illinicare health

Billing Manual

Claims Filing Instructions

IlliniCare.com

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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 request for reconsiderations must be received within 180 days of the DOS or date of discharge, whichever is later. Claim disputes must be received within 90 days of paid date, not to exceed 1 year from DOS.

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 received outside of the 180 day timeframe or for claim disputes received outside of the 90 day from paid date timeframe, or exceeding 1 year from DOS, 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

Corrected claims and claim requests for reconsideration must be received within 180 calendar days from the DOS or date of discharge, whichever is later. Claim disputes must be received within 90 days of paid date, not to exceed 1 year from DOS.

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 3000
   Farmington, MO 63640-3800
   - 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 DISPUTES

Disputes for unsuccessful request for reconsiderations must be submitted in writing and concluded within 90 days of paid date, not to exceed 1 year from DOS. Submit claim disputes to:

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

Procedures for Electronic Submission

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 healthcare 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 as proof of claim receipt. This 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 format. 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. Claims that are not submitted correctly or containing the allowed field data will be rejected and/or denied.

FILING CLAIMS ELECTRONICALLY

How to Start

- First, the provider will need specific 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, whether through direct submission to the clearinghouse or through another clearinghouse, you can submit claims electronically.
- Second, the provider needs to contact their clearinghouse and confirm they will transmit the claims to one of the clearinghouses used by IlliniCare Health. For a list of vendors used by IlliniCare Health, please visit our website at www.illinicare.com. Go to the Provider page and click on Resources.
- Third, the provider should confirm with their clearinghouse the accurate location of the IlliniCare Health Payer ID number.
- Last, the provider needs to verify with IlliniCare Health that their provider record is set up within the claim adjudication system.

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 to identify any claims that were not transmitted to IlliniCare Health. 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 provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are 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.

Acknowledgments for accepted or rejected claims received from the clearinghouse 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 IlliniCare Health.

- If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

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

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.

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.

Excluded Claim Categories

- Claim records requiring supportive documentation or attachments. Note: COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim.
- Claim records billing with miscellaneous codes
- Claim records for medical, administrative or claim reconsideration or dispute requests
- Claim requiring documentation of the receipt of an informed consent form
- Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics). Provider is required to submit the invoice with the claim.
- Claim for services requiring clinical review (e.g. complicated or unusual procedure). Provider is required to submit medical records with the claim.
- Claim for services needing documentation and requiring Certificate of Medical Necessity - oxygen, motorized wheelchairs

NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the provider number fields are empty.

Electronic Billing Inquiries

Please direct inquiries as follows:

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

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.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Add

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

Bilateral Surgery – bilateral surgeries are identical procedures performed on bilateral anatomical sites during the same operative session.

Example:

Code	Description	Status
69436		
DOS=01/01/10	Tympanostomy	Disallow
69436 50		
DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

Explanation: identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure). Note: Modifiers RT (right), or LT (left) should not be billed for bilateral procedures

Duplicate services – submission of the same procedure more than once on the same date for services that cannot be or are normally not performed more than once on the same date.

Example: excluding a duplicate CPT

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation:

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower 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: global surgery period

Code	Description	Status
27447		
DOS=05/20/09	Arthroplasty, knee, condoyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213		
DOS=06/02/09	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 & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient &/or family.	Disallow

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

Code	Description	Status
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
99213 DOS=01/23/10	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 w/ nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 minutes face-to-face with patient and/or family.	Disallow

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

Code	Description	Status
99215	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 w/ 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.	Allow
99242	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.	Disallow

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

NOTE:

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:

Code	Description	Status
78278 POS = Inpatient	Acute gastrointestinal blood loss imaging	Disallow
78278-26 POS = Inpatient	Acute gastrointestinal blood loss imaging	Allow

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:

Code	Description	Status
42820-81	Tonsillectomy and adenoidectomy; under age 12	Disallow

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 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

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.

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.

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 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.

Waste, Abuse, and Fraud (WAF) System

Example: ICD-10-CM Indicator and Diagnosis Codes

IlliniCare Health takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a Waste, Abuse, and Fraud (WAF) program that complies with state and federal laws. IlliniCare Health, in conjunction with its management company, Centene Corporation, successfully operates a Special Investigations Unit that mines claims data for upcoding, unbundling, and other systematic deviations that suggest fraudulent or abusive billing practices and investigates all reports of waste, fraud, and abuse. The WAF unit performs back end audits, which in some cases may result in prosecution and/or recoupment of previously paid monies. Some of the most common errors seen are:

- Unbundling of codes
- Up-coding
- Add-on codes without primary CPT
- Excessive use of units
- Diagnosis and/or procedure codes not consistent with the member's age/gender

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. IlliniCare Health and/or Centene take all reports of potential fraud, waste or abuse very seriously and investigate all reported issues.

HIGH DOLLAR INPATIENT REVIEW

All high dollar inpatient reviews for the Medicaid, Medicare, and MMP population are handled by Centene's high dollar clean claim review vendor. The review is conducted to ensure the services provided in the inpatient setting were appropriately billed for the Medicaid, Medicare, and MMP population. During the inpatient high dollar review process, qualified clinicians and coding experts conduct an in-depth review of the billing material (the UB-04 claim form and the Itemized Bill) to identify potential defects or improprieties in the billing, according to published CMS billing guidelines. Providers will be notified within 15 business days of claims payment of any findings during the review, including instructions to file an appeal.

