Provider Claims and Billing Manual

Updated November 2024

CONTENTS

INTRODUCTION

AmeriHealth Caritas Ohio (ACOH), hereafter referred to as the Plan (where appropriate), 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.

Section 6401 of the Affordable Care Act (ACA) requires that all providers must be enrolled in Medicaid in order to be paid by Medicaid. This means all providers must enroll and meet all requirements of the Ohio Department of Medicaid which then issues a Medicaid identification number.

All claims submitted to AmeriHealth Caritas by providers are required to be billed via the Electronic Equivalent (EDI) of the CMS- 1500 or UB-04 Forms.

REQUIRED DATA ELEMENTS FOR CLAIM FILING

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 Diagnosis and Procedure Codes are valid for the date of service.
- Verification of charges submitted reflect the usual and customary charge of services (the amount charged to the general public) on all claims.
- Verification of electronic claims against 837 edits at Change Healthcare™.
- 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 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.

Rejected claims are defined as claims with invalid or required missing data elements, such as the provider tax identification number, Provider Medicaid ID number, member ID number, that are returned to the designated EDI[1] source without registration in the claim processing system.

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

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

- **Denied claims** must be resubmitted as a corrected claim within 180 calendar days from the date of denial or 365 days from date of service provided.
    - Corrected and voided claims must be sent electronically.
    - The original claim number must be submitted as well as the correct frequency code:
        - You can find the original claim number from the 835 ERAS, or from the claim status search in NaviNet®.
        - **If you do not have the claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet® to get the claim number.**
        - The *claim frequency code* (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim) may only contain the values '**7**' for the Replacement (correction) of a prior claim and '**8**' for the void of a prior claim. The value '**6**' should no longer be sent.
        - In addition, the submitter must also provide the original Plan claim number in ***Payer Claim Control Number*** (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files).

The requirements outlined above apply to claims submitted electronically.

All providers are required to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or **Change Healthcare's Provider Support Line at 1-877-363-3666** to arrange transmission.

CLAIM FILING DEADLINES

Original invoices must be submitted to the Plan within 365 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 180 calendar days from the date services were denied.

[1] *For more information on EDI, please refer to the section title Electronic Data Interchange (EDI) within this document.*

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

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

EXCEPTIONS

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted 90 days after final determination by the primary payer.

ADJUSTMENTS

Claims with issues, where resolution does not require complete re-submission of a claim, may be easily adjusted. Adjusted claims cannot involve changing any field on a claim (for example an incorrect code). To complete an adjustment, you may open a claims investigation via NaviNet with the claim's adjustment inquiry function. Requests for adjustments may also be submitted by telephone to Provider Claims Services at 1-833-644-6001.

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

APPEALS AND DISPUTES

Medical appeals must be submitted in writing to:

Claim Processing Department
AmeriHealth Caritas Ohio
P.O. Box 7346
London, KY 40742

Written Disputes should be mailed to:

Claims Disputes
AmeriHealth Caritas Ohio
P.O. Box 7126
London, KY 40742

AmeriHealth Caritas Ohio EDI Payer ID # **35374**

Please refer to the Provider Manual for complete instructions on submitting appeals and disputes.

Is it a Dispute, Inquiry, or Appeal?	Timeframe	Contact Information
Appeal Filed by the member or provider on behalf of the member (with a waiver), related to a denied Service/IP service (Prior Auth denials, Limit to service/Auth) when there is no claim on file.	60 days from the date of denial letter sent by UM	**Medical appeals must be submitted in writing to:** Claim Processing Department AmeriHealth Caritas Ohio P.O. Box 7346 London, KY 40742
Inquiry Provider asking for more information on a claim and how it was processed.	None - If determined the claim can be adjusted, then the inquiry is a dispute and should follow that timeframe.	**NaviNet Portal** (www.navinet.net)
Dispute (or called a Provider Claim Appeal) Provider disagreeing with the way a claim was processed, paid, or denied. ODM outlines the following categories of items that are considered a dispute: Claim Status | Eligibility | Other insurance | Improper claim submission |Overpaid | Underpaid | Provider not eligible to provide service | Payment amount clarification | Provider not credentialed | Duplicate claim | Timely filing | Documentation issues | Recoupments | Prior Authorization | Medical Necessity | Level of Care (LOC) | Non-covered services | Provider affiliation | Payment not received | Patient Liability | Sterilization/Hysterectomy consent form | Past Dispute Timeframe	12 months from the DOS or 60 days from the EOB date.	**Written Disputes should be mailed to:** Claims Disputes AmeriHealth Caritas Ohio P.O. Box 7126 London, KY 40742

All claims sent to AmeriHealth Caritas Ohio, through the central PNM portal, should include the AmeriHealth Caritas Ohio Payer ID in 1000B Receiver Loop and 2010BB Payer Name Loop.

CLAIM FORM FIELD REQUIREMENTS

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

The CMS 1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. **All claims must be submitted within the required filing deadline of 365 days from the date of service**.
Claim data requirements apply to all claim submissions, regardless of the method of submission.

REQUIRED FIELDS (CMS 1500 CLAIM FORM):

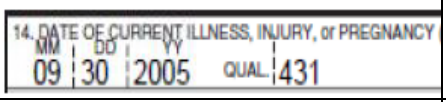
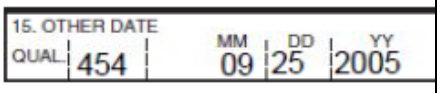
*Required [R] fields must be completed on all claims. Conditional [C] fields must be completed if the information applies to the situation, or the service provided. Refer to the NUCC, www.nucc.org or NUBC Reference Manuals for additional information.

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

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
4	**Insured's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's Health Plan ID card or enter the newborn's name when the patient is a newborn.	R	2010BA	NM103 NM104 NM105 NM107	Titled Subscriber in 837P.
5	**Patient's Address (Number, Street, City, State, Zip+4) Telephone (include area code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	R	2010CA	N301 N401 N402 N403 N404	
6	**Patient Relationship to Insured**	Always indicate self unless covered by someone else's insurance.	R	2000B 2000C	SBR02 PAT01	Titled Individual Relationship code in 837P.
7	**Insured's Address (Number, Street, City, State, Zip+4 Code) Telephone (Include Area Code)**	If same as the patient, enter "Same." Otherwise, enter insured's information.	C	2010BA	N301 N302 N401 N402 N403	Titled Subscriber Address in 837P.
8	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	N/A
9	**Other Insured's Name (Last, First, Middle Initial)**	Refers to someone other than the patient. **Completion of fields 9a through 9d is Required** if patient is covered by another insurance plan. Enter the complete name of the insured.	C	2330A	NM103 NM104 NM105 NM107	If patient can be uniquely identified to the other provider in this loop by the unique member ID, then the patient is the subscriber and identified in this loop. Titled Other Subscriber Name in 837P.
9a	**Other Insured's Policy or Group #**	**Required** if # 9 is completed.	C	2320	SBR03	Titled Group or Policy Number in 837P.
9b	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	Does not exist in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
9c	**Reserved for NUCC use**	N/A	Not Required	N/A	N/A	Does not exist in 837P.
9d	**Insurance Plan Name or Program Name**	**Required** if # 9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other medical insurance is available, or if 9a completed.	C	2320	SBR04	Titled other insurance group in 837P.
10a, b, c	**Is Patient's Condition Related to**	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident c) Other Accident	R	2300	CLM11	Titled related causes code in 873P.
10d	**Claim Codes (Designated by NUCC)**	To comply with EPSDT reporting requirements, continue to use this field to report EPSDT referral codes as follows: YD – Dental (Required for Age 3 and above) YO – Other* YV – Vision YH – Hearing YB – Behavioral YM – Medical For all other claims enter new Condition Codes as appropriate. Available 2-digit Condition Codes include nine codes for abortion services and four codes for worker's compensation. Please refer to NUCC for the complete list of codes. Examples include: • AD – Abortion Performed due to a Life Endangering Physical Condition Caused by, arising from or Exacerbated by the Pregnancy Itself	C	2300	NTE	NTE 01 position – input "ADD" Upper case/capital format. NTE 02 position – first six-character input "EPSDT=" (upper case/capital format where the sixth character will be the = sign. Input applicable referral directly after "=" For multiple code entries: Use "_" (underscore) to separate as follows: NTE*ADD*EPSDT=YD_YM_YO~

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		• W3 – Level 1 Appeal				
11	**Insured's Policy Group or FECA #**	Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.	C	2000B	SBR03	Titled Subscriber Group or Policy # in 837P.
11a	**Insured's Birth Date / Sex**	Same as # 3. Required if 11 is completed.	C	2010BA	DMG02 DMG03	Titled Subscriber DOB and Gender on 837P.
11b	**Other Claim ID**	Enter the following qualifier and accompanying identifier to report the claim number assigned by the payer for worker's compensation or property and casualty: • Y4 – Property Casualty Claim Number Enter qualifier to the left of the vertical, dotted line, identifier to the right of the vertical, dotted line.	C	2010BA	REF01 REF02	Titled Other Claim ID in 837P.
11c	**Insurance Plan Name or Program Name**	Enter name of Health Plan. Required if 11 is completed.	C	2000B	SBR04	Titled Subscriber Group Name in 837P.
11d	**Is There Another Health Benefit Plan?**	Y or N by check box. If yes, indicate Y for yes. If yes, complete # 9 a-d.	R	2320		Presence of Loop 2320 indicates Y (yes) to the question on 837P.
12	**Patient's Or Authorized Person's Signature**	On the 837, the following values are addressed as follows at Change Healthcare: "A," "Y," "M," "O" or "R," then change to "Y," else send "I" (for "N" or "I").	R	2300	CLM09	Titled Release of Information code in 837P.
13	**Insured's Or Authorized Person's Signature**		C	2300	CLM08	Titled Benefit Assignment Indicator in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
14	**Date Of Current Illness Injury, Pregnancy (LMP)**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier to right of vertical dotted line. Qualifiers include: • 431 – Onset of Current Symptoms or Illness • 439 – Accident Date • 484 – Last Menstrual Period (LMP) Use the LMP for pregnancy. Example: 	C	2300	DTP01 DTP03	Titled in the 837P: Date – Onset of Current Illness or Symptom Date – Last Menstrual Period
15	**Other Date**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) • 444 – First Visit or Consultation  Example:	C	2300	DTP01 DTP03	Titled in the 837P: Date – Initial Treatment Date Date – Last Seen Date Date – Acute Manifestation Date – Accident Date – Last X-ray Date Date – Hearing and Vision Prescription Date Date – Assumed and Relinquished Care Dates Date – Property and Casualty Date of First Contact If Patient Has Had Same or Similar Illness does not exist in 837P
16	**Dates Patient Unable to Work in**		C	2300	DTP03	Titled Disability from Date and Work Return Date in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
	Current Occupation					
17	**Name Of Referring Physician or Other Source**	**Required** if a provider other than the member's primary care physician rendered invoiced services. Enter applicable 2-digit qualifier to left of vertical dotted line. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Qualifiers include: • DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider Example: 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jane A Smith MD	C	2310A (Referring) 2310D (Supervising) 2420E (Ordering)	NM 101 NM103 NM104 NM105 NM107	
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 G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The NUCC defines the following qualifiers: 0B State License Number 1G Provider UPIN Number G2 Provider Commercial Number LU Location Number (This qualifier is used for Supervising Provider only.) Required if # 17 is completed.	C	2310A (Referring) 2010D (Supervising) 2420E (Ordering)	REF01 REF02	Titled Referring Provider Secondary Identifier, Supervising Provider Secondary Identifier, and Ordering Provider Secondary Identifier in 837P.
17b	**National Provider**	Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.	R	2310D	NM109	Titled Referring Provider Identifier, Supervising Provider Identifier, and

