Claim Filing Instructions

For AmeriHealth Caritas Louisiana Providers

Revised January 2015

AmeriHealth Caritas Louisiana

Claim Filing Instructions

Contents

Claim Filing

Procedures for Claim Submission

AmeriHealth Caritas Louisiana, hereinafter referred to as the 'Plan' or 'AmeriHealth Caritas Louisiana' is required by state and federal regulations to capture specific data regarding services rendered to its members. All billing requirements must be adhered to by the provider in order to ensure timely processing of claims.

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

Claims for billable services provided to AmeriHealth Caritas Louisiana members must be submitted by the provider who performed the services.

Claims filed with AmeriHealth Caritas Louisiana are subject to the following procedures:

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

IMPORTANT:

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

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

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

- Denied claims must be re-submitted as corrected claims within 180calendar days from the date of service if the error is a repairable edit.

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

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

Claim Mailing Instructions

Submit claims to AmeriHealth Caritas Louisiana at the following address:

AmeriHealth Caritas Louisiana
Claims Processing Department
P.O. Box 7322
London, KY 40742

The Plan encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or **Emdeon's Provider Support Line at 877-363-3666** to arrange transmission.

Any additional questions may be directed to the AmeriHealth Caritas Louisiana EDI Technical Support Hotline at **866-428-7419** or by e-mail at edi@amerihealthcaritasla.com.

Claim Filing Deadlines

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

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

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 180days of the date of the primary insurer's EOB.

Refunds for Claims Overpayments or Errors

It is the provider's responsibility to return any Medicaid Program funds that were improperly paid. If the provider's practice determines that it has received overpayments or improper payments, the provider is required to make arrangements immediately to return the funds.

Please follow the process listed below to return overpayments:

For all overpayments, please submit a check in the correct amount to:

AmeriHealth Caritas Louisiana
P.O. Box 7322
London, KY 40742

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

Important: Requests for adjustments may be submitted electronically, on paper or by telephone.

By Telephone:
Provider Claim Services

1-888-922-0007

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

On Paper:
If you prefer to write, please be sure to stamp each claim submitted "corrected" or "resubmission" and address the letter to:
Claims Processing Department
AmeriHealth Caritas Louisiana
P.O. 7322
London, KY 40742

Administrative or medical appeals must be submitted in writing to:

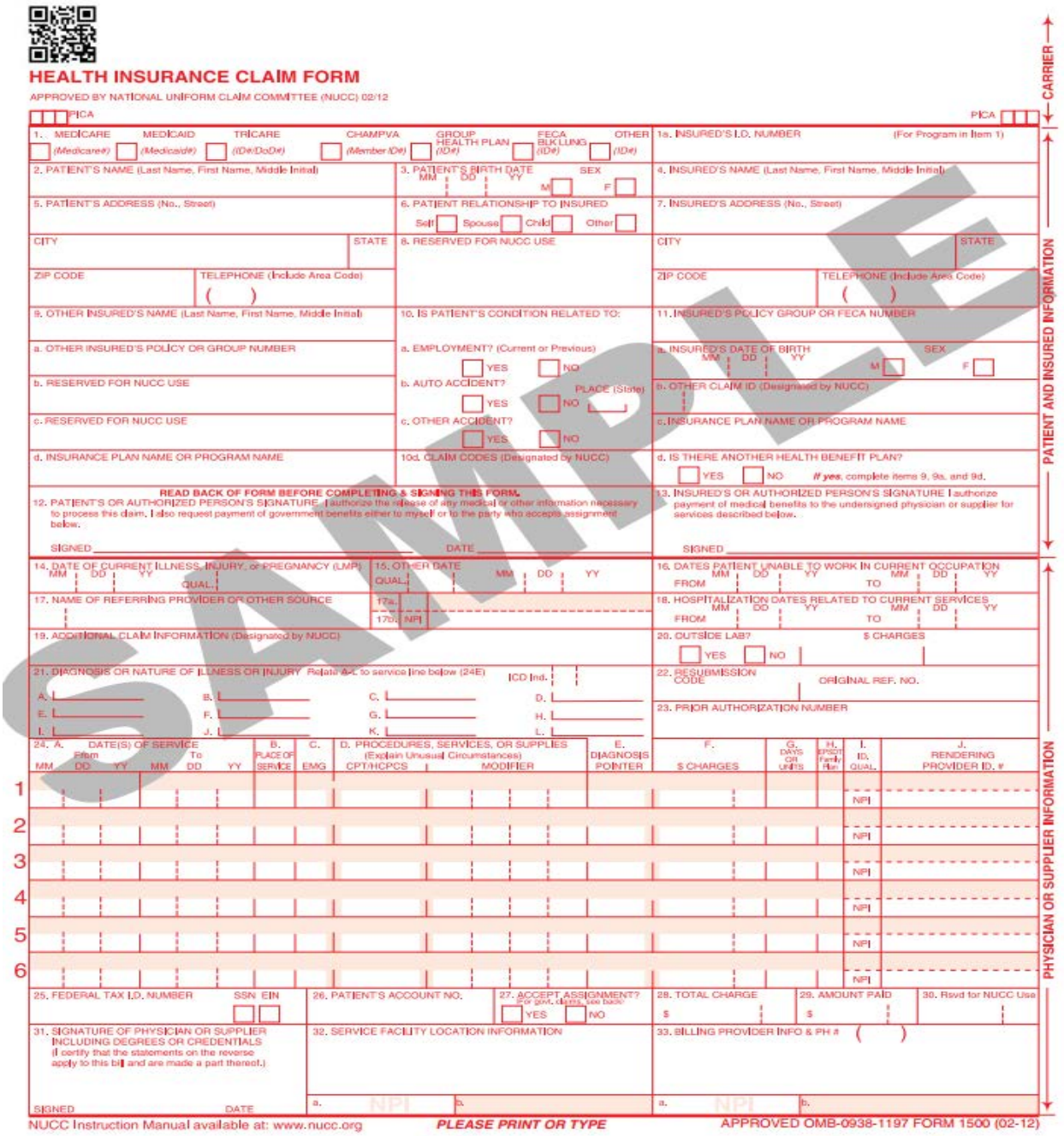
Provider Appeals Department
AmeriHealth Caritas Louisiana
P.O. Box 7324
London, KY 40742

Refer to the Provider Handbook or look online at the Provider Center of the AmeriHealth Caritas Louisiana website at www.amerihealthcaritasla.com for complete instructions on submitting appeals.

Important: Claims *originally rejected for missing or invalid data elements* must be corrected and re-submitted within 180calendar days from the date of service. Rejected claims are not registered as received in the claim processing system. (Refer to the definitions of rejected and denied claims on page 1.) **Note:** AmeriHealth Caritas Louisiana EDI Payer ID# 27357 (273575066)

CMS 1500 Claim Form Field Requirements

Claim Form Field Requirements



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

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

CMS 1500 Claim Form Field Requirements

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

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

Required Fields (CMS 1500 Claim Form)

CMS 1500 Claim Form			
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	**R**
1a	**Insured ID Number** **(AmeriHealth Caritas Louisiana member's identification number)**	AmeriHealth Caritas Louisiana member identification number. If submitting a claim for a newborn that does not have an identification number, enter the baby's Medicaid ID number. For electronic submissions, ID must be less than 13 alphanumeric characters.	**R**
2	**Patient's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's AmeriHealth Caritas Louisiana I.D. card Refer to page 51 for additional newborn billing information, including Multiple Births.	**R**
3	**Patient's Birth Date/Sex**	MMDDYY / M or F If submitting a claim for a newborn, enter "newborn" and DOB/Sex	**R**
4	**Insured's Name (Last, First, Middle Initial)**	Enter the patient's name as it appears on the member's AmeriHealth Caritas Louisiana I.D. card, or enter the newborn's name when the patient is a newborn.	**R**
5	**Patient's Address (Number, Street, City, State, Zip) Telephone (include area code)**	Enter the patient's complete address and telephone number. (Do not punctuate the address or phone number.)	**R**
6	**Patient Relationship To Insured**	Always indicate self.	**R**

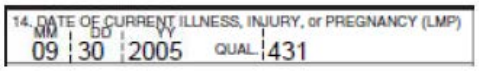
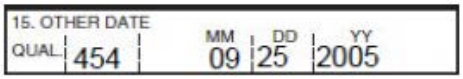
*** Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.**

7	**Insured's Address (Number, Street, City, State, Zip Code) Telephone (Include Area Code)**		**RC**
8	**Reserved for NUCC use**		**Not Required**
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**
9a	**Other Insured's Policy Or Group #**	**Required** if # 9 is completed. Input the 6-digit TPL carrier code if 9a is completed from Medicaid Eligibility Verification System (MEVS)	**C**
9b	**Reserved for NUCC use**		**Not Required**
9c	**Reserved for NUCC use**		**Not Required**
9d	**Insurance Plan Name Or Program Name**	**Required** if # 9 is completed.	**C**
10a,b,c	**Is Patient's Condition Related To:**	Indicate Yes or No for each category. Is condition related to: a) Employment b) Auto Accident c) Other Accident	**R**
10d	**Claim Codes (Designated by NUCC)**	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	**C**

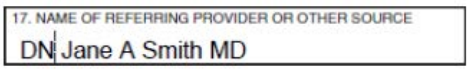
*** Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.**

		Exacerbated by the Pregnancy Itself • 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, c.	**C**
11a	**Insured's Birth Date / Sex**	Same as # 3. Required if 11 is completed.	**C**
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**
11c	**Insurance Plan Name Or Program Name**	Enter name of Health Plan. Required if 11 is completed.	**C**
11d	**Is There Another Health Benefit Plan?**	Y or N by check box. If yes, complete # 9 a-d.	**R**
12	**Patient's Or Authorized Person's Signature**		**R**
13	**Insured's Or Authorized Person's Signature**		**Not required** **C**
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 • 484 – Last Menstrual Period (LMP)	**C**

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

		Use the LMP for pregnancy. Example: 	
15	**Other Date**	MMDDYY or MMDDYYYY Enter applicable 3-digit qualifier between the left-hand set of vertical dotted lines. Qualifiers include: • 454 – Initial Treatment • 304 – Latest Visit or Consultation • 453 – Acute Manifestation of a Chronic Condition • 439 – Accident • 455 – Last X-Ray • 471 – Prescription • 090 – Report Start (Assumed Care Date) • 091 – Report End (Relinquished Care Date) • 444 – First Visit or Consultation Example: 	**C**
16	**Dates Patient Unable To Work In Current Occupation**		**C**
17	**Name Of Referring Physician Or Other Source**	**Required** if a provider other than the member's primary care physician rendered invoiced services. 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:	**C**

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

		• DN – Referring Provider • DK – Ordering Provider • DQ – Supervising Provider Example: 	
17a	**Other ID Number Of Referring Physician** **(AmeriHealth Caritas Louisiana Provider ID#)**	Enter the AmeriHealth Caritas Louisiana 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 AmeriHealth Caritas Louisiana ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. **Required** if # 17 is completed.	**C**
17b	**National Provider Identifier (NPI)** **(enter the referring provider's NPI)**	**Enter the NPI number of the referring provider, ordering provider or other source. Required if #17 is completed.**	**R**
18	**Hospitalization Dates Related To Current Services**	**Required** when place of service is in-patient. **MMDDYY** (indicate **from** and **to** date)	**C**
19	**Additional Claim Information (Designated by NUCC)** **Reserved for Louisiana Medicaid Provider ID**	.	
20	**Outside Lab**	**Optional**	**C**
21	**Diagnosis Or Nature Of Illness Or Injury. (Relate To 24E)**	Enter the applicable ICD indicator to identify which version of ICD codes is being reported: • 9 - ICD-9-CM • 0 - ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.	**R**

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

		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. Diagnosis codes must be valid ICD-9 codes for the date of service. "E" codes are **not** acceptable as a primary diagnosis.	
22	**Resubmission Code and/or Original Ref. No.**	For resubmissions or adjustments, 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 that appears on the remittance advice in this field. Additionally, stamp "resubmitted" or "corrected" on the claim • 7 – Replacement of Prior Claim • 8 – Void/cancel of Prior Claim	**C**
23	**Prior Authorization Number**	Enter the prior authorization number. Refer to the Provider Handbook to determine if services rendered require an authorization	**C**
24A	**Date(s) Of Service**	"From" date: MMDDYY and "to" date: MMDDYY. See page 43 for Important Note (instructions) for completing the shaded portion of field 24.	**R**
24B	**Place Of Service**	Enter the CMS standard place of service code. "00" for place of service is not acceptable.	**R**
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	**C**
24D	**Procedures, Services Or Supplies CPT/HCPCS/ Modifier**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of	**R**

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

		service. **Note:** Modifiers affecting reimbursement must be placed in the first modifier position ***See additional information on page 55 for EDI requirements**	
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 ICD9 codes for the date of service.	**R**
24F	**Charges**	**Enter charges. Value entered must be greater than zero ($0.00)**	**R**
24G	**Days Or Units**	Enter quantity. Value entered must be greater than zero. (Field allows up to 3 digits).	**R**
24H	**EPSDT Family Plan**	Leave blank or enter a "Y" if services were performed as a result of an EPDST referral.	**C**
24I	**ID Qualifier**	If the rendering provider does not have a NPI number, the qualifier indicating what the number represents is reported in the qualifier field in 24I. If the Other ID number is the AmeriHealth Caritas Louisiana ID number, enter G2. If the Other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier.	**R**
24J	**Rendering Provider ID** **In the top (shaded) portion, enter the AmeriHealth Caritas Louisiana Provider ID number** **In the bottom (unshaded) portion, enter the NPI**	The individual rendering the service is reported in 24J. Enter the AmeriHealth Caritas Louisiana ID number in the shaded area of the field. **Enter the NPI number in the unshaded area of the field**. Use qualifier G2	**Recommended** **R**
25	**Federal Tax ID Number SSN/EIN**	Physician or Supplier's Federal Tax ID number.	**R**

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

26	**Patient's Account No.**	Enter the patient's account number assigned by the provider	**R**
27	**Accept Assignment**	Yes or No must be checked.	**R**
28	**Total Charge**	Enter the total of all charges listed on the claim.	**R**
29	**Amount Paid**	**Required** when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	**C**
30	**Reserved for NUCC Use**		**Not Required**
31	**Signature Of Physician Or Supplier Including Degrees Or Credentials / Date**	Signature on file, signature stamp, computer generated or actual signature is acceptable.	**R**
32	**Name And Address Of Facility Where Services Were Rendered (If Other Than Home Or Office).**	**Required**. Enter the physical location. **(P.O. Box #'s are not acceptable)**	**R**
32a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	**R**
32b.	**Other ID#** **(AmeriHealth Caritas Louisiana issued Provider Identification Number)** **Refer to NUCC CMS 1500 claims filing guidelines for the two digit qualifiers used to describe the non-NPI provider ID number.**	Enter the AmeriHealth Caritas Louisiana Provider ID # (strongly recommended) Enter the G2 qualifier followed by the AmeriHealth Caritas Louisiana Provider ID # **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	**R**
33	**Billing Provider Info & Ph #**	**Required** – Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location;	**R**

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

		P.O. Boxes are not acceptable	
33a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	**R**
33b.	**Other ID#** **(AmeriHealth Caritas Louisiana issued Provider Identification Number)** **Refer to NUCC CMS 1500 claims filing guidelines for the two digit qualifiers used to describe the non-NPI provider ID number.**	Enter the AmeriHealth Caritas Louisiana Provider ID # (strongly recommended.) Enter the G2 qualifier followed by the AmeriHealth Caritas Louisiana Provider ID #. **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	**R**

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

EDI Mapping for CMS 1500

CMS 1500 Claim EDI Mapping			
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***
1	**Insurance Program Identification**	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed.	**R**
1a	**Insured ID Number** **AmeriHealth Caritas Louisiana member's identification number**	2330A/NM109	**R**
2	**Patient's Name (Last, First, Middle Initial)**	2010BA/NM103 2010BA/NM104 2010CA/NM105 2010CA, NM107,	**R**
3	**Patient's Birth Date/Sex**	2010CA/DMG02 2010CA/DMG03	**R**
4	**Insured's Name (Last, First, Middle Initial)**	2010BA/NM103 2010BA/NM104 2010BA/NM105 2010BA/NM107	**R**
5	**Patient's Address (Number, Street, City, State, Zip) Telephone (Include Area Code)**	2010CA/N301, N302 2010CA/N401 2010CA/N402 2010CA/N403	**R**
6	**Patient Relationship To Insured**	2000C, PAT01	**R**
7	**Insured's Address (Number, Street, City, State, Zip Code) Telephone (Include Area Code)**	2010BA N301 2010BA N302 2010BA N401 2010BA N402 2010BA N403	**C**
8	**Patient Status**	Blank	**C**
9	**Other Insured's Name (Last, First, Middle Initial)**	2330 NM103, NM104, NM105 2320 DMG02, 2320 SBR04, 2000B SBR04	**C**
9a	**Other Insured's Policy Or Group #**	**Required** if # 9 is completed.	**C**

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

CMS 1500 Claim EDI Mapping			
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***
9b	**Other Insured's Birth Date / Sex**	2000B SBR03 2330C REF01 Move IG	**C**
9c	**Employer's Name Or School Name**	2330C REF01 Move IG 2320 DMG02	**C**
9d	**Insurance Plan Name Or Program Name**	2320 SBR04, 2000b SBR04	**C**
10a,b,c	**Is Patient's Condition Related To:**	2300 CLM11	**R**
10d	**Reserved For Local Use**	2300 CLM11	**C**
11	**Insured's Policy Group Or FECA #**	2010/REF01 2010/DMG02 2010/DMG03 2310/NM103 2000B/SBR05	**C**
11a	**Insured's Birth Date / Sex**	2010/REF01 2010/DMG02	**C**
11b	**Employer's Name Or School Name**	2010/DMG03	**C**
11c	**Insurance Plan Name Or Program Name**	2310/NM103	**C**
11d	**Is There Another Health Benefit Plan?**	2000B/SBR05	**R**
12	**Patient's Or Authorized Person's Signature**	2320/OI04	**R**
13	**Insured's Or Authorized Person's Signature**	2320/OI04	**Not required**
14	**Date Of Current: Illness (First Symptom) Or Injury (Accident) Or Pregnancy (LMP)**	2300/DTP03	**C**
15	**If Patient Has Same Or Similar Illness, Give First Date**	2300 DTP02	**C**
16	**Dates Patient Unable To Work In**	Blank	**C**

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

	Current Occupation		
17	**Name Of Referring Physician Or Other Source**		**C**
17a	**Other ID Number Of Referring Physician (AmeriHealth Caritas Louisiana Provider ID#)**	2310A/NM103-04-05	**C**
17b	**National Provider Identifier (NPI)** **(enter the referring provider's NPI)**	2310A/NM109.	**C**
18	**Hospitalization Dates Related To Current Services**	2300/DTP02	**C**
19	**Reserved For Local Use – Reserved for Louisiana Medicaid Provider ID**	NOT USED	**R**
20	**Outside Lab**		**C**
21	**Diagnosis Or Nature Of Illness Or Injury. (Relate Items 1,2,3, Or 4 To Item 24E By Line)**	2300, HI01-HI04	**R**
22	**Medicaid Resubmission Code Original Ref. No.**	Not mapped	**C**
23	**Prior Authorization Number**	2400 REF01 G1	**C**
24A	**Date(s) Of Service**	2400/DTP03	**R**
24B	**Place Of Service**	2300 CLM05	**R**
24C	**EMG**	Blank	**C**
24D	**Procedures, Services Or Supplies CPT/HCPCS Modifier**	2400 HCP09	**R**
24E	**Diagnosis Pointer**	2400 SV101-1	**R**
24F	**Charges**	2300 CLM02	**R**

