included on the claim form. Note: Home- and Community-Based Services (HCBS) Provider who do not have an NPI must enter the legacy provider ID provided by the Plan.

Spanning Dates of Service Do Not Match the Listed Days/Units – Claims billed with a span of dates are not accepted. Please bill each date of service (DOS) individually on Form CMS-1500 and 837P (Professional). All claims submitted electronically or on paper must be line-item billed. Each individual service code must be billed with its corresponding DOS and number of units provided on that particular date. Claims can be submitted with multiple DOS on a single claim. If a shift or service spans multiple dates, each DOS must be billed with the procedure code and units.

Signature Missing – The signature of the practitioner or provider of service must be present on the claim form and must match the service provider name, NPI and TIN on file with the Plan.

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

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

- CMS-1500 field 19 (Rendering Taxonomy) and 33b (Billing Taxonomy)

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

Type of Bill – A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. Do not include the leading zero on electronic claims. Adjusted claims may be sent via paper or EDI.

Important Billing Reminders:

- Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.

- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.
- Append the appropriate modifiers to the HCPCS/CPT code when performing a service or separate, distinct or independent procedure on the same day that a procedure or other service is performed.
- The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- Submitting the original copy of the claim form will assist in assuring claim information is legible.
- *The individual provider name* and NPI number as opposed to the group NPI number must be indicated on the claim form. **Note**: Home- and Community-Based Services (HCBS) Providers who do not have an NPI must enter the legacy provider ID provided by the Plan.
- Reimbursement for all rendering network providers for claims subject to the ordering/referring/prescribing (ORP) requirement is determined by validating that participating ordering/referring/prescribing Practitioners have a valid Pennsylvania Medical Assistance (MA) Provider ID. Claims subject to the ORP requirement will be denied when billed with the NPI of a network ordering/referring/prescribing provider that is not enrolled in MA. For more information on claims subject to ORP requirements please go to: https://www.keystonefirstpa.com/pdf/provider/communications/bulletins/mab-99-17-02.pdf
- Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.
- Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.
- Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.
- *The individual service provider name and NPI number* must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments. **Note**: Home- and Community-Based Services (HCBS) providers who do not have an NPI must enter the legacy provider ID provided by the Plan.
- When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI numbers results in inaccurate payments or denials. **Note**: Home- and Community-Based Services (HCBS) providers who do not have an NPI must enter the legacy provider ID provided by the Plan.

- When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day. **Note**: Home- and Community-Based Services (HCBS) providers who do not have an NPI must enter the legacy provider ID provided by the Plan.
- Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.
- Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.
- **Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately.** Contact your Provider Account Executive to assist in updating the Plan's records.
- The PA Aligned product (Community Health Choice/Dual Special Needs Plan or DSNP) includes both Medicare and Medicaid benefits, where Medicare is Primary and Medicaid is Secondary. Currently, for this product, single claim submission is required and in return, providers receive two 835 Electronic remittance advices (remits) and Paper remits with same claim ID – one with Primary Medicare payment details and another with Secondary Medicaid payment details.

835 Electronic Remit

- Below is information indicating how 835 remit can be identified for Medicare and Medicaid coverage.

Split 835 ERA for Dual Coverage	Comments
BPR*I*71*C*CHK**********20181127 TRN*1*11111111*Tax ID N1*PR*Plan Name CLP*0*1*572*70.65*64.47*MA*23001367000~ NM1*QC*1*PARTICIPANT*NAME****MI*222222222~ DTM*050*20181120~ AMT*AU*70.65~ SVC*HC:73562:TC*286*17.12*0320~ DTM*472*20181015~ CAS*CO*235*.35**131*217.72~ CAS*PR*1*46.44**2*4.37~ AMT*B6*68.28~ SVC*HC:73562:TC*286*53.53*0320~ DTM*472*20181015~ CAS*CO*235*1.09**131*217.72~ CAS*PR*2*13.66~ AMT*B6*68.28~ CLP*0*2*572*.35*1*MC*23001367000~ NM1*QC*1*PARTICIPANT*NAME****MI*222222222~ DTM*050*20181120~ AMT*AU*.35~ SVC*HC:73562:TC*286*.35*0320~ DTM*472*20181015~ CAS*PR*3*1~ CAS*CO*45*284.65~ AMT*B6*17.82~ LQ*HE*N381~ SVC*HC:73562:TC*286*0*0320~ DTM*472*20181015~ CAS*CO*45*286~ AMT*B6*17.82~ LQ*HE*N381~	For Medicare coverage CLP06 Value would be – • MA for Medicare Part A • MB for Medicare Part B Medicare coverage paid $70.65 For Medicaid coverage CLP06 Value would be – • MC for Medicaid Medicaid coverage paid $0.35

Paper Remit

Below information indicates how a Paper remit will be shown for Medicare and Medicaid coverage for single claim ID.

