Procedures for Claim Submission

IlliniCare Health is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. Claims will be rejected or denied if not submitted correctly. In general, IlliniCare Health follows the CMS (Centers for Medicare & Medicaid Services) billing requirements. For questions regarding billing requirements, contact an IlliniCare Health Provider Services Representative at 866-329-4701.

When required data elements are missing or are invalid, claims will be rejected or denied by IlliniCare Health for correction and re-submission.

- Rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).

Claims for billable services provided to IlliniCare Health members must be submitted by the provider who performed the services or by the provider’s authorized billing vendor.

All claims filed with IlliniCare Health are subject to verification procedures. These include but are not limited to verification of the following:

- All required fields are completed on an original CMS 1500 (02/12), UB-04 1450 paper claim form, or EDI electronic claim format.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.
- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4th, 5th, and 6th character requirements and 7th character extension requirements).
- Principle Diagnosis billed reflects an allowed Principle Diagnosis as defined in the volume of ICD-10 CM or ICD-10 CM update for the date of service billed.
- Member is eligible for services under IlliniCare Health during the time period in which services were provided.
- Services were provided by a participating provider or if provided by an “out of network” provider, authorization has been received to provide services to the eligible member (excludes services by an “out of network” provider for an emergency medical condition; however authorization requirements apply for post-stabilization services).
- An authorization has been given for services that require prior authorization by IlliniCare Health.
- Medicare coverage or other third party coverage.

**CLAIMS FILING DEADLINES**

To be eligible for reimbursement, providers must file claims within a qualifying time limit. A claim will be considered for payment only if it is received by IlliniCare Health no later than 180 days from the date on which services or items are provided. This time limit applies to both initial and resubmitted claims. Rebilled claims, as well as initial claims, received more than 180 days from the date of service will not be paid. Any claim disputes / reconsiderations must be received within 180 days of the DOS or date of discharge, whichever is later.

When IlliniCare Health is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 180 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider’s business office or records by a natural disaster.
- Mechanical or administrative delays or errors by IlliniCare Health or the Illinois Department of Health and Family Services (HFS).
- The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
  - The provider’s records document that the member refused or was physically unable to provide their ID card or information.
  - The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered or Health Safety Net, if applicable.
  - The provider can substantiate that a claim was filed within 180 days of discovering Plan eligibility.
  - The provider has not filed a claim for this member prior to the filing of the claim under review.
CLAIM REQUESTS FOR RECONSIDERATION, CLAIM DISPUTES AND CORRECTED CLAIMS

All claim requests for reconsideration, corrected claims or claim disputes must be received within 180 calendar days from the DOS or date of discharge, whichever is later.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four (4) effective ways in which the provider can contact IlliniCare Health.

1. Contact a IlliniCare Health Provider Service Representative at 866-329-4701
   - Providers may discuss questions with IlliniCare Health Provider Services Representatives regarding amount reimbursed or denial of a particular service.

2. Submit an Adjusted or Corrected Claim to IlliniCare Health, Attn: Corrected Claim, PO Box 4020, Farmington MO 63640-4402
   - Resubmissions should be typed or printed on a red and white claim form and must include the original claim number in field 22 of a CMS 1500 (02/12) or field 64 of a CMS 1450 (UB-04) and the original EOP must be included with the resubmission.
   - Failure to resubmit on a red and white claim form and include the original claim number and include the EOP may result in the claim being denied as a duplicate, a delay in the reprocessing, or denied for exceeding the timely filing limit.

3. Submit a "Request for Reconsideration" to IlliniCare Health, Attn: Reconsideration, PO Box 4020, Farmington MO 63640-4402
   - A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
   - The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name.
   - The documentation must also include a detailed description of the reason for the request.

4. Submit a "Claim Dispute Form" to IlliniCare Health, Attn: Dispute, PO Box 4020, Farmington MO 63640-4402
   - A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
   - The Claim Dispute Form can be located on the provider website at www.illinicare.com.

If the Provider Service contact, the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

IlliniCare Health shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 45 business days of receipt of the corrected claim, request for reconsideration or claim dispute.

CLAIM PAYMENT

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:
- 90% of clean claims will be processed within 30 business days of receipt
- 99% of clean claims will be processed within 90 business days of receipt

Adjusted claims, requests for reconsideration and disputed claims will be finalized to a paid or denied status 45 business days of receipt.