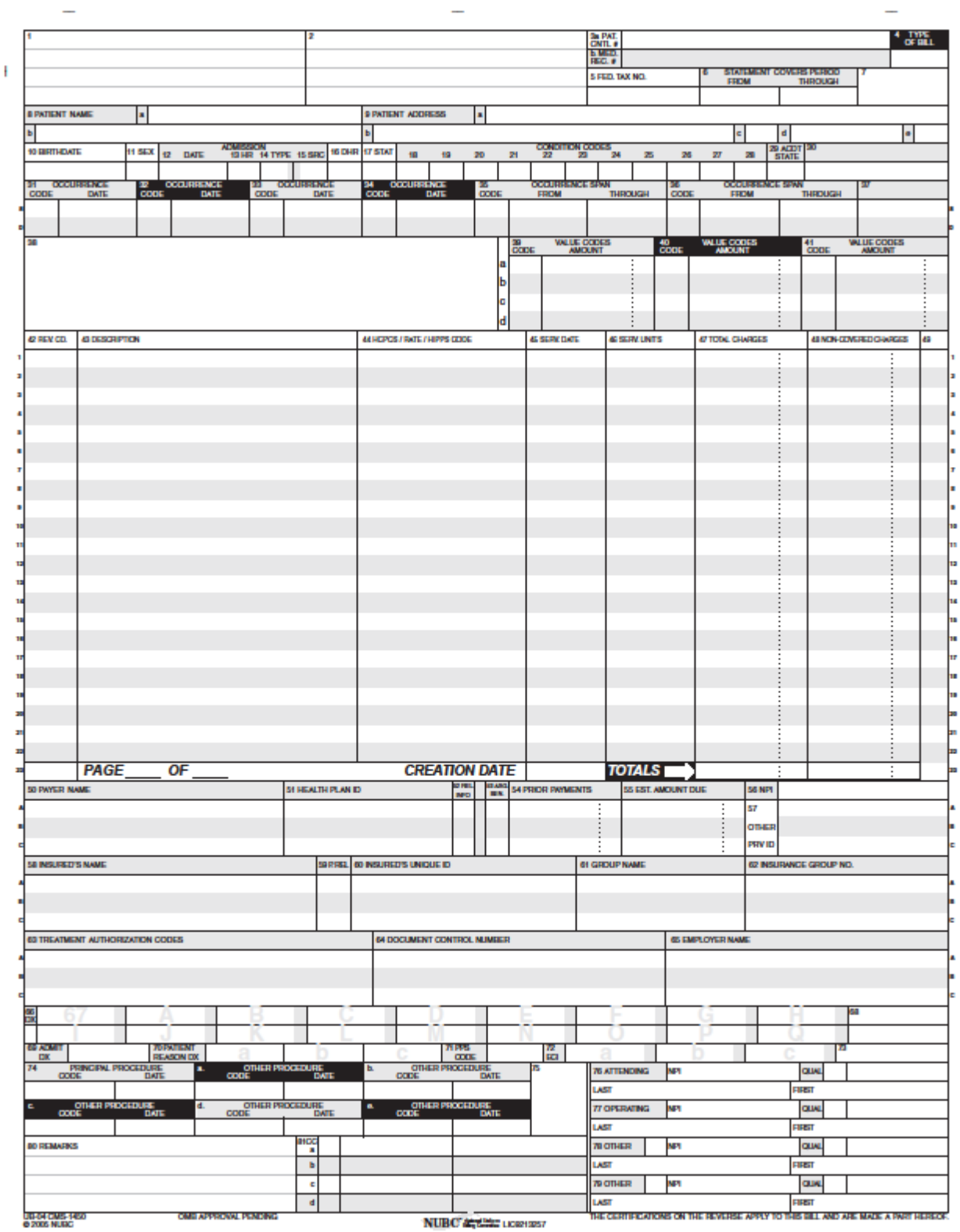
*** Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.**

24G	**Days Or Units**	2400 SV502	**R**
24H	**EPSDT Family Plan**	2400 SV111	**Not required**
24I	**ID Qualifier**	2400 SV101-1	**R**
24J	**Rendering Provider ID**	2310 NM109	**Recommended** **R**
25	**Federal Tax ID Number SSN/EIN**	2010AAREF01	**R**
26	**Patient's Account No.**	2300/CML01	**R**
27	**Accept Assignment**	hard-coded yes	**C**
28	**Total Charge**	Loop 2300/SV103	**R**
29	**Amount Paid**	2300/AMT02	**C**
30	**Balance Due**	Not mapped	**C**
31	**Signature Of Physician Or Supplier Including Degrees Or Credentials / Date**	Not mapped	**R**
32	**Name And Address Of Facility Where Services Were Rendered (If Other Than Home Or Office).**		**R**
32a.	**NPI number**	23010D/NM101	**R**
32b.	**Other ID#** **(AmeriHealth Caritas Louisiana issued Provider Identification Number)** **Strongly recommended**	23010D/NM109	**R**
33	**Billing Provider Info & Ph #**	2010AA/NM103 2010AA/N3012010AA/N401, N402, N4032010AA/NM109	**R**
33a.	**NPI number**	**Required** unless Rendering Provider is an Atypical Provider and is not required to have an NPI number.	**R**

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

33b.	**Other ID#** **(AmeriHealth Caritas Louisiana issued Provider Identification Number)** **Strongly recommended** **Refer to NUCC CMS 1500 claims filing guidelines for the two digit qualifiers used to describe the non-NPI provider ID number.**	Enter the Health Plan Legacy ID # (strongly encouraged.) Enter the G2 qualifier followed by the Health Plan ID #. **Required** when the Rendering Provider is an Atypical Provider and does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.	**R**

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



the situation of the service provided. Refer to the NUCC or NUBC Reference Manuals for additional information.

Required Fields (UB-04 Claim Forms)

UB-04 Claim Form Field Requirements				
Field #	**Field Description**	**Instructions and Comments**	**Required or Conditional***	**Required or Conditional***
			Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	**Outpatient, Bill Types 13X, 23X, 33X 83X**
1	**Unlabeled Field** Billing Provider Name, Address and Telephone Number	**Service Location, no P.O. Boxes** Left justified Line a: Enter the complete provider name. Line b: Enter the complete address. Line c: City, State, and zip code Line d: Enter the area code, telephone number.	**R**	**R**
2	**Unlabeled Field** Billing Provider's Designated Pay-to Name and Address	**Enter Remit Address** Billing Provider's designated pay-to address Enter the AmeriHealth Caritas Louisiana Facility Provider I.D. number. Left justified	**R**	**R**
3a	**Patient Control No.**	Provider's patient account/control number.	**R**	**R**
3b	**Medical/Health Record Number**	The number assigned to the patient's medical/health record by the provider	**C**	**C**

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4	**Type Of Bill**	Enter the appropriate three or four - digit code. First position is a leading zero – Do not include the leading zero on electronic claims. Second position indicates type of facility. Third position indicates type of care. Fourth position indicates billing sequence.	**R**	**R**
5	**Fed. Tax No.**	Enter the number assigned by the federal government for tax reporting purposes.	**R**	**R**
6	**Statement Covers Period From/Through**	Enter dates for the full ranges of services being invoiced. MMDDYY	**R**	**R**
7	**Unlabeled**	Not Used. Leave Blank.		
8a	**Patient Identifier**	Patient AmeriHealth Caritas Louisiana ID is conditional if number is different from field 60	**C**	**C**

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8b	**Patient Name**	Patient name is required. Last name, first name, and middle initial. Enter the patient name as it appears on the AmeriHealth Caritas Louisiana ID card. 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 a name enter "Baby Girl" or "Baby Boy" and last name. Refer to page 51 for additional newborn billing information, including Multiple Births.	**R**	**R**
9a-e	**Patient Address**	The mailing address of the patient 9a. Street Address 9b.City 9c. State 9d. ZIP Code 9e. Country Code (report if other than U.S.A.)	**R**	**R**
10	**Patient Birth Date**	The date of birth of the patient. Right-justified; MMDDYYYY	**R**	**R**
11	**Patient Sex**	The sex of the patient recorded at admission, outpatient service, or start of care.	**R**	**R**
12	**Admission 12 – 15**			

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12	**Admission Date**	The start date for this episode of care. For inpatient services, this is the date of admission. Right-justified	R	**R**
13	**Admission Hour**	The code referring to the hour during which the patient was admitted for inpatient or outpatient care. Left Justified	**R**	**R**
14	**Admission Type**	A code indicating the priority of this admission/visit.	**R**	**Not Required**
15	**Source of Referral for Admission or Visit**	A code indicating the source of the referral for this admission or visit.	**R**	**Not Required**
16	**Discharge Hour**	Code indicating the discharge hour of the patient from inpatient care.	**R**	**R**
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in Field 6.	**R**	**R**
18 - 28	**Condition Codes**	A code used to identify conditions or events relating to the bill that may affect processing. Please see NUCC Specifications Manual Instructions for condition codes and descriptions to complete fields 18 - 28	**C**	**C**
29	**Accident State**	The accident state field contains the two-digit state abbreviation where the accident occurred. **Required when applicable.**	**C**	**C**
30	**Unlabeled Field**	**Leave Blank.**		
31a,b – 34a,b	**Occurrence Codes and Dates**	Enter the appropriate occurrence code and date. **Required** when applicable.	**C**	**C**
35a,b – 36a,b	**Occurrence Span Codes And Dates**	A code and the related dates that identify an event that relates to the payment of the claim. **Required** when applicable.	**C**	**C**
37a,b	**Reserved**	**Leave Blank.**	**C**	**C**
38	**Responsible Party Name and Address**	**The name and address of the party responsible for the bill.**	**C**	**C**
39a,b,c,d – 41a,b,c,d	**Value Codes and Amounts**	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. Value Codes and amounts. If more	**C**	**C**

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		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 to complete fields 39 – 41. **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 and the Number of Days in the "Dollar" portion of the "Amount" section. Enter "00" in the "Cents" field.		
42	**Revenue Code**	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. Refer to the DHH web site for a list of billable revenue codes: http://www.lamedicaid.com/provweb1/billing_information/revenuecodes.htm	**R**	**R**
43	**Revenue Description**	The standard abbreviated description of the related revenue code categories included on this bill. See NUBC instructions for Field 42 for description of each revenue code category.	**R**	**R**
44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	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	**R**	**R**

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		systems. Enter the applicable rate, HCPCS or HIPPS code and modifier based on the Bill Type of Inpatient or Outpatient. HCPCS are required for all Outpatient Claims. (Note: NDC numbers are required for physician administered drugs.)		
45	**Serv. Date**	Report line item dates of service for each revenue code or HCPCS/HIPPS code.	**R**	**R**
46	**Serv. Units**	Report units of service. A quantitative measure of services rendered by revenue category or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, observation hours etc.	**R**	**R**
47	**Total Charges**	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges includes both covered and non-covered charges. Report grand total of submitted charges. Value entered must be greater than zero ($0.00).	**R**	**R**
48	**Non-Covered Charges**	To reflect the non-covered charges for the destination payer as it pertains to the related revenue code. **Required** when Medicare is Primary.	**C**	**C**
49	**Unlabeled Field**		**Not required**	**Not required**
50	**Payer**	Enter the name for each payer being invoiced. When the patient has other coverage, list the payers as indicated below. Line A refers to the primary payer; Line B refers to the , secondary; and Line C refers to the tertiary.	**R**	**R**

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51	**AmeriHealth Caritas Louisiana Identification Number**	The number used by the health plan to identify itself. AmeriHealth Caritas Louisiana's Payer ID is #27357	**R**	**R**
52	**Rel. Info**	Release of Information Certification Indicator. This field is required on Paper and Electronic Invoices. Line A refers to the primary payer; Line B refers to the secondary; and Line C refers to the tertiary. It is expected that the provider have all necessary release information on file. It is expected that all released invoices contain "Y".	**R**	**R**
53	**Asg. Ben.**	Valid entries are "Y" (yes) and "N" (no).	**R**	**R**
54	**Prior Payments**	The A, B, C indicators refer to the information in Field 50.	**R**	**R**
55	**Est. Amount Due**	Enter the estimated amount due (the difference between "Total Charges" and any deductions such as other coverage).	**C**	**C**
56	**National Provider Identifier – Billing Provider**	The unique NPI 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. (10) digit NPI	**R**	**R**
57 A,B,C	**Other (Billing) Provider Identifier** **AmeriHealth Caritas Louisiana issued Provider Identification Number**	A unique identification number assigned to the provider submitting the bill to AmeriHealth Caritas Louisiana. Complete if NPI is not mandated in Field 56. The UB-04 does not use a qualifier to specify the type of Other (Billing) Provider Identifier. Use this field to report other provider identifiers as assigned by the health plan listed in Field 50	**C**	**C**

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		A,B,C		
58	**Insured's Name**	Information refers to the payers listed in field 50. In most cases this will be the patient name. When other coverage is available, the insured is indicated here.	**R**	**R**
59	**Patient Rel**	Enter the patient's relationship to insured. For Medicaid programs the patient is the insured. Code 01: Patient is Insured	**R**	**R**
60	**Insured's Unique Identifier** **AmeriHealth Caritas Louisiana member's Identification number**	Enter the patient's AmeriHealth Caritas Louisiana ID exactly as it appears on the patient's ID card on line B or C. When other insurance is present, enter the plan ID on line A.	**R**	**R**
61	**Group Name**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	**C**	**C**
62	**Insurance Group No.**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	**C**	**C**
63	**Treatment Authorization Codes**	Enter the AmeriHealth Caritas Louisiana prior authorization number. Line A refers to the primary payer; B, secondary; and C, tertiary. Field 63A is required.	**R**	**R**

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64	**DCN**	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. **Note:** Resubmitted claims must contain the original claim ID.	**C**	**C**
65	**Employer Name**	The name of the employer that provides health care coverage for the insured individual identified in field 58. Required when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B, secondary; and C, tertiary.	**C**	**C**
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported.	**Not Required**	**Not Required**
67	**Prin. Diag. Cd. and Present on Admission (POA) Indicator**	The ICD codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).	**R**	**R**
67 A - Q	**Other Diagnosis Codes**	The ICD diagnoses codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.	**C**	**C**
68	**Unlabeled Field**			
69	**Admitting Diagnosis Code**	The ICD diagnosis code describing the patient's diagnosis at the time of admission. **Required** for inpatient and outpatient admissions.	**R**	**R**

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70	**Patient's Reason for Visit**	The ICD diagnosis codes 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,c.	**C**	**R**
71	**Prospective Payment System (PPS) Code**	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. Required when the Health Plan/ Provider contract requires this information. Up to 4 digits.	**C**	**C**
72a-c	**External Cause of Injury (ECI) Code**	The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. Required if applicable.	**C**	**C**
73	**Unlabeled Field**			
74	**Principal Procedure Code and Date**	The ICD code that identifies the principal procedure performed at the claim level during the period covered by this bill and the corresponding date. **Inpatient facility** – ICD 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** **R** **R**	**C** **R** **R**
74a-e	**Other Procedure Codes and Dates**	The ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed.	**C**	**C**

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		Inpatient facility – ICD 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**
75	**Unlabeled Field**			
76	**Attending Provider Name and Identifiers NPI#/Qualifier/Other ID#** **Enter the NPI number of the attending physician** **Enter the AmeriHealth Caritas Louisiana issued Provider ID number** **Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number**	Enter the NPI of the physician who has primary responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the attending physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the Attending Physician.	**R**	**R**
77	**Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#** **Enter the NPI number of the physician who**	**Enter the** NPI of the physician who performed surgery on the patient in the upper line, and their name in the lower line, last name first. If the operating physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#. Enter the last name and first name of the	**C**	**C**

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	performed surgery **Enter the AmeriHealth Caritas Louisiana issued Provider ID number** **Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number**	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 number of another attending physician** **Enter the AmeriHealth Caritas Louisiana issued Provider ID number** **Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number**	Enter the NPI# of any physician, other than the attending physician, who has responsibility for the patient's medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID#, enter the appropriate descriptive two-digit qualifier followed by the other ID#	**C**	**C**
80	**Remarks Field**	Area to capture additional information necessary to adjudicate the claim.	**C**	**C**
81CC,a-d	**Code-Code Field**	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	**C**	**C**

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EDI Mapping Table (UB04)

UB-04 Claim EDI Mapping Requirements				
			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 ***
1	**Unlabeled Field** Billing Provider Name, Address and Telephone Number *Provider Name*	2010AA/N402 2010AA/N403 2010AA/PER04(n) 2010AA/PER06(n) 2010AA/PER08	**R**	**R**
2	**Unlabeled Field** Billing Provider's Designated Pay-to Name and Address *Pay to Provider Name*	2010AB PER-02 N3-01 N4-01 N4-02	**R**	**R**
3a	**Patient Control No.**	CLM05-2	**R**	**R**
3b	**Medical/Health Record Number**	2300/REF02 Medical record	**C**	**C**
4	**Type Of Bill**	CLM05-1	**R**	**R**
5	**Fed. Tax No.**	2010AA, REF02	**R**	**R**
6	**Statement Covers Period From/Through**	2400/DTP03. 2400/DTP02 = RD8 move first date in range. 2300/DTP03. If 2300/DTP02 = RD8	**R**	**R**
7	**Unlabeled**	Not Mapped		

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8a	**Patient Identifier**	NM1-09, 2010BA/NM108	**C**	**C**
8b	**Patient Name**	2010CA, NM103 2010CA, NM104 2010CA, NM105	**R**	**R**
9a-e	**Patient Address**	2010CA/N301(1) Else if 2000B/SBR02 = 18, 2010BA/N301(1) N3-2, If 2010CA, 2010CA/N302(1) Else if 2000B/SBR02 = 18 2010BA/N302(1) N4-1, If 2010CA, 2010CA/N401 Else if 2000B/SBR02 = 18, 2010BA/N401 N4-2, If 2010CA, 2010CA/N402 2000B/SBR02 = 18, 2010BA/N402 N4-3, If 2010CA, 2010CA/N403 2000B/SBR02 = 18, 2010BA/N403	**R**	**R**
10	**Patient Birth Date**	DMG-02, If 2010CA 2010CA/DMG02 2000B/SBR02 = 18 2010BA/DMG02	**R**	**R**
11	**Patient Sex**	DMG-03, If 2010CA, 2010CA/DMG03 Else if 2000B/SBR02 = 18, 2010BA/DMG03	**R**	**R**
12	**Admission 12 – 15**	DTP-03, If 2400/DTP01 = 472 SB2300		