Remittance Advice

Provider ID: [redacted] **NPI #:** [redacted] **Member ID:** [redacted] **Patient ID:**
Provider Name: [redacted] **Member Name:** [redacted] **Claim ID:** 23001367000

Plan Type	Date of Service	Proc/Rev DRG Code	Mod	Description	Qty	Charged Amount	Allowed Amount	OIC	COB	Deductible	Coins	Co Pay	Withhold	Amount Paid	Adj/Den
Medicare	10/15/18-10/15/18	73562 0320		Radiologic examination, kne	001	286.00	68.28	0.00	0.00	46.44	4.37	0.00	0.35	17.12	131 N381 PDC SEQ
Medicare	10/15/18-10/15/18	73562 0320		Radiologic examination, kne	001	286.00	68.28	0.00	0.00	0.00	13.66	0.00	1.09	53.53	131 N381 PDC SEQ
													Interest Payment	0.00	
													Prior Payment	0.00	
Patient Responsibility: 64.47				Claim Total		572.00								70.65	

Provider ID: [redacted] **NPI #:** [redacted] **Member ID:** [redacted] **Patient ID:**
Provider Name: [redacted] **Member Name:** [redacted] **Claim ID:** 23001367000

Plan Type	Date of Service	Proc/Rev DRG Code	Mod	Description	Qty	Charged Amount	Allowed Amount	OIC	COB	Deductible	Coins	Co Pay	Withhold	Amount Paid	Adj/Den
Medicaid	10/15/18-10/15/18	73562 0320		Radiologic examination, kne	001	286.00	17.82	0.00	17.12	0.00	0.00	1.00	0.00	0.35	45 N381 PXN
Medicaid	10/15/18-10/15/18	73562 0320		Radiologic examination, kne	001	286.00	17.82	0.00	53.53	0.00	0.00	0.00	0.00	0.00	45 N381 PXN
													Interest Payment	0.00	
													Prior Payment	0.00	
Patient Responsibility: 1.00				Claim Total		572.00								0.35	

- First claim details with Plan Type "Medicare" indicate Primary Medicare processing
- Second claim details with Plan Type "Medicaid" indicate Secondary Medicaid processing. Primary paid amount is displayed as COB amount in Secondary coverage

Providers must verify whether a participant has insurance coverage in addition to Medical Assistance (MA). Providers can verify Participant eligibility and benefits through any of the following methods:

- **NaviNet (www.navinet.net)**
- Keystone First eligibility line **– 1-800-521-6007**
- Pennsylvania Eligibility Verification System (EVS) **– 1-800-766-5387**

Electronic Data Interchange (EDI) for Medical and HCBS Claims

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

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.

- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

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

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

Important: In order to verify satisfactory receipt and acceptance of submitted records, please review both the Optum/Change Healthcare, Availity, or other clearinghouse Acceptance report, and the R059 Plan Claim Status Report.

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

Electronic Claims Submission (EDI)

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

Hardware/Software Requirements

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

Contracting with Optum/Change Healthcare, Availity, and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Optum/Change Healthcare or Availity EDI capabilities, you can contact the Optum/Change Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 AM to 8 PM ET.. You may also choose to contract with another EDI clearinghouse or vendor who already has Optum/Change Healthcare capabilities.

Contacting the EDI Technical Support Group

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

When ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your EDI software vendor and/or clearinghouse to inform them you wish to initiate electronic submissions to the Plan.

- Be prepared to inform the vendor of the Plan's electronic payer identification number.

Important: Contact EDI Technical Support at **1-877-234-2460** or by email at edi.support@amerihealthcaritas.com

Important: Providers are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

Important: **the Payer ID for Keystone First CHC is 42344**

NOTE: Plan payer specific edits are described in Exhibit 99 at Optum/Change Healthcare.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Optum/Change Healthcare or any other EDI clearinghouse or vendor may require additional data record requirements.