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
	Identifier (NPI)					Ordering Provider Identifier in 837P.
18	**Hospitalization Dates Related to Current Services**	**Required** when place of service is in-patient. **MMDDYY** (indicate **from** and **to** date)	C	2300	DPT01 DTP03	Titled Related Hospitalization Admission and Discharge Dates in 837P.
19	**Additional Claim Information (Designated by NUCC)**	Enter additional claim information with identifying qualifiers as appropriate. For multiple items, enter three blank spaces before entering the next qualifier and data combination. The NUCC defines the following qualifiers: • **0B** State License Number • **1G** Provider UPIN Number • **G2** Provider Commercial Number • **LU** Location Number *(This qualifier is used for Supervising Provider only.)* • **N5** Provider Plan Network Identification Number • **SY** Social Security Number • **X5** State Industrial Accident Provider Number • **ZZ** Provider Taxonomy	Required	2300 2310 (Rendering Provider Taxonomy)	NTE PWK PRV03	
20	**Outside Lab**	If applicable, indicate Yes. (If patient had outside lab work completed.) Otherwise, leave blank.	C	2400	PS102	
21	**Diagnosis Or Nature of Illness or Injury. (Relate To 24E)**	Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. **Note:** Claims with invalid diagnosis codes will be denied for payment.	R	2300	HIXX-02 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		External diagnosis or "E" codes are not acceptable as a primary diagnosis.				
22	**Resubmission Code and/or Original Ref. No**	This field is required for resubmissions or adjustments/corrected claims. Enter the appropriate bill frequency code (7 or 8 – see below) left justified in the Submission Code section, and the Claim ID# of the original claim in the Original Ref. No. section of this field. • 7 – Replacement of Prior Claim • 8 – Void/cancel of Prior Claim	C **Required** for resubmitted or adjusted claims.	2300 2300	CLM05-3 REF02 Where REF01 = F8	Titled Claim Frequency Code in the 837P. Titled Payer Claim Control Number in the 837P. Send the original claim number if this field is used.
23	**Prior Authorization Number** **CLIA Number Locations**	Enter the referral or authorization number. Refer to the Provider Manual to determine if services rendered require an authorization. Laboratory Service Providers must enter CLIA number here for the location. EDI claims: CLIA must be represented in the 2300 loop, REF02 element.	C	2300	REF02 Where REF01 – G1 REF02 Where REF01 = 9F REF02 Where REF01 = X4	Titled Prior Authorization Number in 837P. Titled Referral Number in 837P. Titled CLIA Number in 837P.
24A	**Date(s) Of Service**	"From" date: MMDDYY. If the service was performed on one day leave "To" blank or re-enter "From" Date. See below for Important Note (instructions) for completing the shaded portion of field 24.	R	2400	DTP01 DTP03	Titled Service Date in 837P.
24B	**Place Of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	R	2300 2400	CLM05-1 SV105	Titled Facility Code Value in 837P. Titled Place of Service Code in 837P.
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for	C	2400	SV109	Titled Emergency Indicator in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		"No" in the bottom (unshaded area of the field).				
24D	**Procedures, Services or Supplies CPT/HCPCS Modifier**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. **Note:** Modifiers affecting reimbursement must be placed in the 1st modifier position *See additional information below for EDI requirements	R	2400	SV101 (2-6)	Titled Product/Service ID and Procedure Modifier in 837P.
24E	**Diagnosis Pointer**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). Diagnosis codes must be valid ICD-10 codes for the date of service and must be entered in field 21. Do not enter diagnosis codes in 24E. Note: The Plan can accept up to twelve (12) diagnosis pointers in this field. Diagnosis codes must be valid ICD codes for the date of service.	R	2400	SV107 (1-4)	Titled Diagnostic Code Pointer in 837P.
24F	**Charges**	Enter charges. A value must be entered. Enter zero ($0.00) or actual charged amount. *Providers are expected to submit their usual and customary charge (the amount charged to the general public) on all claims.	R	2400	SV102	Titled Line-Item Charge Amount in 837P.
24G	**Days Or Units**	Enter quantity. Value entered must be greater than or equal to zero. Blank is not acceptable. (Field allows up to 3 digits.)	R	2400	SV104	Titled Service Unit Count in 837P.
24H	**EPSDT Family Plan**	**In Shaded area of field:** AV - Patient refused referral. S2 - Patient is currently under treatment for referred diagnostic or corrective health problems. NU - No referral given; or ST - Referral to another provider for diagnostic or corrective treatment. **In unshaded area of field:**	C	2300 2400	CRC SV111 SV112	

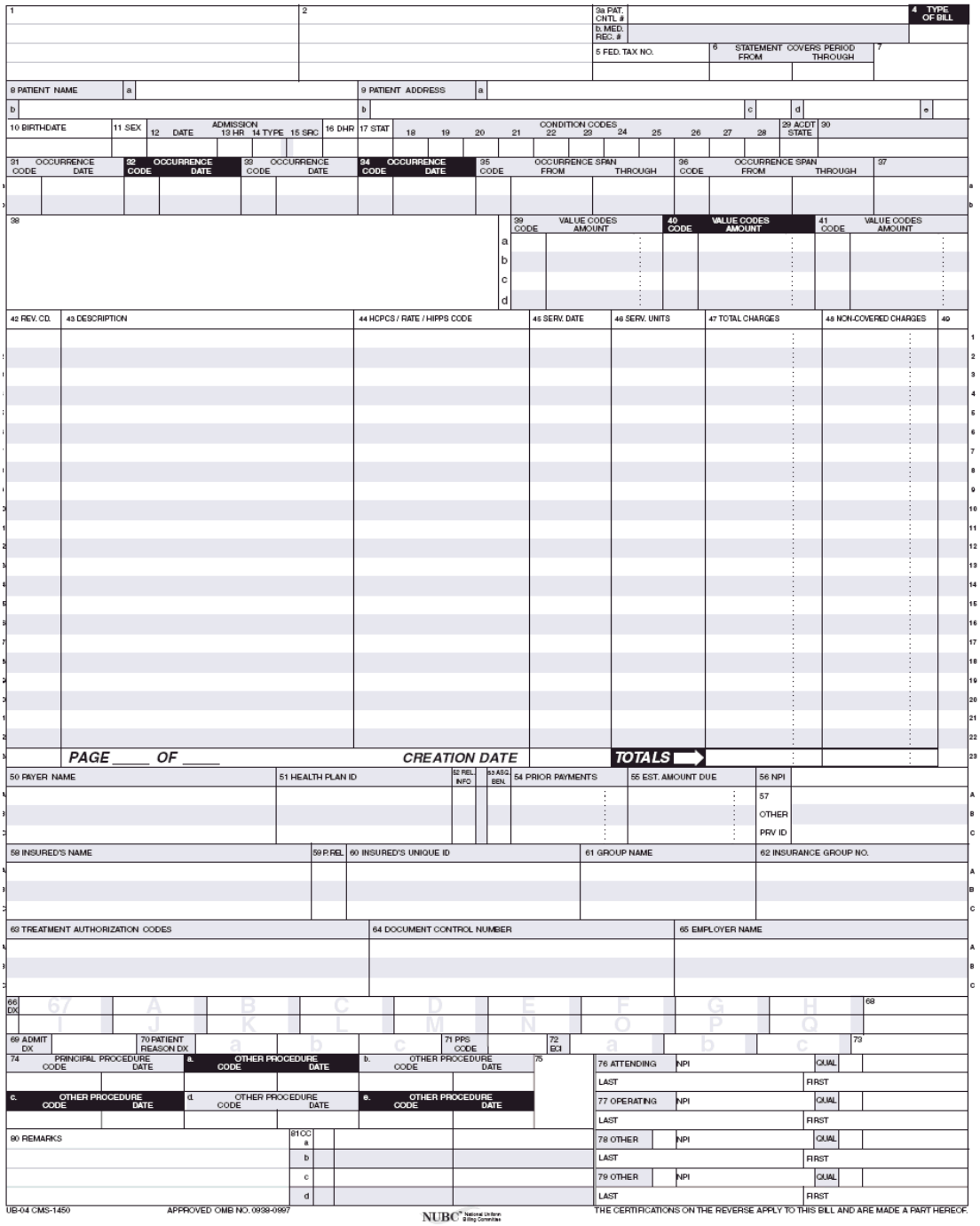
CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		"Y" for Yes – if service relates to a pregnancy or family planning "N" for No – if service does not relate to pregnancy or family planning				
24I	**ID Qualifier**	If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I. • **0B** State License Number • **1G** Provider UPIN Number • **G2** Provider Commercial Number • **LU** Location Number If the rendering provider does have an NPI see field 24J below... If the Other ID number is the Health Plan ID number, enter G2.	R	2310B	REF (01) NM108	Titled Reference Identification Qualifier in 837P. XX required for NPI in NM109.
24J	**Rendering Provider ID**	The individual rendering the service is reported in 24J. Enter the Provider Health Plan legacy ID number in the shaded area of the field. Use Qualifier G2 for Provider Health Plan legacy ID. Enter the NPI number in the unshaded area of the field. Use qualifier. Enter Taxonomy in shaded area • ZZ Provider Taxonomy Box 19 can also be used for sending Rendering Provider taxonomy	R	2310B	REF02 NM109 PRV03	Change HealthCare will pass this ID on the claim when present. NPI Rendering provider taxonomy
25	**Federal Tax ID Number SSN/EIN**	Physician or Supplier's Federal Tax ID numbers.	R	2010AA	REF01 REF02	EI Tax SY SSN
26	**Patient's Account No.**	The provider's billing account number.	R	2300	CLM01	Titled Patient Control Number in 837P.
27	**Accept Assignment**	Always indicate **Yes**. Refer to the back of the CMS 1500 (08-05) form for the section pertaining to Medicaid Payments.	R	2300	CLM07	Titled Assignment or Plan Participation Code in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
28	**Total Charge**	Enter charges. A value must be entered. Enter zero (0.00) or actual charges (this includes capitated services. Blank is not acceptable.	R	2300	CLM02	May be $0.
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C	2300 2320	AMT02 AMT02	Patient Paid Payer Paid
30	**Reserved for NUCC Use**		Not Required			
31	**Signature Of Physician or Supplier Including Degrees or Credentials / Date**	Actual signature is required.	R	2300	CLM06	Titled Provider or Supplier Signature Indicator on 837P.
32	**Name and Address of Facility Where Services Were Rendered (If other than Home or Office)**	**Required** unless #33 is the same information. Enter the physical location. **(P.O. Box #'s are not acceptable here)**	R	2310C	NM103 N301 N401 N402 N403	
32a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2310C	NM109	Titled Laboratory or Facility Primary Identifier in the 837P.
32b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers used in 5010A1: • **0B** State License Number • **G2** Provider Commercial Number	C Recommended	2310C	REF01 REF02	Titled Reference Identification Qualifier and Laboratory or Facility secondary Identifier in 837P.

CMS-1500 Claim Form						
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Loop ID**	**Segment**	**Notes**
		• **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.				
33	**Billing Provider Info & Ph. #**	**Required** – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location; P.O. Boxes are not acceptable	R	2010AA	NM103 NM104 NM105 NM107 N301 N401 N402 N403 PER04	
33a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	R	2010AA	NM109	Titled Billing Provider Identifier in 837P.
33b.	**Other ID#**	Enter the Health Plan ID # (strongly recommended) Enter the G2 qualifier followed by the Health Plan ID # The NUCC defines the following qualifiers: • **0B** State License Number • **G2** Provider Commercial Number • **LU** Location Number **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	R	2000A 2010BB	PRV03 REF02 where REF01 = G2	Titled Provider Taxonomy Code in 837P. Titled Reference Identification Qualifier and Billing Provider Additional Identifier in 837P.

REQUIRED FIELDS (UB-04 CLAIM FORM)

UB-04 Form Instructions: https://medicaid.ohio.gov/static/Providers/Billing/BillingInstructions/HospitalBillingGuidelines-20210901.pdf



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*	Loop	Segment	Notes
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 + 4 Line d: Enter the area code, telephone number.	R	R	2010AA	NM1/85 N3 N4	Billing Provider Name Billing Provider Address
2	**Unlabeled Field NUBC – Pay-to Name and Address**	**Enter Remit Address. No PO Boxes** Enter the Facility Provider ID number. Left justified	R	R	2010AB	NM1/87 N3 N4	Pay-To Name Pay-To Address
3a	**Patient Control No.**	Provider's patient account/control number	R	R	2300	CLM01	Patient's Control Number
3b	**Medical/Health Record Number**	The number assigned to the patient's medical/health record by the provider	C	C	2300	REF02 where REF01 = EA	Medical Reference Number
4	**Type Of Bill**	Enter the appropriate three or four -digit code. 1st position is a leading zero – Do not include the leading zero on electronic claims.	R	R	2300	CLM05	If Adjustment or Replacement or Void claim, include frequency code as the last digit. Include the frequency code by using bill type in loop 2300.

