

AmeriHealth Mercy Health Plan

Claim Filing Instructions

Revised July 2011

NOTES

AmeriHealth Mercy Health Plan

Claim Filing Instructions

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AmeriHealth Mercy Health Plan Claim Filing Instructions

Claim Filing Procedures for Claim Submission

AmeriHealth Mercy Health Plan, hereafter referred to as the Plan, is required by State and Federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

When required data elements are missing or are invalid, claims will be **rejected** by the Plan for correction and re-submission.

Claims for billable and capitated services provided to Plan members must be submitted by the provider who performed the services.

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

- Verification that all required fields are completed on the CMS 1500 or UB-04 forms.
- Verification that all Diagnosis and Procedure Codes are valid for the date of service.
- Verification of the referral for Specialist or non-Primary Care Physician claims.
- Verification of member eligibility for services under the Plan during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out of plan" provider has received authorization to provide services to the eligible member.
- Verification that the provider participated with the Medical Assistance Program at the time of service.
- Verification that an authorization has been given for services that require prior authorization by the Plan.
- Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that the Plan is the "payer of last resort" on all claims submitted to the Plan.

IMPORTANT:

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

- **Rejected claims** are not registered in the claim processing system and can be resubmitted as a new claim.

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

- **Denied claims must be re-submitted as corrected claims** within 180 calendar days from the date of service.

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

* For more information on EDI, review the section titled Electronic Data Interchange (EDI) for Medical and Hospital Claims in this booklet.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

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Claim Mailing Instructions

Submit claims to AmeriHealth Mercy Health Plan at the following address:

AmeriHealth Mercy Health Plan
Claim Processing Department
P.O. Box 7118
London, KY 40742

The Plan encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or **Emdeon's Provider Support Line at 1-800-845-6592** to arrange transmission.

Any additional questions may be directed to the EDI Technical Support Hotline at **1-877-234-4271** or by E-mail at **edi.amhp@kmhp.com**

Claim Filing Deadlines

Original invoices must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.

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

Exceptions

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

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 1.)

Important: Requests for adjustments may be submitted by telephone to:

Provider Claim Services
1-800-521-6007 (Select the prompts for the correct Plan, and then, select the prompt for claim issues.)

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

Claims Processing Department
AmeriHealth Mercy Health Plan
P.O. Box 7118
London, KY 40742

Outpatient medical appeals must be submitted in writing to:

Provider Appeals Department
AmeriHealth Mercy Health Plan
PO Box 7316
London, KY 40742

Inpatient medical appeals must be submitted in writing to:

Provider Appeals Department
AmeriHealth Mercy Health Plan
PO Box 7307
London, KY 40742

Refer to the Provider Manual or look online at the Provider Center of the AmeriHealth Mercy Web site at www.amerhealthmercyhp.com for complete instructions on submitting appeals.

Written Disputes should be mailed to:

Informal Practitioner Dispute
AmeriHealth Mercy Health Plan
8040 Carlson Road, Suite 500
Harrisburg, PA 17112

Note: AmeriHealth Mercy Health Plan
EDI Payer ID# 22248

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Claim Form Field Requirements

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

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. **All claims must be submitted within the required filing deadline of 180 days from the date of service.**

Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

Required Fields (CMS 1500 Claim Form)

CMS 1500 Claim Form			
Field #	Field Description	Instructions and Comments	Required or Conditional*
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	R
1a	Insured I.D. Number	Health Plan’s member identification number. If submitting a claim for a newborn that does not have an identification number, enter the mother’s ID number. For electronic submissions, ID must be less than 13 alphanumeric characters. In-network providers: please omit the three alpha characters preceding the member’s ID number on the claim. Out of area providers: please enter the three alpha characters preceding the member’s ID number on the claim.	R
2	Patient’s Name (Last, First, Middle Initial)	Enter the patient’s name as it appears on the member’s Health Plan I.D. card. If submitting a claim for a newborn that does not have an identification number, enter “Baby Girl” or “Baby Boy” and last name. Refer to page 22 for additional newborn billing information, including Multiple Births.	R

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

CMS 1500 Claim Form			
Field #	Field Description	Instructions and Comments	Required or Conditional*
4	Insured's Name (Last, First, Middle Initial)	Enter the patient's name as it appears on the member's Health Plan I.D. card, or Enter the newborn's name when the patient is a newborn.	R
5	Patient's Address (Number, Street, City, State, Zip) Telephone (include area code)	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R
6	Patient Relationship To Insured	Always indicate self.	R
7	Insured's Address (Number, Street, City, State, Zip Code) Telephone (Include Area Code)		C
8	Patient Status	Enter the patient's marital status, indicate if the patient is employed or is a student.	C
9	Other Insured's Name (Last, First, Middle Initial)	Refers to someone other than the patient. Completion of fields 9a through 9d is Required if patient is covered by another insurance plan. Enter the complete name of the insured. Note: "COB claims that require attached EOBs must be submitted on paper."	C
9a	Other Insured's Policy Or Group #	Required if # 9 is completed.	C
9b	Other Insured's Birth Date / Sex	Required if # 9 is completed. MMDDYY / M or F by check box	C
9c	Employer's Name Or School Name	This field is related to the insured in field # 9.	C
9d	Insurance Plan Name Or Program Name	Required if # 9 is completed.	C
10a,b,c	Is Patient's Condition Related To:	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident c) Other Accident	R
10d	Reserved For Local Use EPSDT Referral Codes	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YO – Other YV – Vision YH – Hearing YB – Behavioral YM – medical YD – Dental *(Required for Age 3 and Above)	C C C C C *C
11	Insured's Policy Group Or FECA #	Required when other insurance is available. Complete if more than one Other Medical insurance is available, or if "yes" to 10a, b, c.	C