CLAIM APPEALS

 Appeals for unsuccessful request for reconsiderations must be submitted in writing and concluded within 180 days from the date on which services or items are provided. Submit claim appeals to:

IlliniCare Health
Attn: Claim Appeals
PO Box 3000
Farmington, MO 63640-3800

If the Provider Service contact, the corrected claim, the request for reconsideration or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

IlliniCare Health shall process, and finalize all adjusted claims, requests for reconsideration and disputed claims to a paid or denied status 45 business days of receipt of the corrected claim, request for reconsideration or claim dispute.
Questions regarding electronically submitted claims should be directed to our EDI BA Support at 800-225-2573 Ext. 6075525 or via e-mail at EDIBA@centene.com. At times, a voicemail will have to be left on the EDI line. You will receive a return call within 24 business hours.

The companion guides and clearinghouse options are on the IlliniCare Health website at www.illinicare.com.

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.

Specific Data Record Requirements
Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The companion guide is located on IlliniCare Health website at www.illinicare.com.

Electronic Claim Flow Description & Important General Information
In order to send claims electronically to IlliniCare Health, all EDI claims must first be forwarded to one of IlliniCare Health’s clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily. The name of this report can vary based upon the provider’s contract with their intermediate EDI clearinghouse. Accepted claims are passed to IlliniCare Health, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to IlliniCare Health by a clearinghouse are validated against their proprietary specifications and Plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims and these claims need to be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts.
Exclusions
Certain claims are excluded from electronic billing.

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

These exclusions apply to inpatient and outpatient claim types.

Invalid Electronic Claim Record Rejections/Denials
All claim records sent to IlliniCare Health must first pass the clearinghouse proprietary 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 by IlliniCare Health. 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 claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Our companion guides to billing electronically are available on our website at www.illinicare.com. See section on electronic claim filing for more details.

Electronic Billing Inquiries
Please direct inquiries as follows:

<table>
<thead>
<tr>
<th>ACTION</th>
<th>CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you would like to transmit claims electronically...</td>
<td>Contact one of the clearinghouses for IlliniCare Health’s payer ID.</td>
</tr>
<tr>
<td>If you have a general EDI question...</td>
<td>Contact EDI Support at 800-225-2573 Ext.6075525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a>.</td>
</tr>
<tr>
<td>If you have questions about specific claims transmissions or acceptance Claim Status reports...</td>
<td>Contact your clearinghouse technical support area</td>
</tr>
<tr>
<td>If you have questions about your Claim Status (if claim has been accepted or rejected by the clearinghouse)...</td>
<td>Contact EDI Support at 800-225-2573 Ext.6075525 or via e-mail at <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a>.</td>
</tr>
<tr>
<td>If you have questions about claims that are reported on the Remittance Advice...</td>
<td>Contact Provider Services at 866-329-4701</td>
</tr>
<tr>
<td>If you would like to update provider, payee, UPIN, Tax ID number or payment address information...</td>
<td>Notify Provider Services in writing at: IlliniCare Health 999 Oakmont Plaza Dr., Westmont, IL 60559</td>
</tr>
<tr>
<td>For questions about changing or verifying provider information...</td>
<td>Attn: Provider Services 999 Oakmont Plaza Dr., Westmont, IL 60559 Telephone: 866-329-4701 Or By Fax: 855-254-1791</td>
</tr>
</tbody>
</table>
Important Steps to a Successful Submission of EDI Claims

1. Select clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to IlliniCare Health.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Provider Relations at IlliniCare Health that the provider is set up in the IlliniCare Health system before submitting EDI claims.
5. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to IlliniCare Health and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by IlliniCare Health. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted correct and resubmit.
6. MOST importantly, all claims must be submitted with providers identifying numbers. See the CMS 1500 (2/12) and UB-04 1450 claim form instructions and claim forms for details.

EFT and ERA

IlliniCare Health has partnered with PaySpan to provide an innovative web-based solution for Electronic Funds Transfers (EFT’s) and Electronic Remittance Advices (ERA’s). Through this free service, providers can take advantage of EFTs and ERAs to settle claims electronically. For more information, please visit our provider home page on our website at www.illinicare.com or to sign up for this quick and efficient service you may go directly to www.payspan.com.

Procedures for Online Claim Submission

For participating providers who have internet access and choose not to submit claims via EDI, IlliniCare Health has made it easy and convenient to submit claims directly to us on our website at www.illinicare.com.