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		2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates billing sequence.					Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number. (No dashes or spaces.)
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R	2010AA	REF02 Where REF01 = EI	Pay to provider = Billing Prov use 2010AA Billing Provider Tax ID
6	**Statement Covers Period From/Through**	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R	2300	DTP03 where DTP01 = 434	MMDDCCYY Statement Dates
7	**Unlabeled Field**	Not Used. Leave Blank.	N/A	N/A	N/A	N/A	N/A
8a	**Patient Identifier**	Patient Health Plan ID is conditional if number is different from field 60	R	R	2010BA 2010CA	NM109 where NM101 = IL NM109 where NM101 = QC	Patient =Subscriber Use 2010BA Subscriber ID Patient is not =Subscriber, Use 2010CA Patient ID
8b	**Patient Name**	Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the Health Plan ID card.	R	R	2010BA 2010CA	NM103, NM104, NM107 where NM101=IL NM103, NM104, NM107	Patient =Subscriber Use 2010BA Subscriber Name Patient is not =Subscriber, Use 2010CA Patient Name

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		Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should **not** be reported in this field. Prefix: No space should be left after the prefix of a name e.g., McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix. Newborns and Multiple Births: If submitting a claim for a newborn that does not have an identification number, enter "Baby Girl" or "Baby Boy" and last name. Additional newborn billing information, including Multiple Births information, may be found within this document.				where NM101 = QC	

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9a-e	**Patient Address**	The mailing address of the patient 9a. Street Address 9b. City 9c. State 9d. ZIP Code + 4 9e. Country Code (report if other than USA)	R	R	2010BA 2010CA	N301, N302 N401, 02, 03, 04 N301, N302 N401, 02, 03, 04	Patient =Subscriber, Use 2010BA Subscriber Address Patient is not =Subscriber, Use 2010CA Patient Address
10	**Patient Birth Date**	The date of birth of the patient Right justified; MMDDYYYY	R	R	2010BA 2010CA	DMG02 DMG02	Subscriber Demographic Info
11	**Patient Sex**	The sex of the patient recorded at admission, outpatient service, or start of care. M for male, F for female or U for unknown.	R	R	2010BA 2010CA	DMG03 DMG03	Subscriber Demographic Info
12	**Admission Date**	The start date for this episode of care. For inpatient services, this is the date of admission. Right Justified	R	R	2300	DTP03 where DTP01=435	Required on inpatient. **Admission date/HR**
13	**Admission Hour**	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	R for bill types other than 21X.	R	2300	DTP03 where DTP/43/	Required on inpatient. Admission date/HR
14	**Admission Type**	A code indicating the priority of this admission/visit.	R	R	2300	CL101	Institutional Claim Code

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15	**Point of Origin for Admission or Visit**	A code indicating the source of the referral for this admission or visit.	R	R	2300	CL102	Institutional Claim Code
16	**Discharge Hour**	Valid national NUBC Code indicating the discharge hour of the patient from inpatient care.	R	R	2300	DTP03 where DTP01=096	
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	2300	CL103	Institutional Claim Code
18 - 28	**Condition Codes** **The following is unique to Medicare eligible Nursing Facilities. Condition codes should be billed when Medicare Part A does not cover Nursing Facility Services** **Applicable Condition Codes:** **X2 – Medicare EOMB on File** **X4 – Medicare Denial on File**	When submitting claims for services not covered by Medicare and the resident is eligible for Medicare Part A, the following instructions should be followed: 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: • There was no 3-day prior hospital stay	C	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1=BG Condition info

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		• 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 All other fields must be completed as per the appropriate billing guide.					
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. **Required when applicable.**	C	C	2300	REF02 Where REF01 = LU	
30	**Unlabeled Field**	Leave Blank	N/A	N/A	N/A	N/A	Reserved for future use
31a, b – 34a, b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code and date. Code must be 01 – 69, or A0-A9 or B1.	C	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BH

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Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		Dates must be in YYYYMMDD format. **Required** when applicable.					
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. Code must be 70 – 99 or M0-Z9. Dates must be in MMDDYY format. **Required** when applicable.	C	C	2300	HIXX-2 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BI
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. YD – Dental *(Required for Age 3 and above) YO – Other YV – Vision YH – Hearing YB – Behavioral YM – medical	C C* C C C C C	C C* C C C C C	2300	NTE	NTE 01 position – input “ADD” Upper case/capital format. NTE 02 position – first six-character input “EPSDT=” upper case/capital format where the sixth character will be the = sign. Input applicable referral directly after “=” For multiple code entries: Use “_” (underscore) to separate as follows: NTE*ADD*EPSDT =YD_YM_YO~

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38	**Responsible Party Name and Address**	The name and address of the party responsible for the bill.	C	C	N/A	N/A	Not required Not mapped 837I
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.** Please see NUCC Specifications Manual Instructions for value codes and descriptions. **Documenting covered and non-covered days**: Value Code 81 – non-covered days; 82 to report co-insurance days; 83- Lifetime reserve days. Code in the code portion	C	C	2300	HIXX-2 HIXX-5 Where XX = 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12	HIXX-1 = BE

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		and the Number of Days in the "Dollar" portion of the "Amount" section. Enter "00" in the "Cents" field.					
42	**Rev. Cd.**	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. Hospital: Enter the rev code that corresponds to the rev description in field 43. Refer to NUBC for valid rev codes. The last entry on the claim detail lines should be 0001 for total charges. PPED: Use the rev code that appears on the approved prior authorization letter for covered services. LTC state facility: Use rev code 0100 for room and board, plus ancillary LTC non-state/assisted living: Use rev code 0101 for room and board,	R	R	2400	SV201	Revenue Code

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		without ancillary. Use appropriate rev code for covered ancillary service. Leave of Absence codes: LTC – state and non-state facilities: Use LOA rev codes 0183, 0185 and 0189 as appropriate. Assisted Living Facilities: Use only 0189 as a LOA code, no payment is made for days billed with rev code 0189. Use for any days when patient is out of the facility for the entire day.					
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. Use this field to enter NDC information. Refer to supplemental information section.	R	R	N/A	N/A	Not mapped 837I

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44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	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. HCPCS	R	R	2400	SV202-2	SV202-1=HC/HP

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Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		are required for all Outpatient Claims. (Note: NDC numbers are required for all administered or supplied drugs.)					
45	**Serv. Date**	Report line-item dates of service for each revenue code or HCPCS/HIPPS code. Multiple-day service codes require an RR modifier.	R	R	2400	DTP03 where DTP01=472	Date of Service
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. Note: For drugs, service units must be consistent with the NDC code and its unit of measure. NDC unit of measure must be a valid HIPAA UOM code or claim may be rejected.	R	R	2400	SV205	Service Units

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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. Enter a zero ($0.00) or actual charged amount.	R	R	2300	SV203	Total Charges- Providers are expected to submit their usual and customary charge (the amount charged to the public) on all claims
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	2400	SV207	Non-Covered Charges
49	**Unlabeled Field**	N/A	Not required	Not required	N/A	N/A	N/A
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	R	R	2000B 2010BA 2320	SBR NM103 where NM101=PR SBR	Subscriber Information Payer Name

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		to the primary payer; B, secondary; and C, tertiary.			2330B	NM103 where NM101=PR	Other Subscriber Information Other Payer Name
51	**Health Plan Identification Number**	The number used by the health plan to identify itself. AmeriHealth Caritas Ohio Payer ID for all claims EXCEPT transportation: 35374 All claims sent to AmeriHealth Caritas Ohio, through the central PNM portal, should include the AmeriHealth Caritas Ohio Payer ID in 1000B Receiver Loop and 2010BB Payer Name Loop.	R	R	2330B	NM109 where NM101=PR	Payer ID
52	**Rel. Info**	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the	R	R	2300	CLM09	Release of Information code

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		primary payer; B, secondary; and C, tertiary. It is expected that the provider has all necessary release information on file. It is expected that all released invoices contain "Y"					
53	**Asg. Ben.**	Valid entries are "Y" (yes) and "N" (no). The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	R	R	2300	CLM08	Benefits Assignment Certification Indicator
54	**Prior Payments**	The A, B, C indicators refer to the information in Field 50. The A, B, C indicators refer to the information in Field 50. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary.	C	C	2320	AMT02 where AMT01=D	Prior Payment Amounts
55	**Est. Amount Due**	Enter the estimated amount due (the difference between	C	C	2300	AMT02 where AMT01 =EAF	Payment Estimated Amount Due

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		"Total Charges" and any deductions such as other coverage).					
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	2010AA	NM109 where NM101 = 85	NPI
57 A, B, C	**Other (Billing) Provider Identifier**	A unique identification number assigned to the provider submitting the bill by the health plan. Required for providers not submitting NPI in field 56. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50 A, B and C.	C	C	2010AA 2010BB	REF02 where REF01 = EI REF02 where REF01 = G2 REF02 where REF01 = 2U	Tax ID Only sent if needed to determine the Plan ID Legacy ID
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	R	R	2010BA 2330A	NM103, NM104, NM105 where NM101 = IL NM103, NM104, NM105	Use 2010BA is insured is subscriber Other Insured Name

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		insured is indicated here.				where NM101 = IL	
59	**P. Rel**	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured Code 18: Self	R	R	2000B	SBR02	Individual Relationship code
60	**Insured's Unique Identifier**	Enter the patient's Health Plan ID on the appropriate line, exactly as it appears on the patient's ID card on line B or C. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2010BA	NM109 where NM101= IL REF02 where REF01 = SY	Insured's Unique ID
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	2000B	SBR04	Subscriber Group Name
62	**Insurance Group No.**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for	C	C	2000B	SBR03	Subscriber Group or Policy Number

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		individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.					
63	**Treatment Authorization Codes**	Enter the Health Plan referral or authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R	2300	REF02 where REF01 = G1	Prior Authorization Number
64	**DCN**	Document Control Number. 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	2320	REF02 where REF01 = F8	Original Claim Number
65	**Employer Name**	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when	C	C	2320	SBR04	

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		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.					
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	2300	Determined by the qualifier submitted on the claim.	Not Required
67	**Prin. Diag. Cd. and Present on Admission (POA) Indicator**	The appropriate ICD codes corresponding to all conditions that coexist at the time of service, 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 service.	R	R	2300	HIXX-2 HIXX-9 Where HI01-1 = ABK	Principal Diagnosis POA
67 A - Q	**Other Diagnosis Codes**	The appropriate ICD codes corresponding to all conditions that	C	C	2300	HIXX-2 HIXX-9 Where HI01-1 = ABF	Other Diagnosis Information

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		coexist at the time of service, 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 service.					
68	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
69	**Admitting Diagnosis Code**	The appropriate ICD code describing the patient's diagnosis at the time of admission as stated by the physician. **Required** for inpatient and outpatient.	R	R	2300	HI01-2 Where HI01-1= ABJ	Admitting diagnosis
70	**Patient's Reason for Visit**	The appropriate ICD code(s) describing the patient's reason for visit at the time of outpatient registration. Required for all outpatient visits. Up to three ICD codes may be entered in fields A, B and C.	C	R	2300	HIXX-2 **Where HIXX-1=APR** **Where XX = 01, 02, 03**	Patient reason for visit
71	**Prospective Payment System (PPS) Code**	The PPS code assigned to the	C	C	2300	HI01-2	DIAGNOSIS Related Group

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		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.				Where HI01-1 = DR	(DRG) Information
72a-c	**External Cause of Injury (ECI) Code**	The appropriate ICD code(s) 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	2300	HIXX-2 Where HIXX-1 = ABN	External Cause of Injury
73	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
74	**Principal Procedure code and Date**	The appropriate 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** – Surgical procedure code is required if	C R	C R	2300	HI01-2 HI01-4 Where HI01-1 = BBR	

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		the operating room was used. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.					
74a-e	**Other Procedure Codes and Dates**	The appropriate 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** – Surgical procedure code is required when a surgical procedure is performed. **Outpatient facility or Ambulatory Surgical Center** – CPT, HCPCS or ICD code is required when a surgical procedure is performed.	C C	C C	2300	HIXX-2 Where HI01-1 = BBQ	Other Procedure Information
75	**Unlabeled Field**	N/A	N/A	N/A	N/A	N/A	Not mapped.
76	**Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#**	Enter the NPI of the physician who has primary responsibility for	R	R	2310A 2310A	NM109 where NM101 = 71	REF01=G2/

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		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. Note: If a qualifier is entered, a secondary ID must be present, and if a secondary ID is present, then a qualifier must be present. Otherwise, the claim will reject. ZZ Attending Provider Taxonomy			2310A 2301A	REF02 NM103 where NM101=71 PRV01 PRV03	Attending Provider Taxonomy
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#,	C	C	2310B	NM103, NM104, NM107, NM109 where NM101 = 72 REF02 where REF01 = G2	

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Field #	**Field Description**	Instructions and Comments	Required or Conditional*	Required or Conditional*	Loop	Segment	Notes
		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.					
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#	R	R	2310C 2310C	NM103, NM104, NM107, NM109 where NM101 = ZZ REF02where REF01 = G2	
80	**Remarks Field**	Area to capture additional information necessary to adjudicate the claim.	C	C	2300	NTE02 Where NTE01=ADD	Billing Note
81CC, a-d	**Code-Code Field**	To report additional codes related to	C	C	2000A	PRV01 PRV03	Billing Provider Taxonomy

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*	Loop	Segment	Notes
		Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. B3 Billing Provider Taxonomy					

SPECIAL INSTRUCTIONS AND EXAMPLES FOR EDI CLAIM SUBMISSIONS

SUPPLEMENTAL INFORMATION

EDI – Field 33b (Professional)

Field 33b – Other ID# - Professional: 2310B loop, REF01=G2, REF02+ Plan's Provider Network Number. Less than 13 Digits Alphanumeric. Field is required.