Electronic Claim Flow Description

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

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

Accepted claims are passed to the Plan, and the clearinghouse returns an acceptance report to the sender immediately.

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

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

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

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Optum/Change Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-3548)**.Assistance is available Monday through Friday 8AM-8PM ET. .
- If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support Hotline at **1-877-234-2460** or by email at: edi.support@amerihealthcaritas.com

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

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

* An Acceptance report verifies acceptance of each claim by the clearinghouse.
** An R059 Plan Claim Status Report is a list of claims that passed the clearinghouse's validation edits. However, when the claims were submitted to the Plan, they encountered provider or Participant eligibility edits.

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

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

Important: Contact Optum/Change Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548**). Assistance is available Monday through Friday from 8 AM to 8 PM ET..

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

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

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass clearinghouse HIPAA edits and Plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at the Plan. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 180 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from the clearinghouse or your EDI software vendor in order to identify and re-submit these claims accurately.

Plan Specific Electronic Edit Requirements

The Plan currently has two specific edits for professional and institutional claims sent electronically.
837P –005010X222A1– Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
837I – 005010X223A2 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Exclusions
Certain claims are excluded from electronic billing. These exclusions fall into two groups and apply to inpatient and outpatient claim types.

Excluded Claim Categories. At this time, these claim records must be submitted on paper.
Claim records for medical, administrative or claim appeals
Excluded Provider Categories. Claims issued on behalf of the following providers must be submitted on paper.
Providers not transmitting through Optum/Change Healthcare or Availity, or providers sending to Vendors that are not transmitting (through Optum/Change Healthcare, Availity, or other clearinghouse) NCPDP Claims
Pharmacy (through Optum/Change Healthcare, Availity, or other clearinghouse)

Important: Requests for adjustments may be submitted by telephone to:
Provider Claim Services: 1-800-521-6007

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

Claim Processing Department
Keystone First CHC
P.O. Box **7146**
London, KY 40742-7146

Provider Disputes: A verbal or written expression of dissatisfaction by a network Provider regarding a decision by Keystone First CHC that directly impacts the network Provider. Disputes are generally administrative in nature and do not include decisions concerning Medical Necessity.

Disputes may focus on issues concerning Keystone First CHC services and processes, other health care Providers, Participants, or claims (e.g. frequency of on-site visits, dissatisfaction with detail of Participant information on panel list, Participant noncompliance, timeliness of claims payments, etc.).

Submit written disputes to:
Informal Provider Dispute
Keystone First CHC
P.O. Box **7146**
London, KY 40742-7146
Provider Appeal is a written request from a Health Care Provider for the reversal of a denial by Keystone First CHC, through its Formal Provider Appeals Process, with regard to two (2) major types of issues:

1. Disputes not resolved to the Network Provider's satisfaction through Keystone First CHC's Informal Provider Dispute Process
2. Denials for services already rendered by the Health Care Provider to a Participant including denials that do not clearly state the Health Care Provider is filing a Participant Complaint or Grievance on behalf of a Participant (even if the materials submitted with the Appeal contain a Participant consent)

Important: Provider Appeals may not be requested for claims denied because they were not filed within the Plan's 180-day filing time limit.

Clinical provider medical appeals must be submitted in writing to:
Clinical Provider Appeals Department
Keystone First CHC
P.O. Box **8011**
London, KY 40742-0113

Refer to the Provider Manual at https://www.keystonefirstchc.com/pdf/providers/provider-manual.pdf for complete instructions on submitting administrative or medical appeals.

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Optum/Change Healthcare, Availity, or other clearinghouses
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
Claims without provider numbers
Claims without Participant numbers
Claims in which the date of birth submitted does not match the Participant ID.
Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)

Claims received with invalid provider numbers
Claims received with invalid Participant numbers
Claims received with invalid Participant date of birth
Claims without Billing Taxonomy IDs, Attending Taxonomy IDs, Rendering Taxonomy IDs

Resubmitted Professional Corrected Claims

Providers using electronic data interchange (EDI) can submit "professional" corrected claims* electronically rather than via paper to the Plan.

* A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original claim number.