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12	**Admission Date**		R	**R**
13	**Admission Hour**	DTP-03, If 2300/DTP01 = 435, move time portion of 2300/DTP03	**R**	**R**
14	**Admission Type**	CL1-01, 2300/CL101	**R**	**R**
15	**Source of Referral for Admission or Visit**	CL1-02, If 2300/CL102 [1] blank, 2300/CL102	**R**	**Not Required**
16	**Discharge Hour**	Loop 2300, DTP03	**R**	**R**
17	**Patient Discharge Status**	Loop 2300, DTP01	**R**	**R**
18 - 28	**Condition Codes**	2300 CRC01 2300 CRC02 2300 CRC03 2300 CRC04 2300 CRC05 2300 CRC06 2300 CRC07	**C**	**C**
29	**Accident State**	2300 REF02	**C**	**C**
30	**Unlabeled Field**	Not Used		
31a,b – 34a,b	**Occurrence Codes and Dates**	E HI-01,If CLCL_CL_SUB_TYPE = M (Move BH Qualifier) 2300/HI01 found, 01 2300/HI02 found, 02 2300/HI03 found, 03 2300/HI04 found, 04 2300/HI05 found, 05 2300/HI06 found, 06 2300/HI07 found, 07 If 2300/HI08 found, 08	**C**	**C**
35a,b – 36a,b	**Occurrence Span Codes And Dates**	2300, HI01, Value for BI qualifier	**C**	**C**
37a,b	**Reserved**	**Leave Blank**	**C**	**C**
38	**Responsible Party Name and Address**	2010BD	**C**	**C**
39a,b,c,d – 41a,b,c,d	**Value Codes and Amounts**	2300, H101-5, BE qualifier	**C**	**C**

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42	**Rev. Cd.**	SV2-01, If 2400/SV2, 2400/SV201 Refer to the DHH web site for a list of billable revenue codes: http://www.lamedicaid.com/provweb1/billing_information/revenuecodes.htm	**R**	**R**
43	**Revenue Description**	Not mapped	**R**	**R**
44	**HCPCS/Accommodation Rates/HIPPS Rate Codes**	SV2-02, If 2400/SV2 segment 2400/SV202-2 2400/SV202-3	**R**	**R**
45	**Serv. Date**	DTP-03, If 2400/DTP01 = 472 2400/DTP03. If 2400/DTP02 = RD8 first date in range. Else if 2300/DTP01 = 434, 2300/DTP03. If 2300/DTP02 = RD8 first date in range.	**R**	**R**
46	**Serv. Units**	CLM-05	**R**	**R**
47	**Total Charges**	SV2-03, Compute using total of line item charges 2400/SV203, Else move zero.	**R**	**R**
48	**Non-Covered Charges**	2300, AMT01	**C**	**C**
49	**Unlabeled Field**	Not Mapped	**Not required**	**Not required**
50	**Payer**	2010BB/NM102 = 1, 2010B/NM103. 2010BB/NM102 = 1, 2010BB/NM104	**R**	**R**
51	**Health Plan Identification Number**	2330A/NM109	**R**	**R**
52	**Rel. Info**	Not Mapped	**R**	**R**
53	**Asg. Ben.**	Not Mapped	**R**	**R**
54	**Prior Payments**	Not Mapped	**R**	**R**

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55	**Est. Amount Due**	Not Mapped	**C**	**C**
56	**National Provider Identifier – Billing Provider**	NM1-09, If 2010AA/NM108 = XX, 2010AA/NM109 2010AB/NM108 = XX, 2010AB/NM109 2310B/NM108 = XX, 2310B/NM109 2420A/NM108 = XX, 2420A/NM109	**R**	**R**
57 A,B,C	**Other (Billing) Provider Identifier**		**C**	**C**
58	**Insured's Name**	NM1-03,If 2010CA, 2010CA/NM103 Else, if 2000B/SBR02 = 18, 2010BA/NM103 NM1-04, If 2010CA, 2010CA/NM104 Else if 2000B/SBR02 = 18, 2010BA/NM104 If 2010CA, 2010CA/NM105 Else if 2000B/SBR02 = 18, 2010BA/NM105	**R**	**R**

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59	**P. Rel**	If 2000C/PAT01 = 0, 02 If 2000C/PAT01 = 04, 17 If 2000C/PAT01 = 05, 13 If 2000C/PAT01 = 07, 14 If 2000C/PAT01 = 09, 21 If 2000C/PAT01 = 10, 6 If 2000C/PAT01 = 15, 07 If 2000C/PAT01 = 17, 05 If 2000C/PAT01 = 19, 03 If 2000C/PAT01 = 20, 08 If 2000C/PAT01 = 21 09 If 2000C/PAT01 = 22, 10 If 2000C/PAT01 = 23,16 If 2000C/PAT01 = 24, 17 If 2000C/PAT01 = 29, 22 If 2000C/PAT01 = 32,33, 18 If 2000C/PAT01 = 39, 11 If 2000C/PAT01 = 40 12 If 2000C/PAT01 = 41 15 If 2000C/PAT01 = 43 04 If 2000C/PAT01 = anything else, 09 Set to self, child, spouse or other	**R**	**R**
60	**Insured's Unique Identifier**	NM1-09, If ClmeSfxOpt = 1 If 2010BA/NM108 = MI, 2010BA/NM109 Else, if 2010CA/NM108 = MI, 2010CA/NM109. If ClmeSfxOpt = 2 If 2010BA/NM108 = MI, positions 1-9 of 2010BA/NM109 Else, if 2010CA/NM108 =MI, positions 1-9 of 2010CA/NM109. If 2010CA/NM108 = MI, positions 1-9 of 2010CA/NM109 Else, if 2010BA/NM108 = MI, positions 1-9	**R**	**R**
61	**Group Name**	REF-02, 2000B/SBR04	**C**	**C**

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62	**Insurance Group No.**	200/2320, SBR01	**C**	**C**
63	**Treatment Authorization Codes**	2300, REF02	**R**	**R**
64	**DCN**	Loop 2300 Ref*D9	**C**	**C**
65	**Employer Name**	Not Mapped	**C**	**C**
66	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**	Hard coded to "9"	**Not Required**	**Not Required**
67	**Prin. Diag. Cd. and Present on Admission (POA) Indicator**	HI-01, the first occurring 2300/HI01-2 value where HI01-1 = BK or BJ.	**R**	**R**
67 A - Q	**Other Diagnosis Codes**		**C**	**C**
68	**Unlabeled Field**	Not Used		
69	**Admitting Diagnosis Code**	HI-02, If CLCL_CL_SUB_TYPE = M (BJ qualifier) If 2300/HI01 found, 2300/HI01-2.	**C**	**C**
70	**Patient's Reason for Visit**	2300, HI01, PR qualifier	**C**	**C**
71	**Prospective Payment System (PPS) Code**	DR qualifier information. Up to 4 digits.	**C**	**C**

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72a-c	**External Cause of Injury (ECI) Code**	Not Mapped	**C**	**C**
73	**Unlabeled Field**	Not Mapped		
74	**Principal Procedure code and Date**	If 2400/SV2 segment, 2400/SV202-2 And, if Found, 2400/SV202-3. 2300/HIXX-4 for each corresponding occurrence of the HI segment. (Principal BP qualifier, other BO or BQ qualifier)	**C** **R**	**C** **R**
74a-e	**Other Procedure Codes and Dates**	If 2400/SV2 segment, 2400/SV202-2 And, if Found, 2400/SV202-3. 2300/HIXX-4 for each corresponding occurrence of the HI segment. (Principal BP qualifier, other BO or BQ qualifier)	**C**	**C**
75	**Unlabeled Field**	Not Mapped		

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

76	**Attending Provider Name and Identifiers** **NPI#/Qualifier/Other ID#** **Enter the NPI number of the attending physician** **Enter the AmeriHealth Caritas Louisiana issued Provider ID number** **Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number**	NM1-09, If 2310A/NM101 = 71 If 2310A/NM108 = XX, 2310A/NM109 If 2310B/NM101 = 72 If 2310B/NM108 = XX, 2310B/NM109 If 2310C/NM101 = 73 If 2310C/NM108 = XX, 2310C/NM109 REF-02, If 2310A/NM101 = 71 If 2310A/REF01 = 1G, 2310A/REF02 If 2310B/NM101 = 72 If 2310B/REF01 = 1G 2310B/REF02 If 2310C/NM101 = 73 If 2310C/REF01 = 1G 2310C/REF02 NM1-03, If 2310A/NM101 = 71 If 2310A/NM102 = 1 2310A/NM103 If 2310B/NM101 = 72 If 2310B/NM102 = 1 2310B/NM103 If 2310C/NM101 = 73 If 2310C/NM102 = 1 2310C/NM103 NM1-04, If 2310A/NM101 = 71 If 2310A/NM102 = 1, 2310A/NM104 If 2310B/BNM101 = 72 If 2310B/NM102 = 1 2310B/NM104 If 2310C/NM101 = 73 If 2310C/NM102 = 1 2310C/NM104	**R**	**R**

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

77	**Operating Physician Name and Identifiers – NPI#/Qualifier/Other ID#** **Enter the NPI number of the physician who performed surgery** **Enter the AmeriHealth Caritas Louisiana issued Provider ID number** **Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number**	NM1-09, If 2310A/NM101 = 71 If 2310A/NM108 = XX, 2310A/NM109 If 2310B/NM101 = 72 If 2310B/NM108 = XX, 2310B/NM109 If 2310C/NM101 = 73 If 2310C/NM108 = XX, 2310C/NM109 REF-02, If 2310A/NM101 = 71 If 2310A/REF01 = 1G, 2310A/REF02 If 2310B/NM101 = 72 If 2310B/REF01 = 1G 2310B/REF02 If 2310C/NM101 = 73 If 2310C/REF01 = 1G 2310C/REF02 NM1-03, If 2310A/NM101 = 71 If 2310A/NM102 = 1 2310A/NM103 If 2310B/NM101 = 72 If 2310B/NM102 = 1 2310B/NM103 If 2310C/NM101 = 73 If 2310C/NM102 = 1 2310C/NM103 NM1-04, If 2310A/NM101 = 71 If 2310A/NM102 = 1, 2310A/NM104 If 2310B/BNM101 = 72 If 2310B/NM102 = 1 2310B/NM104 If 2310C/NM101 = 73 If 2310C/NM102 = 1 2310C/NM104	**C**	**C**

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

78 – 79	**Other Provider (Individual) Names and Identifiers – NPI#/Qualifier/Other ID#** **Enter the NPI number of another attending physician** **Enter the AmeriHealth Caritas Louisiana issued Provider ID number** **Enter the two digit qualifier that identifies the Other ID number as the AmeriHealth Caritas Louisiana issued Provider ID number**	78. NM1-09, If 2310A/NM101 = 71 If 2310A/NM108 = XX, 2310A/NM109 If 2310B/NM101 = 72 If 2310B/NM108 = XX, 2310B/NM109 If 2310C/NM101 = 73 If 2310C/NM108 = XX, 2310C/NM109 REF-02, If 2310A/NM101 = 71 If 2310A/REF01 = 1G, 2310A/REF02 If 2310B/NM101 = 72 If 2310B/REF01 = 1G 2310B/REF02 If 2310C/NM101 = 73 If 2310C/REF01 = 1G 2310C/REF02 NM1-03, If 2310A/NM101 = 71 If 2310A/NM102 = 1 2310A/NM103 If 2310B/NM101 = 72 If 2310B/NM102 = 1 2310B/NM103 If 2310C/NM101 = 73 If 2310C/NM102 = 1 2310C/NM103 NM1-04, If 2310A/NM101 = 71 If 2310A/NM102 = 1, 2310A/NM104 If 2310B/BNM101 = 72 If 2310B/NM102 = 1 2310B/NM104 If 2310C/NM101 = 73 If 2310C/NM102 = 1 2310C/NM104 79. Reserved	**C**	**C**
80	**Remarks Field**	Not Mapped	**C**	**C**
81CC,a-d	**Code-Code Field**	Not Mapped	**C**	**C**

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

Special Instructions and Examples for CMS 1500, UB-04 and EDI (837) Claims Submissions

I. Supplemental Information

A. CMS 1500 Paper Claims – Field 24:

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

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

- Anesthesia duration in hours and/or minutes with start and end times
- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs and then leave (1) space and enter qualifiers:
  F2 – International Unit
  ML – Milliter
  GR – Gram
  UN- Unit
- Vendor Product Number – Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN) formerly Universal Product Code (UPC) for products
- Contract rate

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

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

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

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

B. EDI – Field 24D (Professional)

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

- Details sent in NTE that will be included in claim processing:

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

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

C. 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.

D. EDI – Field 45 and 51(Institutional)

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

Service Line Loop 2400, DTP*472

Claim statement date Loop 2300, DTP*434

Field 51 – **Health Plan ID** – the number used by the health plan to identify itself. AmeriHealth Caritas Louisiana's Health Plan EDI Payer ID# is 27357

E. EDI – Reporting DME

DME Claims requiring specific instructions should begin with DME followed by specific details.

Example: NTE* DME AEROSOL MASK, USED W/DME NEBULIZER

Example: NTE*ADD* NO LIABILITY, PATIENT FELL AT HOME~

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

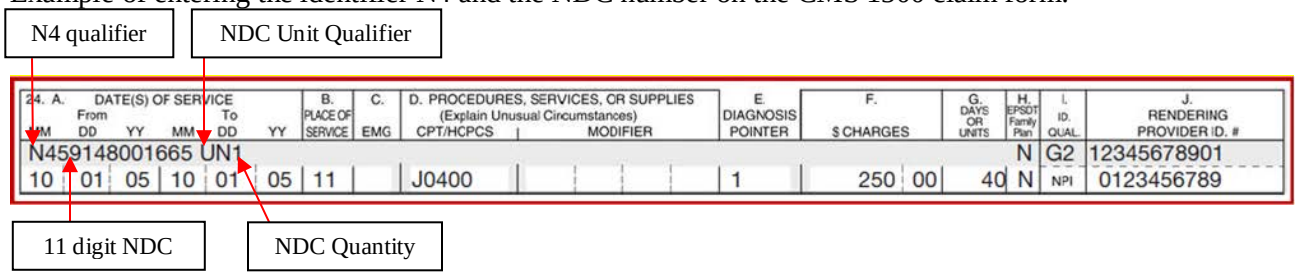
1. NDC on CMS 1500

- NDC should be entered in the shaded sections of item 24A through 24G
- To enter NDC information, begin at 24A by entering the qualifier N4 and then the 11 digit NDC information
    - Do not enter a space between the qualifier and the 11 digit NDC number
    - Enter the 11 digit NDC number in the 5-4-2 format (no hyphens)
    - Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Enter the drug name and strength
- Enter the NDC quantity unit qualifier
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN – Unit
- Enter the NDC quantity

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

- Do not use a space between the NDC quantity unit qualifier and the NDC quantity
- Note: The NDC quantity is frequently different than the HCPC code quantity

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



2. NDC on UB-04

- NDC should be entered in Form Locator 43 in the Revenue Description Field
- Report the N4 qualifier in the first two (2) positions, left-justified
  - Do not enter spaces
  - Enter the 11 character NDC number in the 5-4-2 format (no hyphens)
  - Do not use 99999999999 for a compound medication, bill each drug as a separate line item with its appropriate NDC
- Immediately following the last digit of the NDC (no delimiter), enter the Unit of Measurement Qualifier
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Unit
- Immediately following the Unit of Measure Qualifier, enter the unit quantity with a floating decimal for fractional units limited to 3 digits (to the right of the decimal)
  - Any unused spaces for the quantity are left blank

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

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

3. NDC via EDI

The NDC is used to report prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes.

EDI claims with NDC info should be reported in the LIN segment of Loop ID-2410. This segment is used to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1. Please consult your EDI vendor if not submitting in X12 format for details on where to submit the NDC number to meet this specification.

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

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

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

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

- Federal Tax ID on UB04:

  Federal Tax ID on UB04 (Box# 5) will come from Loop 2010AA, REF02.

- Condition codes

  Condition codes (Box number 18 thru 29) will come from 2300 CRC01 – CRC07

- Patient reason DX

  Patient reason DX (Box 70) qualifier will be PR qualifier from 2300, HI01.

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

Common Causes of Claim Processing Delays, Rejections or Denials

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

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 claim form. A valid medical license number is formatted as two alpha, six numeric, and one alpha character (AANNNNNNA) **OR** two alpha and six numeric characters (AANNNNNN).

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

Diagnosis Code Missing 4th or 5th Digit – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-9-CM or ICD-10-CM manual for the 4th and 5th digit extensions. Look for the ✓4th or ✓5th symbols in the coding manual to determine when additional digits are required.

Diagnosis, Procedure or Modifier Codes Invalid or Missing Coding from the most current coding manuals (ICD-9-CM, ICD-10-CM, CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure and modifier fields must be completed.

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

External Cause of Injury Codes – External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis.

Important: Include all primary and secondary diagnosis codes on the claim.

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

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

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

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

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

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

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

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

Handwritten Claims –Completely handwritten claims will be rejected. Legible handwritten claims are acceptable on resubmitted claims. (See Illegible Claim Information)

Highlighted Claim Fields – (See Illegible Claim Information)

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

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

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

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

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

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

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

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

Important: Submit newborn's facility bill for child at the time of delivery using the baby's Medicaid ID. The newborn's Medicaid ID is to be used on well babies, babies with extended stays (sick babies) past the mother's stay and on all aftercare and professional bills. The facility or provider should obtain the newborn's Medicaid ID# from DHH's Newborn Eligibility System before submitting the claim to AmeriHealth Caritas Louisiana.

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

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

Place of Service Code Missing or Invalid – A valid and appropriate two digit numeric code must be included on the claim form. Refer to

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

CMS 1500 coding manuals for a complete list of place of service codes.

Provider Name Missing – The name of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Plan.
For claims with COB, the adjudication date of the other payer is required for EDI and paper claims

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

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

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

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.

Third Party Liability (TPL) Information Missing or Incomplete – Any information indicating a work related illness/injury, no fault, or other liability condition must be included on the claim form. Additionally, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.
Type of Bill – A code indicating the specific type of bill (e.g., hospital inpatient, outpatient, adjustments, voids, etc). The first digit is a leading zero. Do not include the leading zero on electronic claims.

Taxonomy –The provider's taxonomy number is required if needed by the plan to determine the provider's plan ID when using NPI only is not effective.

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

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

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

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

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

Important: Any changes in a participating provider's name, address, NPI number, or tax identification number(s) must be reported to AmeriHealth Caritas Louisiana immediately. Contact your Network Management Representative to assist in updating the AmeriHealth Caritas Louisiana's records.

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

Electronic Data Interchange (EDI) for Medical and Hospital Claims

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

The benefits of billing electronically include:

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

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

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

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

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

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

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

Electronic Claims Submission (EDI)

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

Hardware/Software Requirements

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

Contracting with Emdeon and Other Electronic Vendors

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

Contacting the EDI Technical Support Group

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

When ready to proceed:

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

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

Important: Contact AmeriHealth Caritas Louisiana's EDI Technical Support at:

1-866-428-7419

Or by e-mail at

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

edi@amerihealthcaritasla.com

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

Important: The Payer ID for AmeriHealth Caritas Louisiana is **27357**

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

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

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the EDI Claim Filing sections of this booklet. EDI guidance for Professional Medical Services claims can be found beginning on page 10. EDI guidance for Facility Claims can be found beginning on page 31. Emdeon or any other EDI clearing-house or vendor may require additional data record requirements.