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

CMS 1500 Claim Form			
Field #	Field Description	Instructions and Comments	Required or Conditional*
11a	Insured's Birth Date / Sex	Same as # 3. Required if 11 is completed.	C
11b	Employer's Name Or School Name	Required if employment is indicated in field # 10.	C
11c	Insurance Plan Name Or Program Name	Enter name of Health Plan. Required if 11 is completed.	C
11d	Is There Another Health Benefit Plan?	Y or N by check box. If yes, complete # 9 a-d.	R
12	Patient's Or Authorized Person's Signature		R
13	Insured's Or Authorized Person's Signature		Not required
14	Date Of Current: Illness (First Symptom) Or Injury (Accident) Or Pregnancy (LMP)	MMDDYY	C
15	If Patient Has Same Or Similar Illness. Give First Date	MMDDYY	C
16	Dates Patient Unable To Work In Current Occupation		C
17	Name Of Referring Physician Or Other Source	Required if a provider other than the member's primary care physician rendered invoiced services.	C
17a	Other I.D. Number Of Referring Physician	Enter the Health Plan provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. If the Other ID number is the Health Plan ID number, enter N5. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. Required if # 17 is completed.	C
17b	National Provider Identifier (NPI)	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	C
18	Hospitalization Dates Related To Current Services	Required when place of service is in-patient. MMDDYY (indicate from and to date)	C
19	Reserved For Local Use – Reserved for PPID	Enter the Individual Provider's PROMISe Provider I.D. (PPID)	R

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

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CMS 1500 Claim Form			
Field #	Field Description	Instructions and Comments	Required or Conditional*
20	Outside Lab Charges		Not Required
21	Diagnosis Or Nature Of Illness Or Injury. (Relate Items 1,2,3, Or 4 To Item 24E By Line)	Diagnosis codes must be valid ICD-9 codes for the date of service. "E" codes are not acceptable as a primary diagnosis. Note: Claims with invalid diagnosis codes will be denied for payment.	R
22	Medicaid Resubmission Code Original Ref. No.	For re-submissions or adjustments, enter the Claim ID# of the original claim. Note: Re-submissions may not currently be submitted via EDI. Note: Original Claim ID is required if claim is a CORRECTED OR RESUBMITTED CLAIM.	C
23	Prior Authorization Number	Enter the referral or authorization number. Refer to the Provider Manual to determine if services rendered require an authorization or referral.	C
24A	Date(s) Of Service	"From" date: MMDDYY. If the service was performed on one day there is no need to complete the "to" date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R
24B	Place Of Service	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R
24C	EMG	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	R
24D	Procedures, Services Or Supplies CPT/HCPCS Modifier	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. Note: Modifiers affecting reimbursement must be placed in the 1 st modifier position *See additional information below for EDI requirements	R
24E	Diagnosis Pointer	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1,2,3, or 4). Diagnosis codes must be valid ICD-9 codes for the date of service.	R
24F	Charges	Enter charges. Value entered must be greater than zero (\$0.00) including capitated services.	R
24G	Days Or Units	Enter quantity. Value entered must be greater than zero. (Field allows up to 3 digits)	R

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AmeriHealth Mercy Health Plan Claim Filing Instructions

CMS 1500 Claim Form			
Field #	Field Description	Instructions and Comments	Required or Conditional*
24H	EPSDT Family Plan		Not required
24I	ID Qualifier	If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I. If the Other ID number is the Health Plan ID number, enter N5. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier.	R
24J	Rendering Provider ID	The individual rendering the service is reported in 24J. Enter the Health Plan ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field. Use qualifier N5	Recommended R
25	Federal Tax I.D. Number SSN/EIN	Physician or Supplier's Federal Tax ID numbers.	R
26	Patient's Account No.	The provider's billing account number.	R
27	Accept Assignment	Always indicate Yes . Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R
28	Total Charge	Enter charges. Value entered must be greater than zero (\$0.00) including capitated services.	R
29	Amount Paid	Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C
30	Balance Due	Required when # 29 is completed.	C
31	Signature Of Physician Or Supplier Including Degrees Or Credentials / Date	Actual signature is required.	R
32	Name And Address Of Facility Where Services Were Rendered (If Other Than Home Or Office).	Required unless # 33 is the same information. Enter the physical location. (P.O. Box #'s are not acceptable here.)	R

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CMS 1500 Claim Form			
Field #	Field Description	Instructions and Comments	Required or Conditional*
32a.	NPI number	Required unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R
32b.	Other ID#	Enter the Health Plan ID # (strongly recommended) Enter the N5 qualifier followed by the Health Plan ID # Required when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	R
33	Billing Provider Info & Ph #	Required – Identifies the provider that is requesting to be paid for the services rendered and should always be completed.	R
33a.	NPI number	Required unless Rendering Provider is an Atypical Provider and is not required to have an NPI number	R
33b.	Other ID#	Enter the Health Plan ID # (strongly recommended) Enter the N5 qualifier followed by the Health Plan ID # Required when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	R

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Required Fields (UB-04 Claim Forms)

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X Required or Conditional*	Outpatient, Bill Types 13X, 23X, 33X 83X Required or Conditional*
1	Unlabeled Field NUBC – Billing Provider Name, Address and Telephone Number	Service Location, no PO Boxes Left justified Line a: Enter the complete provider name. Line b: Enter the complete address Line c: City, State, and zip code Line d: Enter the area code, telephone number.	R	R
2	Unlabeled Field NUBC – Pay-to Name and Address	Enter Remit Address Enter the Facility PROMISe Provider I.D. (PPID) number. Left justified	R	R
3a	Patient Control No.	Provider's patient account/control number	R	R
3b	Medical/Health Record Number	The number assigned to the patient's medical/health record by the provider	R	R
4	Type Of Bill	Enter the appropriate three or four -digit code. 1 st position is a leading zero – Do not include the leading zero on electronic claims. 2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates billing sequence.	R	R
5	Fed. Tax No.	Enter the number assigned by the federal government for tax reporting purposes.	R	R
6	Statement Covers Period From/Through	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R
7	Unlabeled	Not Used. Leave Blank.		