Note: Do not send the provider on the 2400 loop. This loop is not used in determining the provider ID on the claims

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.

Note: AmeriHealth Caritas Ohio EDI Payer ID: 35374

For all claims EXCEPT transportation: 35374

All claims sent to AmeriHealth Caritas Ohio, through the central PNM portal, should include the AmeriHealth Caritas Ohio Payer ID in 1000B Receiver Loop and 2010BB Payer Name Loop.

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

NDC via EDI

The NDC is used to report prescribed drugs and biologics as required by government regulation.

EDI claims with NDC info must 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.

When submitting NDC in the LIN segment, the CTP segment is required. 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.

II. PROVIDER PREVENTABLE CONDITIONS PAYMENT POLICY AND INSTRUCTIONS FOR SUBMISSION OF POA INDICATORS FOR PRIMARY AND SECONDARY DIAGNOSES

The Plan payment policy with respect to Provider Preventable Conditions (PPC) complies with the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA defines PPCs to include two distinct categories: Health Care Acquired Conditions; and Other Provider-Preventable Conditions. It is the Plan's policy to deny payment for PPCs.

Health Care Acquired Conditions (HCAC) apply to Medicaid inpatient hospital settings only. An HCAC is defined as "condition occurring in any inpatient hospital setting, identified currently or in the future, as a hospital-acquired condition by the Secretary of Health and Human Services under Section 1886(d)(4)(D) of the Social Security Act. HCACs presently include the full list of Medicare's hospital acquired conditions, except for DVT/PE following total knee or hip replacement in pediatric and obstetric patients.

Other Provider-Preventable Conditions (OPPC) is more broadly defined to include inpatient and outpatient settings. An OPPC is a condition occurring in any health care setting and includes, at a minimum, three existing Medicare National Coverage Determinations for OPPCs. Under this category, [Health Plan] will not reimburse providers for any of the following never events in any inpatient or outpatient setting: (i) surgery performed on the wrong body part; (ii) surgery performed on the wrong patient; (iii) wrong surgical procedure performed on a patient.

Submitting Claims Involving a PPC

In addition to broadening the definition of PPCs, the ACA requires payers to make ***pre-payment*** adjustments. That is, a PPC must be reported by the Provider at the time a claim is submitted.
There are some circumstances under which a PPC adjustment will not be taken or will be lessened. For example:

- No payment reduction will be imposed if the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by the Provider. Please refer to the Reporting a Present on Admission section for details.
- Reductions in Provider payment may be limited to the extent that the identified PPC would otherwise result in an increase in payment; and the Plan can reasonably isolate for nonpayment the portion of the payment directly related to treatment for and related to the PPC.

Practitioner/Dental Providers

- If a PPC occurs, Providers must report the condition through the claim's submission process. Note that this is required even if the Provider does not intend to submit a claim for reimbursement for the services. The requirement applies to Providers submitting 837-P forms, as well as 837D formats.

Inpatient/Outpatient Facilities

- Providers submitting claims for facility fees must report a PPC via the claim submission process. Note that this reporting is required even if the Provider does not intend to submit a claim for reimbursement of the services. This requirement applies to Providers who bill inpatient or outpatient services and 837I formats.

For Inpatient Facilities

When a PPC is not present on admission (POA) but is reported as a diagnosis associated with the hospitalization, the payment to the hospital will be reduced to reflect that the condition was hospital-acquired**.** When submitting a claim which includes treatment as a result of a PPC, facility providers are to include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury on the claim. Examples of ICD-10 and external cause of injury include:

- Wrong surgery on correct patient Y65.51.
- Surgery on the wrong patient, Y65.52.
- Surgery on wrong site Y65.53
- If, during an acute care hospitalization, a PPC causes the death of a patient, the claim should reflect the Patient Status Code 20 "Expired".

For DRG-based hospital contracts, claims with a PPC will be adjudicated systematically, and payment will be adjusted based on exclusion of the PPC DRG. Facilities need not submit copies of medical records for PPCs associated with this payment type.

For Outpatient Providers

Outpatient facility providers submitting a claim that includes treatment required because of a PPC must include the appropriate ICD-10 diagnosis codes, including applicable external cause of injury on the claim in field 67 A – Q. Examples of ICD-10 and external cause of injury codes include:

- Wrong surgery on correct patient Y65.51.
- Surgery on the wrong patient, Y65.52; and
- Surgery on wrong site Y65.53.

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
- Blank = Exempt from POA reporting for electronic claims

B. Reporting POA in Electronic 837I Format

Provider is to submit their POA data via the NTE segment on all 837I claims.

- Although this segment can repeat, Plan requires provider submit POA data on a single NTE Segment. No additional NTE segments with the letters POA will be validated.
- NTE01 must contain POA as the first three characters or the POA data will not be picked up. NTE*POA~
- NTE 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 NTE segment with POA is entered following the ending Z (or X). This is required by Change Healthcare (formerly Emdeon) for Medicare Claims as well.
- No POA Indicator is to be sent for the BJ/ZZ – Admitting Diagnosis Data. Following the letters POA in the NTE 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 E Code indicator.

  Example:
  1st claim:
  1 Principal and 2 Other Diagnosis
  NTE*ADD*POAYNUZ~
  2nd Claim:
  1 Principal and 3 Other Diagnosis and an ECode
  NTE*ADD*POAYYNIZY~

CAUSES OF CLAIM PROCESSING DELAYS, REJECTIONS OR DENIALS

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

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 (AANNNNNNA) **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.
Please note-Providers are expected to submit their usual and customary charge (the amount charged to the general public) on all claims.

Diagnosis Code Missing Required Digits – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-10-CM or ICD-10 manual for the appropriate categories, subcategories, and extensions. After October 1, 2015, three-digit category codes are required at a minimum. Refer to the coding manuals to determine when additional alpha or numeric digits are required. Use "X" as a place holder where fewer than seven digits are required. Submit the correct ICD qualifier to match the ICD code being submitted.

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

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. Payment from the previous payer may be submitted on the 837I or 837P. Besides the information supplied in this document, the line-item details may be sent in the SVD segment. Include the adjudication date at the other payer in the DTP, qualifier 573. COB pertains to the other payer found in 2330B. For COB, the plan is considered the payer of last resort.

EPSDT Information Missing or Incomplete – The Plan requires EPSDT screening claims to be submitted 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.

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

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 ODM Medicaid Identification Number Missing or Invalid – The Plan's assigned identification number must be included 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 pended 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.

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

Provider NPI Number Missing or Invalid – The individual NPI and group NPI numbers for the service provider must be included.

Revenue Codes Missing or Invalid – Facility claims must include a valid four-digit numeric revenue code

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.

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

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

- Professional services Rendering Taxonomy and Billing Taxonomy.
- Facility services Attending Taxonomy and Billing Taxonomy.

Third Party Liability (TPL) Information Missing or Incomplete – Any information indicating a work-related illness/injury, no fault, or other liability condition and the primary insurer's explanation of benefits (EOB) or applicable documentation must be reported.
Reminder: When billing Electronic Data Interchange (EDI) 837 coordination of benefit services to the Plan as a secondary payer for a member that has traditional Medicare or a Medicare Advantage plan, indicate the appropriate primary insurer. Claims submitted indicating the primary payer is a commercial carrier rather than Medicare may be delayed or processed incorrectly.

Correct EDI submission
The claims filing indicator (located in Loop 2320, segment SBR09) identifies whether the primary payer is Medicare or another commercial payer. When the member has a Medicare Advantage plan, the claim should be billed to the secondary payer with a Medicare Part A or B indicator, not as commercial insurance. Please ensure you are using the appropriate indicator on EDI claims as follows:

- MA -the primary payer is Medicare Part A (use for both traditional Medicare and Medicare Advantage)
- MB -the primary payer is Medicare Part B (use for both traditional Medicare and Medicare Advantage)
- Cl -the primary payer is commercial insurance (non-Medicare)

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 BILLING REMINDERS:

- Include all primary and secondary diagnosis codes for Professional claims. Facilities billing primary and secondary diagnosis codes must have a corresponding POA indicator.
- Missing or invalid data elements or incomplete claim forms will cause claim processing delays, inaccurate payments, rejections, or denials.
- Regardless of whether reimbursement is expected, the billed amount of the service must be documented on the claim. Missing charges will result in rejections or denials.
- All billed codes must be complete and valid for the time period in which the service is rendered. Incomplete, discontinued, or invalid codes will result in claim rejections or denials.
- State level HCPCS coding takes precedence over national level codes unless otherwise specified in individual provider contracts.
- Append the appropriate modifiers to the HCPCS/CPT code when performing a service or separate, distinct, or independent procedure on the same day that a procedure or other service is performed; refer to modifiers 25 or 59 guide on the claims section of the provider website for details.
- 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.
- Reimbursement for all rendering network providers subject to the ordering/referring/prescribing (ORP) requirement for an approved authorization is determined by satisfying the mandatory requirement to have a valid Medicaid ID. Any claim submitted by rendering network providers that are subject to the ORP requirement will be denied when billed with the NPI of an ORP provider that is not enrolled in Medicaid. Providers based upon the requirements developed by ODM in compliance with federal regulation 42 CFR 438.602 and 42. CFR 455.410. Claims billed with the attending field information will also be used to satisfy the ORP requirements.
- 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.
- The claim for baby *must* include the *baby's date of birth* as opposed to the mother's date of birth. Must also include *baby's birth weight.*
- On claims for twins or other multiple births, indicate the birth order in the patient's name field, e.g., Baby Girl Smith *A*, Baby Girl Smith *B*, etc.
- Date of service and billed charges should exactly match the services and charges detailed on the accompanying EOB. If the EOB charges appear different due to global coding requirements of the primary insurer, submit claim with the appropriate coding which matches the total charges on the EOB.

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

ELECTRONIC CLAIMS SUBMISSION (EDI) REQUIRED

CLAIMS WITH ATTACHMENTS

Ohio Department of Medicaid has notified participating MCO's that due to a system upgrade still in process, a work around is required to process attachments required for services related to abortion, sterilization, hysterectomy, medical supplies, or other identified services not listed.

How will this impact your claim submission?

EDI Providers

- AmeriHealth's Payer ID is ***35374****. Change Healthcare will also accept claims with Payer ID* ***84243****.*
- Submit the 837-claim information utilizing your designated clearinghouse.
    - Do not attach the consent/itemized bill information at this time.
    - Copy the claim number information from EDI submission
- Go to our Change Healthcare Portal (https://paymentsconnector.changehealthcare.com/) to log in/ register to submit the required attachments for claims processing. There are multiple ways in which attachments can be sent to the plan:
    - There are three ways the 275 attachments can be submitted. The acceptable supported formats are PDF, TIF, TIFF, JPEG, JPG, PNG, DOCX, RTF, XML, DOC, and TXT.
    - Batch — You may either connect to Change Healthcare directly or submit via your EDI clearing house.
    - API via JSON — You may submit an attachment for a single claim.
    - Portal — Individual providers can register at Change Healthcare Opens a new window to submit attachments.
- Please reference the instruction guide link for details on options for submitting attachments.
    - Change Healthcare Medical Attachments

Direct Data Entry Providers

Log in to Change Healthcare using the tool called *ConnectCenter* to improve claims management functionality. Providers who have a limited ability to submit claims through their hospital or project management system may now benefit from key features of the *ConnectCenter* tool. There is no cost to providers to use *ConnectCenter.*

- Go to our Change Healthcare Portal (https://paymentsconnector.changehealthcare.com/) to log in/register to submit claim information and associated attachments.
- To register for *ConnectCenter*, visit ConnectCenter Sign-Up. If you need assistance, Change Healthcare customer support is available through online chat or by phone at **1-800-527-8133, option 2**.
    - **Video Tutorial:** Create a Claim

ELECTRONIC CLAIMS

The Plan participates with Change Healthcare (CHC). AmeriHealth Caritas Ohio accepts claim submissions electronically (EDI) through Ohio's PNM portal centralized claims submission process. For more information on electronic claim submission and how to become an electronic biller, please contact your Account Executive or refer to the billing information available on our Plan website at www.amerihealthcaritasoh.com.