- Your EDI clearinghouse or vendor needs to:
- Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)
- Use "8" for void/cancel of prior claim, utilizing bill type in loop 2300, CLM05-03 (837P)
- Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- **Do** include the plan's claim number in order to submit your claim with the 7 or 8
- **Do** use this indicator for claims that were previously processed (approved or denied)
- **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- **Do not** submit corrected claims electronically and via paper at the same time
    - For more information, please contact the EDI Hotline at **1-877-234-2460** or: edi.support@amerihealthcaritas.com
    - Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims faster than available with paper submission processing.

Important: Claims originally rejected for missing or invalid data elements must be corrected and re-submitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 6-7.)

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

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

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

Claim Processing Department

Keystone First CHC w/o Medicare	Keystone First CHC (with aligned Medicare)
Claims Processing Department	Claims Processing Department
P.O. Box 7146	P.O. Box 7143
London, KY 40742	London, KY 40742

Important: Corrected Institutional and Professional claims can be resubmitted electronically using the appropriate bill type to indicate that it is a corrected claim.

Contact Optum/Change Healthcare Provider Support Line at: **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548)**. Assistance is available Monday through Friday from 8 AM to 8 PM ET**.**

Contact EDI Technical Support at: **1-877-234-2460** or by email at edi.support@amerihealthcaritas.com

Important: Provider NPI number validation is not performed by the clearinghouse. The clearinghouse will reject claims for provider NPI only if the provider number fields are empty.

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

837P – Loop 2310B, REF*G2[PIN]
837I – Loop 2310A, REF*G2 [PIN]

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

1. Plan ID, Tax ID and NPI number
2. If no single match is found, the Service Location's ZIP code is used
3. If no service location is include, the billing address ZIP code will be used
4. If no single match is found, the Taxonomy is used
5. If no single match is found, the required Taxonomy is used
6. If a plan provider ID is sent using the G2 qualifier, it is used as provider on the claim. The legacy Plan ID is used as the primary ID on the claim
7. If you have submitted a claim, and you have not received a rejection report, but are unable to locate your claim via NaviNet, it is possible that your claim is in review by the Plan. Please check with provider services and update you NPI data as needed. It is essential that the service location of the claim match the NPI information sent on the claim in order to have your claim processed effectively.

Keystone First CHC claims can be submitted electronically through any clearinghouse. Contact your EDI clearinghouse or Optum/Change Healthcare at **1-877-363-3666** or Availity Client Services at **1-800-AVAILITY (282-4548)** to inform them that you wish to initiate electronic claim submissions to Keystone First CHC. Or visit https://support.changehealthcare.com/customer-resources/enrollment-services for information on enrolling.

Keystone First CHC does not require you to enroll with Optum/Change Healthcare or Availity to submit electronic claims. If you already use another EDI vendor to submit claims electronically, inform your vendor of the **EDI payer ID: 42344**.

Direct Submission
Providers can submit claims directly to Optum/Change Healthcare Connect Center or PCH Global. The Optum/Change Healthcare direct entry claims portal, Connect Center, provides two methods for submitting claims: key them in manually or import batches of claims. There is no cost to manually key claims in using Connect Center, but claims must be entered one at a time, which may not be feasible for practices with high claim volume. Providers should call Optum/Change Healthcare at **1-800-527-8133, option 2** and follow the appropriate prompts, or go to: https://support.changehealthcare.com/customer-resources/enrollment-services to enroll for direct submission with Optum/Change Healthcare. Optum/Change Healthcare will also provide information on their various electronic solutions, the requirements for connectivity, and setup instructions.

Electronic Claim Payment Options
Optum/Change Healthcare is now partnering with ECHO Health, Inc. (ECHO Health), a leading innovator in electronic payment solutions, to offer more electronic payment options to our healthcare providers so that they can select the payment method that best suits their accounts receivable workflow.