You must request access to our secure site by registering for a user name and password and have requested claims access. To obtain an ID, please contact Provider Relations at 866-329-4701. Requests are processed within two (2) business days.

Once you have access to the secure portal you may view web claims, allowing you to re-open and continue working on saved, un-submitted claims and this feature allows you to track the status of claims submitted using the website.
Claim Form Requirements

CLAIM FORMS
IlliniCare Health only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional services and medical supplies are billed on the CMS 1500 (02/12) claim form and institutional services are billed on the CMS 1450 (UB-04) claim form. IlliniCare Health does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms submitted must be typed or printed with either 10 or 12 Times New Roman font and on the required original red and white version. To ensure clean acceptance and processing, be sure typed data is strictly within the outlines of the data fields; any information that extends beyond the box may cause the claim form to be rejected. Black and white forms and handwritten forms will be rejected and returned to the provider. To reduce document handling time, do not use highlights, italics, bold text or staples. If you have questions regarding what type of form to complete, contact an IlliniCare Health Provider Services Representative at 866-329-4701.

Coding of Claims
IlliniCare Health requires claims to be submitted using codes from the current version of ICD-10 CM, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Claims will be rejected or denied if billed with:

- Missing, invalid, or deleted codes
- Codes inappropriate for the age or sex of the member
- An ICD-10 CM code missing the 4th, 5th, and 6th character requirements and 7th character extension requirements

For more information regarding billing codes, coding, and code auditing and editing refer to your IlliniCare Health Provider Manual or contact an IlliniCare Health Provider Services Representative at 866-329-4701.

Code Auditing and Editing
IlliniCare Health uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes against rules that have been established by the American Medical Association (AMA), Center for Medicare and Medicaid Services (CMS), public-domain specialty society guidance, clinical consultants, who research, document, and provide edit recommendations based on the most common clinical scenario and the State of Illinois. Claims billed in a manner that does not adhere to these standard coding conventions will be denied.

The code editing software contains a comprehensive set of rules, addressing coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider’s View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA’s CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Services – identifies procedures that have been unbundled.

Example: Unbundling lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>80053</td>
<td>Comprehensive Metabolic Panel</td>
<td>Disallow</td>
</tr>
<tr>
<td>85025</td>
<td>Complete CBC, automated and automated differential WBC count</td>
<td>Disallow</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid Stimulating Hormone</td>
<td>Disallow</td>
</tr>
<tr>
<td>80050</td>
<td>General Health Panel</td>
<td>Allow</td>
</tr>
</tbody>
</table>
Cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.

- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services – submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

GLOBAL SURGERY

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

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.

- Evaluation and management services, submitted with minor surgical procedures (0-day), are not recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the Illinois Fee Schedule with an asterisk.

**Example:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Example:** global surgery period

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling &amp; coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) &amp; patient’s &amp;/or family’s needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient &amp;/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>
**Explanation:**
- Procedure code 27447 has a global surgery period of 90 days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

**Example:** evaluation and management service submitted with minor surgical procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11000</td>
<td>Debridement of extensive eczematous or infected skin; up to 10% of body surface.</td>
<td>Allow</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's and/or family's needs. Problems are low/moderate severity. Physicians spend 15 minutes face-to-face with patient and/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

**SAME DATE OF SERVICE**

One (1) evaluation and management service is recommended for reporting on a single date of service.

**Example:** same date of service

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient’s and/or family’s needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with patient and/or family.</td>
<td>Allow</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient’s/family’s needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with patient/family.</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.
- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services.
- Interventions, provided during an evaluation and management service, typically include the components of an office consultation.
MODIFIER – 24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

MODIFIER – 25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

MODIFIER – 79 is used to report an unrelated procedure or service by the same physician during the post-operative period.

When MODIFIERS – 24 AND – 25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

When MODIFIER – 79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

MODIFIERS – Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

MODIFIER – 26 (professional component)
Definition: Modifier - 26 identifies the professional component of a test or study.
- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier - 26 appended.

**Example:**
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>78278</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Disallow</td>
</tr>
<tr>
<td>78278-26</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier - 26.