Appendix

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

Denial Code	***Denial Description***
07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
16	DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED
18	DENY: DUPLICATE CLAIM/SERVICE
1K	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
1L	DENY: VISIT & PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION
20	DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER
21	DENY: CLAIM THE RESPONSIBLITY OF THE NO-FAULT CARRIER
22	DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER
23	DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY-COB
24	DENY: CHARGES COVERED UNDER CAPITATION
25	DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET
26	DENY: EXPENSES INCURRED PRIOR TO COVERAGE
27	DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT
46	DENY: THIS SERVICE IS NOT COVERED
48	DENY: THIS PROCEDURE IS NOT COVERED
4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT
6L	EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL
86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
99	DENY:MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT
9I	INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED
A1	DENY: AUTHORIZATION NOT ON FILE
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
C2	CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT
C6	CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT
C8	CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT
CV	DENY: BILL WITH SPECIFIC VACCINE CODE
DD	DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED
DJ	DENY:INAPPROPRIATE CODE BILLED,CORRECT & RESUBMIT
DS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
DT	DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING.
DW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE.
DY	DENY: APPEAL DENIED
DZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
EB	DENY: DENIED BY MEDICAL SERVICES
EC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
FP	DENY: CLAIMS DENIED FOR PROVIDER FRAUD.
FQ	DENY: RESUBMIT CLAIM UNDER FQHC/RHC CLINIC MEDICAID NUMBER
GL	SERVICE COVERED UNDER GLOBAL FEE AGREEMENT
GM	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K
H1	DENY: PROVIDER MUST USE HCPC/CPT FOR CORRECT PRICING
HL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH
HP	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING
HQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED

HS	DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING
Denial Code	***Denial Description***
HT	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING
I1	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT
I9	DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD-10 CODE
IE	CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE
IK	DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 & MED RECORDS, PLEASE RESUBMIT
IL	VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT
IM	DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT
IV	DENY: INVALID/DELETED/MISSING CPT CODE
L0	PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS
L6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.
LO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.
M5	DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE
MA	MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT
MG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
MH	DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING
MO	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.
MQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT
MY	DENY: MEMBER'S PCP IS CAPITATED - SERVICE NOT REIMBURSABLE TO OTHER PCPS
N5	DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM
ND	DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE
NT	DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
NV	DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION
NX	DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT
OX	DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED
PF	DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM
RC	DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING
RD	DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.
RX	DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.
TM	TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT.
U1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
U5	DENY:UNLISTED / UNSPECIFIC CODE -RE-BILL MORE SPECIFIC CODE
V3	MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE
V4	MED RECORDS RECEIVED NOT LEGIBLE
V5	MED RECORDS RECEIVED FOR WRONG PATIENT
V6	MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS
V8	MED RECORDS RECEIVED WITHOUT DOS
VC	DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES
VS	DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	PROCEDURE CODE/ICD-10 CODE INCONSISTENT WITH MEMBERS GENDER
x5	PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE
x6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
x7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID
xd	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
xe	PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE
xf	MAXIMUM ALLOWANCE EXCEEDED
xg	SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS
xh	SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED

ZC DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY

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

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.

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
2
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

Examples:

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. #
7Begin 1315 End 1445 Time 90 minutes								NPI	

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

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
VPA123ABC7D9E1F								NPI	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
OZ01234567891112								NPI	

UNSPECIFIED CODE:

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

NDC CODE:

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

APPENDIX 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.

Please see IlliniCare Health's list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

ML Milliliter

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; Prv 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 Proc
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
44 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46 Prv not valid at DOS; Invalid Proc
48 Invalid Mbr; Prv not valid at DOS; Invalid Proc
49 Mbr not valid at DOS; Invalid Prv; Invalid Proc
51 Invalid Diag; Invalid Proc
52 Invalid Mbr DOB; Invalid Diag; Invalid Proc
53 Invalid Mbr; Invalid Diag; Invalid Proc
55 Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
57 Invalid Prv; Invalid Diag; Invalid Proc
58 Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59 Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60 Mbr not valid at DOS; Invalid Diag; Invalid Proc
61 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63 Prv not valid at DOS; Invalid Diag; Invalid Proc
64 Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65 Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66 Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72 Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74 Services performed prior to Contract Effective Date
75 Invalid units of service
76 Original Claim Number Required
81 Invalid units of service, Invalid Pvr

83 Invalid units of service, Invalid Pvr, Invalid Mbr

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.

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:

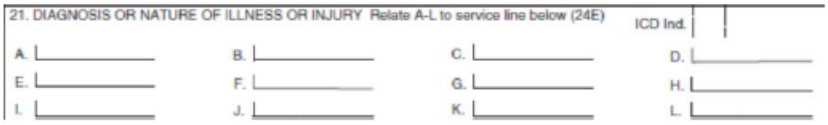
F2 International Unit
GR Gram
ME Milligram UN Unit
ML Milliliter
UN Unit

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 provider 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.