Virtual Credit Card (VCC)
Echo Health offers Virtual Credit Cards as an optional payment method. Virtual Credit Cards are randomly generated, temporary credit card numbers that are either faxed or mailed to providers for claims reimbursement. Major advantages to VCC are that providers do not have to enroll or fill out multiple forms in order to receive VCC, and personal information, like practice bank account information, will never be requested. Providers will also be able to access their payment the day the VCC is received. In the future, Keystone First CHC providers who are not currently registered to receive payments electronically will receive VCC payments as their default payment method, instead of paper checks. Your office will receive either faxed or mailed VCC payments, each containing a VCC with a number unique to that payment transaction with an instruction page for processing and a detailed Explanation of Payment /Remittance Advice (EOP/RA). **Normal transaction fees apply based on your merchant acquirer relationship**. If you do not wish to receive your claim payments through VCC, you can opt out by contacting ECHO Health directly at **1-888-492-5579.**

Electronic Funds Transfers (EFT)
Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be accessible to download from

the ECHO provider portal (www.providerpayments.com). If you are new to EFT, you will need to enroll with ECHO Health for EFT from Keystone First CHC.

Please note: Payment will appear on your bank statement from PNC Bank and ECHO as "PNC – ECHO".

To sign-up to receive EFT from Keystone First CHC, visit https://enrollments.ECHOhealthinc.com/efteradirect/enroll. There is no fee for this service.

To sign-up to receive EFT from all of your payers processing payments on the Settlement Advocate platform, visit https://enrollments.ECHOhealthinc.com. **A fee for this service may be required**.

If you have questions regarding how to enroll in EFT, please reference the Keystone First CHC Enrollment Guide (https://www.keystonefirstchc.com/pdf/providers/eft-quick-guide.pdf)

Electronic Remittance Advice (ERA)
Keystone First CHC now also offers ERAs (also referred to as an 835 file) through Optum/Change Healthcare/ECHO Health. To receive ERAs from Optum/Change Healthcare and ECHO, you will need to include both the Optum/Change Healthcare Keystone First CHC payer ID **42344** and the ECHO payer ID **58379**. Contact your practice management/hospital information system for instructions on how to receive ERAs from Keystone First CHC Payer ID **42344** and the ECHO Payer ID **58379**. If your practice management/hospital information system is already set up and can accept ERAs from Keystone First CHC, then it is important to check that the system includes both Keystone First CHC payer ID **42344** and ECHO Heath Payer ID **58379** for ERAs.

If you are not receiving any payer ERAs, please contact your current practice management/hospital information system vendor to inquire if your software has the ability to process ERAs. Your software vendor is then responsible for contacting Optum/Change Healthcare to enroll for ERAs under both Keystone First CHC payer ID **42344** and ECHO Health Payer ID **58379**.

If your software does not support ERAs or you continue to reconcile manually, and you would like to start receiving ERAs only, please contact the ECHO Health Enrollment team at **1-888-834-3511**.

For enrollment support, please contact ECHO Health Inc. at **1-888-834-3511**.
If you have additional questions regarding VCC, EFT, or ERAs, please reference our FAQ or call ECHO Health Support team at 1-888-492-5579.

For additional detailed resources visit our website at:
www.keystonefirstchc.com/providers/claims-billing/electronic-billing-services.aspx

- EFT Enrollment Guide
- Quick Guide
- FAQ

Electronic Billing Inquiries

Action	Contact
If you would like to transmit claims electronically…	Contact Optum/Change Healthcare Provider Support Line at: **1-800-527-8133 option 2** or Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.
If you have general EDI questions …	Contact EDI Technical Support at: **1-877-234-2460** Or via email: edi.support@amerihealthcaritas.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports	Contact your EDI Software Vendor or call the Optum/Change Healthcare Provider Support Line at **1-800-527-8133, option 2** or Availity Client Services at **1-800-AVAILITY (282-4548).** Assistance is available Monday through Friday from 8 AM to 8 PM ET.
If you have questions about your R059 – Plan Claim Status (receipt or completion dates) …	Contact Provider Claim Services at-**1-800-521-6007**
If you have questions about claims that are reported on the Remittance Advice….	Contact Provider Claim Services at-**1-800-521-6007**
If you need to know your provider NPI number…	Contact Provider Claim Services at-**1-800-521-6007**
If you would like to update provider, payee, NPI, tax ID number or payment address information… For questions about changing or verifying provider information…	Notify Provider Network Management in writing at Keystone First CHC 200 Stevens Drive Philadelphia, PA 19113 Or email at: chcproviders@keystonefirstchc.com Or by fax at: **215-937-5343**
If you would like information on the 835 Remittance Advice:	Contact your EDI Vendor
Check the status of your claim:	Review the status of your submitted claims on NaviNet at www.navinet.net
Sign up for NaviNet	www.navinet.net

Tips for Accurate Diagnosis Coding: How to Minimize Retrospective Chart Review

What is the Risk Score Adjustment Model?