**MODIFIER - 80, -81, -82, and -AS (assistant surgeon)**

**Definition:** This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

**Example:**
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>42820-81</td>
<td>Tonsillectomy and adenoidectomy; under age 12</td>
<td>Disallow</td>
</tr>
</tbody>
</table>

**Explanation:**
- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure.

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

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

**CODE EDITING ASSISTANT**
A web-based code auditing reference tool designed to “mirror” how IlliniCare Health code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows IlliniCare Health to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:
- Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
- Proactively determine the appropriate code/code combination representing the service for accurate billing purposes.
Claims Mailing Instructions
Submit claims to IlliniCare Health at the following address:

First Time Claims, Corrected Claims and Requests for Reconsiderations:
IlliniCare Health, Inc. Claim Processing Department
P. O. Box 4020
Farmington, MO 63640-4402

Claim Disputes must be submitted to:
IlliniCare Health, Inc.
Attn: Claim Disputes
P. O. Box 3000
Farmington, MO 63640-3800

Please do not use any other post office box that you may have for IlliniCare Health as it may cause a delay in processing. IlliniCare Health encourages all providers to submit claims electronically. Our companion guides to billing electronically are available on our website at www.illinicare.com. See section on electronic claim filing for more details. You may also submit claims on-line using our secure website at www.illinicare.com.

Claim Form Instructions
Our companion guides to billing are available on our website at www.illinicare.com.

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

The Code Editing Assistant is intended for use as a ‘what if’ or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements or other coverage considerations.

BILLING CODES
It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-10 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-10 codes and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member’s diagnosis. We require the use of valid ICD-10 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-10 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-10 manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-10 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the seventh digit, if appropriate. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use Z00.00 for Laboratory Exam (as part of a general medical examination), Z00.00 for Radiological Exam (as part of a general medical examination), and Z04.8 for Specified type or reason NEC as the primary diagnosis. Please consult your ICD-10 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of IlliniCare Health.
Rejections Vs. Denials

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

A REJECTION is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.illinicare.com. A list of common upfront rejections can be found listed below and a more comprehensive list with explanations can be located in Appendix 1.

If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A DENIAL is defined as a claim that has passed minimum edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An EOP (Explanation of Payment) will be sent that includes the denial reason. A list of common delays and denials can be found listed below and a more comprehensive list with explanations can be located in Appendix 2.

COMMON CAUSES OF UPFRONT REJECTIONS

- Unreadable Information – Information within the claim form cannot be read. The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or information is hand written or submitted on a black and white claim form.
- Member DOB (date of birth) is missing.
- Member Name or identification (ID) number is missing or invalid.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) number is missing.
- DOS – The DOS (date of service) on the claim is not prior to receipt of claim (future date of service).
- DATES – A date or dates are missing from required fields. Example: "Statement From" UB-04 & Service From" 1500 (02/12). "To Date" before "From Date".
- TOB – Invalid TOB (Type of Bill) entered.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail – No service line detail submitted.
- DOS (date of service) entered is prior to the member’s effective date.
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14)
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17).
- Occurrence Code/Date is missing or invalid.
- RE Code (revenue code) is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- Incorrect Form Type – The form is not a form accepted by IlliniCare Health or not allowed for the provider type.
- CLIA – Missing/incomplete/invalid CLIA certification number.
- Wrong Form Type – The paper claim form submitted is not on a “red” dropout OCR form.
- Procedure or Modifier Codes entered are invalid or missing.
- Revenue Code is invalid.

COMMON CAUSES OF CLAIM PROCESSING DELAYS AND DENIALS

- Diagnosis Code is missing the 4th, 5th, and 6th character requirements and 7th character extension requirements.
- DRG code is missing or invalid.
- EOB (Explanation of Benefits) from the Primary insurer is missing or incomplete.
- Place of Service Code is invalid.
- Provider TIN and NPI does not match.
- Dates of Service span do not match the listed Days/Units.
- Physician Signature is missing.
- Tax Identification Number (TIN) is invalid.
- Third Party Liability (TPL) information is missing or incomplete.

IMPORTANT STEPS TO A SUCCESSFUL SUBMISSION OF PAPER CLAIMS

1. Complete all required fields on an original, red CMS 1500 (02/12) or UB-04 form.
2. Ensure all Diagnosis, Procedure, Modifier, Location (Place of Service), Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.
3. Ensure all diagnosis and procedure codes are appropriate for the age and sex of the member.
4. Complete the ICD code type on both HCFA (box 21 upper right corner and UB-04 box 66) with a 0 for ICD-10.
5. Ensure all diagnosis codes are coded to their highest number of digits available (fourth and fifth digit).
6. Ensure member is eligible for services under IlliniCare Health during the time period in which services were provided.
7. Ensure an authorization has been given for services that require prior authorization by IlliniCare Health.
8. Ensure claims are submitted on an original red and white form. Handwritten and black and white claim forms will be rejected and returned to the provider.
RESUBMITTED CLAIMS
All requests for reconsideration, claim disputes or corrected claims must be received within 180 calendar days of the DOS or date of discharge, whichever is later.