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
			Required or Conditional*	Required or Conditional*
8a	Patient Identifier	Patient Health Plan ID is conditional if number is different from field 60	R	R
8b	Patient Name	<p>Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the Health Plan ID card.</p> <p>Use a comma or space to separate the last and first names. <u>Titles</u> (Mr., Mrs., etc.) should not be reported in this field.</p> <p><u>Prefix</u>: No space should be left after the prefix of a name e.g. McKendrick.</p> <p><u>Hyphenated names</u>: Both names should be capitalized and separated by a hyphen (no space).</p> <p><u>Suffix</u>: A space should separate a last name and suffix.</p> <p><u>Newborns and Multiple Births</u>: If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Refer to page 22 for additional newborn billing information, including Multiple Births.</p>	R	R
9a-e	Patient Address	The mailing address of the patient 9a. Street Address 9b. City 9c. State 9d. ZIP Code 9e. Country Code (report if other than USA)	R	R
10	Patient Birth Date	The date of birth of the patient Right-justified; MMDDYYYY	R	R
11	Patient Sex	The sex of the patient recorded at admission, outpatient service, or start of care.	R	R
12	Admission 12 – 15			

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AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X Required or Conditional*	Outpatient, Bill Types 13X, 23X, 33X 83X Required or Conditional*
12	Admission Date	The start date for this episode of care. For inpatient services, this is the date of admission. Right-justified	R	R
13	Admission Hour	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R	R
14	Admission Type	A code indicating the priority of this admission/visit.	R	Not Required
15	Source of Referral for Admission or Visit	A code indicating the source of the referral for this admission or visit.	R	Not Required
16	Discharge Hour	Code indicating the discharge hour of the patient from inpatient care.	R	R
17	Patient Discharge Status	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6.	R	R
18 - 28	<p>Condition Codes</p> <p>The following is unique to Medicare eligible Nursing Facilities. Condition codes should be billed when Medicare Part A does not cover Nursing Facility Services</p> <p>Applicable Condition Codes: X2 – Medicare EOMB on File X4 – Medicare Denial on File</p>	<p>When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed:</p> <ul style="list-style-type: none"> • Condition codes: Enter condition code X2 or X4 when one of the following criteria is applicable to the nursing facility service for which you are billing: <ul style="list-style-type: none"> ○ There was no 3-day prior hospital stay ○ The resident was not transferred within 30 days of a hospital discharge ○ The resident's 100 benefit days are exhausted ○ There was no 60 day break in daily skilled care ○ Medical Necessity Requirements are not met ○ Daily skilled care requirements are not met <p>All other fields must be completed as per the appropriate billing guide</p>	C	C

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AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
			Required or Conditional*	Required or Conditional*
29	Accident State	The accident state field contains the two-digit state abbreviation where the accident occurred. Required when applicable.	C	C
30	Unlabeled Field	Leave Blank		
31a,b – 34a,b	Occurrence Codes and Dates	Enter the appropriate occurrence code and date. Required when applicable.	C	C
35a,b – 36a,b	Occurrence Span Codes And Dates	A code and the related dates that identify an event that relates to the payment of the claim. Required when applicable.	C	C
37a,b	EPSDT Referral Code	Required when applicable. Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YO – Other YV – Vision YH – Hearing YB – Behavioral YM – medical YD – Dental *(Required for Age 3 and Above)	C C C C C C*	C C C C C C*
38	Responsible Party Name and Address	The name and address of the party responsible for the bill.	C	C
39a,b,c,d – 41a,b,c,d	Value Codes and Amounts	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Codes and amounts. If more than one value code applies, list in alphanumeric order. Required when applicable. Note: If value code is populated then value amount must also be populated and vice versa.	C	C
42	Rev. Cd.	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.	R	R

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UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
			Required or Conditional*	Required or Conditional*
43	Revenue Description	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category.	R	R
44	HCPCS/Accommodation Rates/HIPPS Rate Codes	<ol style="list-style-type: none"> 1. The Healthcare Common Procedure Coding system (HCPCS) applicable to ancillary service and outpatient bills. 2. The accommodation rate for inpatient bills. 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. 	R	R
45	Serv. Date	Report line item dates of service for each revenue code or HCPCS/HIPPS code.	R	R
46	Serv. Units	Report units of service. A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.	R	R
47	Total Charges	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total Charges includes both covered and non-covered charges. Report grand total of submitted charges. Value entered must be greater than zero (\$0.00).	R	R

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AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*
48	Non-Covered Charges	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code. Required when Medicare is Primary.	C	C
49	Unlabeled Field		Not required	Not required
50	Payer	Enter the name for each Payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R
51	Health Plan Identification Number	The number used by the health plan to identify itself. AmeriHealth Mercy's Payer ID is #22248	R	R
52	Rel. Info	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; B, secondary; and C, tertiary. It is expected that the provider have all necessary release information on file. It is expected that all released invoices contain "Y".	R	R
53	Asg. Ben.	Valid entries are "Y" (yes) and "N" (no).	R	R
54	Prior Payments	The A, B, C indicators refer to the information in Field 50.	R	R
55	Est. Amount Due	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage).	C	C
56	National Provider Identifier – Billing Provider	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. Required if the health care provider is a Covered Entity as defined in HIPAA Regulations.	R	R
57 A,B,C	Other (Billing) Provider Identifier	A unique identification number assigned to the provider submitting the bill by the health plan. Required on or after May	C	C