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

Electronic Claim Flow Description

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

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

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

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

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

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

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Claim Status reports, contact the Emdeon Provider Support Line at 1-800-845-6592.

If you need assistance in resolving submission issues identified on the R059 Plan Claim Status report, contact the AmeriHealth Caritas Louisiana EDI Technical Support Hotline at 1-866-428-7419 or by e-mail at edi@amerihealthcaritasla.com

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

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

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

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

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

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

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

Invalid Electronic Claim Record Rejections/Denials

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

Plan Specific Electronic Edit Requirements

The Plan currently has two specific edits for professional and institutional claims sent electronically.
837P – 005010X098A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
837I – 005010X096A1 – Provider ID Payer Edit states the ID must be less than 13 alphanumeric digits.
Member Number must be less than 17 AN
Statement date must be not be earlier than the date of
Service Plan Provider ID is strongly encouraged

Exclusions

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

These exclusions apply to inpatient and outpatient claim types.

Excluded Claim Categories At this time, these claim records must be submitted on paper.
Claim records requiring supportive documentation.
Claim records for medical, administrative or claim appeals
Excluded Provider Categories Claims issued on behalf of the following providers must be submitted on paper.
Providers not transmitting through Emdeon *or providers sending to Vendors that are not transmitting (through Emdeon) NCPDP Claims*
Pharmacy (through Emdeon)

Important: Requests for adjustments may be submitted electronically, on paper or by telephone.

By Telephone:

Provider Claim Services

1-888-922-0007

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

On Paper:

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

Claims Processing Department
AmeriHealth Caritas Louisiana
P.O. 7322
London, KY 40742

Administrative or medical appeals must be submitted in writing to:

Provider Appeals Department

AmeriHealth Caritas Louisiana
PO Box 7324
London, KY 40742

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

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

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

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

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

Common Rejections

Invalid Electronic Claim Records – Common Rejections from Emdeon
Claims with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT-4, HCPCS, ICD-9 or ICD-10, etc)
Claims without member numbers
Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims received with invalid provider numbers
Claims received with invalid member numbers
Claims received with invalid member date of birth

Resubmitted Professional Corrected Claims

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

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

Your EDI clearinghouse or vendor needs to:

- ✓ Use frequency code "6" for replacement of a prior claim or frequency code "7" for adjustment of prior claims utilizing bill type in loop 2300, CLM05-03 (837P)
- ✓ Include the original claim number in segment REF01=F8 and REF02=the original claim number; no dashes or spaces
- ✓ **Do** include the plan's claim number in order to submit your claim with the 6 or 7
- ✓ **Do** use this indicator for claims that were previously processed (approved or denied)
- ✓ **Do not** use this indicator for claims that contained errors and were not processed (rejected upfront)
- ✓ **Do not** submit corrected claims electronically and via paper at the same time
  - o *For more information, please contact the AmeriHealth Caritas Louisiana EDI Hotline at 1-866-428-7419 or edi.AmeriHealth Caritas Louisiana@amerihealthcaritas.com*
  - o *Providers using our NaviNet portal (www.navinet.net) can view their corrected claims faster than available with paper submission processing.*

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

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

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

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

Claims Processing Department
AmeriHealth Caritas Louisiana
P.O. Box 7322
London, KY 40742

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

Common Rejections, continued

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

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

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

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

Contact AmeriHealth Caritas Louisiana EDI Technical Support at: 1-866-428-7419

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

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

837P – Loop 2310B, REF*G2[PIN]

837I – Loop 2310A, REF*G2[PIN]

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

Supplemental Information

Ambulance
Ambulatory Surgical Centers
Anesthesia
Audiology
Behavioral Health
Chemotherapy
Chiropractic Care
Dental Services
Diabetic Self-Management
Dialysis
Durable Medical Equipment (DME)
EPSDT
- **Medical Screening**
- **Vision Screening**
- **Hearing Screening**
- **Interperiodic Screening**
- **Consultation**
- **FQHCRHC EPSDT**

Home Health Care (HHC)
Family Planning
Immunization
Infusion Therapy
Injectable Drugs
Maternity
Observation
Outpatient Hospital Services
Radiology Services
Surgery
Therapies
Transplants

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

Ambulance

Ground and Air Ambulance Services are billed on CMS 1500 or 837 Format

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

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

The following table identifies the valid modifiers for air ambulance.

Modifier	Description
IH	Transfer Airport Heli Pad/Hospital
SI	Accident Scene, Acute Event/Transfer Airport, Heli Pad

Ambulatory Surgical Centers

- Ambulatory Surgical Centers (ASC) are required to bill on CMS 1500 or 837 Format.
- Providers are to bill only the highest compensable surgical code and all ancillary services.
- Outpatient hospitals are to bill only one 490 rev code line along with the highest compensable surgical code present on the Louisiana Ambulatory Surgical Fee Schedule.
- If providers is looking to perform a service in the Ambulatory Surgical Center that is not on the Louisiana Medical Assistance Fee Schedule, provider must obtain prior authorization and rate negotiation prior to service being rendered. Failure to obtain prior authorization for procedures not on Ambulatory Surgical Fee Schedule will result in claim denial.

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

Anesthesia

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

- Reimbursement for surgical anesthesia procedures will be based on formulas utilizing base units, time units (1= 15 min) and a conversion factor.
- Reimbursement for moderate sedation and maternity-related procedures, other than general anesthesia for vaginal delivery, will be a flat fee.
- Minutes must be reported on all anesthesia claims except where policy states otherwise.

The following modifiers are to be used to bill for surgical anesthesia services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction by an anesthesiologist
QZ	CRNA	CRNA service without medical direction by an anesthesiologist

The following is an explanation of billable modifiers:

- Modifiers which can stand alone: AA, QZ, QK, QX and QY
- All ASA codes still require a valid ASA modifier to be billed in first position in conjunction with the ASA code.

Audiology

Audiology services must be billed on a CMS 1500 claim form.

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

Behavioral Health

- AmeriHealth Caritas Louisiana covers basic behavioral health services, which include but are not limited to screening, prevention, early intervention, medication, and referral services as defined the Medicaid State Plan.
- Basic behavioral health services may further be defined as those provided in the member's PCP or medical office by the member's (non-specialist) physician (i.e., DO, MD, ARNP) as part of routine physician evaluation and management activities (*e.g.*, CPT codes 99201 through 99204),and all behavioral health services provided at FQHCs/RHCs).
- Behavioral health services performed in a FQHC/RHC are reimbursed as encounters. The encounter reimbursement includes all services provided to the recipient on that date of service. In addition to the encounter code, it is necessary to indicate the specific services provided by entering the individual procedure code, description, and total charges for each service provided on subsequent lines
- FQHC/RHC must bill HCPCS Code "T1015" with detail level Behavioral Health codes.
- Behavioral Health services are billed on the CMS-1500 claim form or electronically in the 837 format
- Behavioral Health diagnosis code must be billed in the primary diagnosis code position to be considered a Behavioral Health claim
- All other Behavioral health Claims should be submitted to Merit Health\Magellan Health. For information call 800-424-4399 or TTY 800-424-4416.

Chemotherapy

- Services may be billed electronically via 837 Format or via paper on a CMS 1500 or UB-04.
- Chemotherapy administration is covered by Louisiana Medicaid. 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

- Claims for chiropractic services are billed on a CMS 1500 or via 837 format.
- Chiropractors are to bill for services using the appropriate, CPT code for the service provided. HCPCS modifier "AT" (Acute Treatment) may be appended.

Dental Services

- Dental Services for members under 21 are handled by DHH.

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

- Dental Services for members over 21 are limited to following three codes, which should be submitted to the dental vendor:
    - D1110-prophylaxis-adult;
    - D0120-periodic oral evaluation
    - D0150-comprehensive oral evaluation.
- Submit on an ADA Dental Claim form to:
  DentaQuest – Claims
  12121 N. Corporate Parkway
  Mequon, WI 53092

  or to submit electronically, contact DentaQuest at 800-508-6785 to arrange EDI submission.
- All other "D" codes for members over 21 are not covered.

Diabetic Self-Management Training

- Services are billed using G0108 – individual session; and G0109 – group session.
- Services may be billed on either a HCFA1500 or UB04 or via 837 Format.
- Services billed on UB04 should be billed with revenue code 0942.
- Services for pregnant members must be billed with a "TH" modifier.

Dialysis

- Reimbursement for dialysis services must be billed using the UB-04 claim form or using the electronic submission 837I.
- Epogen must be reported using procedure code Q4081 in conjunction with revenue code 0634 and revenue code 0635.
- The following formula is used in calculating Epogen units of service: (Total number of Epogen units/100) = units of services
- The units of service field for Epogen must be reported based on the HCPCS code dosage description as is done with all other physician administered drugs. For example: The HCPCS code description for Q4081 is Injection, Epogen. If the provider administers 12,400 units of Epogen on that date of service, then 124 should be entered as unit of service. Standard rounding should be applied to the nearest whole number.

Durable Medical Equipment

- Services are billed on a CMS 1500 claim form
- An "NU" modifier is used for all purchases

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

- An "RR" modifier is required for all rentals
- Repair codes on the DME Fee Schedule require the submission of procedure code "K0739" in conjunction with "RP" modifier for payment consideration
- The following DME procedure codes that are manually priced based on the Louisiana Fee Schedule will require an invoice.

A4244	ALCOHOL OR PEROXIDE, PER PINT
A4466	GARMENT, BELT, SLEEVE OR OTHER COVER
A4483	MOISTURE EXCHANGER
A4550	SURGICAL TRAYS
A4570	SPLINT
A4649	SURGICAL SUPPLIES NOT ELSEWHERE CLAS
A4663	BLOOD PRESSURE CUFF ONLY
A4670	AUTOMATIC BLOOD PRESSURE MONITOR
A4680	ACTIVATED CARBON FILTERS FOR DIALYSI
A4690	DIALYZER'S (ARTIFICIAL KIDNEY'S) AL
A4730	FISTULA CANNULATION SET FOR DIALYSIS
A4740	SHUNT ACCESSORIES FOR DIALYSIS ONLY
A4750	BLOOD TUBING, ARTERIAL OR VENOUS, E
A4755	BLOOD TUBING, ARTERIAL AND VENOUS C
A4760	DIALYSATE STANDARD TESTING SOLUTION
A4765	DIALYSATE CONCENTRATE ADDITIVES, EA
A4770	BLOOD TESTING SUPPLIES (E.G. VACUTA
A4771	SERUM CLOTTING TIME TUBE, PER BOX
A4860	DISPOSABLE CATHETER CAPS
A4913	MISCELLANEOUS DIALYSIS SUPPLIES, NO
A4918	VENOUS PRESSURE CLAMPS, EACH
A5119	SKIN BARRIER; WIPES, BOX PER 50
A6020	COLLAGEN DRESSING COVER EA
A6025	SILICONE GEL SHEET, EACH
A6215	FOAM DRESSING WOUND FILLER
A6230	GAUZE > 48 SQ IN WATER/SALNE
A6250	SKIN SEAL PROTECT MOISTURIZR
A6260	WOUND CLEANSER ANY TYPE/SIZE
A6261	WOUND FILLER GEL/PASTE /OZ
A6262	WOUND FILLER DRY FORM / GRAM
A6404	STERILE GAUZE > 48 SQ IN
A6507	CMPRS BURNGARMENT FOOT-KNEE

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

A6531	GRAD COMP STOCKING BELOW KNEE 30-40M
A6549	GRADIENT COMPRESSION STOCKING/SLEEVE
A9284	SPIROMETER, NON-ELECTRONIC, INCLUDES
A9900	MISCELLANEOUS DME SUPPLY ACCESSORY
A9999	MISCELLANEOUS DME SUPPLY ACCESSORY
B4035	ENTERAL FEEDING SUPPLY KIT;-PUMP FE
B4104	ADDITIVE FOR ENTERAL FORMULA (E.G.FI
B4149	EF BLENDERIZED FOODS
B9002	ENTERAL PUMP WITH ALARM
B9998	NOC FOR ENTERNAL SUPPLIES
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH
E0245	TUB STOOL OR BENCH
E0450	VENTILATOR AND EQUIPMENT PACKAGE
E0463	PRESS SUPP VENT INVASIVE INT
E0464	PRESS SUPP VENT NONINV INT
E0483	CHEST COMPRESSION GEN SYSTEM
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL
E0770	FUNCTIONAL ELECTRICAL STIMULATOR, TR
E0965	4" CUSHION, FOR WHEELCHAIR
E0996	TIRE, SOLID, EACH
E1001	WHEEL, SINGLE
E1009	ADD MECH LEG ELEVATION
E1011	PED WC MODIFY WIDTH ADJUSTM
E1017	HD SHOCK ABSRBER FOR HD MAN WC
E1018	HD SHOCK ABSRBER
E1036	MULTI-POSITIONAL PT TRANSFER SYS
E1091	YOUTH WHEELCHAIR, ANY TYPE
E1358	OXYGEN ACCESSORY, DC POWER ADAPTER F
E1390	OXYGEN CONCENTRATOR, EQUIVALENT TO
E1399RR	DURABLE MEDICAL EQUIPMENT,NOR OTHER
E1399	DURABLE MEDICAL EQUIPMENT, NOT OTHER
E1510	KIDNEY, DIALYSATE DELIVERY SYST. KID
E1520	HEPARIN INFUSION PUMP FOR DIALYSIS
E1530	AIR BUBBLE DETECTOR FOR DIALYSIS
E1540	PRESSURE ALARM FOR DIALYSIS
E1550	BATH CONDUCTIVITY METER FOR DIALYSI
E1560	BLOOD LEAK DETECTOR FOR DIALYSIS
E1575	TRANSDUCER PROTECTORS/FLUID BARRIER
E1580	UNIPUNCTURE CONTROL SYSTEM FOR DIALY

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

E1590	HEMODIALYSIS MACHINE
E1592	AUTOMATIC INTERMITTENT PERITIONEAL
E1594	CYCLER DIALYSIS MACHINE
E1600	DELIVERY AND/OR INSTALLATION CHARGES
E1620	BLOOD PUMP FOR DIALYSIS
E1630	RECIPROCATING PERITONEAL DIALYSIS SY
E1632	WEARABLE ARTIFICAL KIDNEY
E1635	COMPACT (PORTABLE) TRAVEL HEMODIALYZ
E1636	SORBENT CARTRIDGES, PER CASE
E1699	DIALYSIS EQUIPMENT, UNSPECIFIED, BY
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PED
E2512	SGD ACCESSORY, MOUNTING SYS
E2599	ACCESSORY FOR SGD NOC
E2609	SIGNATURE 2000 SEAT
E2617	SIGNATURE 2000 BACK
F0113RR	CRUTCH UNDERARM EACH WOOD
K0009	OTHER MANUAL WHEELCHAIR/BASE
K0014	OTHER MOTORIZED/POWER WHEELCHAIR BAS
K0108	WHEELCHAIR ACCESSORIES
K0109	CUSTOMIZATION OF WHEELCHAIR BASE FRA
K0283RR	POWERWHEELCHAIR, GROUP 2 STANDARD
K0452	WHEELCHAIR BEARINGS
K0738	PORTABLE GASEOUS OXYGEN SYSTEM
K0740	REPAIR OR NONROUTINE SERVICE FOR OXY
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLAS
K0899	POWER MOBILITY DEVICE, NOT CODED BY
L1499	UNLISTED PROCEDURE SPINAL ORTHOSIS
L2861	ADDITION TO LOWER EXTREMITY JOINT, K
L2999	UNLISTED PROCEDURES FOR LOWER EXTREM
L3160	FOOT, TORQUE HEELS
L3540RR	MISCELLANEOUS SHOE ADDITIONS, SOLE
L3580RR	MISCELLANEOUS SHOE ADDITIONS,CONVER
L3649	UNLISTED PROCEDURES FOR FOOT ORTHOPE
L3891	ADDITION TO UPPER EXTREMITY JOINT, W
L3956	ADD JOINT UPPER EXT ORTHOSIS
L3999	UNLISTED PROCEDURES FOR UPPER LIMB O
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR
L5999	UNLISTED PROCEDURES FOR LOWER EXTREM

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

L7499	UNLISTED PROCEDURES FOR UPPER EXTREM
L8004	CRANIAL CERVICAL ORTHOSIS
L8499	UNLISTED PROCEDURE FOR MISCELLANEOUS
L8604	INJECTABLE BULKING AGENT, DEXTRANOME
L8692	AUDITORY OSSEOINTEGRATED DEVICE, EXT
L9900	O&P SUPPLY/ACCESSORY/SERVICE
S1015	IV TUBING EXTENSION SET
S8186	SWIVEL ADAPTOR
V2629	PROSTHETIC EYE,INTRAOCULAR LENES NOC
V5269	ALERTING DEVICE, ANY TYPE
V5272	ASSISTIVE LISTENING DEVICE, TDD

- The following list of "B" HCPCS codes for enterals will require the submission of an NDC number and NDC units.

B9998	NOC FOR ENTERNAL SUPPLIES
B4149	EF BLENDERIZED FOODS
B4149	EF BLENDERIZED FOODS

- Submits bills based on a 30 day monthly cycle
- Date span should be billed as a full month (example: 01/25 – 02/25)
- Bill appropriate units – (1) can is equal to a quantity of "1"
- Do not bill in cases, must bill in units only

EPSDT Supplemental Billing Information

EPSDT Medical Screening:

Billing for these screenings should be completed on the CMS 1500 Claim Form or electronically with the 837P claim transaction. Providers must use the age appropriate code in order to avoid claim denial. Billing may not be submitted for a medical screening unless all of the following components are administered:

COMPONENTS OF THE MEDICAL SCREENING
1. Comprehensive health and developmental history (including assessment of both physical and mental health and development)
2. Comprehensive unclothed physical exam or assessment
3. Appropriate immunizations according to age and health history (unless medically contraindicated or parents or guardians refuse at the time)

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

4. Laboratory tests (including appropriate neonatal, iron deficiency anemia, urine, and blood lead screening)
5. Health education (including anticipatory guidance)

NOTE: All components, including specimen collection, must be provided on-site during the same medical screening visit.

- Providers must bill with the V20.0 through V20.3 in the primary diagnosis position
- These codes are billed hard copy on the CMS-1500 form or electronically using the 837P claim transaction.