To initiate electronic claims:

- Contact your practice management software vendor or EDI software vendor.
- Inform your vendor of the Plan's EDI Payer ID#: **35374 (***Change Healthcare will also accept claims with Payer ID* ***84243****)*
- For all claims EXCEPT non -emergent transportation and dental claims: **35374**
  All claims sent to AmeriHealth Caritas Ohio, through the central PNM portal, should include the AmeriHealth Caritas Ohio Payer ID in **1000B Receiver Loop** and **2010BB Payer Name Loop**.
- You may also contact Change Healthcare at **1-877-363-3666** or visit Change Healthcare's website for information on enrolling for direct submission to Change Healthcare.

In order to verify satisfactory receipt and acceptance of submitted records, please review both the Change Healthcare (formerly Change Healthcare) Acceptance report.

Any additional questions may be directed to the Plan's EDI Technical Support Hotline by calling 1-866-334-6446 and selecting the appropriate prompts or by emailing to edi.oh@amerihealthcaritasoh.com.

FOR NON-EMERGENT TRANSPORTATION CLAIM SUBMISSION:

For transportation providers currently contracted with MTM
You may contact MTM at TF 888-597-1180
Or contact your MTM vendor account manager directly
For transportation providers that are not contracted with MTM
Please contact MTM for more information on how to join the NEMT network
At https://www.mtm-inc.net/service-providers/ [mtm-inc.net]

DENTAL CLAIM SUBMISSION:

For Dental services, AmeriHealth is contracted with DentaQuest. DentaQuest receives dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest' s website (https://govservices.dentaquest.com/).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.

DentaQuest works directly with Emdeon 1-888-363-3361, Tesia 1-800-724-7240, EDI Health Group 1-800-576-6412, and Secure EDI 1-877-466-9656 for claim submissions to DentaQuest.

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest' s Payor ID is CX014.

DIRECT SUBMISSION

Providers may submit claims, prior authorizations, and associated attachments through the centralized Ohio Provider Network Management (PNM) system. Providers may submit claims, prior authorization requests, eligibility inquiries, claims status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM-authorized TP. For more information on TPs, please visit the Ohio Department of Medicaid's TP web page https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners. All AmeriHealth Caritas Ohio provider claims may be submitted to the Plan via the central PNM portal for electronic claims submission. Claims for billable services provided to AmeriHealth Caritas Ohio members must be submitted by the provider who performed the services

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 Change Healthcare, whether through direct submission or through another clearinghouse/vendor, you can submit claims electronically.

CONTRACTING WITH CHANGE HEALTHCARE AND OTHER ELECTRONIC VENDORS

If you are a provider interested in submitting claims electronically to the Plan but do not currently have Change Healthcare EDI capabilities, you can contact the Change Healthcare Provider Support Line at **1-877-363-3666**. You may also choose to contract with another EDI clearinghouse or vendor who already has Change Healthcare capabilities.

CONTACTING THE EDI TECHNICAL SUPPORT GROUP

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

- Read over the instructions within this booklet carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your EDI software vendor and/or Change Healthcare 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.

Contact EDI Technical Support at:
AmeriHealth Caritas Ohio EDI Technical Support Hotline: **1-866-334-6446**.
Email: edi.oh@amerihealthcaritasoh.com

Please note, providers using Change Healthcare 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 Caritas Ohio is 35374.

For all claims EXCEPT non-emergent transportation and dental: **35374**

All claims sent to AmeriHealth Caritas Ohio, through the central PNM portal, should include the AmeriHealth Caritas Ohio Payer ID in **1000B Receiver Loop** and **2010BB Payer Name Loop**.

Plan payer specific edits are described in Exhibit 99 at Change Healthcare

SPECIFIC DATA RECORD REQUIREMENTS

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

ELECTRONIC CLAIM FLOW DESCRIPTION

In order to send claims electronically to the Plan, all EDI claims must first be forwarded to Change Healthcare. This can be completed via a direct submission or through another EDI clearinghouse or vendor.
Once Change Healthcare receives the transmitted claims, the claim is validated for HIPAA compliance and the Plan's Payer Edits as described in Exhibit 99 at Change Healthcare. Claims not meeting the requirements are immediately rejected and sent back to the sender via a Change Healthcare error report. The name of this report can vary based upon the provider's contract with their intermediate EDI vendor or Change Healthcare.
Accepted claims are passed to the Plan, and Change Healthcare returns an acceptance report to the sender immediately.

Claims forwarded to the Plan by Change Healthcare are immediately validated against provider and member eligibility records. Claims that do not meet this requirement are rejected and sent back to Change Healthcare, 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 Change Healthcare or other contracted EDI software vendors, must be reviewed, and validated against transmittal records daily.
Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare 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 Change Healthcare Provider Support Line at **1-877-363-3666.** If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the EDI Technical Support Hotline at 1-866-334-6446 or by email at: edi.oh@amerihealthcaritasoh.com.

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

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

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

Your claims must be received by the EDI vendor by 9 p.m. in order to be transmitted to the Plan the next business day.
Claims submitted can only be verified using the Accept and/or Reject Reports. Contact your EDI software vendor or Change Healthcare to verify you receive the reports necessary to obtain this information.
When you receive the Rejection report from Change Healthcare or your EDI vendor, the plan does not receive a record of the rejected claim.

INVALID ELECTRONIC CLAIM RECORD REJECTIONS/DENIALS

All claim records sent to the Plan must first pass Change Healthcare 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 365 calendar days from the date of service. It is important that you review the Acceptance or R059 Plan Claim Status reports received from Change Healthcare or your EDI software vendor in order to identify and re-submit these claims accurately.

PLAN SPECIFIC ELECTRONIC EDIT REQUIREMENTS

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

- 837P –005010X222A1– Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
- 837I – 005010X223A2 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.

Please note, provider NPI number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider NPI only if the provider number fields are empty.

The Plan's Provider ID is recommended as follows:

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

COMMON REJECTIONS

Invalid Electronic Claim Records – Common Rejections from Change Healthcare
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-10, etc.)
Claims without provider numbers
Claims without 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
Claims without Billing Taxonomy IDs, Attending Taxonomy IDs, Rendering Taxonomy IDs

BEST PRACTICES FOR SUBMITTING CORRECTED CLAIMS

The corrected claims process begins when you receive an explanation of payment (EOP) from the Plan detailing the claims processing results.

A corrected claim should only be submitted for a claim that has already paid and you need to correct information on the original submission.

How do I know when to file a new claim vs. a corrected claim?

File a New Claim when…

- The claim was never previously billed.
- Received a rejection notice at your electronic claim clearinghouse (277CA) indicating invalid or missing a required data element.
- The original claim denied for primary carrier EOB and now you have the primary carrier EOB.
- The claim denied for eligibility and now the eligibility has been updated and the member has active coverage.

File a Corrected Claim when…

- You received a full or partial payment on a claim, but you identified that information must be corrected (some examples: billed wrong # of units, missing claim line, updates to charge amounts, adding a modifier).
- You submitted a claim for the wrong member. Submit a frequency code 8 and request a void of the original submission.

Providers using electronic data interchange (EDI) are required to submit "Professional" corrected claims* electronically

*Corrected claims are resubmissions of an existing 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. The successful submission of a corrected claim will cause the retraction and complete replacement of the original claim.

Your EDI clearinghouse or vendor needs to:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Include the original claim number in loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)

Providers using electronic data interchange (EDI) are required to submit "Institutional" corrected claims electronically

Your EDI clearinghouse or vendor needs to:

- ✓ Use "7" for replacement of a prior claim utilizing bill type in loop 2300, CLM05-03 (837P). Use "8" to void a prior claim
- ✓ Include the original claim number in Loop 2300, segment REF01=F8 and REF02=the original claim number; no dashes or spaces.
- ✓ **Do** include the plan's claim number in order to submit your claim with the 7 or 8.
- ✓ Corrected claims for which the original claim number cannot be validated will be rejected.
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)

- ✓ **Do Not** use this indicator if the corrected claim is for a different member ID or Provider Tax ID. The original claim must be voided, and a new claim submitted for these situations.
- ✓ **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 1-866-334-6446
    - or: edi.oh@amerihealthcaritasoh.com
    - Providers using our NaviNet portal, (www.navinet.net) can view their corrected claims. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 180 calendar days from the date of rejection or 365 days from date of service provided. Rejected claims are not registered as received in the claim processing system.

Before resubmitting claims, check the status of both your original and corrected claims online at www.navinet.net. You may open a claims investigation via NaviNet with the claims adjustment inquiry function.

Corrected Professional claims must be resubmitted electronically using the appropriate bill type to indicate that it is a corrected claim.

Provider NPI number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider NPI only if the provider number fields are empty.
The Plan's Provider ID is recommended as follows:
837P – Loop 2310B, REF*G2[PIN]
837I – Loop 2310A, REF*G2 [PIN]

ELECTRONIC BILLING INQUIRIES

Action	Contact
If you would like to transmit claims electronically…	Contact Change Healthcare Provider Support Line at: 1-800-845-6592
If you have general EDI questions …	Contact EDI Technical Support at: 1-866-334-6446 Or via email: edi.oh@amerihealthcaritasoh.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports…	Contact your EDI Software Vendor or call the Change Healthcare 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 1-833-644-6001
If you have questions about claims that are reported on the Remittance Advice….	Contact Provider Claim Services at 1-833-644-6001

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…	Effective October 1, 2022, all provider enrollment applications must be submitted using Ohio Medicaid's new Provider Network Management (PNM) module. After its implementation, the PNM module will be the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service. For more information about the PNM please visit www.managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.
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 or open a claims investigation for submitted claims on NaviNet at www.navinet.net via the claims adjustment inquiry function.
Sign up for NaviNet	www.navinet.net NaviNet Customer Service: 1-888-482-8057

NATIONAL CORRECT CODING INITIATIVE

The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims.

Any specific claim is subject to current claim logic and other established coding benchmarks. Any consideration of a provider's claim payment concern regarding clinical edit logic will be based upon review of generally accepted coding standards and the clinical information particular to the specific claim in question.

HIPAA specifies that the health care industry use the following four code sets when submitting health care claims electronically. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. Local or proprietary codes are no longer allowed.

- International Classification of Diseases, 10th Edition, Clinical Modification (ICD- 10- CM). Available from the U.S. Government Printing Office at (202) 512-1800, (202) 512-2250 (fax) and from many other vendors.
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at www.ama-assn.org/amaone/cptcurrent-procedural terminology.
- HCFA Common Procedure Coding System (HCPCS). Available at http://www.cms.hhs.gov
- Procedures and Nomenclature. 2nd Edition. (CDT-2). Available from the American Dental Association at
- 1-800-947-4746 or www.ada.org.
- NDC: available at http://www.fda.gov/.

Tips for Accurate Diagnosis Coding: How to Minimize Retrospective Chart Review. We must obtain health status documentation from the diagnoses contained in claims data.

WHY ARE RETROSPECTIVE CHART REVIEWS NECESSARY?

- A retrospective review is a request for an initial review for authorization of care, service, or benefit which an authorization is required but was not obtained prior to the delivery of the care, service, or benefit.
- PA is required to ensure that services provided to our members are medically necessary and provided appropriately. The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- The new service was not known to be needed at the time the original PA service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

WHAT IS THE SIGNIFICANCE OF THE ICD-10-CM DIAGNOSIS CODE?

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

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

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

WHAT ARE YOUR RESPONSIBILITIES?

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

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

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

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

DOCUMENTATION GUIDELINES

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

PHYSICIAN DOCUMENTATION TIPS

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

PHYSICIAN COMMUNICATION TIPS

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

SOAP stands for:
Subjective: How the patients describe their problems or illnesses.
Objective: Data obtained from examinations, lab results, vital signs, etc.
***Assessment*:** Listing of the patient's current condition and status of all chronic conditions. Reflects how the objective data relate to the patient's acute problem.
Plan: Next steps in diagnosing problem further, prescriptions, consultation referrals, patient education, and recommended time to return for follow-up.