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
			Required or Conditional*	Required or Conditional*
57 A, B, C cont'd		23, 2007 if NPI is not mandated in Field 56. The UB-04 does not use a qualifier to specify the type of Other (Billing) Provider Identifier. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A,B,C.		
58	Insured's Name	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the insured is indicated here.	R	R
59	P. Rel	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured)	R	R
60	Insured's Unique Identifier	Enter the patient's Health Plan ID exactly as it appears on the patient's ID card on line B or C. When other insurance is present, enter the plan ID on line A.	R	R
61	Group Name	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C
62	Insurance Group No.	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C
63	Treatment Authorization Codes	Enter the Health Plan referral or authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary. Field 63A is required.	R	R

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*
64	DCN	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code. The ESC field has been eliminated. Note: Resubmitted claims must contain the original claim ID	C	C
65	Employer Name	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C
66	Diagnosis and Procedure Code Qualifier (ICD Version Indicator)	The qualifier that denotes the version of International Classification of Diseases (ICD) reported.	Not Required	Not Required
67	Prin. Diag. Cd. and Present on Admission (POA) Indicator	The ICD-9-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care). Present on Admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, are considered as present on admission. The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses that are reported. (See page 20 for detailed Paper and EDI Instructions)	R	R

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*
67 A - Q	Other Diagnosis Codes	The ICD-9-CM diagnoses codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.	C	C
68	Unlabeled Field			
69	Admitting Diagnosis Code	The ICD diagnosis code describing the patient's diagnosis at the time of admission. Required for inpatient admissions.	C	C
70	Patient's Reason for Visit	The ICD-9-CM diagnosis codes describing the patient's reason for visit at the time of outpatient registration. Required for all unscheduled outpatient visits. Up to three ICD-9-CM codes may be entered in fields a,b,c.	C	C
71	Prospective Payment System (PPS) Code	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.	C	C
72a-c	External Cause of Injury (ECI) Code	The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	C	C
73	Unlabeled Field			
74	Principal Procedure code and Date	The ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corresponding date. Inpatient facility – ICD 9 is	C R	C R

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
Field #	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*
74 cont'd		Required when a surgical procedure is performed. Outpatient facility or Ambulatory Surgical Center – CPT, HCPCS or ICD 9 is required when a surgical procedure is performed.	R	R
74a-e	Other Procedure Codes and Dates	The ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Inpatient facility – ICD 9 is required when a surgical procedure is performed. Outpatient facility or Ambulatory Surgical Center – CPT, HCPCS or ICD 9 is required when a surgical procedure is performed.	C C	C C
75	Unlabeled Field			
76	Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the attending physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.	R	R
77	Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#	Enter the NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician. Required when a surgical procedure code is listed.	C	C

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

UB-04 Claim Form				
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X 83X
Field #	Field Description	Instructions and Comments	Required or Conditional*	Required or Conditional*
78 – 79	Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID#	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient’s medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#	C	C
80	Remarks Field	Area to capture additional information necessary to adjudicate the claim.	C	C
81CC,a-d	Code-Code Field	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Special Instructions and Examples for CMS 1500, UB-04 and EDI Claims Submissions

I. Supplemental Information

A. CMS 1500 Paper Claims – Field 24:

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

The following are types of supplemental information that can be entered in the shaded lines of Item Number 24:

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) formerly Universal Product Code (UPC) for products
- Contract rate

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

7 Anesthesia information
ZZ Narrative description of unspecified code (all miscellaneous fields require this section be reported)
N4 National Drug Codes
VP Vendor Product Number Health Industry Business Communications Council (HIBCC)
OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)
CTR Contract rate

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

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

B. EDI – Field 24D (Professional)

Details pertaining to EPSDT, Anesthesia Minutes, and corrected claims may be sent in Notes (NTE) or Remarks (NSF format).

- Details sent in NTE that will be included in claim processing:
- Please include L1, L2, etc. to show line numbers related to the details. Please include these letters AFTER those specified below:
 - EPSDT claims need to begin with the letters EPSDT followed by the specific code as per DPW instructions
 - Anesthesia Minutes need to begin with the letters ANES followed by the specific times
 - Corrected claims need to begin with the letters RPC followed by the details of the original claim (as per contract instructions)
 - DME Claims requiring specific instructions should begin with DME followed by specific details

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

C. EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=N5, REF02+ Plan’s Provider Network Number. Less than 13 Digits Alphanumeric. Field is required. **Note:** do not send the provider on the 2400 loop.

D. EDI – Field 45 and 51 (Institutional)

Field 45 – Service Date must not be earlier than the claim statement date.
 Service Line Loop 2400, DTP*472
 Claim statement date Loop 2300, DTP*434

Field 51 – Health Plan ID – the number used by the health plan to identify itself. AmeriHealth Mercy’s Health Plan EDI Payer ID# is 22248

E. EDI – Reporting DME

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

F. Reporting NDC on CMS-1500 and UB-04 and EDI

1. NDC on CMS 1500

- NDC should be entered in the shaded sections of item 24A through 24G.
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information.
 - Do not enter a space between the qualifier and the 11 digit NDC number.
 - Enter the 11 digit NDC number in the 5-4-2 format (no hyphens).
 - Do not use 9999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Enter the drug name and strength
- Enter the NDC quantity unit qualifier
 - F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit
- Enter the NDC quantity
 - Do not use a space between the NDC quantity unit qualifier and the NDC quantity
 - Note: The NDC quantity is frequently different than the HCPC code quantity

Example of entering the identifier N4 and the NDC number on the CMS 1500 claim form:

24 A.	DATE(S) OF SERVICE	B.	C.	D.	E.	F.	G.	H.	I.	J.
From	To	PLACE OF	EMG	PROCEDURES, SERVICES, OR SUPPLIES	DIAGNOSIS	\$ CHARGES	DAYS	SPQT	ID.	RENDERING
DD	YY	MM	DD	(Explain Unusual Circumstances)	POINTER		OF	Family	QUAL	PROVIDER ID. #
DD	YY	MM	DD	CPT/HCPCS	1		UNITS	Plan		
N4	0074202302	KETOROLAC 15MG/ML SYRING	ML	J1885	13	21 15	2	N	1B	12345678901
10	01 05	10 01 05 11							NPI	0123456789

Annotations: N4 qualifier points to 'N4', Drug Name points to 'KETOROLAC 15MG/ML SYRING', NDC Quantity points to '13', 11 digit NDC points to '0074202302', NDC Unit Qualifier points to 'ML'.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

2. NDC on UB-04

- NDC should be entered in Form Locator 43 in the Revenue Description Field.
- Report the N4 qualifier in the first two (2) positions, left-justified.
 - Do not enter spaces
 - Enter the 11 character NDC number in the 5-4-2 format (no hyphens).
 - Do not use 9999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC

Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier.