The following procedure codes are used to bill for the medical screening:

99381*	Initial comprehensive preventive medicine; Infant (age under 1 year)
99382*	Initial comprehensive preventive medicine; Early Childhood (ages 1-4)
99383*	Initial comprehensive preventive medicine; Late Childhood (ages 5-11)
99384*	Initial comprehensive preventive medicine; Adolescent (ages 12-17)
99385*	Initial comprehensive preventive medicine; Adult (ages 18-20)
99391*	Periodic comprehensive preventive medicine; Infant (age under 1 year)
99392*	Periodic comprehensive preventive medicine; Early Childhood (ages 1-4)
99393*	Periodic comprehensive preventive medicine; Late Childhood (ages 5-11)
99394*	Periodic comprehensive preventive medicine; Adolescent (ages 12-17)
99395*	Periodic comprehensive preventive medicine; Adult (ages 18-20)

***Providers should use the TD Modifier in conjunction with the appropriate CPT code to report a screening that was performed by a registered nurse**.

Note: Providers must bill the age appropriate code in order to avoid claim denial.

EPSDT Vision Screening

The purpose of the vision screening is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malfunctions, eye diseases, strabismus, amblyopia, refractive errors, and color blindness.

EPSDT Subjective Vision Screening

The subjective vision screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of

- any eye disorders of the child or his family
- any systemic diseases of the child or his family which involve the eyes or affect vision
- behavior on the part of the child that may indicate the presence or risk of eye problems
- medical treatment for any eye condition

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

EPSDT Objective Vision Screening

EPSDT objective vision screenings (99173 -EP) may be performed by trained office staff under the supervision of a LICENSED Medicaid physician, physician assistant, registered nurse, or optometrist.

Objective vision screenings begin at **age 4**. The objective vision screening must include tests of:

- visual acuity (Snellen Test or Allen Cards for preschoolers and equivalent tests such as Titmus, HOTV or Good Light, or Keystone Telebinocular for older children);
- color perception (must be performed at least once after the child reaches the age of 6 using polychromatic plates by Ishihara, Stilling, or Hardy-Rand-Ritter); and
- muscle balance (including convergence, eye alignment, tracking, and a cover-uncover test).

The following procedure code is used to bill for vision screening:

99173 with **EP** modifier	Vision Screening

EPSDT Hearing Screening

The purpose of the hearing screening is to detect central auditory problems, sensorineural hearing loss, conductive hearing impairments, congenital abnormalities, or a history of conditions which may increase the risk of potential hearing loss.

EPSDT Subjective Hearing Screening

The subjective hearing screening is part of the comprehensive history and physical exam or assessment component of the medical screening and must include the history of:

- the child's response to voices and other auditory stimuli
- delayed speech development
- chronic or current otitis media
- other health problems that place the child at risk for hearing loss or impairment

EPSDT Objective Hearing Screening

EPSDT objective hearing screenings may be performed by trained office staff under the supervision of a licensed Medicaid audiologist or speech pathologist, physician, physician assistant, or registered nurse.

Objective hearing screenings begin at **age 4**. The objective hearing screening must test at 1000, 2000, and 4000 Hz at 20 decibels for each ear using the puretone audiometer, Welsh Allyn audioscope, or other approved instrument.

The following procedure code is used to bill for hearing screening:

92551 with EP Modifier	Hearing Screening

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

EPSDT Interperiodic Screenings

An interperiodic screening can only be billed if the recipient has received an age-appropriate medical screening. If their medical screening has not been performed, the provider should bill an age-appropriate medical screening. It is not acceptable to bill for an interperiodic screening if the age-appropriate medical screening had not been performed.

An interperiodic screening by a AmeriHealth Caritas Louisiana provider must include all of the components required in the periodic screening. This includes a complete unclothed exam or assessment, health and history update, measurements, immunizations, health education, and other age appropriate procedures.

Medically necessary laboratory, radiology, or other procedures may also be performed and should be billed separately.

These codes are billed hard copy on the CMS-1500 form or electronically using the 837P claim transaction.

EPSDT Registered Nurse Interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TD plus TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TD plus TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TD plus TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TD plus TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TD plus TS	Interperiodic Re-evaluation and Management (ages 18-21)

TD: To be used to report services provided by RN

TS: To be used to report interperiodic screenings

Physician Interperiodic screening codes:

Procedure Code	Modifier	Description
99391	TS	Interperiodic Re-evaluation and Management (infant under 1 year)
99392	TS	Interperiodic Re-evaluation and Management (ages 1-4)
99393	TS	Interperiodic Re-evaluation and Management (ages 5-11)
99394	TS	Interperiodic Re-evaluation and Management (ages 12-17)
99395	TS	Interperiodic Re-evaluation and Management (ages 18-21)

TS: To be used to report Interperiodic screening

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

Family Planning

Submit claims via CMS-1500, UB-04 or via 837 Format.

AmeriHealth Caritas Louisiana members may access family planning services through any family planning clinic or provider without a referral. Some services may require prior authorization. Certain services such as abortion, sterilizations and hysterectomy require the submission of a consent form with the claim.

FQHC/RHC EPSDT Claim Filing Instructions

- Bill using the CMS-1500, UB-04 or via 837 Format
- EPSDT Services are billed with HCPCS Code T1015 with " EP" modifier and detail level procedure codes.
- Procedure code "T1015" will be denied, if detail procedure code lines are not billed with procedure code "T1015" or any of the detail procedure codes billed is not present on the Louisiana Medicaid Fee-for –Service Fee Schedule .
- Procedure code "T1015" cannot be billed as a single line claim. EPSDT service will deny for payment if billed as a single line item.The entire claim will deny if the provider bills procedure code "T1015" with a valid detail procedure code and an invalid detail procedure code or a procedure code that is not on the Louisiana Medicaid Fee-for-Service Fee schedule.
- All claim line items must be billed with an valid detail procedure code that is listed on the Louisiana Medicaid fee-for-Service Fee Schedule.
- Providers must bill with the V20.0 through V20.3 in the primary diagnosis position

FQHC/RHC Non-EPSDT Claim Filing Instructions

- Requires the submission of procedure code "T1015" in conjunction with detail level procedure codes, including mental/behavioral health. If detail procedure code lines are not billed with procedure code "T1015" or any of the detail procedure codes billed is not present on the Louisiana Medicaid Fee-for-Service Fee Schedule, then, procedure code "T1015" will be denied. Procedure code "T1015" cannot be billed as a single lien claim. Claims billed with a single line item will deny.
- The entire claim will deny if procedure code "T1015" is billed with a valid detail procedure code and an invalid detail procedure code or a procedure code that is not on the Louisiana Medicaid Fee-for-Service Fee Schedule. All claim line items must be billed with a valid detail procedure code that is listed on the Louisiana Medicaid Fee-for-Service Fee Schedule for payment consideration.
- RHC/FQHCs will not be reimbursed for family planning services in addition to the encounter payment.
- Maternity Care Visits – RHC/FQHC requires the submission of procedure code "T1015" in conjunction with "TH" modifier in the first position after the CPT procedure code. Obstetricians providing maternity care must append "TH" modifier to the CPT code.
- RHC/FQHCs may bill for adjunct services. Requires the submission of procedure code "T1015" in conjunction with adjunct procedure codes.

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

Home Health Care (HHC)

- Provider must bill on UB04 or via 837 Format
- Bill the appropriate revenue code for the homecare service.
- Eligible revenue codes/procedure code combinations and modifiers can be found below.
- Providers must bill the appropriate modifier in the first position when more than one modifier is billed. See tables below.

Home Health Services Fee Schedule

CODE	Eligible Rev Code	MODIFIER(S)	DESCRIPTION
G0151	420;421		SERVICES OF PT IN HH SETTING, 15 MIN
G0152	430;431		SERVICES OF OT-HH SETTING, 15 MIN
G0153	440;441		SERVICES OF SPEECH; LANG, HH, 15 MIN
G0154	550;551;580;581		SERVICES OF SKILLED NURSE-HH- 15 MIN
G0154	550;551;580;581	TD	SERVICES OF SKILLED NURSE-HH-15 MIN
G0154	550;551;580;581	TD, TT	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TD, TT, U2	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TD, TT, U3	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TD, U2	SERVICES OF SKILLED NURSE-HH-15 MIN
G0154	550;551;580;581	TD, U3	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TE	SERVICES OF SKILLED NURSE-HH-15 MIN
G0154	550;551;580;581	TE, TT	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TE, TT, U2	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TE, TT, U3	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TE, U2	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TE, U3	SERVICES OF SKILLED NURSE HH 15 MIN
G0154	550;551;580;581	TT, TD	SERVICES OF SKILLED NURSE-HH-15 MIN
G0154	550;551;580;581	TT, TE	SERVICES OF SKILLED NURSE-HH-15 MIN
G0156	570;571		SERVICES OF HH AIDE, EACH 15 MINS
S9123	552		NURSE CARE IN HOME, RN; PER HOUR
S9123	552	TT	NURSE CARE IN HOME, RN; PER HOUR
S9124	582		NURSE CARE IN HOME-LPN-PER HOUR
S9124	582	TT	NURSE CARE IN HOME, LPN, PER HOUR
92506	440		EVAL OF SPEECH, LANG, VOICE, AUDITOR
97001	424		PHYSICAL THERAPY EVALUATION
97001	424	UD	PHYSICAL THERAPY EVALUATION
97003	434		OCCUPATIONAL THERAPY EVALUATION
97003	434	UD	OCCUPATIONAL THERAPY EVALUATION
NOTE: ALL CPT CODES AND DESCRIPTIONS ARE COPYRIGHTED BY THE AMERICAN MEDICAL ASSOCIATION.			

Valid Home Health Procedure Modifiers For Nurse and Aide Services:

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

TD = RN	Pricing Modifier
TE = LPN	Pricing Modifier
TG = High Complexity	Informational
TN = Rural, Outside Area	Informational
TT = Multiple Recipients	Pricing Modifier
TV = Holiday/Weekend	Informational
U2 = 2nd (second) Daily Visit	Informational
U3 = 3rd (third) Daily Visit	Informational
UH = Evening	Informational
UJ = Night	Informational

Immunization

Single Administration

- Providers must bill administration code(s) 90465, 90467, 90471, or 90473 and the specific CPT Code for the vaccine, with $0.00 in the "billed charges" field
- CPT Codes 90465 and 90467 may not be billed together on the same date of service
- CPT Codes 90471 and 90473 may not be billed together on the same date of service

Multiple Administrations

- Providers must bill administration code(s) 90466, 90468, 90472, and 90474 with the appropriate number of units for the additional vaccines. The specific CPT code for the vaccine must be billed with $0.00 in the "billed charges" field. The number of vaccines billed must equal the number of units indicated for the administration code.
- Use CPT Codes 90466 and/or 90468 with 90465 OR 90467 to report more than one vaccine administered. Do NOT use CPT Codes 90466 and/or 90468 with 90471 or 90473.
- Use CPT Codes 90472 and/or 90474 with 90471 OR 90473 to report more than one vaccine administered. Do NOT use CPT Codes 90472 and/or 90474 with 90465 or 90467.

Billing For a Single Administration

- Providers should bill the appropriate CPT immunization administration code(s) 90465, 90467, 90471, or 90473 (Immunization administration: first injection/first administration/one vaccine) when administering one immunization. The next line on the claim form must contain the specific CPT code for the vaccine, with $0.00 in the "billed charges" field.
- Do not report CPT Codes 90465 and 90467 on the same date of service
- Do not report CPT Codes 90471 and 90473 on the same date of service

Billing for Multiple Administrations

- When administering more than one immunization, providers should bill as described above for a single administration. The appropriate procedure code(s) 90466, 90468, 90472, and 90474 (Immunization administration: each additional injection/administration/vaccine) should then be

listed with the appropriate number of units for the additional vaccines placed in the "units" column. The specific vaccines should then be listed on subsequent lines. The number of specific vaccines listed after CPT administration codes should match the number of units listed in the "units" field.

- Use CPT Codes 90466 and/or 90468 with 90465 OR 90467 to report more than one vaccine administered. Do NOT use CPT Codes 90466 and/or 90468 with 90471 or 90473.
- Use CPT Codes 90472 and/or 90474 with 90471 OR 90473 to report more than one vaccine administered. Do NOT use CPT Codes 90472 and/or 90474 with 90465 or 90467.

Hard Copy Claim Filing for Greater Than Four Administrations

- When billing hard copy claims for more than four immunizations and the six-line claim form limit is exceeded, providers should bill on two CMS-1500 claim forms. The first claim should follow the instructions above for billing the single administration. A second CMS-1500 claim form should be used to bill the remaining immunizations as described above for billing multiple administrations.

Infusion Therapy

- Drugs administered by physician or outpatient hospital on the Louisiana Medical Assistance Fee Schedule will be reimbursed but are subjected to Prior Authorization if billed charge is $250 or greater.
- Drugs require the provider to also bill the NDC and related NDC information.
- Failure to bill the NDC required information will result in denial.
- Infusion supplies can be provided by DME provider or home care providers; nursing services are provided by home care agency.
- Infusions/drugs provided in the home are not billed by the home care or DME provider and are not covered by the CCN.
- Drugs would need to be obtained through the pharmacy benefit for any home infusion.
- Nursing and supplies would be covered by the CCN.

Injectable Drugs

All drugs billed are required to be submitted with NDC information and may be submitted via CMS-1500 or 837 electronic format. Refer to NDC instructions in Supplemental Information section on page 47.

The NDC number and the HCPCS code for drug products are required on both the 837 format and the CMS-1500 for reimbursable medications. Claims submitted without NDC information and a valid HCPCS code will be denied.

Maternity

Visits:

Pregnancy diagnosis code must be billed in primary or secondary DX code position

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

Initial Prenatal Visits- must be billed with modifier "TH" in the first position after the CPT code (99201-99205).

Follow Up Prenatal Visits - must be billed with modifier "TH" in the first position after the CPT code (99211-99215)

Postnatal Visits - CPT code 59430

Delivery:
The most appropriate CPT code should be billed for deliveries.

In cases of multiple births (twins, triplets, etc.), the diagnosis code must indicate a multiple birth.

Modifier 22 for unusual circumstances should be used with the most appropriate CPT code for a vaginal or C-Section delivery when the method of delivery is the same for all births.

If the multiple gestation results in a C-Section delivery and a vaginal delivery, the provider should bill the most appropriate CPT code for the C-Section delivery without a modifier and should also bill the most appropriate CPT code for the vaginal delivery and append modifier "51".

Acute Level of Care	Description	Revenue Code
NICU	Nursery/Neonatal	NICU payment is eligible if authorized for admission to NICU unit. Provider should bill Revenue Code 174
Border Baby	Nursery	Border Baby Rate is only payable if baby is detained and services not approved as NICU. Provider should bill Revenue Code 170.
Well Baby	Nursery/Newborn, Nursery/Premature, Other Nursery	Well Baby claim should be billed with Revenue Code 171-172 and 179
PICU I	Pediatric Intensive Care	PICU per diem is paid when PICU bed type is authorized. Provider should bill Revenue Code 203
BURN	Burn	BURN per diem is paid when BURN bed type is authorized. Provider should bill Revenue Code 207.

Note: Babies admitted to NICU require prior authorization from date admitted to NICU; even if during mother's stay. NICU services require separate authorization for baby in order to be paid.

Note: Mother's delivery and baby stay should be billed on two separate claims. Mother's claim should only include mother's room, board and ancillary charges. Baby claim should only include baby's room, board and ancillary charges.

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

Note: Rural facilities that have general per diem only rates and border baby rates: if baby is discharged with mother and not in NICU, for rural hospitals, "well baby" is not eligible for payment on baby's claim. Baby services are considered inclusive in mother's stay. If baby is discharged with mother, but goes to NICU for any days prior to discharge with mother, facility must notify and receive authorization in order to receive payment for NICU days. If baby is detained and not in NICU: the facility would be eligible for reimbursement under border baby rate, if authorized by Medical Management. If baby is detained and in

NICU, facility would be eligible for payment at the NICU rate (which for rural facilities is the general per diem rate) if authorized.

Note: Border baby rate is payable for detained babies only when authorized, it should not be authorized for babies discharged with mother.

Note: NICU rate is only payable for babies in NICU when NICU bed-type is authorized (authorization begins with date admitted to NICU)

Note: Well Baby per diem rate is only payable to facilities that have published well baby per diem rate, well baby is paid to those facilities when baby is discharged with mother and stay is not in NICU; can be covered under mother's maternity authorization.

Observation

The entire observation visit may not exceed 30 hours duration. Provider should bill no more than 30 hours/units for observation visit.

Observation services must be billed in units and populated in the units field

When billing for these services, hospitals must include the admission hour and discharge hour in addition to the other required items on the observation claim.
An Observation visit should be billed as follows:
Revenue code 720

HCPCS Code G0378

Hospital observation service, per hour

HCPCS Code G0379

Direct admission of patient for hospital observation care

Outpatient Hospital Services

Providers are required to bill a revenue code on the Louisiana Medicaid FFS Hospital Outpatient Fee Schedule. Most outpatient services must be billed with a CPT or HCPCS code. Please see list

below of revenue codes that require valid hcpc/cpt code when billed on OP UB04. Drugs are required to be billed with NDC information (valid NDC, NDC units and NDC unit of measure).