Resubmissions should be typed or printed on a red and white claim form and must include the original claim number in field 22 of a CMS 1500 (02/12) or field 64 of a CMS 1450 (UB-04). The original EOP must also be included with the resubmission. Failure to do this could result in a claim denying as a duplicate, a delay in processing, or denied for exceeding the timely filing limit.
Appendix

I. Common Rejections for Paper Claims
II. Common Causes of Paper Claim Processing Denial
III. EOP Denial Codes
IV. Instructions for Supplemental Information CMS1500 (02/12) Form, Shaded Field 24a-G
V. HIPAA Compliant EDI Rejection Codes
VI. Instructions for Submitting NDC Information
VII. Instructions for Item Number 21 on CMS1500

APPENDIX I: COMMON REJECTIONS FOR PAPER CLAIMS

- Member DOB missing from the claim.
- Member Name or Id Number missing or invalid from the claim.
- Provider Name, TIN, or NPI Number missing from claim.
- Claim data is unreadable due to either too light (insufficient toner), dot-matrix printers, or too small font to allow for clear electronic imaging of claim. All black and white and handwritten claims will be rejected back to the provider.
- Diagnosis Code missing or invalid.
- REV Code missing or invalid.
- CPT/Procedure Code missing or invalid.
- Dates missing from required fields. Example: “Statement From” UB-04 & “Service From” 1500 (02/12). “To Date” before “From Date.”
- DOS on claim is not prior to receipt of claim (future date of services).
- DOS prior to effective date of Health Plan or prior to member eligibility date.
- Incorrect Form Type Used (approved form types are CMS 1500 (02/12) for professional medical services or the UB-04 for all facility claims).
- Invalid TOB or invalid type of bill.
- No detail service line submitted.
- Admission Type missing (when Inpatient Facility Claim only).
- Patient Status missing (when Inpatient Facility Claim only).
- CLIA certification missing/invalid or incomplete.
- Procedure or Modifier Codes Invalid or Missing – Coding from the most current coding manuals (CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.
- Revenue Codes Missing or Invalid – Facility claims must include a valid three or four-digit numeric revenue code. Refer to UB-92 coding manual for a complete list of revenue codes.

APPENDIX II: COMMON CAUSES OF PAPER CLAIM PROCESSING DELAYS OR DENIALS

- Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form.
- Diagnosis Code Missing 4th, 5th, and 6th character requirements and 7th character extension requirements – Diagnosis should be billed to the highest intensity for proper coding and processing. Review the ICD-10 CM manual for coding to the 4th, 5th, and 6th character requirements and 7th character extension requirements.
- DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG (Diagnosis Related Grouping) codes should include this information on the claim form for accurate payment. Invalid DRG codes will result in denial.
- Primary Insurers EOB (Explanation of Benefits) is Missing or Incomplete – Claims for Members who have OIC (other insurance carrier) must be billed along with a copy of the primary EOB from the OIC (either paid or denied). Include pages with run dates, coding explanations, and messages.
- Place of Service Code Invalid – A valid and appropriate two digit numeric code must be included on the claim form. Refer to CMS 1500(02/12) coding manuals for a complete list of place of service codes.
- Provider TIN and NPI Do Not Match – The submitted NPI does not match Provider’s Tax ID number on file.
- Date Span Billed does not match Days/Units Billed – spanned dates of service can only be billed for consecutive days along with matching number of days/units (i.e. Date Span of 01/01 to 01/03 and days/units = 3).
- Signature Missing – The signature of the provider of service, or an authorized representative must be present on the claim form
- Tax Identification Number (TIN) Missing or Invalid – Provider’s Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with IlliniCare Health.
# APPENDIX III: EOP DENIAL CODES AND DESCRIPTIONS