- F2 – International Unit
 - GR – Gram
 - ML – Milliliter
 - UN – Unit
-
- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal).
 - Any unused spaces for the quantity are left blank.

Note that the decision to make all data elements left-justified was made to accommodate the largest quantity possible. The description field on the UB-04 is 24 characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	4	5	.	5	6	7	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--

3. NDC via EDI

The NDC is used to report prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. EDI claims with NDC info should be reported in the LIN segment of Loop ID-2410. This segment is used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

When LIN02 equals N4, LIN03 contains the NDC number. This number should be 11 digits sent in the 5-4-2 format with no hyphens. Submit one occurrence of the LIN segment per claim line. Claims requiring multiple NDC's sent at claim line level should be submitted using CMS-1500 or UB-04 paper claim.

When submitting NDC in the LIN segment, the CTP segment is requested. This segment is to be submitted with the Unit of Measure and the Quantity.

When submitting this segment, CTP03, Pricing; CTP04, Quantity; and CTP05, Unit of Measure are required.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

II. Instructions for Submission of POA Indicators for Primary and Secondary Diagnoses

UB-04 or 837I

Valid POA indicators are as follows, blanks are not acceptable:

- “Y” = Yes = present at the time of inpatient admission
- “N” = No = not present at the time of inpatient admission
- “U” = Unknown = documentation is insufficient to determine if condition was present at time of inpatient admission
- “W” = Clinically Undetermined = provider is unable to clinically determine whether condition was present at time of inpatient admission or not
- “1” = Exempt from POA reporting

A. Reporting POA on the UB-04 Claim Form

Fields 67 A – Q:

Valid primary and secondary diagnosis codes (up to 5 digits), are to be placed in the unshaded portion of 67 A – Q, followed by the applicable POA indicator (1 character) in the shaded portion of 67 A – Q.

Sample UB-04 populated with primary and secondary diagnosis codes, and POA indicators:

66 DX	2449	67	Y	25001	A	N	29620	B	U	V1581	C	W	D	
	I			J			K			L			M	
69 Admit DX				70 Patient Reason DX	a	b		C			71 PPS CODE			

FL 67 A – Q
POA

B. Reporting POA in Electronic 837I Format

Provider is to submit their POA data via the K3 segment on all 837I claims, (004010X096A1), for Pennsylvania.

- Although this segment can repeat, Plan requires provider submit POA data on a single K3 Segment. No additional K3 segments with the letters POA will be validated.
- K301 must contain POA as the first three characters or the POA data will not be picked up. K3*POA~
 - K3 Segment must only contain details pertaining to the Principal and Other Diagnosis found in the HI segment with qualifiers BK for Principal and BF for Other Diagnosis prior to the ending Z (or X).
 - The POA indicator for the BN – External Cause of Injury on the K3 segment with POA is entered following the ending Z (or X). This is required by Emdeon for Medicare Claims as well.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

- No POA Indicator is to be sent for the BJ/ZZ – Admitting Diagnosis Data. Following the letters POA in the K3 Segment is to be only those identified on the Medicare Bulletin. 1, Y, N, U, W are valid, with ending characters of X or Z and ECode indicator.
- Blank is not a valid POA Indicator for the Plan.

Example:

1st claim:

1 Principal and 2 Other Diagnosis

K3*POAYNUZ~

2nd Claim:

1 Principal and 3 Other Diagnosis and an ECode

K3*POAYNIZY~

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

III. EPSDT Billing Guidelines – CMS 1500, UB-04 or Electronic 837 Format

EPSDT Billing Guidelines for Paper or Electronic 837 Claim Submissions

Providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens may bill using the CMS 1500 or UB-04 paper claim forms or electronically, using the 837 format.

Providers choosing to bill for complete EPSDT screens, including immunizations, on the CMS 1500 or UB-04 claim form or the 837 electronic formats must:

- **Use V20.0, V20.1 or V20.2 as the primary diagnosis code**
- Accurate payment of EPSDT claims will be determined solely by the presence of EPSDT modifiers to identify an EPSDT Claim. Failure to append EPSDT modifiers will cause claims to be processed as non-EPSDT related encounters
- Use one of the individual age-appropriate procedure codes outlined on the most current EPSDT Periodicity Schedule (listed below), as well as any other EPSDT related service, e.g., immunizations, etc.
- Use EPSDT Modifiers as appropriate: EP - Complete Screen; 52 - Incomplete Screen; 90 - Outpatient Lab; U1 - Autism.
 - Use U1 modifier in conjunction with CPT code 96110 for Autism screening
 - CPT code 96110 without a U1 modifier is to be used for a Developmental screening

Age Appropriate Evaluation and Management Codes

(As listed on the current EPSDT Periodicity Schedule and Coding Matrix)

Newborn Care:

99460 Newborn Care (during the admission)

99463 Newborn (same day discharge)

New Patient:

99381 Age < 1 yr

99382 Age 1-4 yrs

99383 Age 5-11 yrs

99384 Age 12-17 yrs

99385 Age 18-20 yrs

Established Patient:

99391 Age < 1 yr

99392 Age 1-4 yrs

99393 Age 5-11 yrs

99394 Age 12-17 yrs

99395 Age 18-20 yrs

Billing example: New Patient EPSDT screening for a 1 month old. The diagnosis and procedure code for this service would be:

- V20.2 (Primary Diagnosis)
- 99381EP (E&M Code with “Complete” modifier)

(As a reminder the National Code S0302 for EPSDT Screening is no longer a valid code)

* Enter charges. Value entered must be greater than zero (\$0.00) including capitated services.