The below revenue codes require a valid HCPC/CPT code to be billed in order for the line to be reimbursable:

Rev Code	Description
HR251	PHARMACY,GENERIC DRUGS
HR252	PHARMACY,NON-GENERIC DRUGS
HR258	PHARMACY,IV SOLUTIONS
HR259	PHARMACY, OTHER PHARMACY
HR260	IV THERAPY
HR261	INFUSION PUMP
HR269	OTHER IV THERAPY
HR278	OTHER IMPLANTS
HR300	LABORATORY-GEN CLASSIFICATION
HR301	LAB/CHEMISTRY
HR302	LAB/IMMUNOLOGY
HR303	LAB/RENAL PATIENT (HOME)
HR304	LAB NON ROUTINE DIALYSIS
HR305	LAB HEMATOLOGY
HR306	LAB BACTERIOLOGY AND MICROBIOLOGY
HR307	LABORATORY-UROLOGY
HR309	LABORTORY-OTHER LABORATORY
HR310	LAB PATHOLOGY/GENERAL CLASS
HR311	LAB PATHOLOGY/CYTOLOGY
HR312	LAB PATHOLOGY/HISTOLOGY
HR314	LAB PATHOLOGY/BIOPSY
HR319	LAB PATHOLOGY OTHER
HR320	RADIOLOGY-DIAGNOSTIC GEN CLASS
HR321	ANGIOCARDIOLOGY
HR324	CHEST X-RAY
HR329	RADIOLOGY-DIAGNOSTIC OTHER
HR330	RADIOLOGY-THERAPEUTIC/GEN CLASS
HR331	CHEMOTHERAPY-INJECTED
HR332	CHEMOTHERAPY-ORAL
HR333	RADIATION THERAPY
HR335	CHEMOTHERAPY IV
HR339	RADIOLOGY-THERAPEUTIC OTHER
HR340	NUCLEAR MEDICINE GENERAL
HR341	NUCLEAR MEDICINE DIAGNOSTIC
HR342	NUCLEAR MEDICINE THERAPEUTIC
HR349	NUCLEAR MEDICINE OTHER

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

HR350	CT SCAN GENERAL CLASSIFICATION
HR351	CT SCAN-HEAD
HR352	CT SCAN-BODY
HR359	OTHER CT SCANS
HR370	ANESTHESIA GENERAL
HR379	OTHER ANESTHESIA
HR380	BLOOD GENERAL CLASSIFICATION
HR381	PACKED RED CELLS
HR382	WHOLE BLOOD
HR383	PLASMA
HR384	PLATELETS
HR385	BLOOD/LEUKOCYTES
HR386	BLOOD OTHER COMPONENTS
HR387	BLOOD-OTHER DERIVATIVES
HR389	OTHER BLOOD
HR390	BLOOD STORAGE-PROCESSING G C
HR391	BLOOD ADMINISTRATRION
HR392	BLOOD PROCESSING STORAGE
HR399	OTHER BLOOD HANDLING
HR400	OTHER IMAGING SERVICES
HR401	DIAGNOSTIC MAMMOGRAPHY
HR402	ULTRASOUND
HR403	SCREENING MAMMOGRAPHY
HR409	OTHER IMAGING SERVICES
HR410	RESPIRATORY SERVICES GEN CLASS
HR412	INHALATION SERVICES
HR413	HYPERBARIC OXYGEN THERAPY
HR419	OTHER RESPIRATORY SERVICES
HR420	PHYSICAL THERAPY GENERAL
HR421	PHYSICAL THERAPY-VISIT CHARGE
HR422	PHYSICAL THERAPY-HOURLY CHARGE
HR424	PT EVALUTION/RE-EVALUATION
HR430	OCCUPATIONAL THERAPY GENERAL
HR431	OCCUPATIONAL THERAPY-VISIT CHARGE
HR432	OCCUPATIONAL THERAPY-HOURLY
HR434	OT EVALUATION/RE-EVALUATION
HR440	SPEECH/LANGUAGE PATHOLOGY GENERAL
HR441	SPEECH/LANGUAGE-VISIT CHARGE
HR442	SPEECH/LANGUAGE HOURLY CHARGE
HR444	S/L EVALUATION/RE-EVALUATION
HR450	EMERGENCY ROOM-GENERAL
HR459	OTHER EMERGENCY ROOM
HR460	PULMONARY FUNCTION-GENERAL

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

HR469	OTHER PULMONARY
HR470	AUDIOLOGY-GENERAL
HR471	AUDIOLGY-DIAGNOSTIC
HR472	AUDIOLOGY-TREATMENT
HR479	OTHER AUDIOLOGY
HR480	CARDIOLOGY-GENERAL
HR481	CARDIAC CATH LAB
HR482	STRESS TEST
HR489	OTHER CARDIOLOGY
HR490	AMBULATORY SURGICAL CARE GENERAL
HR510	CLINIC-GENERAL
HR514	OB-GYN CLINIC
HR515	PEDIATRIC CLINIC
HR517	FAMILY PRACTICE CLINIC
HR519	OTHER CLINIC
HR540	AMBULANCE-GENERAL
HR610	MAGNETIC RESONANCE IMAGE GEN CL
HR611	MAGNETIC RESONANCE IMAGE-BRAIN
HR612	MAGNETIC RESONANCE IMAGE-SPINE
HR619	MAGNETIC RESONANCE IMAGE-OTHER
HR636	DRUGS REQUIRING DETAILED CODING
HR730	EKG ECG-GENERAL CLASSIFICATION
HR731	HOLTER MONITOR
HR732	TELEMETRY
HR739	OTHER EKG/ECG
HR740	EEG-GENERAL CLASSIFICATION
HR750	GASTRO-INTEST SERV-GEN CLASSIFICATIO
HR761	TREATMENT RM
HR790	EXTRA-CORPOREAL SHOCK WAVE THERAPY
HR820	HEMDIAL-OUTPAT/HOME GEN CLASSIFICATI
HR821	HEMODIALYSIS/COMPOSITE
HR822	HOME SUPPLIES-HEMODIALYSIS
HR823	HOME EQUIPMENT-HEMODIALYSIS
HR824	MAINTENANCE/100%-HEMODIALYSIS
HR825	SUPPORT SERVICES-HEMODIALYSIS
HR829	OTHER OP HEMODIALYSIS
HR830	PERITONEAL DIALYSIS OP/HM G CLASS
HR831	PERITONEAL/COMPOSITE RATE
HR832	HOME SUPPLIES-PERITONEAL DIALYSIS
HR833	HOME EQUIPMENT-PERITONEAL DIALYSIS
HR834	MAINTENANCE/100%-PERITONEAL DIALYSIS
HR839	OTHER OUTPATIENT PERITONEAL DIALYSIS
HR840	CAPD-HOME/OP GEN CLASS

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

HR841	CAPD/COMPOSITE OR OTHER RATE
HR850	GEN CLASSIF-CCP DIALYSIS OP/HM
HR851	CCP DIALYSIS/COMPOSITE RATE
HR855	SUPPORT SERVICES CCP DIALYSIS
HR880	MISC DIALYSIS GEN CLASS
HR881	MISC DIALYSIS ULTRAFILTRATION
HR920	OTHER DIAG SERV GEN CLASSIFICATION
HR921	PERIPHERAL VASCULAR LAB
HR922	ELECTROMYELGRAM
HR923	PAP SMEAR
HR924	ALLERGY TEST
HR925	PREGNANCY TEST
HR929	OTHER DIAGNOSTIC SERVICE

Radiology Services

Free Standing radiology centers should bill on CMS 1500. Outpatient hospitals should bill on UB-04. 837 electronic format is also acceptable.

Hospitals must bill the appropriate revenue code from the Louisiana Medicaid Outpatient hospital fee schedule.

Surgery

Bill on UB-04, or via 837 electronic format

Surgery services should be billed with Revenue Code 490 only.

Multiple modifiers - Bilateral secondary procedures should be billed with modifiers 50/51

Physical/Occupational and Speech Therapies

Therapy services may be billed on a UB-04 or CMS 1500 claim form or via 837 electronic format.

Transplants

Transplants should be billed on an UB-04 for facility services and CMS 1500 for professional services or via appropriate 837 electronic format.

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

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically…	Contact Emdeon at: 877-363-3666
If you have general EDI questions …	Contact AmeriHealth Caritas Louisiana EDI Technical Support at: 1-866-428-7419 or by e-mail at: edi@amerihealthcaritasla.com
If you have questions about specific claims transmissions or acceptance and R059 - Claim Status reports…	Contact your EDI Software Vendor or call the Emdeon Provider Support Line at 1-800-845-6592
If you have questions about your R059 – Plan Claim Status (receipt or completion dates)…	Contact Provider Claim Services at 1-888-922-0007
If you have questions about claims that are reported on the Remittance Advice….	Contact Provider Claim Services at 1-888-922-0007 for claim inquiries.
If you need to know your provider NPI number…	Contact Provider Services at: 1-888-922-0007
If you would like to update provider, payee, NPI, UPIN, tax ID number or payment address information… For questions about changing or verifying provider information…	Notify Provider Network Management in writing at: AmeriHealth Caritas Louisiana 10000 Perkins Rowe, Block G, 4th Floor Baton Rouge, LA 70810 Or by fax at: 225-300-9126 Or by telephone at: 1-877-588-2248
If you would like information on the 835 Remittance Advice…	Contact your EDI Vendor or call Emdeon at 877-363-3666
Check the status of your claim…	Review the status of your submitted claims on NaviNet at: www.navinet.net
Sign up for NaviNet	www.navinet.net NaviNet Customer Service: 1-888-482-8057
Sign up for Electronic Funds Transfer	Contact Emdeon at 866-506-2830, Option 1

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

NOTES

NOTES

APPENDIX 11

Form Approved: OMB No. 0937-0166
Expiration date: 12/31/2012

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (*Interpreter's Signature*) _____ (*Date*)

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STATEMENT OF PERSON OBTAINING CONSENT

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Newborn Request Form

Facility Notification System User Guide

7/1/2013

Table of Contents

DHH Facility Notification System

The Department of Health and Hospitals Facility Notification System provides an electronic means of form submission from hospitals and facilities to Medicaid, Office of Aging and Adult Services (OAAS), Statistical Resources, Inc. and Office of Citizens with Developmental Disabilities (OCDD). The following forms are available for electronic submission using this system: Newborn Request Form, Form 142BH, Form 148 and 148W, Notification of Admission, Status Change, Discharge for Facility Care or Waiver Services, 148 PLI requests and Demographic Change forms.

Obtaining Access to the System

To access the Facility Notification System, type the following URL into your internet browser: https://bhsfweb.dhh.louisiana.gov/DHH148/

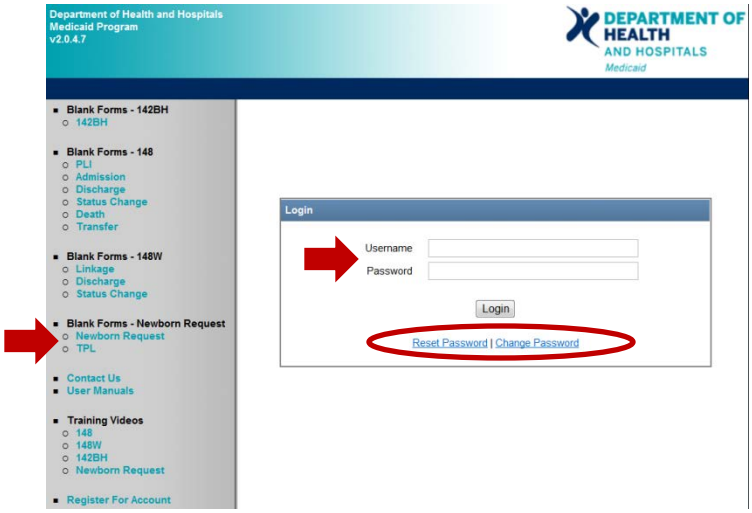
DHH Provider Facilities, Statewide Management Organization (SMO) and Support Coordination Agencies can request access to the system by clicking the link **Register for Account** in the left menu. Each user will be required to sign a confidentiality agreement when requesting a user id. The original signed copies must be mailed to the address on the form. Each user within the facility must complete their own access form, and provide a separate email address. **User names and passwords are not to be shared.**

Login Process

To log into the system enter your assigned username and password. The password will appear as a series of hidden characters to prevent unauthorized persons from viewing the actual password.

Once both username and password are entered, either click the **Login** button or press the **Enter** key. If any information is incorrect or invalid, you will be redirected to the login screen and prompted to make corrections before continuing.

NOTE: In the left menu of the login screen there are links for blank forms. If the system is unavailable or you are unable to log in, you may still submit information to DHH by selecting a form to download, print, and mail.



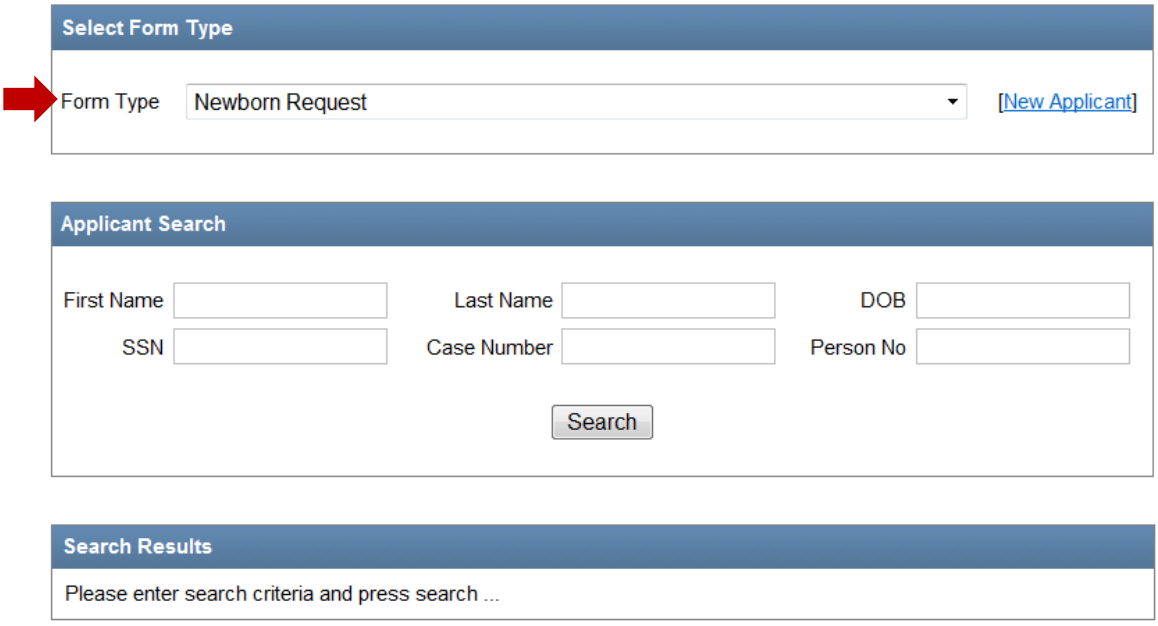
Reset or Change Password

Your username will always be your email address. If you require a password reset or change, there are **Reset Password** and **Change Password** options on the Login screen. Your new password will be sent to you via email.

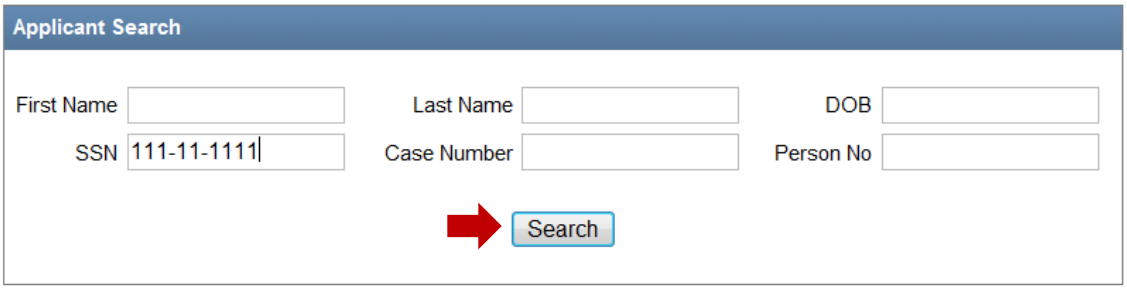
Completing a Newborn Request-Newborn

Once logged in, you'll be directed to the main FNS screen shown below.

If not already selected for you, choose the **Newborn Request** option from the dropdown provided in the **Select Form Type** section.

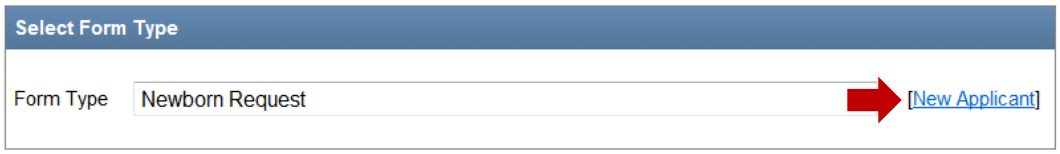


In the **Applicant Search** section, fill in any information you have for the mother of the child then click **Search**.

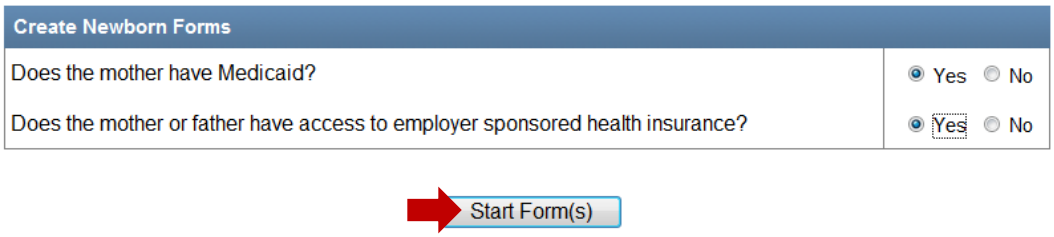


Results will appear in the **Search Results** section at the bottom of the screen. If the applicable result appears, click the hyperlink titled **Select** next to the search result. By choosing to search for an applicant before starting the form, the applicant's personal information will prepopulate the Newborn Request.

If your search doesn't produce a result, proceed by clicking the **New Applicant** hyperlink in the **Select Form Type** section.

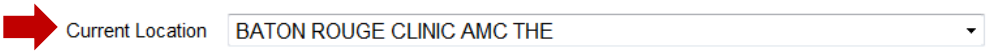


The **Create Newborn Forms** screen will appear. Answer the two questions provided in this step. If the answer to the second question, "Does the mother or father have access to employer sponsored health insurance?" is **Yes**, you'll be required to complete a **Third Party Liability (TPL)** form after completing the Newborn Request. Click **Start Form(s)** when finished answering the questions.



Part I: Mother's Information

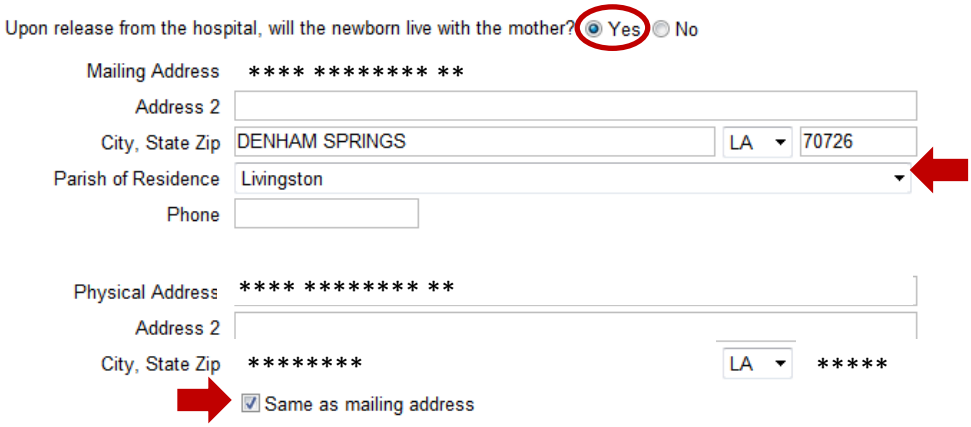
The next screen that appears is the Newborn Request form. If not already chosen for you, choose your **Current Location** from the dropdown menu at the top of the page.