AMBULANCE

Emergent Ambulance claims are to billed to AmeriHealth Caritas directly per below instructions. For instructions on Non-Emergency Medical Transportation (NEMT) see "Transportation" Section.

When billing for Procedure Codes A0425 – A0429 and A0433 – A0434 for Ambulance Transportation services, the provider must also enter a valid 2-digit modifier at the end of the associated 5-digit Procedure Code. Different modifiers may be used for the same Procedure Code.

- Providers must bill the transport codes with the appropriate destination modifier.
- Mileage must also be billed with the ambulance transport code and be billed with the appropriate transport codes.

- Providers who submit transport codes without a destination modifier will be denied for invalid/missing modifier.
- Providers who bill mileage alone will be denied for invalid/inappropriate billing.
- Mileage when billed will only be paid when billed in conjunction with a PAID transport code.
- A second trip is reimbursed if the recipient is transferred from first hospital to another hospital on same day in order to receive appropriate treatment. Second trip must be billed with a (HH) destination modifier.

For 837 claims, all ambulance details are required. Ambulance Transport information; Ambulance Certification; pick-up and drop-off locations.

Procedure Code Modifiers: The following procedure code modifiers are required with all transport procedure codes. The first-place alpha code represents the origin, and the second-place alpha code represents the client's destination. Codes may be used in any combination unless otherwise noted.
D - Diagnostic or therapeutic site (other than physician's office or hospital)
E - Residential, domiciliary, or custodial facility (other than skilled nursing facility)
G - Hospital-based dialysis facility (hospital or hospital-related)
H - Hospital
I - Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J - Non-hospital-based dialysis facility
N - Skilled nursing facility
P - Physician's office (includes HMO non-hospital facility, clinic, etc.)
R - Residence
S - Scene of accident or acute event
X - (DESTINATION CODE ONLY) Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

ANESTHESIA

Procedure codes in the Anesthesia section of the Current Procedural Terminology manual are to be used to bill for surgical anesthesia procedures.

- Anesthesia claims must be submitted using anesthesia (ASA) procedure codes only (base plus time units).
- All services must be billed in minutes.
- 15-minute time increments will be used to determine payment.

CHEMOTHERAPY

- Providers are to use the appropriate chemotherapy administration procedure code in addition to the “J-code” for the chemotherapeutic agent.

If a significant separately identifiable Evaluation and Management service is performed, the appropriate E/M procedure code may also be reported.

CHIROPRACTIC CARE

- Age 0-21: 30 visits per calendar year and no prior authorization required.
- Age 21 and over: 30 visits per calendar year. First 15 visits do not require prior authorization. Subsequent visits as part of Living Beyond Pain will require prior authorization.
- Allowable up to 4 Evaluation & Management (E&M) of low to moderate levels per calendar year.
- Must bill appropriate CPT code and modifiers.

COVID-19 VACCINATION, TESTING, AND TREATMENT

- Please refer to the guidance from ODM provided at the links below for the most up to date information of Covid-19 vaccine administration & counseling, testing, and treatment.
    - https://medicaid.ohio.gov/resources-for-providers/billing/billing

- Please refer to ODM Behavioral Health for the most recent provider billing information for Behavioral Health providers.
    - https://bh.medicaid.ohio.gov/manuals

DOULA SERVICES

Effective October 1st, 2024, Independent doulas (Provider Type 09) may receive payment for submitting professional claims for covered services they provide.

Covered Services include:

- **T1032**- Services performed by a doula birth worker, per 15 minutes, described as services related to, antepartum and postpartum support services/visits including consultation and telehealth visits.
    - Up to 48 fifteen-minute units at any time from the first prenatal visit to 12 months postpartum.
        - Units over 48 will require an authorization.
    - Can be delivered via telehealth.
    - Reimbursable for any place of service
- **T1033**- Services performed by a doula birth worker, per diem, described as one comprehensive support service, regardless of duration, provided during labor and delivery.
    - Separate reimbursement for birth, regardless of length of service time.
    - Reimbursable for any place of service.

Please refer to https://codes.ohio.gov/ohio-administrative-code/rule-5160-8-43 for additional information.

DURABLE MEDICAL EQUIPMENT

- An “RR” modifier is required for all rentals.
- Repair codes on the DME Fee Schedule require the submission of procedure code K0739.
- Refer to the Provider Manual for DME authorization rules and guidelines.

- Any service in which exceeds ODM outlined benefit limits (https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/schedules-and-rates) is subject to review and/or authorization rules.

- Benefit Exceptions – items/services not listed on ODM's DME fee schedule will be reviewed on an individual basis based on coverage, benefit guidelines, and medical necessity.
- Miscellaneous codes will not be eligible for use if deemed an appropriate code is applicable on the DME fee schedule.
- If billing a code from the DMEPOS with BR -- Payment by report, providers are required to be submit an itemized invoice with all claim's submissions. All BR codes are subject to Plans prior authorization requirements, please reference the Provider Manual for Prior Authorization information.

EPSDT/ HEATHCHEK

Our Pediatric Preventive Healthcare Program is designed to improve the health of members from birth to under age 21 who are enrolled in Medicaid by increasing adherence to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines through identification of growth and development needs and coordination of appropriate healthcare services. All Plan, Ohio-licensed practitioners (including registered nurses, physicians, or physician's assistants; or a person with a master's degree in health services, public health, or healthcare administration or another related field, and/or who is a Certified Professional in Healthcare Quality or CHCQM) are responsible to provide EPSDT/Healthchek services to AmeriHealth Caritas Ohio members from birth to under age 21 according to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule or upon request to evaluate the general physical and mental health, growth, development, and nutritional status of a member. The most current periodicity schedules are available online https://brightfutures.aap.org/Pages/default.aspx.

EPSDT services include all mandatory and optional medically necessary services (including treatment) and items listed in 42 USC 1396d(a) to correct or ameliorate defects, and physical and mental illness and conditions discovered by a Healthchek screening. Such services and items, if approved through prior authorization, include those services and items listed at 42 USC 1396d(a), including services provided to members with a primary diagnosis of autism spectrum disorder, in excess of state Medicaid plan limits applicable to adults.

For the initial examination and assessment of a child, practitioners are required to perform the relevant EPSDT/Healthchek screenings and services, as well as any additional assessment, using the Ohio Department of Medicaid (ODM) developed, standardized, developmental screening tools to determine whether or not a child has special healthcare needs.

Periodic assessments must consist of the following components:

- Routine physical examinations as recommended by the AAP and "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents"
- Comprehensive health and developmental history that assesses for both physical and mental health, as well as for substance use disorders.
- Screening for developmental delay at each visit through the fifth year using a validated screening tool.
- Screening for Autism Spectrum Disorders per AAP guidelines.
- Comprehensive, unclothed physical examination.
- All appropriate immunizations in accordance with the schedule established by the Advisory Committee on Immunization Practices.
- Vision and hearing screening.

- Dental screening and education.
- Nutrition assessment and education.
- Laboratory tests including blood lead screening.
- Health education and anticipatory guidance for both the child and caregiver.
- Referral for further diagnostic and treatment services, if needed.

EPSDT/Healthchek providers (PCPs) are expected to provide written and verbal explanation of EPSDT services to AmeriHealth Caritas Ohio members including pregnant women, parent(s) and/or guardian(s), child custodians and sui juris (of one's own right) teenagers. This explanation of EPSDT/Healthchek services should occur on the member's first visit and quarterly thereafter and must include distribution of appropriate EPSDT/Healthchek educational tools and materials.

Please reference (https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-14).

EPSDT BILLING GUIDELINES ELECTRONIC 837 FORMAT

Providers billing for complete EPSDT screens, including immunizations, must:

- 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

NEWBORN CARE

99460 Newborn Care (during the admission) 99463 Newborn (same day discharge)

NEW PATIENT	ESTABLISHED PATIENT
99381 Age < 1 yr.	99391 Age < 1 yr.
99382 Age 1-4 yrs.	99392 Age 1-4 yrs.
99383 Age 5-11 yrs.	99393 Age 5-11 yrs.
99384 Age 12-17 yrs.	99394 Age 12-17 yrs.
99385 Age 18-20 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:

- Z76.2 (Primary Diagnosis)
- 99381EP (E&M Code with "Complete" modifier)

FAMILY PLANNING

Members are covered for Family Planning Services without a referral or Prior Authorization from the Plan regardless of Provider Network status.

Members may self-refer for routine Family Planning Services and may go to any physician or clinic**.**

Members that have questions or need help locating a Family Planning Services provider can be referred to Member Services at 1-833-764-7700 or 1-833-889-6446 (TTY).

HYSTERECTOMY AND STERILIZATION SERVICES

Sterilization is the procedure to remove or block the portion of the genital tract for the sole purpose of rendering a person sterile or incapable of reproduction (tubal ligation or vasectomy). Providers must submit the appropriate required consent forms with claim submissions and prior authorization approval information, if applicable. The member seeking sterilization must voluntarily give informed consent not less than 30 full calendar days (or not less than 72 hours in the case of emergency abdominal surgery) but not more than 180 days before the date of the sterilization. In the case of premature delivery, informed consent must have been given at least 30 days prior to the expected date of delivery. A new consent form is required if 180 days have passed before the sterilization procedure is provided.

- Consent for Sterilization Form (HHS-687) is required to be included with claims for services and must be completed in full in accordance with instructions.
    - All areas of the form must be completed.
        - The interpreter's section must only be completed if interpreter service were used for the patient.
    - The patient must be a least 21 years old, mentally competent, and not in an institution at the time he/she signed the consent form.
    - The date the person obtains consent must be the same as the date the patient signed the consent and is not to exceed 180 days.
    - **IMPORTANT:** The physician's name must be typed, and the physician's signature must be in the physician's own handwriting. The date the physician signed the consent must be within 30 days after the date the patient signed the consent form and is not to exceed 180 days.
- There are multiple ways in which attachments can be sent to the plan:
    - There are three ways the 275 attachments can be submitted. The acceptable supported formats are PDF, TIF, TIFF, JPEG, JPG, PNG, DOCX, RTF, XML, DOC, and TXT.
    - Batch — You may either connect to Change Healthcare directly or submit via your EDI clearing house.
    - API via JSON — You may submit an attachment for a single claim.
    - Portal — Individual providers can register at Change Healthcare Opens a new window to submit attachments.
    - Please reference the instruction guide link for details on options for submitting attachments.
    - Change Healthcare Medical Attachments
- The ODM Consent for Sterilization Form requirement **applies to the following Procedure codes**

CPT (Professional Claims)

✓ 00851	✓ 58565	✓ 58611	✓ 58670	✓ 58720*
✓ 00921	✓ 58600	✓ 58615	✓ 58671	✓ 58940*
✓ 55250	✓ 58605	✓ 58611*	✓ 58700*	

*This procedure does not necessarily make someone incapable of reproducing. If an individual has not been rendered sterile, the provider should submit appropriate documentation through the secure provider portal. The provider should not submit an HHS-687 or HHS-687-1 consent form.

ICD-10 (Institutional Inpatient Claims)

✓ 0U750ZZ	✓ 0UL74CZ	✓ 0VBQ0ZZ	✓ 0VLH0DZ	✓ 0VLQ3CZ
✓ 0U573ZZ	✓ 0UL74DZ	✓ 0VBQ3ZZ	✓ 0VLH0ZZ	✓ 0VLQ3DZ
✓ 0U574ZZ	✓ 0UL74ZZ	✓ 0VBQ4ZZ	✓ 0VLH3CZ	✓ 0VLQ3ZZ
✓ 0U577ZZ	✓ 0UL77DZ	✓ 0VBQ8ZX	✓ 0VLH3DZ	✓ 0VLQ4CZ
✓ 0U578ZZ	✓ 0UL77ZZ	✓ 0VBQ8ZZ	✓ 0VLH3ZZ	✓ 0VLQ4DZ
✓ 0UL70CZ	✓ 0UL78DZ	✓ 0VHR0YZ	✓ 0VLH4CZ	✓ 0VLQ4ZZ
✓ 0UL70DZ	✓ 0UL78ZZ	✓ 0VHR3YZ	✓ 0VLH4DZ	✓ 0VLQ8CZ
✓ 0UL70ZZ	✓ 0V5Q0ZZ	✓ 0VHR4YZ	✓ 0VLH4ZZ	✓ 0VLQ8DZ
✓ 0UL73CZ	✓ 0C5Q3ZZ	✓ 0VHR7YZ	✓ 0VLQ0CZ	✓ 0VLQ8ZZ
✓ 0UL73DZ	✓ 0V5Q4ZZ	✓ 0VHR8YZ	✓ 0VLQ0DZ	✓ 0VTQ0ZZ
✓ 0UL73ZZ	✓ 0V5Q8ZZ	✓ 0VLH0CZ	✓ OVLQ0ZZ	✓ 0VTL4ZZ

Hysterectomy is defined as the surgical removal of the uterus and sometimes the cervix and supporting tissues. Hysterectomies are most often done for the following reasons: Uterine fibroids, Endometriosis, Uterine prolapse, Cancer, Hyperplasia.