Please consult the EPSDT Program Periodicity Schedule and Coding Matrix, as well as the Recommended Childhood Immunization Schedule for screening timeframes and the services required to bill for a complete EPSDT screen. (Both are available in a printable PDF format online at the Provider Center at www.amerihealthmercyhp.com)

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Completing the CMS 1500 or UB-04 Claim Form

The following blocks must be completed when submitting a CMS 1500 or UB-04 claim form for a complete EPSDT screen:

- EPSDT Referral Codes (when a referral is necessary, use the listed codes in the example below to indicate the type of referral made)
- Diagnosis or Nature of Illness or Injury
- Procedures, Services or Supplies CPT/HCPCS Modifier
- EPSDT/Family Planning

UB-04	CMS 1500	Item	Description	C/R
37	10d	Reserved for Local Use EPSDT Referrals	Enter the applicable 2-character EPSDT Referral Code for referrals made or needed as a result of the screen. YO – Other YV – Vision YH – Hearing YB – Behavioral YM – Medical YD – Dental *(Required for ages 3 and over)	 C C C C C C*
18	N/A	Condition Codes	Enter the Condition Code A1 EPSDT	R
67	21	Diagnosis or Nature of Illness or Injury	When billing for EPSDT screening services, diagnosis code V200, V201 or V202 (Routine Infant or Child Health Check) must be used in the primary field (21.1) of this block. Additional diagnosis codes should be entered in fields 21.2, 21.3, 21.4. An appropriate diagnosis code must be included for each referral. Immunization V-Codes are not required.	R
42	N/A	Revenue code	Enter Revenue Code 510	R
44	24D	Procedures, Services or Supplies CPT/HCPCS Modifier	Populate the first claim line with the age appropriate E & M codes along with the EP modifier when submitting a “complete” EPSDT visit, as well as any other EPSDT related services, e.g., immunizations	R
N/A	24H	EPSDT/Family Planning	Enter Visit Code 03 when providing EPSDT screening services.	R

Key:

- **Block Code** – Provides the block number as it appears on the claim.
- **C** – Conditional must be completed if the information applies to the situation or the service provided.
- **R** – Required – must be completed for all EPSDT claims.

Important: Failure to follow these billing guidelines may result in rejected electronic claims and/or non-payment of completed EPSDT screenings.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Common Causes of Claim Processing Delays, Rejections or Denials

Authorization or Referral Number Invalid or Missing A valid authorization number must be included on the claim form for all services requiring prior authorization or referral from an assigned Primary Care Physician (PCP).

Attending Physician ID Missing or Invalid – Inpatient claims must include the name of the physician who has primary responsibility for the patient's medical care or treatment, and the medical license number on the appropriate lines in field number 82 (Attending Physician ID) of the UB-04 (CMS 1450) claim form. A valid medical license number is formatted as 2 alpha, 6 numeric, and 1 alpha character (AANNNNNA) **OR** 2 alpha and 6 numeric characters (AANNNNNN).

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 or 5th Digit – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-9-CM manual for the 4th and 5th digit extensions. Look for the ✓4th or ✓5th symbols in the manuals to determine when additional digits are required.

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-9-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG codes must include this information on the claim form.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third party insurers must be submitted with the original claim form. Include pages with run dates, coding explanations and messages.

EPSDT Information Missing or Incomplete – AmeriHealth Mercy requires EPSDT screening claims to be submitted by mail using the CMS 1500 Federal claim form, the Universal Billing form (UB-04), or electronically using the HIPAA compliant 837 Professional Claims (837P) transaction or the Institutional Claims (837I) transaction.

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

Important: Include all primary and secondary diagnosis codes on the claim. All primary and secondary diagnosis codes must have a corresponding POA indicator.

Important: Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections or denials.

Important: Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.

Important: All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.

Important: State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.

Important: The services billed on the claim form should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.

Important: EPSDT services may be submitted electronically or on paper.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

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

Handwritten Claims – Beginning October 2009, completely handwritten claims will be rejected. Legible handwritten claims are acceptable on resubmitted claims. (See Illegible Claim Information)

Highlighted Claim Fields (See Illegible Claim Information)

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

Incomplete Forms – All required information must be included on the claim forms in order to ensure prompt and accurate processing.

Member Name Missing – The name of the member must be present on the claim form and must match the information on file with the Plan.

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

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

Newborn Claim Information Missing or Invalid – Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert "Baby Girl" or "Baby Boy" in front of the mother's last name as the baby's first name. Verify that the appropriate last name is recorded for the mother and baby.

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

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

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

Important: Submitting the original copy of the claim form will assist in assuring claim information is legible.

Important: The *individual provider name* and NPI number as opposed to the group NPI number must be indicated on the claim form.

Important: Do not highlight any information on the claim form or accompanying documentation. Highlighted information will become illegible when scanned or filmed.

Important: Do not attach notes to the face of the claim. This will obscure information on the claim form or may become separated from the claim prior to scanning.

Important: Although the newborn claim is submitted under the mother's ID, the claim must be processed under the baby's ID. The claim will not be paid until the state confirms eligibility and enrollment in the plan.

Important: The claim for baby *must* include the *baby's date of birth* as opposed to the mother's date of birth.

Important: On claims for twins or other multiple births, indicate the birth order in the patient name field e.g. Baby Girl Smith **A**, Baby Girl Smith **B**, etc.

Important: Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Provider NPI number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included on the claim form.