Complete all of the mother's personal information in **Part I: Mother's Information**. You are required to answer the question, "Upon release from the hospital, will the newborn live with the mother?". Your answer to this question will determine the next section of the form. See the two options below:

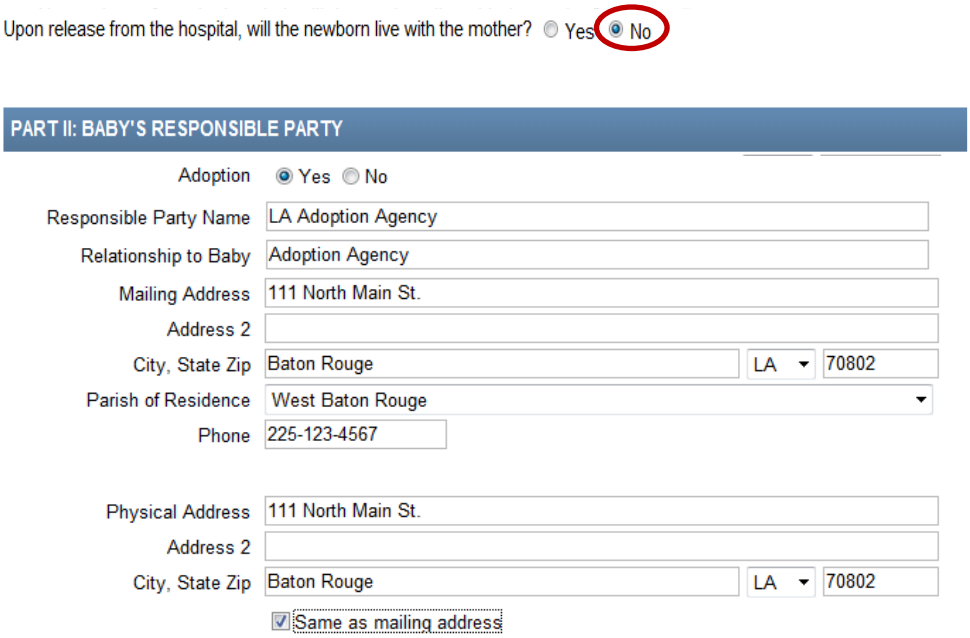
If you answer, "**Yes**", the below section will appear. Please choose the **Parish of Residence** from the dropdown menu and complete the **Phone** information if known. If the **Physical Address** is the same as the mailing address, check off the box at the bottom of this section next to **Same as mailing address**.

If the **Physical Address** is different than the **Mailing Address**, complete the **Physical Address** section.



Part II: Baby's Responsible Party

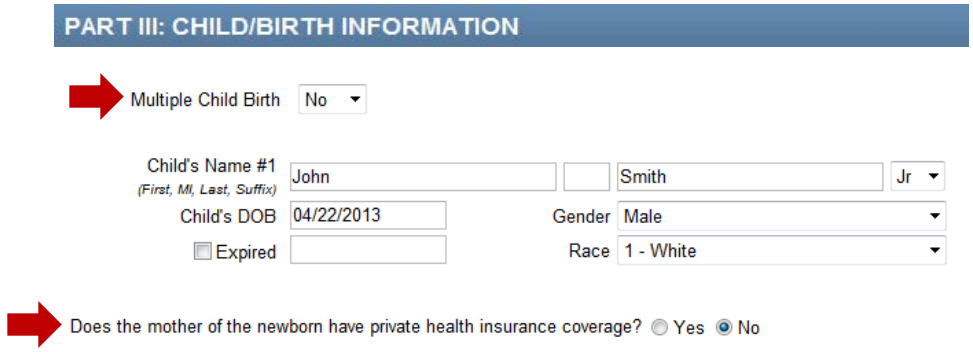
If you answer, "**No**", the **Part II: Baby's Responsible Party** section will appear. Fill in all categories in this section. This information may consist of personal information or agency information depending on the circumstances.



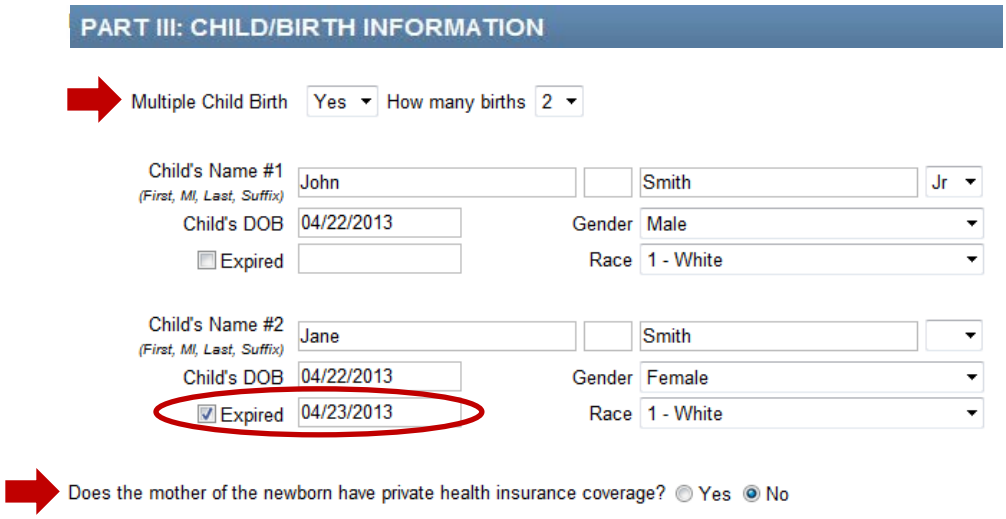
Part III: Child/Birth Information

The next section is **Part III: Child/Birth Information**. From the dropdown menu next to **Multiple Child Birth**, choose **Yes** or **No**. This answer will determine the next step. See the below information based on the choices:

If you answer "**No**" from the **Multiple Child Birth** dropdown, personal information fields for one baby will appear. Complete each field provided in this section. If the **Expired** box is chosen, you must fill in the baby's date of death. You are required to answer the question, "**Does the mother of the newborn have private health insurance coverage?**".

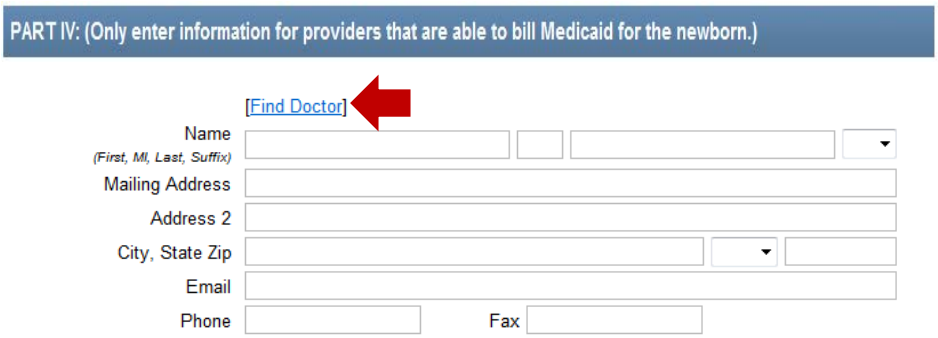


If you answer "**Yes**" from the **Multiple Child Birth** dropdown, an additional section will appear asking "**How many births?**". From the dropdown provided, choose the number of births. The number chosen in this dropdown will dictate the number of personal information fields provided for each baby born. Complete the appropriate sections. If the **Expired** box is checked, you must fill in the baby's date of death. You are required to answer the question, "**Does the mother of the newborn have private health insurance coverage?**".

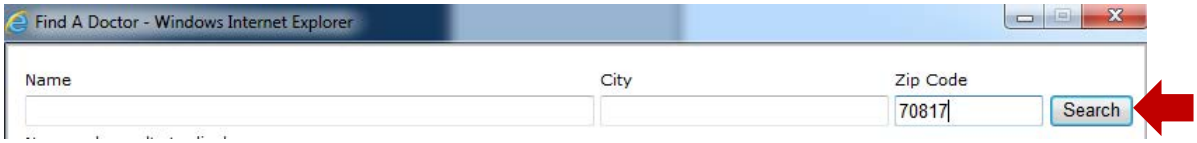


Part IV: Provider Information

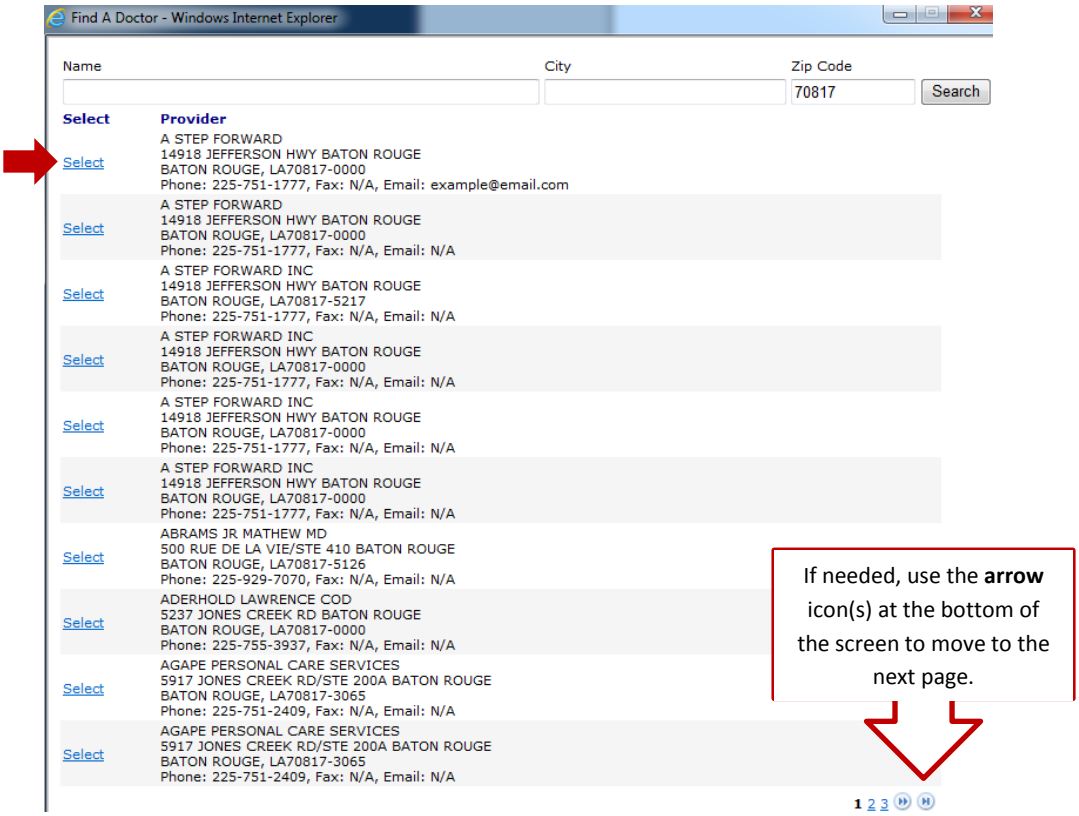
To complete **Part IV**, click the **Find Doctor** hyperlink at the top of this section.



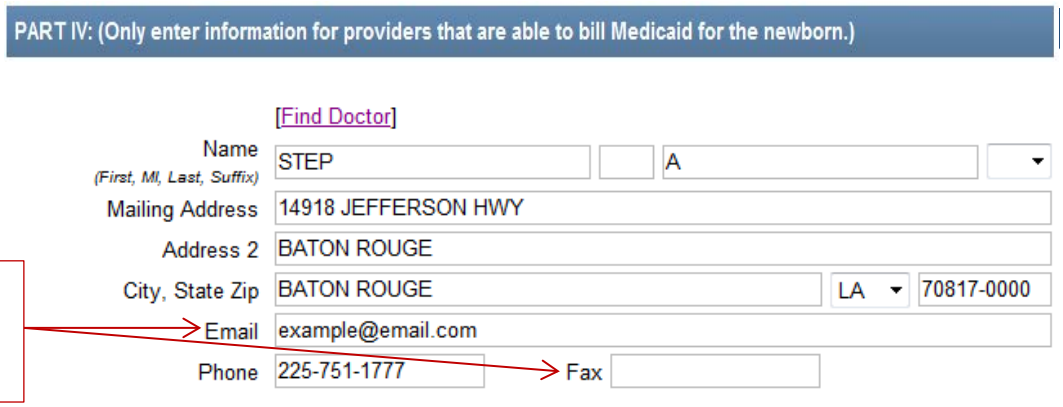
The **Find A Doctor** window will appear. Search for the appropriate doctor using the **Name**, **City**, and/or **Zip Code** fields and click **Search**.



Based on the criteria you enter for the search, the filtered results will appear in the **Find A Doctor** window. Depending on the number of results, you may need to move to the next page of search results to find the appropriate doctor. Click the **Select** hyperlink next to the appropriate **Provider**.



The provider information you selected in the **Find A Doctor** window will prepopulate in the fields provided in **Part IV**. An **Email** or **Fax** is required so Medicaid can provide the child's Medicaid number.



An **Email** or **Fax** is required in **Part IV**.

Pediatrician Information

Complete the **Pediatrician Information** section in the same manner as you completed **Part IV**.

Additional Providers

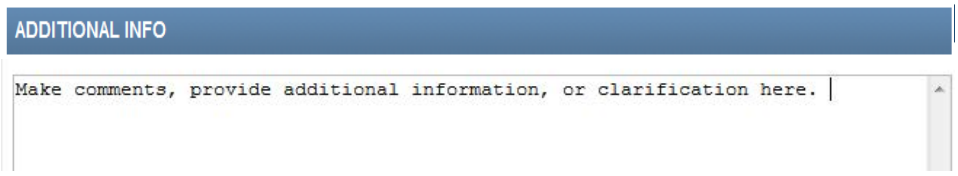
If additional providers are needed, check the box next to **Include Additional Providers** in the section heading. Complete this section in the same manner you completed **Part IV** and **Pediatrician**.

Facility Representative Information

The **Facility Representative Information** section will be prepopulated based on the information Medicaid has on file.

Additional Information

You can provide additional information or clarification if needed in the text box provided.



Submitting a Newborn Request

Click the **Submit** button at the bottom of the form to send the form to DHH. Click the **Save Draft** button to save the information entered and return later for completion. Click **Cancel** to end and close the form you are completing. Cancelling the form will not save any of the information entered.

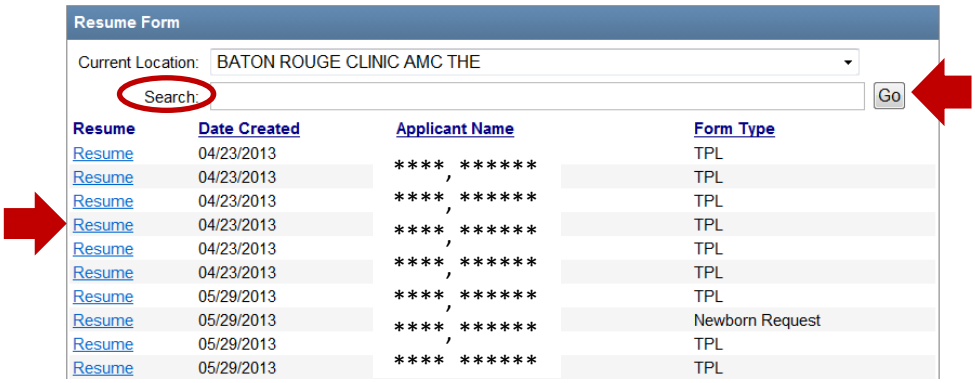
When you click **Submit**, one of two things will occur. You will either receive a "**Please correct the following items**" error message or your request will be sent without an error and you'll be returned to the main screen of the Facility Notification System or the **TPL** page, if a **TPL** is required.

An error message similar to the one shown below may appear when submitting a Newborn Request. This message occurs when required fields are missing information. Review the bulleted items in the error message and correct the required fields and click **Submit**.

Resuming a Newborn Request

To resume a form saved as a draft, click on the **Resume Form** link on the top left of the home page. A list of forms that have been saved as a draft will be displayed. Click **Resume** next to the form to open the saved form.

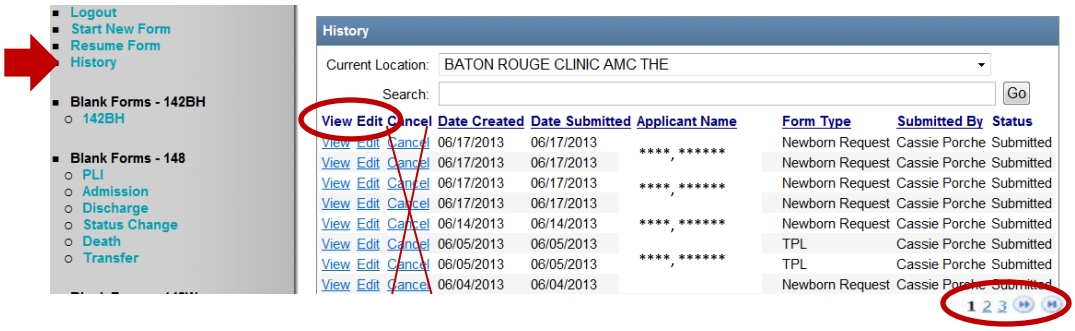
NOTE: A **Search** field is available to make it easier to find saved drafts. Enter your search criteria in the field provided and click the **Go** button.



The saved form will open prepopulated with the information previously saved. Complete the required fields and click **Submit**. A successful submission will bring you to the home page of FNS. An unsuccessful submission will produce an error message detailing what required information is needed to submit the form.

History

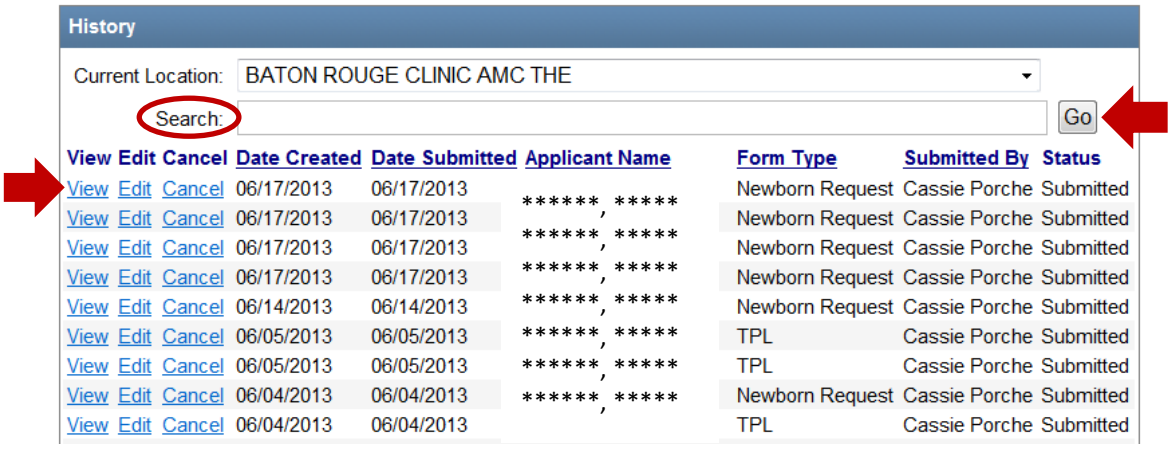
From the home page, click the **History** link in the left menu. Under the **History** section, a grid view of all of the forms submitted will be displayed. Paging arrows and links will appear on the bottom right hand side of the screen if more than one page of data is available. From here, a form can be **viewed** or **edited**. The **cancel** feature cannot be used from **History**. **Any attempts to cancel a form will not be honored.**



Viewing a Form

To view a printable report of a specific form, click the **View** hyperlink to the left of the item.