<table>
<thead>
<tr>
<th>Denial Code</th>
<th>Denial Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07</td>
<td>DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT’S SEX</td>
</tr>
<tr>
<td>09</td>
<td>DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT’S AGE</td>
</tr>
<tr>
<td>10</td>
<td>DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT’S SEX</td>
</tr>
<tr>
<td>16</td>
<td>DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED</td>
</tr>
<tr>
<td>18</td>
<td>DENY: DUPLICATE CLAIM/SERVICE</td>
</tr>
<tr>
<td>1K</td>
<td>DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT</td>
</tr>
<tr>
<td>1L</td>
<td>DENY: VISIT &amp; PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION</td>
</tr>
<tr>
<td>20</td>
<td>DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER</td>
</tr>
<tr>
<td>21</td>
<td>DENY: CLAIM THE RESPONSIBILITY OF THE NO-FAULT CARRIER</td>
</tr>
<tr>
<td>22</td>
<td>DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER</td>
</tr>
<tr>
<td>23</td>
<td>DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY-COB</td>
</tr>
<tr>
<td>24</td>
<td>DENY: CHARGES COVERED UNDER CAPITATION</td>
</tr>
<tr>
<td>25</td>
<td>DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET</td>
</tr>
<tr>
<td>26</td>
<td>DENY: EXPENSES INCURRED PRIOR TO COVERAGE</td>
</tr>
<tr>
<td>27</td>
<td>DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED</td>
</tr>
<tr>
<td>28</td>
<td>DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED</td>
</tr>
<tr>
<td>29</td>
<td>DENY: THE TIME LIMIT FOR FILING HAS EXPIRED</td>
</tr>
<tr>
<td>35</td>
<td>DENY: BENEFIT MAXIMUM HAS BEEN REACHED</td>
</tr>
<tr>
<td>3D</td>
<td>DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT</td>
</tr>
<tr>
<td>46</td>
<td>DENY: THIS SERVICE IS NOT COVERED</td>
</tr>
<tr>
<td>48</td>
<td>DENY: THIS PROCEDURE IS NOT COVERED</td>
</tr>
<tr>
<td>4D</td>
<td>DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT</td>
</tr>
<tr>
<td>6L</td>
<td>EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL</td>
</tr>
<tr>
<td>86</td>
<td>DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE</td>
</tr>
<tr>
<td>99</td>
<td>DENY: MISCELLANEOUS/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT</td>
</tr>
<tr>
<td>9I</td>
<td>INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED</td>
</tr>
<tr>
<td>A1</td>
<td>DENY: AUTHORIZATION NOT ON FILE</td>
</tr>
<tr>
<td>BG</td>
<td>DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT</td>
</tr>
<tr>
<td>BI</td>
<td>DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL</td>
</tr>
<tr>
<td>C2</td>
<td>CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>C6</td>
<td>CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>C8</td>
<td>CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT</td>
</tr>
<tr>
<td>CV</td>
<td>DENY: BILL WITH SPECIFIC VACCINE CODE</td>
</tr>
<tr>
<td>DD</td>
<td>DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED</td>
</tr>
<tr>
<td>DJ</td>
<td>DENY: INAPPROPRIATE CODE BILLED, CORRECT &amp; RESUBMIT</td>
</tr>
<tr>
<td>DS</td>
<td>DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS</td>
</tr>
<tr>
<td>DT</td>
<td>DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING</td>
</tr>
<tr>
<td>DW</td>
<td>DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT</td>
</tr>
<tr>
<td>DX</td>
<td>DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE</td>
</tr>
<tr>
<td>DY</td>
<td>DENY: APPEAL DENIED</td>
</tr>
<tr>
<td>DZ</td>
<td>DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT</td>
</tr>
<tr>
<td>EB</td>
<td>DENY: DENIED BY MEDICAL SERVICES</td>
</tr>
<tr>
<td>EC</td>
<td>DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>FP</td>
<td>DENY: CLAIMS DENIED FOR PROVIDER FRAUD</td>
</tr>
<tr>
<td>FQ</td>
<td>DENY: RESUBMIT CLAIM UNDER FQHC/RHC CLINIC MEDICAID NUMBER</td>
</tr>
<tr>
<td>GL</td>
<td>SERVICE COVERED UNDER GLOBAL FEE AGREEMENT</td>
</tr>
<tr>
<td>GM</td>
<td>DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K</td>
</tr>
<tr>
<td>HI</td>
<td>DENY: PROVIDER MUST USE HCPC/CPT FOR CORRECT PRICING</td>
</tr>
<tr>
<td>HL</td>
<td>DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH</td>
</tr>
<tr>
<td>HP</td>
<td>DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING</td>
</tr>
<tr>
<td>HQ</td>
<td>DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED</td>
</tr>
<tr>
<td>HS</td>
<td>DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING</td>
</tr>
<tr>
<td>Denial Code</td>
<td>Denial Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>HT</td>
<td>DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING</td>
</tr>
<tr>
<td>I1</td>
<td>OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>I9</td>