The Department of Human Services (DHS) utilizes medical encounter data supplied by the Plan to evaluate disease severity and risk of increased medical expenditures. DHS employs the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, to support health-

based capitation payments to the Plan. Accurate payments from DHS help us ensure that providers are reimbursed appropriately for services provided to our Participants.

- We must obtain health status documentation from the diagnoses contained in claims data.

Why are retrospective chart reviews necessary?

Although the Plan captures information through claims data, certain diagnosis information is commonly contained in medical records but is not reported via claim submission. Complete and accurate diagnosis coding will minimize the need for retrospective chart reviews.

What is the significance of the ICD-10-CM Diagnosis code?

International Classification of Diseases-10th Edition-Clinical Modification (ICD-10-CM) codes are identified as 3 to 7 alpha-numeric codes used to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-10-CM Official Guidelines for Coding and Reporting (October, 1, 2015), providers must code all documented conditions that were present at time of the encounter/visit, and require or affect patient care treatment or management.

Have you coded for all chronic conditions for the Participant?

Examples of disease conditions that should always be considered and included on the submission of the claim if they coexist at the time of the visit:

Amputation status	Dialysis status	Quadriplegia
Bipolar disorder	Drug/alcohol psychosis	Renal failure
Cerebral vascular disease	Drug/alcohol dependence	Schizophrenia
COPD	HIV/AIDS	Simple chronic bronchitis
Chronic renal failure	Hypertension	Tumors and other cancers
Congestive heart failure	Lung, other severe cancers	(Prostate, breast, etc.)
CAD	Metastatic cancer, acute leukemia	
Depression	Multiple sclerosis	
Diabetes mellitus	Paraplegia	

What are your responsibilities?

Physicians must accurately report the ICD-10-CM diagnosis codes to the highest level of specificity.

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:

- E11.40 Diabetes with neurological manifestations and E08.40 for diabetic polyneuropathy

Accurate coding can be easily accomplished by keeping accurate and complete medical record documentation.

Documentation Guidelines

- Reported diagnoses must be supported with medical record documentation.
- Acceptable documentation is clear; concise, consistent, complete, and legible.

Physician Documentation Tips

- First list the ICD-10CM code for the diagnosis, condition, problem or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- Strike through, initial, and date. Do not obliterate.
- Use only standard abbreviations.
- Identify patient and date on each page of the record.
- Ensure physician signature and credentials are on each date of service documented.
- Update physician super bills annually to reflect updated ICD-10CM coding changes, and the addition of new ICD-10CM codes.

Physician Communication Tips

When used, the SOAP note format can assist both the physician and record reviewer/coder in identifying key documentation elements.

SOAP stands for:

Subjective: How the patients describe their problems or illnesses.

Objective: Data obtained from examinations, lab results, vital signs, etc.

Assessment: Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.

Plan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

Supplemental Information:

Ambulance
Durable Medical Equipment (DME)
Home Health Care (HHC)
Incontinence Supplies
Most Common Claims Errors

Ambulance

Ground and Air Ambulance Services are billed on CMS 1500 or 837 Format
When billing for Procedure Codes A0425 – A0429 and A0433 – A0434 for Ambulance Transportation services, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit Procedure Code. Different modifiers may be used for the same Procedure Code.

- Providers must bill the transport codes with the appropriate destination modifier.
- Mileage must also be billed with the ambulance transport code and be billed with the appropriate transport codes.
- Effective January 1, 204, starting with mile 1, loaded miles must be billed with the appropriate ambulance transport codes. Providers must use the Place of Service Codes for ground and air transportation.
- Providers who submit transport codes without a destination modifier will be denied for invalid/missing modifier.
- Providers who bill mileage alone will be denied for invalid/inappropriate billing.
- Mileage when billed will only be paid when billed in conjunction with a PAID transport code.
- A second trip is reimbursed if the recipient is transferred from first hospital to another hospital on same day in order to receive appropriate treatment. Second trip must be billed with a (HH) destination modifier.
- For 837 claims, all ambulance details are required. Ambulance Transport information; Ambulance Certification; pick-up and drop-off locations.