Revenue Codes Missing or Invalid – Facility claims must include a valid four-digit numeric revenue code. Refer to UB-04 coding manuals for a complete list of revenue codes.

Spanning Dates of Service Do Not Match the Listed Days/Units – Span-dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field.

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

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

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

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

Important: The *individual service provider name and NPI number* must be indicated on all claims, including claims from outpatient clinics. Using only the group NPI or billing entity name and number will result in rejections, denials, or inaccurate payments.

Important: When the provider or facility has more than one NPI number, use the NPI number that matches the services submitted on the claim form. Imprecise use of NPI number's results in inaccurate payments or denials.

Important: When submitting electronically, the provider NPI number must be entered at the claim level as opposed to the claim line level. Failure to enter the provider NPI number at the claim level will result in rejection. Please review the rejection report from the EDI software vendor each day.

Important: Claims without the provider signature will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.

Important: Claims without a tax identification number (TIN) will be rejected. The provider is responsible for re-submitting these claims within 180 calendar days from the date of service.

Important: Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to the Plan immediately. Contact your Provider Account Executive to assist in updating the Plan's records.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Electronic Data Interchange (EDI) for Medical and Hospital Claims

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

The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

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

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

Important: In order to verify satisfactory receipt and acceptance of submitted records, please review both the Emdeon Acceptance report, and the R059 Plan Claim Status Report.

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

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

ELECTRONIC CLAIMS SUBMISSION (EDI)

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

Hardware/Software Requirements

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

Contracting with Emdeon and Other Electronic Vendors

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Emdeon EDI capabilities, you can contact the Emdeon Provider Support Line at **1-800-845-6592**. You may also choose to contract with another EDI clearinghouse or vendor who already has Emdeon capabilities.

Contacting the EDI Technical Support Group

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

When ready to proceed:

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your EDI software vendor and/or Emdeon to inform them you wish to initiate electronic submissions to the Plan.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.

Important: Emdeon is the largest clearinghouse for EDI Healthcare transactions in the world. It has the capability to accept electronic data from numerous providers in several standardized EDI formats and then forwards accepted information to carriers in an agreed upon format.

Important: Contact EDI Technical Support at:

1-877-234-4271 (prompt #4)

Or by E-mail at

edi.amhp@kmhp.com

Important: Providers using Emdeon or other clearinghouses and vendors are responsible for arranging to have rejection reports forwarded to the appropriate billing or open receivable departments.

Important: The Payer ID for AmeriHealth Mercy Health Plan is 23284

NOTE: Plan payer specific edits are described in Exhibit 99 at Emdeon.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Specific Data Record Requirements

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

Electronic Claim Flow Description

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

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

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

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

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

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

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Emdeon Provider Support Line at 1-800-845-6592.
- If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support Hotline at 1-877-234-4271 (prompt #4) or by E-mail at edi.amhp@kmhp.com

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

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

* An Acceptance report verifies acceptance of each claim at Emdeon.

** A R059 Plan Claim Status Report is a list of claims that passed Emdeon's validation edits. However, when the claims were submitted to the Plan, they encountered provider or member eligibility edits.

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

Timely filing Note: Your claims must be received by the EDI vendor by 9:00 P.M. in order to be transmitted to the Plan the next business day.

Important: Contact Emdeon Provider Support Line at **1-800-845-6592**

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

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

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Invalid Electronic Claim Record Rejections/Denials

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

Plan Specific Electronic Edit Requirements

The Plan currently has two specific edits for professional and institutional claims sent electronically.

837P – 004010X098A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

837I – 004010X096A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Exclusions

Certain claims are excluded from electronic billing. These exclusions fall into two groups:

- Excluded Claim Categories – At this time, these claim records must be submitted on paper.
- Excluded Provider Categories – Claims issued from or on behalf of the following providers must be submitted on paper.

These exclusions apply to inpatient and outpatient claim types.

Excluded Claim Categories
Claim records requiring supportive documentation or attachments such as COB claims with a primary insurer's EOB
Claim records for medical, administrative or claim appeals

Excluded Provider Categories
Providers not transmitting through Emdeon or providers sending to Vendors that are not transmitting (through Emdeon) NCPDP Claims
Pharmacy (through Emdeon)

Important: Requests for adjustments may be submitted by telephone to:

Provider Claim Services

1-800-521-6007

(Select the prompt for the correct Plan, and then, select the correct prompt for claim issues.)

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

**Claims Processing Department
AmeriHealth Mercy Health Plan
P.O. Box 7118
London, KY 40742**

Outpatient medical appeals must be submitted in writing to:

**Provider Appeals Department
AmeriHealth Mercy Health Plan
PO Box 7316
London, KY 40742**

Inpatient medical appeals must be submitted in writing to:

**Provider Appeals Department
AmeriHealth Mercy Health Plan
PO Box 7307
London, KY 40742**

Submit written disputes to:

**Practitioner Dispute
AmeriHealth Mercy Health Plan
8040 Carlson Road, Suite 500
Harrisburg, PA 17112**

Refer to the Provider Manual or the Provider Center online at www.amerihealthmercyhp.com for complete instructions on submitting administrative or medical appeals.

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Emdeon
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-9, etc)
Claims without provider numbers
Claims without member numbers
Claims in which the date of birth submitted does not match the member ID.

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers
Claims received with invalid member numbers
Claims received with invalid member date of birth

Resubmitted Professional Corrected Claims

Providers using electronic data interchange (EDI) can submit “professional” corrected claims* electronically rather than via paper to AmeriHealth Mercy Health Plan.

** A corrected claim is defined as a resubmission of a claim with a specific change that you have made, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim.*

Your EDI clearinghouse or vendor needs to:

- ✓ Use “6” for adjustment of prior claims or “7” for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P)
- ✓ Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- ✓ **Do** include the plan’s claim number in order to submit your claim with the 6 or 7
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
 - For more information, please contact the EDI Hotline at 1-877-234-4271 or edi.amhp@kmhp.com
 - Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims faster than available with paper submission processing.