<td>DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD-10 CODE</td>
</tr>
<tr>
<td>IE</td>
<td>CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE</td>
</tr>
<tr>
<td>IK</td>
<td>DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 &amp; MED RECORDS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>IL</td>
<td>VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT</td>
</tr>
<tr>
<td>IM</td>
<td>DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT</td>
</tr>
<tr>
<td>IV</td>
<td>DENY: INVALID/DELETED/MISSING CPT CODE</td>
</tr>
<tr>
<td>LO</td>
<td>PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS</td>
</tr>
<tr>
<td>L6</td>
<td>DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.</td>
</tr>
<tr>
<td>L9</td>
<td>DENY: CPT &amp; LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>MS</td>
<td>DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE</td>
</tr>
<tr>
<td>MA</td>
<td>MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT</td>
</tr>
<tr>
<td>MG</td>
<td>DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>MH</td>
<td>DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING</td>
</tr>
<tr>
<td>MO</td>
<td>MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.</td>
</tr>
<tr>
<td>MQ</td>
<td>DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>MY</td>
<td>DENY: MEMBER'S PCP IS CAPITATED - SERVICE NOT REIMBURSABLE TO OTHER PCPS</td>
</tr>
<tr>
<td>NS</td>
<td>DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM</td>
</tr>
<tr>
<td>ND</td>
<td>DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE</td>
</tr>
<tr>
<td>NT</td>
<td>DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT</td>
</tr>
<tr>
<td>NV</td>
<td>DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION</td>
</tr>
<tr>
<td>NX</td>
<td>DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>OX</td>
<td>DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED</td>
</tr>
<tr>
<td>PF</td>
<td>DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM</td>
</tr>
<tr>
<td>RC</td>
<td>DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING</td>
</tr>
<tr>
<td>RD</td>
<td>DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>RX</td>
<td>DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.</td>
</tr>
<tr>
<td>TM</td>
<td>TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT.</td>
</tr>
<tr>
<td>U1</td>
<td>CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS</td>
</tr>
<tr>
<td>U5</td>
<td>DENY: UNLISTED / UNSPECIFIC CODE - RE-BILL MORE SPECIFIC CODE</td>
</tr>
<tr>
<td>V3</td>
<td>MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE</td>
</tr>
<tr>
<td>V4</td>
<td>MED RECORDS RECEIVED NOT LEGIBLE</td>
</tr>
<tr>
<td>V5</td>
<td>MED RECORDS RECEIVED FOR WRONG PATIENT</td>
</tr>
<tr>
<td>V6</td>
<td>MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS</td>
</tr>
<tr>
<td>V8</td>
<td>MED RECORDS RECEIVED WITHOUT DOS</td>
</tr>
<tr>
<td>VC</td>
<td>DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES</td>
</tr>
<tr>
<td>VS</td>
<td>DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.</td>
</tr>
<tr>
<td>x3</td>
<td>PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE</td>
</tr>
<tr>
<td>x4</td>
<td>PROCEDURE CODE/ICD-10 CODE INCONSISTENT WITH MEMBERS GENDER</td>
</tr>
<tr>
<td>x5</td>
<td>PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE</td>
</tr>
<tr>
<td>x6</td>
<td>ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE</td>
</tr>
<tr>
<td>x7</td>
<td>ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE</td>
</tr>
<tr>
<td>x8</td>
<td>MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED</td>
</tr>
<tr>
<td>x9</td>
<td>PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED</td>
</tr>
<tr>
<td>xa</td>
<td>CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE</td>
</tr>
<tr>
<td>xb</td>
<td>PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA</td>
</tr>
<tr>
<td>xc</td>
<td>PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID</td>
</tr>
<tr>
<td>xd</td>
<td>PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM</td>
</tr>
<tr>
<td>xe</td>
<td>PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE</td>
</tr>
<tr>
<td>xf</td>
<td>MAXIMUM ALLOWANCE EXCEEDED</td>
</tr>
<tr>
<td>xg</td>
<td>SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS</td>
</tr>
<tr>
<td>xh</td>
<td>SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED</td>
</tr>
<tr>
<td>ZC</td>
<td>DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY</td>
</tr>
</tbody>
</table>
APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION
CMS-1500 (02/12) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) form field 24A-G:

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

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

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

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

F2 International Unit
GR Gram
ME Milligram
ML Milliliter
UN Unit

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.

When reporting dollar amounts in the shaded area, always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not use commas. Do not enter dollar signs.

Examples: 1000.00, 123.45

Additional Information for Reporting NDC

When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas.

Examples: 1234.56
99999999.999

When a dollar amount is being reported, enter the following after the quantity: one space, dollar amount. Do not enter a dollar sign.

The following qualifiers are to be used when reporting NDC unit/basis of measurement:

F2 International Unit
ME Milligram UN Unit
GR Gram
ML Milliliter

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) form field 24A-G:

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

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

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

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

F2 International Unit
GR Gram
ME Milligram
ML Milliliter
UN Unit

if required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

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.

Examples:
APPENDIX V: HIPAA COMPLIANT EDI REJECTION CODES

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

1. Invalid Mbr DOB
2. Invalid Mbr
6. Invalid Prv
7. Invalid Mbr DOB & Prv
8. Invalid Mbr & Prv
9. Mbr not valid at DOS
10. Invalid Mbr DOB; Mbr not valid at DOS
12. Prv not valid at DOS
13. Invalid Mbr DOB; Prv not valid at DOS
14. Invalid Mbr; Prv not valid at DOS
15. Mbr not valid at DOS; Invalid Prv
16. Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17. Invalid Diag
18. Invalid Mbr DOB; Invalid Diag
19. Invalid Mbr; Invalid Diag
21. Mbr not valid at DOS; Prv not valid at DOS
22. Invalid Mbr DOB; Mbr not valid at DOS
23. Invalid Prv; Invalid Diag
24. Invalid Mbr DOB; Invalid Prv; Invalid Diag
25. Invalid Mbr; Invalid Prv; Invalid Diag
26. Mbr not valid at DOS; Invalid Diag
27. Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29. Prv not valid at DOS; Invalid Diag
30. Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31. Invalid Mbr; Prv not valid at DOS; Invalid Diag
32. Mbr not valid at DOS; Prv not valid; Invalid Diag
33. Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
34. Invalid Diag
35. Invalid Mbr DOB; Invalid Proc
36. Invalid Mbr; Invalid Proc
38. Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39. Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40. Invalid Prv; Invalid Proc
41. Invalid Mbr DOB; Invalid Prv; Invalid Proc
42. Invalid Mbr; Invalid Prv; Invalid Proc
43. Mbr not valid at DOS; Invalid Proc

Original Claim Number Required
Invalid units of service, Invalid Prv
Invalid units of service, Invalid Mbr
Invalid Proc
Invalid units of service, Invalid Proc
Invalid units of service, Invalid Prv
Invalid Proc
APPENDIX VI: INSTRUCTIONS FOR SUBMITTING NDC INFORMATION

Instructions for Entering the NDC:

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

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

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

For Paper, use Form Locator 43 of the CMS1450 and the red shaded detail of 24A on the CMS1500 line detail. Do not enter a space, hyphen, or other separator between N4, the NDC code, Unit Qualifier, and number of units.

APPENDIX VII: INSTRUCTIONS FOR ITEM NUMBER 21

Title: Diagnosis or Nature of Illness or Injury

Instructions: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

9  ICD-9-CM
0  ICD-10-CM

Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.

Enter the codes left justified on each line to identify the patient’s diagnosis and/or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A – L to the lines of services in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field.

Description: The “ICD Indicator” identified the version of the ICD code set being reported. The “Diagnosis or Nature of Illness or Injury” is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

Field Specification: This field allow for the entry of a 1 character indicator and 12 diagnosis codes at a maximum of 7 characters in length.

Example: ICD-9-CM Indicator and Diagnosis Codes

The NDC must be entered with 11 digits in a 5-4-2 digit format. The first five digits of the NDC are the manufacturer’s labeler code, the middle four digits are the product code, and the last two digits are the package size. If you are given an NDC that is less than 11 digits, add the missing digits as follows:

For a 4-4-2 digit number, add a 0 to the beginning. For a 5-3-2 digit number, add a 0 as the sixth digit. For a 5-4-1 digit number, add a 0 as the tenth digit.

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

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