- Payment will only be made for hysterectomies performed for medical reasons, such as diseased uterus, and only if the patient has been advised orally and provided consent in writing prior to surgery that sterility will result. Prior consent is required unless the following circumstances occurred:
    - The patient was already sterile before the hysterectomy.
    - Hysterectomy was required due to a life-threatening emergency in which the physician determined that prior acknowledgement was not possible.

- The ODM Acknowledgement of Hysterectomy Information Form (HHS-687) must be submitted with all claims provided for services. The form contains two section, A and B, however only one section is required to be completed. The appropriate section must be completed in full, and signatures must be handwritten.
- The consent form **applies to the following Procedure codes:**

CPT (Professional Claims)

✓ 51925	✓ 58262	✓ 58291	✓ 58548	✓ 58573
✓ 58150	✓ 58263	✓ 58292	✓ 58550	✓ 58575
✓ 58152	✓ 58267	✓ 58293	✓ 58552	✓ 58951
✓ 58180	✓ 85270	✓ 58294	✓ 58553	✓ 58953
✓ 58200	✓ 58275	✓ 58541	✓ 58554	✓ 58954
✓ 58210	✓ 58280	✓ 58542	✓ 58570	✓ 58956
✓ 58240	✓ 28285	✓ 58543	✓ 58571	✓ 59135
✓ 58260	✓ 58290	✓ 58544	✓ 58572	✓ 59525

ICD-10 (Institutional Inpatient Claims):

✓ 0UT90ZL	✓ 0UT94ZL	✓ 0UT97ZL	✓ 0UT98ZL	✓ 0UT9FZL
✓ 0UT90ZZ	✓ 0UT94ZZ	✓ 0UT97ZZ	✓ 0UT98ZZ	✓ 0UT9FZZ

- Diagnosis Codes
  - A Primary diagnosis is required for claim submissions; however, providers are not limited to a specific set of diagnosis codes. Some common reasons why a hysterectomy may be performed include cancer of the uterus, cervix, or ovaries; endometriosis; uterine fibroids that cause pain, bleeding, or other problems; and chronic pelvic pain.

Associated Ancillary Services

- Payment cannot be made for associated services such as anesthesia, lab testing, or hospital services if services of sterilization, or hysterectomy do not meet qualifications for payment.

Note: When procedures are performed as part of a hospital stay, the appropriate form should be attached to both the hospital claim and the professional claim.

Please refer to Ohio Administrative Code 5160-21-02.2 (https://codes.ohio.gov/ohio-administrative-code/rule-5160-21-02.2) for full details.

Please refer to the Provider manual for Prior Authorization, appeals, and dispute information.

HOME HEALTH CARE (HHC)

Please refer to *OAC Rule 5160-12-05 Reimbursement: Home Health Care* (https://codes.ohio.gov/ohio-administrative-code/rule-5160-12-05) for details of eligible services and reimbursement information.

Please refer to *OAC Rule 5160-12-04 Home Health and Private Duty Nursing: Visit Policy* (https://codes.ohio.gov/ohio-administrative-code/rule-5160-12-04) for reimbursement and eligible services associated. All services provided are verified using Electronic Visit Verification at the time of claims processing.

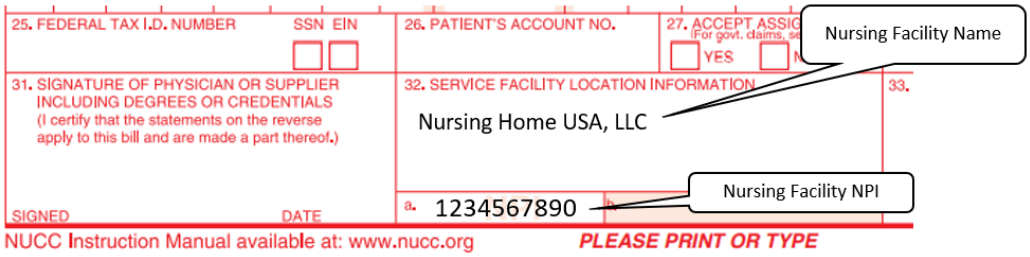
- Provider must bill on an 837 electronic format.
- When billing on a UB04, bill the appropriate revenue code(s) for the homecare service.
- Providers must bill the appropriate modifier in the first position when more than one modifier is billed.
- Refer to NDC instructions in the manual.

HOSPICE

Only accepting HCFA form (CMS-1500)

Hospice Nursing Facility Room and Board (HCPC T2046)

Hospice providers billing for nursing facility room and board must bill using the HCFA (CMS 1500). The name **of the nursing facility** in which the services were delivered must be placed in **Box 32** and the National Provider Identifier (NPI) related to the nursing facility must be placed in **32a**.



HOSPITAL BILLING (NPI AND CLAIMS SUBMISSIONS)

Hospital Payment Policy
Inpatient acute care hospital services are reimbursed on a prospective basis using the All-Patient Refined Diagnosis Related Group (APR-DRG) system. Outpatient acute care and ambulatory surgical center (ASC) services are reimbursed on a prospective basis using the Enhanced Ambulatory Patient Groups (EAPG) system. A small portion of hospital services provided in freestanding rehabilitation or long-term hospitals, in hospitals which are licensed as HMOs, and in cancer hospitals are not subject to APR-DRG or EAPG reimbursement.

The billing guidelines for hospitals and ASCs are available on the Billing webpage.

Inpatient
Under the APR-DRG system, hospitals are reimbursed based on the principal diagnosis or condition requiring the hospital admission. The APR-DRG system is designed to classify patients into groups that are clinically coherent with

respect to the number of resources required to treat a patient with a specific diagnosis. Applicable additional payments are added for capital, medical education, and outliers.

Ohio chose to use this system in an effort to contain costs, to permit providers to operate in a less regulated environment, and to allow sharing of savings for those providers who identify ways to provide quality services more efficiently and economically. Just as hospitals do not get more than their fixed payment if the APR-DRG amount is less than charges, their APR-DRG payment rate is not lowered to match the billed charge amount.

Outpatient

Under the EAPG system, outpatient hospital and ASC facility claims are reimbursed based on the principal diagnosis and procedure codes submitted for a date of service. The EAPG system is designed to classify services into groups that utilize similar resources and have similar costs. The EAPG system also applies discounting factors which could cause a detail line to consolidate, package, or discount.

With the implementation of the EAPG system, Ohio moves away from prospectively determined fee schedule rates. The EAPG reimbursement methodology enables the department to cover new procedure codes more efficiently as the EAPG system maps the new procedure codes to a specific EAPG, which already have established relative weights.

- Providers must use the general acute care hospital NPI (Primary NPI) on all claims submitted directly to Medicaid, including claims where the recipient has Medicare coverage. Medicaid will deny claims submitted directly with other NPIs other than the general acute care hospital NPI.
    - On claims that automatically "cross-over" from Medicare, Medicaid will accept "secondary" NPIs associated with a psychiatric unit, rehabilitation unit, or renal dialysis services.
    - Providers must report "secondary" NPIs to Medicaid in order to have them accepted on "automatic" cross-over claims from Medicare. They are then mapped to the general acute care hospital (Primary NPI) for direct processing and payment purpose.

INTERIM BILLING

To ensure a streamlined process for payment for interim billing, AmeriHealth aligns with ODM guidelines for payment under the prospective payment system. Hospitals subject to the prospective payment system, should utilize the billing types defined by the National Uniform Billing Committee as they provide a foundational framework for correct interim billing.

Billing Types: Hospitals under the DRG system must use bill type 112 or 113 (NUBC-defined) for interim bill payments.

Admission Date Alignment: Ensure 113 bill types match the admission date of the preceding 112 bill type. This alignment will ensure accuracy and consistency in the process.

Admission Flexibility: 113 bill types don't require admission dates within the statement period.

Covered Days: Hospitals should submit bills covering at least 30 days to meet criteria.

Patient Status Code: Use code 30 for existing patients

Discharge Process: Hospitals should void interim bills before submitting the final admit through discharge bill type (111). Providers can use Electronic Data Interchange (EDI) or through NaviNet provider portal.

Final Billing Completeness: Final claims (Type 111) must encompass the entire care cycle, reiterating all charges from interim bills.

IMMUNIZATIONS, INJECTIONS, AND INFUSIONS (INCLUDING TRIGGER-POINT INJECTIONS), SKIN SUBSTITUTES, AND PROVIDER ADMINISTERED PHARMACEUTICALS

AmeriHealth Caritas Ohio aligns to reporting requirements outlined by American Medical Association (AMA), International Classification of Diseases, 10th revision, Procedure Code System (ICD-10-PCS) and Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS), and OAC 5160-4-12.

- **Reporting requirements for Therapeutic, prophylactic, or diagnostic injections or infusions (excluding chemotherapy and other complex procedures)**
    - An injection or infusion has two components: the administration of a fluid medium **and**, except in the case of hydration, the pharmaceutical itself.
    - No separate payment is made for the administration service if an injection or infusion is given during an office visit or in conjunction with another medical service that includes an evaluation and management element.
- **Reporting requirements for Immunizations-**
    - An immunization has two components: the administration of the vaccine or toxoid **and** the vaccine or toxoid itself.

A "not otherwise specified," "unlisted," or "miscellaneous" procedure code should be reported on a claim only if no procedure code is available that identifies the service or item provided.

VACCINES FOR CHILDREN (VFC) PROGRAM

AmeriHealth Caritas Ohio PCPs are required to enroll with the Ohio Department of Health (ODH) Immunization Program to receive vaccines for members under age 19 years through the Vaccines for Children (VFC) Program. Vaccinations covered by the VFC program will not be reimbursed by AmeriHealth Caritas Ohio; however, the Plan reimburses providers for appropriate vaccine administration to members aged 18 years and younger. Providers are expected to plan for a sufficient supply of vaccines and are required to report the use of VFC vaccines immunizations by:

- Use of the “SL” modifier to indicate the provider is participating in the program.
- The SL modifier must be listed on the administration and all associated immunization & toxoid lines of the claim. By applying the SL modifier, this will indicate no reimbursement of the associated toxoid/ immunizations.
- Toxoid/Immunization CPT codes must be submitted with a charge amount greater than zero.
- Providers will receive reimbursement for the administration of the vaccine only.

Effective 4/30/2024- The following guidelines have been updated to no longer require an SL modifier to indicate provider participation in the VFC program. Please see the outlined guidelines below:

- Toxoid/Immunization CPT codes must be submitted with a charge amount greater than zero.
- Providers will receive reimbursement for the administration of the vaccine only.

MATERNITY

- Prenatal care providers are expected to complete the AmeriHealth Caritas of Ohio Pregnancy Needs Assessment Form (PRAF) to assess risk for each expectant mother.
- The form is available on our website at **www.amerihealthcaritasoh.com.**
- The completed form must be submitted to Bright Start through the JIVA system via NaviNet within seven calendar days of the date of the prenatal visit as indicated on the form. Upon submission of the online form, you will receive an authorization number for your obstetrics visits for your patient.
- Providers will receive an incentive payment for each completed form that is submitted within seven (7) calendar days of the member's initial obstetrics visit.

Prenatal visits with a pregnancy diagnosis must be billed separately from the actual delivery. Postpartum visits must be billed with a pregnancy diagnosis and performed within 21 to 56 days after the delivery. Postpartum visit(s) with a pregnancy diagnosis must be performed within 21 to 56 days after delivery.