Procedure Code Modifiers: The following procedure code modifiers are required with all transport procedure codes. The first place alpha code represents the origin and the second place alpha code represents the client's destination. Codes may be used in any combination unless otherwise noted.

D - Diagnostic or therapeutic site (other than physician's office or hospital)

E - Residential, domiciliary, or custodial facility (other than skilled nursing 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

P - Physician's office (includes HMO non-hospital facility, clinic, etc.)

R - Residence

S - Scene of accident or acute event

X - (DESTINATION CODE ONLY) Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

Durable Medical Equipment

- Services are billed on a CMS 1500 claim form.
- An "RR" modifier is required for all rentals.
- Repair codes on the DME Fee Schedule require the submission of procedure code K0739.
- Refer to the Provider Manual for DME authorization rules and guidelines.
- Program Exceptions - codes K0868 through K0891 will be reviewed on a case by case basis.
- Benefit Exceptions – items/services not listed on the Plan's DME fee schedule will be reviewed on an individual basis based on coverage, benefit guidelines, and medical necessity.

Miscellaneous codes will not be used if an appropriate code is on the Plan's First DME fee schedule. Home Health Care (HHC)

- Provider must bill on CMS 1500 or 837 electronic format (whichever format is designated in their Plan contract).
- Providers must bill the appropriate modifier in the first position when more than one modifier is billed.

Incontinence Supplies

- **Code W0137** requires prior authorization when supplied by Provider type 59, specialty type 250 (DME/Medical Supplier). All unspecified Procedure or HCPCS codes require a narrative description be reported in the shaded portion of field 24. The shaded area of lines 1 through 6 allow for the entry of 61 characters from the beginning of 24A to the end of 24G.

Submit claims and all appropriate forms to:

Keystone First CHC (w/o Medicare)	**Keystone First CHC (with aligned Medicare)**
Claims Processing Department	Claims Processing Department
P.O. Box 7146	P.O. Box 7143
London, KY 40742	London, KY 40742

Most Common Claims Errors

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	"**Participant name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"**Participant date of birth (DOB) is missing.**" (If missing month and/or day and/or year, the claim will be rejected.)
3	Patient's Birth Sex	"**Participant's sex is required.**" (If no box is checked, the claim will be rejected.)
4	Insured's Name	"**Insured's name missing or illegible.**" (If first and/or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address(number, street, city, state, zip) phone	"**Patient address is missing.**" (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"**Patient relationship to insured is required.**" (If none of the four boxes are selected, the claim will be rejected.)
7	Insured's Address(number, street, city, state, zip) phone	**"Insured's address is missing.**" (If street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	"Diagnosis code is missing or illegible." (The claim will be rejected.)
24	Supplemental Information	"**National Drug Code** (**NDC) data is missing/incomplete/ invalid.**" (The claim will be rejected if NDC data is missing incomplete, or has an invalid unit/basis of measurement.)
24A	Date of Service	**"Date of service (DOS) is missing or illegible.**" (The claim will be rejected if both the" From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	"Place of service is missing or illegible." (Claim will be rejected.)
24D	Procedure, Services or Supplies	"Procedure code is missing or illegible." (Claim will be rejected.)
24E	Diagnosis Pointer	"**Diagnosis (DX) pointer is required on line ___" [lines 1-6].** (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	"**Line item charge amount is missing on line ___" [lines 1-6].** (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"**Days/units are required on line ___" [lines 1-6].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering Provider identification	"National provider identifier (NPI) of the servicing/rendering provider is missing, or illegible." (If NPI is missing or illegible, claim will be rejected.)

Field #	CMS-1500 (02/12) Field/Data Element	"Reject Statement" (Reject Criteria)
26	Patient Account/Control Number	"Patient Account/Control number is missing or illegible" (If missing or illegible, claim will reject)
27	Assignment Number	"**Assignment acceptance must be indicated on the claim.**" (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	"**Total charge amount is required.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
31	Signature of physician or supplier including degrees or credentials	**"Provider name is missing or illegible."** (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)
33	Billing Provider Information and Phone number	"**Billing provider name and/or address is missing or incomplete.**" (If the name and/or street number and/or street name and/or city and/or state and/or zip are missing, the claim will be rejected.)
33	Billing Provider Information and Phone number	"Field 33 of the CMS1500 claim form requires the provider's physical service address."