Important: Claims originally rejected for missing or invalid data elements must be corrected and re-submitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 1.)

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

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

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

**Claims Processing Department
AmeriHealth Mercy Health Plan
PO Box 7118
London, KY 40742**

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

**Contact the Emdeon Provider
Support Line at:
1-800-845-6592**

**Contact EDI Technical Support at:
1-877-234-4271**

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

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

837P – Loop 2310B, REF*N5[PIN]

837I – Loop 2310A, REF*N5[PIN]

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

AmeriHealth Mercy Health Plan Claim Filing Instructions

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically...	Contact Emdeon Provider Support Line at: 1-800-845-6592
If you have general EDI questions ...	Contact EDI Technical Support at: 1-877-234-4271 or by e-mail at: edi.amhp@kmhp.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports...	Contact your EDI Software Vendor or call the Emdeon Provider Support Line at 1-800-845-6592
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)...	Contact Provider Claim Services at 1-800-521-6007 for claim inquiries.
If you have questions about claims that are reported on the Remittance Advice....	Contact Provider Claim Services at 1-800-521-6007 for claim inquiries.
If you need to know your provider NPI number...	Contact Provider Services at: 1-800-521-6007
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information... For questions about changing or verifying provider information...	Notify Provider Contracting in writing at: AmeriHealth Mercy Health Plan 8040 Carlson Road, Suite 500 Harrisburg, PA 17112 Or by fax at: (717) 651-1673 Or by telephone at: 1-877-693-8271
If you would like information on the 835 Remittance Advice:	Contact your EDI Vendor
Check the status of your claim:	Review the status of your submitted claims on NaviNet at: www.navinet.net
Sign up for NaviNet	www.navinet.net NaviNet Customer Service: 1-888-482-8057

* Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

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

What is the Risk Score Adjustment Model?

The Department of Public Welfare (DPW) utilizes medical encounter data supplied by AmeriHealth Mercy to evaluate disease severity and risk of increased medical expenditures. DPW employs the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system, to support health-based capitation payments to AmeriHealth Mercy. Accurate payments from DPW help us ensure that providers are reimbursed appropriately for services provided to our members.

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

Why are retrospective chart reviews necessary?

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

What is the significance of the ICD-9-CM Diagnosis code?

International Classification of Diseases-9th Edition-Clinical Modification (ICD-9-CM) codes are identified as 3 to 5 digit codes used to describe the clinical reason for a patient's treatment and a description of the patient's medical condition or diagnosis (rather than the service performed).

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Do not code conditions that were previously treated and no longer exist. However, history codes (V10-19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Per the ICD-9-CM Official Guidelines for Coding and Reporting (October, 1, 2010), providers must code all documented conditions that were present at time of the encounter/visit, and require or affect patient care treatment or management.

Have you coded for all chronic conditions for the member?

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

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

What are your responsibilities?

Physicians must accurately report the ICD-9-CM diagnosis codes to the highest level of specificity.

- For example, a diabetic with neuropathy should be reported with the following primary and secondary codes:
 - 250.60 Diabetes with neurological manifestations and 357.2 for diabetic polyneuropathy

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

Documentation Guidelines

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

Physician Documentation Tips

- ✓ First list the ICD-9CM code for the diagnosis, condition, problem or other reason for the encounter visit shown in the medical record to be chiefly responsible for the services provided.
- ✓ Adhere to proper methods for appending (late entries) or correcting inaccurate data entries, such as lab or radiology results.
- ✓ Strike through, initial, and date. Do not obliterate.
- ✓ Use only standard abbreviations.
- ✓ Identify patient and date on each page of the record.
- ✓ Ensure physician signature and credentials are on each date of service documented.
- ✓ Update physician superbills annually to reflect updated ICD-9CM coding changes, and the addition of new ICD-9CM codes.

Physician Communication Tips

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

SOAP stands for:

Subjective: How the patients describe their problems or illnesses.

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

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

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

Multiple Surgical Reduction Payment Policy

AmeriHealth Mercy adheres to the following payment procedure:

- When two or more surgical inpatient or outpatient procedures are performed by the same practitioner on the same day, the practitioner will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures. The only exception to this procedure is practitioner contract language that specifies an alternative payment methodology.
- When two or more surgical procedures are performed and anesthesia is provided by the same anesthesiologist during the same period of hospitalization, the anesthesiologist will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures.
- When two or more surgical procedures are performed during the same surgical event, and anesthesia is provided by the same anesthesiologist, the anesthesiologist should bill for the highest billable anesthesia procedure code. All anesthesia time must be allotted to that single anesthesia procedure code. No payment will be made for additional anesthesia procedures provided during that surgical event, with the exception of codes 01967, 01968 and 01969.

Factor Drug Carve-Out - Provider Submission Instructions

Note: These instructions are only applicable for in-patient facilities for which factor is a carve-out in their AmeriHealth Mercy contract.

Submit clinical information for Factor to:

Factor Carve-Out Documents
P.O. Box 7310
London, KY 40742-7310

- The request is reviewed by a hemophilia Nurse Case Manager who has thirty (30) days from receipt of complete information to review the case.
- Questions regarding status should be directed to Nurse Case Manager at 215-937-5052.
- Upon Nurse Case Manager approval and authorization, an approval notice is sent to the Attending Physician, Member and Hospital contact.
- Upon Case Manager recommendation of denial, the case is sent to a Medical Director for review.
 - After review of the request and the Medical Director concurs with the denial recommendation, a denial notice is sent to the Attending Physician, Member and Hospital Contact.
 - Any appeal should follow the instructions and process that are provided on the denial letter.
 - After review, if the Medical Director decides to approve and authorizes the request, an approval notice is sent to the Attending Physician, Member and Hospital Contact.

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