SPLIT BILLING OF CLAIMS

According to CMS guidelines (Rev. 170, 05-07-04): "There are a number of prescribed situations where a claim is received for certain services that require the splitting of the single claim into one or more additional claims. The splitting of such a claim is necessary for various reasons such as proper recording of deductibles, separating expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Split a claim for processing in the following situations:

- Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year;

EXCEPTION FOR DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCs):

Expendable items (disposable items such as blood glucose test strips and PEN nutrients) that will be used in a time frame that spans two calendar years and are required to be billed with appropriately spanned "from" and "to" dates of service may be processed on a single claim line. For these types of items, DMERCs must base pricing and deductible calculations on the "from" date since that is the date when the item was furnished."

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r170cp.pdf

TELEHEALTH

Telehealth is defined as, the direct delivery of health care services to a patient related to the diagnosis, treatment, and management of a condition. Telehealth is the interaction with a patient via synchronous, interactive, real-time electronic communication that includes both audio and video elements, **OR** the following activities that are asynchronous or do not have both audio and video elements:

- Telephone calls
- Remote patient monitoring
- Communication with a patient through secure electronic mail or a secure patient portal

- Practitioners are also responsible to deliver telehealth services in accordance with rules set forth by their respective licensing board and accepted standards of clinical practice.
- For practitioners who render services to an individual through telehealth for a period longer than twelve consecutive months, the telehealth practice or practitioner is expected to conduct at least one in-person annual visit or refer the individual to a practitioner or their usual source of clinical care that is not an emergency department for an in-person annual visit.
- Eligible Practitioners and eligible services available through the use telehealth are posted and maintained by Ohio Administrative Code 5160-1-18. The following link can also be utilized for the most update to date information, https://codes.ohio.gov/ohio-administrative-code/rule-5160-1-18.
- For services rendered by behavioral health providers as defined in rule 5160-27-01 of the Administrative Code, telehealth is further defined in rule 5122-29-31 of the Administrative Code.
- Behavioral health agency providers certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS), please refer to the billing guidance found at (https://bh.medicaid.ohio.gov/).

  - Excluded places of services in which services are not eligible for reimbursement for Telehealth services:
    - POS 2 and POS 10 will not be accepted unless specified in provider specific billing guidelines.
    - Penal Facility or Public institution such as jail or prison (POS 09), per federal exclusions.
  - Claims submitted for health care services provided through the use have telehealth must include the following:
    - "GT" Modifier
    - A place of service code that reflects the physical location of the treating practitioner at the time a health care service is provided through the use of telehealth.
    - The physical location of the patient when applicable.

TERMINATION OF PREGNANCY / ABORTION

Abortion is defined as the removal of an embryo or fetus from the uterus in order to end a pregnancy. Payment for the abortion procedure is made in accordance with applicable provisions of rule 5160-17-01 of the Ohio Administrative Code; 42 C.F.R. 441 Subpart E; and the Hyde Amendment, which is explained at 84 Fed. Reg. 230 (January 24, 2019).

- First and second trimester terminations of pregnancy require prior authorization.
- Abortions are only covered for limited instances, as indicated on the form, *ODM 03197*:
  1. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed
  2. The pregnancy was the result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction.
  3. The pregnancy was the result of an act of incest and the patient, the patient's legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under

Chapter 5153. of the Revised Code, unless the patient was physically unable to comply with the reporting requirement and the fact is certified by the physician performing the abortion.

- The Abortion Certification Form, ODM 03197, is required to be included with claims for services and must be completed in full.
- Note: Only one reason for the abortion can be selected.
    - Field 2: The full surname (i.e., family name or "last" name) must be listed. An Initial may be used for the given name ("first" name) or a middle name, but the entire name must match the name on the claim form.
    - Fields 6 & 7: identifies the physician who performed the abortion procedure.
    - Field 8: Must be the legal signature of the physician identified in Fields 6 & 7. The physician's signature must be in the physician's handwriting. A stamp is not acceptable.
- The ODM Abortion Certification Form requirement applies to the following Procedure codes:

CPT (Professional Claims)

- 59840
- 59841
- 59850
- 59851
- 59852
- 59855
- 59856
- 59857
- 59866

ICD-10 (Institutional Inpatient Claims):

- 10A00ZZ
- 10A03ZZ
- 10A04ZZ
- 10A07Z6
- 10A07ZX
- 10A07ZW
- 10A07ZZ
- 10A08ZZ

One of the following Diagnosis Codes are required

- 00480
- O0489

Associated Ancillary Services

- Payment will not be made for associated services such as anesthesia, lab testing, or hospital services if services of abortion do not meet qualifications for payment.

NON-EMERGENCY TRANSPORTATION

AmeriHealth Caritas Ohio contracts with MTM for Non-Emergency Medical Transportation (NEMT), all non-emergent transportation claims must be submitted to this vendor with the **exception** of FQHC related transportation, T2003. MTM can be reached by Telephone: 1-833-664-6368.

- For transportation providers currently contracted with MTM
    - You may contact MTM at TF 888-597-1180
    - Or contact your MTM vendor account manager directly.
- For transportation providers that are not contracted with MTM
    - Please contact MTM for more information on how to join the NEMT network
        - At https://www.mtm-inc.net/service-providers/ [mtm-inc.net]

TRANSPORTATION COVERAGE

AmeriHealth Caritas Ohio contracts with MTM for NEMT. Members who must travel 30 or more miles from home to receive covered health services, can access NEMT services for travel to and from the provider's office by contacting MTM at 1-833-664-6368. MTM will arrange NEMT for members via the most cost-effective and least expensive mode of transportation available. In addition, AmeriHealth Caritas Ohio also provides supplemental transportation as outlined below:

- 30 one-way or 15 two-way trips per member per year.
- Additional trips for chemotherapy, radiation, or dialysis appointments, as needed.
- Transportation provided for members to access out-of-network providers for service if we are unable to provide in-network is not counted toward the transportation benefit.

Include medical and non-medical trips to places that are less than 30 miles from the member's home when members cannot access transportation through the county departments of Job and Family Services, including pharmacy stops and non-medical trips. Provider Manual In addition to the transportation assistance offered by AmeriHealth Caritas Ohio, health plan members have access to transportation for certain services through the local county Department of Job and Family Services Non-Emergency Transportation (NET) program. Members should call their county Department of Job and Family Services for questions or assistance with NET services.

TRANSPORTATION FOR FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND RURAL HEALTH CLINIC (RHC)

Transportation services to enable member to make up to four trips to or form an FQHC site (or related location) where a covered service is rendered on the same date.

Procedure code T2003 is payable when billed on a CMS-1500 form by the provider group. Services are not reimbursable when billed by an individual practitioner.

TRANSPORTATION FOR OHIORISE MEMBERS

AmeriHealth Caritas Ohio must arrange and provide transportation for members who are enrolled with the OhioRISE plan in a manner that ensures that children, youth, and their families served by the OhioRISE plan do not face transportation barriers to receive services regardless of Medicaid payer. AmeriHealth Caritas Ohio is responsible for arranging transportation in cases where transportation of families, caregivers, and siblings (other minor residents of the home) when needed to facilitate the treatment needs of the member and their family.

VACCINES FOR CHILDREN (VFC) PROGRAM

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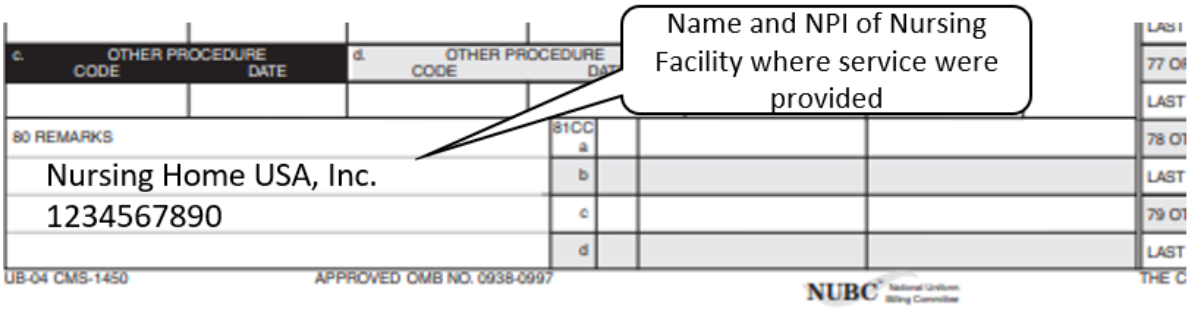
- Toxoid/Immunization CPT codes must be submitted with a charge amount greater than zero.
- Providers will receive reimbursement for the administration of the vaccine only.

VENTILATOR WEANING

Ventilator Dependent and Ventilator Weaning (i.e. 0410, 0419) claims must be billed using the UB04 Institutional form.

Type of Bill – 81X/081X: If the claim is billed with the incorrect Type of Bill, the claim will deny as incorrect billing.

When billing Ventilator Dependent and Weaning claims, the hospice provider is required to include the Name and NPI of the nursing facility in which the services were delivered in Box 80 (Remark code). In addition, when billing for Ventilator and/or Ventilator Weaning services, the diagnosis code **Z99.11** must be included.



Any claims for Nursing Facility Room & Board or Ventilator/Ventilator Weaning that do not meet the instructions in this guidance may be denied and require the submission of an adjusted claim. Nursing facility hospice (T2046) and vent/vent weaning services are not billable on the same date of service.

VISION

AmeriHealth Caritas Ohio contracted with two optical laboratories to provide your patients (our members) with glasses: Robertson Optical and Classic Optical. You are required to order member glasses through one of these labs. If you are a participating provider, prior authorization (PA) is not required; however, you must confirm eligibility.

Classic Optical Laboratories

- The available frame choices are conveniently the same frames included in the Ohio Medicaid frame collection which many provider offices have.
  - If you don't have a frame kit, you may request one by emailing customerservice@classicoptical.comwith your account information and they will send one to your office.
- Orders may be placed through the Classic Optical website [clt1461611.benchmarkurl.com]directly
- Classic Optical will check the member's eligibility in real-time prior to the order being placed.
- If you have questions for Classic Optical, call 1-888-522-2020

Robertson Optical Laboratories

- All vision providers will be required to display the Medicaid frame kits provided by Robertson Optical
- Orders must be placed through the dedicated Robertson Optical portal [clt1461611.benchmarkurl.com]
- The cost per frame kit is $200.
- If you have questions for Robertson Optical Laboratories, they can be reached at: 1-800-922-5525.

VISION BENEFIT AND COVERAGE GUIDELINES

Member coverage is outlined below:

- Members aged twenty-one & under, or sixty-five & older are eligible to receive one comprehensive eye exam and one pair of glasses (frames and lenses) per year.
- Members aged twenty-one through sixty-four are eligible to receive one comprehensive eye exam and one pair of glasses (frames and lenses) every two years.
- For members aged twenty-one through sixty-four with a diagnosis of diabetes are eligible to receive one comprehensive eye exam every year and one new pair of glasses (frame and lenses) every two years, however adjustments to lenses (as needed) every year.

Replacement Lenses Coverage is outlined below:

❖ To indicate a replacement, an **RA modifier is required for claims submissions**.

- Members aged twenty-one & under, or sixty-five & older are eligible to receive one pair of replacement glasses (frames and lenses) per year.
- Members aged twenty-one through sixty-four are eligible to receive one pair of replacement glasses (frames and lenses) every two years.
- For members aged twenty-one through sixty-four with a diagnosis of diabetes are eligible to receive one pair of replacement glasses (frame and lenses) every two years.

BEHAVIORAL HEALTH SERVICES

To participate in the Ohio Medicaid program, including contracting with the managed care plans, OhioMHAS-certified providers must enroll in the Ohio Medicaid program. There are two provider types associated with behavioral health benefits; provider type 84 is used for accessing the mental health benefit while provider type 95 is used for accessing the substance use disorder benefit. Organizations that will be providing both benefits will need to enroll as BOTH provider types.

Please refer to ODM Behavioral Health for the most recent provider billing information, https://bh.medicaid.ohio.gov/manuals.

- Practitioner modifiers are only required when practitioners have multiple credentials/licenses. Please refer to the dual licensure Grid, located under 'Additional Resources' at https://bh.medicaid.ohio.gov/manuals.
    - Reporting additional licensure on claims.
    - For their original license according to information found elsewhere in this manual: rendering NPI, applicable procedure modifiers, etc.

- For services billed under the provider's primary license/specialty modifiers are not to be used.
- For services under their additional licenses/specialty the claims will require a modifier to reflect specialty they are providing services under.

- Supervisor information is not required on claims for dependently or unlicensed providers.
  - Including the supervisor will not impact the reimbursement of claims payment.