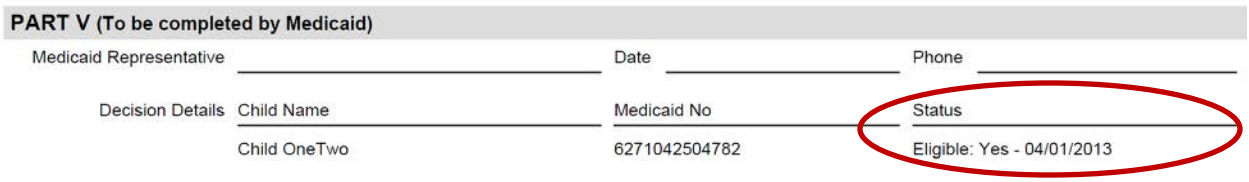
NOTE: A **Search** field is available to make it easier to find submitted forms. Enter your search criteria in the field provided and click the **Go** button. When viewing the form in history, the status of the case can be found in **Part V (To be completed by Medicaid)**



Newborn Request Eligibility Status

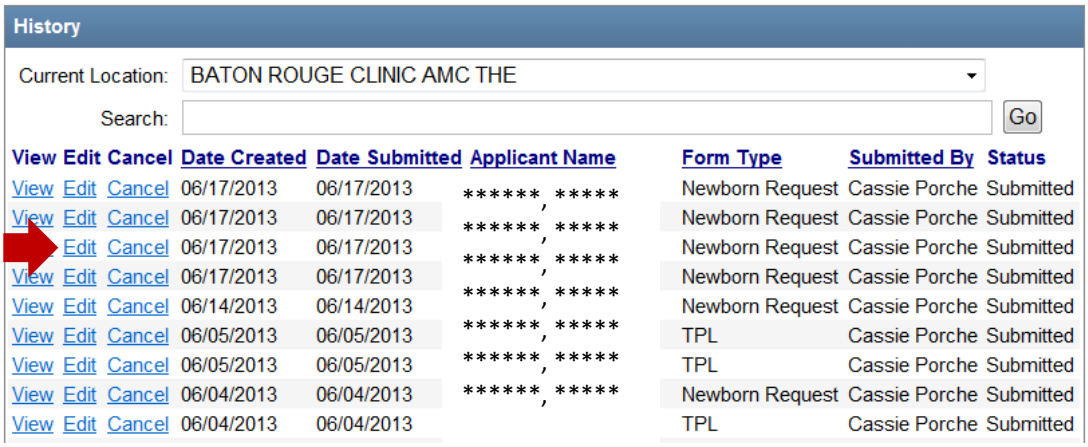
The eligibility status of a Newborn Request submission will be faxed or emailed to the doctor and/or pediatrician based on the information provided in **Part IV** and **Pediatrician Information**.

In addition, the **Status** of the request can be found in **Part V** of the form when in viewing the form from the **History** window.



Editing a Form

In the event that an error has been made on a submitted form, you can edit the form in the history window. Find the form that need editing and click **Edit** to the left of the item.

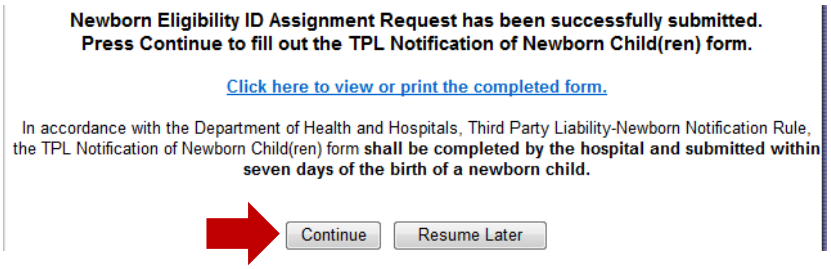


The form will open with a red heading titled **Corrected Copy**. Make the necessary edits and click **Submit** at the bottom of the screen. A successful submission will return you to the home page of FNS.

Third Party Liability Form (TPL)

If a parent has private insurance a **Third Party Liability (TPL)** form is required. You'll be directed to the page below. To print or view a copy of the **TPL** click the hyperlink labeled "**Click here to view or print the completed form.**" When ready to proceed, click the **Continue** button.

To resume the **TPL** form later, click the **Resume Later** button.

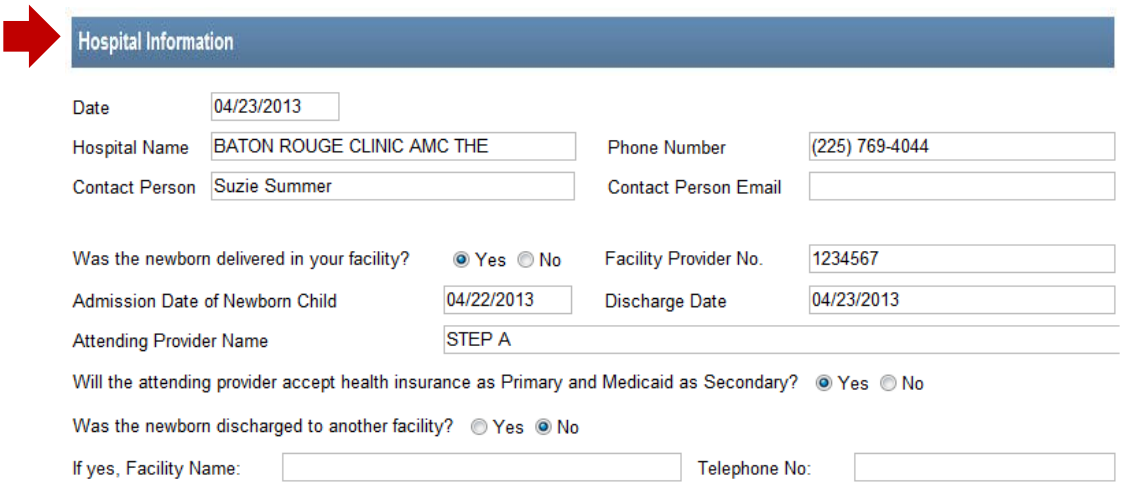


After clicking **Continue**, the Third Party Liability form will appear prepopulated with the information from the Newborn Request. Confirm that the **Current Location** at the top of the form is correct. If it is not, choose the location from the dropdown menu.

Hospital Information

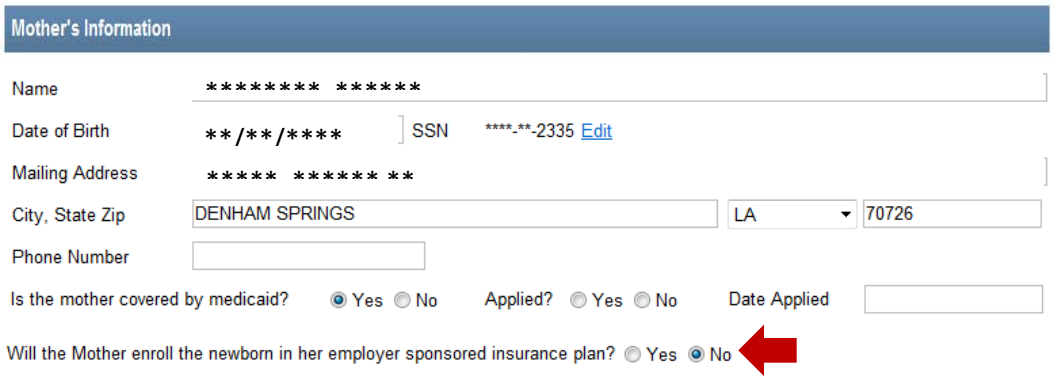
Complete the following required fields in the **Hospital Information** section: **Date, Was the newborn delivered in your facility?, Facility Provider No., Discharge Date, Will the attending provided accept health insurance as Primary and Medicaid as Secondary?,** and **Was the newborn discharged to another facility?**

If the newborn was discharged to another facility, the **Facility Name** and **Telephone No.** are required.



Mother's Information

The mother's information will prepopulate with information from the Newborn Request. The question, "**Will the Mother enroll the newborn in her employer sponsored insurance plan?**" requires an answer.



Mother's Employment

If details regarding the mother's employment are known, fill in the provided fields. This section is not required.

Father's Information

If details about the father are known, fill in the provided fields. This section is not required.

Father's Employment

If details regarding the father's employment are known, fill in the provided fields. This section is not required.

Other Contact- #1 and #2

If additional contact information for the family is known, fill in the **Other Contact** sections.

Newborn Section

Depending on the number of births, there may be more than one **New Born** section. The following information is required in these sections: **Birth Weight, Gestation Age,** and **NICU** information.

Health Insurance-Primary Plan and Secondary Plan

If information regarding a primary or secondary plan are known, fill in the fields provided in these sections. These sections are not required.

Insurance Notification

If information for an insurance company or insurance representative are known, fill in the fields provided in this section. This section is not required.

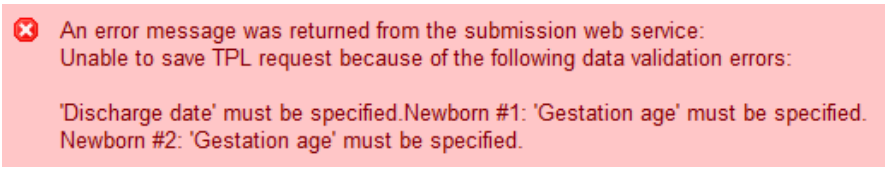
Additional Information

If you feel additional information, notes, or further explanation is needed, use the text box provided in this section.

Submitting a Third Party Liability (TPL)

At the bottom of the TPL form, click **Submit** to send the form to Medicaid, click **Save Draft** to save your work and resume later, or click **Cancel** to stop working on the form. (Cancelling the form will delete any work you've done thus far.)

When you click **Submit,** one of two things will occur. If successful, you'll be returned to the home page of the Facility Notification System. If unsuccessful, you'll be directed to the top of the TPL form where you'll see an error message detailing what required information was missing from the form. See an example of the error message below:



Once you've updated the form to include the required information, click **Submit** at the bottom of the form.

Resuming a TPL Draft

The TPL form can be saved as a draft and finished at a later time. Follow the same process as shown in *Resuming a Newborn Request.*

Resources

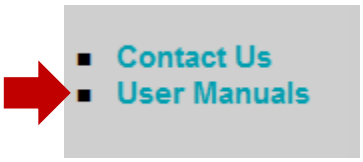
DHH has provided you with several useful resources in the Facility Notification System.

Contact Us

In the left menu of FNS there is a **Contact Us** hyperlink that will direct you to DHH and Medical Vendor Administration contact information.

User Manual

In the left menu of FNS there is a **User Manual** hyperlink that will direct you to the available manuals and guides for the Facility Notification System.



Training Videos

In the left menu of FNS there is a **Training Videos** section where you'll find hyperlinks to the available training videos on how to navigate and submit forms using FNS.

Logout

When you're ready to log out of the Facility Notification System, click the **Logout** hyperlink from the left menu. You'll be returned to the Log In screen of FNS.

AmeriHealth Caritas Louisiana

PATIENT INFORMATION		
Patient's Name (First, Middle Initial, Last)	Patient's Medicaid ID # (13-digits)	Patient's Date of Birth (MM-DD-YYYY)

FIRST BENEFIT PERIOD (90 Days)

Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

SIGNATURES (Physicians must date at time of signature)

Signature of Attending Physician	Date Signed (MM-DD-YYYY)
Printed Name of Above Attending Physician	
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

SECOND BENEFIT PERIOD (90 Days)

Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

SIGNATURES (Physicians must date at time of signature)

Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

THIRD BENEFIT PERIOD (60 Days)

Having reviewed this patient's Medical record and/or Examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

SIGNATURES (Physicians must date at time of signature)

Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG)	Date Signed (MM-DD-YYYY)
Printed Name of Above Hospice Medical Director or Physician Member of IDG	

REFFERING PHYSICIAN NARRATIVE STATEMENT:

Review of the individual's clinical circumstances and medical information to provide clinical justification for admission to hospice services. Narrative must be written legible by the physician.

SIGNATURES (Physicians must date at time of signature)

Signature Referring Physician	Date Signed (MM-DD-YYYY)
Printed Name of Above Physician	

NOTE: If additional periods are to be certified, use an additional form

VERBAL VERIFICATION (within two days of election date)

I certify that on the date signed below a verbal verification was obtained from the physician named below; confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

SIGNATURES

Physician's Name **(printed)**		
Signature of IDG Member Taking Referral	Printed Name of IDG Member Taking Referral	Date Signed (MM-DD-YYYY)

THIS FORM CANNOT BE ALTERED

Please return to ACLA's Utilization Management department via fax to: 1-866-397-4522.

AmeriHealth Caritas Louisiana

PART I: TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE ONLY

1 **Hospice is a program that gives help and support to patients during the final months of life. The program also helps loved ones cope. I choose to receive services from the Hospice provider named below starting**

_____
Election/Admission Date (MM-DD-YYYY)

NOTE: To get hospice services, I must have Medicaid and my doctor must write that I am in my final months of life.

PATIENT'S STATEMENT

I understand and accept:

- I can get hospice for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- If my illness is better. I will no longer get hospice services under the Medicaid Program. If I no longer receive hospice services, I can keep on using my Medicaid card for other services.
- By choosing hospice I understand that I will not be treated for my terminal sickness and any related condition.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- I am signing this paper because I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose to not receive hospice care at any time.

SIGNATURES

Signature of Patient/Legal Representative	Date of Signed (MM-DD-YYYY)	Representative's Daytime Phone # (incl. area code)
Printed Name of Above Signee	Legal Representative's Relationship to Patient	

PART II: TO BE COMPLETED BY HOSPICE PROVIDER

PATIENT INFORMATION

Patient Name (First, Middle Initial, Last)	Patient's Address City State Zip	
Patient Medicaid ID #	Patient Medicare ID #	Date of Birth (MM-DD-YYYY)

Type Bill	Statement Covers Period From (MM-DD-YYYY)	Statement Covers Period Through (MM-DD-YYYY)	Primary Diagnosis Code (s)	List All Other Diagnosis Codes

Discharge/Revocation Reason(s):

PROVIDER INFORMATION

Hospice Provider Name		Hospice Address	
Hospice Provider #	Hospice Provider Phone # (incl. area code & Fax)	Hospice City State Zip	
Attending Physician Printed Name		Attending Physician Provider #s	Hospice Relationship Status

SIGNATURES

Hospice Provider Representative's Signature	Hospice Representative's Printed Name	Date (MM-DD-YYYY)

This form cannot be altered.

Please return to ACLA's Utilization Management department via fax to: 1-866-397-4522.

AmeriHealth Caritas Louisiana

Hospital Notification of Emergent/Urgent Admissions

Fax to: 1-866-397-4522

Patient Care Management Team

Member 1

Date of Admission: ____/____/____(AmeriHealth Caritas Louisiana must be notified on the first business day following date of service.)

Member ID #: _____ DOB: _____/_____/_____Member Name: _____

Type of Admission

❑ Inpatient ❑ Medical Observation less than 23 hours stay

❑ Short Procedure ❑ Obstetric Observation less than 23 hours stay

Diagnosis/Reason for Admission: _____

Attending Physician: _____ AmeriHealth Caritas Louisiana Provider ID #: _____

Procedures Performed (must be completed for SPU Admissions): _____

Is Member Pregnant? ❑ Yes ❑ No

EDC: _____ OB Practitioner: _____

For AmeriHealth Caritas Louisiana Use Only

Case #: _____

6087 -UM Disclaimer -Admissions **1A01**

The case reference number is for identification purposes only. Authorization is based on medical necessity and is subject to member eligibility and applicable Plan benefit limitations. This is not a guarantee of payment.

Member 2

Date of Admission: ____/____/____(AmeriHealth Caritas Louisiana must be notified on the first business day following date of service.)

Member ID #: _____ DOB: _____/_____/_____Member Name: _____

Type of Admission

❑ Inpatient ❑ Medical Observation less than 23 hours stay

❑ Short Procedure ❑ Obstetric Observation less than 23 hours stay

Diagnosis/Reason for Admission: _____

Attending Physician: _____ AmeriHealth Caritas Louisiana Provider ID #: _____

Procedures Performed (must be completed for SPU Admissions): _____

Is Member Pregnant? ❑ Yes ❑ No

EDC: _____ OB Practitioner: _____

For AmeriHealth Caritas Louisiana Use Only

Case #: _____

6087 -UM Disclaimer -Admissions **1A01**

The case reference number is for identification purposes only. Authorization is based on medical necessity and is subject to member eligibility and applicable Plan benefit limitations. This is not a guarantee of payment.

Return response by: ❑Fax ❑Phone

This will be returned by the next business day. If not indicated, will be faxed.

AmeriHealth Caritas
Louisiana

APPENDIX 10

BHSF Form 96A
Revised 05/06

Medicaid Program
Acknowledgment of Receipt of Hysterectomy Information

Recipient Name: _____

MEDS Person No.: _____

Physician Name: _____

Provider No.: _____

Payment by Louisiana's **Medicaid Program cannot** be authorized for **any** hysterectomy performed **solely** for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose for the procedure, the hysterectomy would not be performed except for the purpose of rendering the individual permanently incapable of reproducing.

Medicaid payment for a medically indicated hysterectomy can be authorized **only** if:

(1) the individual and her representative*, if any, are informed orally and in writing that the hysterectomy will render her permanently incapable of reproducing; and,

(2) the individual and her representative* if any, have signed a written acknowledgment of receipt of that information. The written acknowledgment must be signed and dated prior to the operation and must be attached to the claim form when it is submitted for payment.

* A representative is that person who has the legal authority to act for an individual. For purposes of this acknowledgment, a representative shall be defined as either the curator of an interdicted woman or the tutor or parent of an unmarried minor. A minor emancipated by marriage is deemed capable of acting for herself in the matter.

I hereby acknowledge that I have been informed orally and in writing that a hysterectomy (surgical removal of the uterus) will render a woman permanently incapable of bearing children.

_____ _____
Signature of Recipient Date

_____ _____
Signature of Representative, if any Date

AmeriHealth Caritas Louisiana
P.O. Box 83580
Baton Rouge, LA 70884

Appendix 19 – Project Submission Form

Provider Information
Provider Name:
Provider Tax ID #:
Provider Number:

Contact Information
Contact Persons:
Telephone Number:
E-Mail Address:

For AmeriHealth Caritas Louisiana only:

Receive Date:
Processing Instructions:

Patient Account Number	Patient Name	Issue	DOS	Patient ID Number	DOB	Claim Number	Claim Type	Rev Code (Hosp)	Proc Code (All)	Start Date	End Date	Total Days/Units	Total Charges	Expected Payment

ATTACHMENT A

NATIONAL QUALITY FORUM
SERIOUS REPORTABLE EVENTS
IN
HEALTH CARE

Surgical Events

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately post-operative death in a normal health patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)

Product or Device Events

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

Patient Protection Events

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient elopement (disappearance) for more than 4 hours
- Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility

Care Management Events

- Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility

- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, excluding those the progress from Stage 2 to Stage 3
- Patient death or serious disability due to spinal manipulative therapy

Environmental Events

- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

Criminal Events

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of a healthcare facility
- Death or significant injury of a patient resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

AmeriHealth Caritas Louisiana

P.O. Box 83580
Baton Rouge, LA 70884

Non-Participating Provider Emergency Services Payment Guidance

AmeriHealth Caritas Louisiana will reimburse non-participating hospital providers for emergency room services that are rendered to treat an Emergency Medical Condition for ACLA members. An Emergency Medical Condition is defined as,

> A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

Payment

Emergency room services will be reimbursed using the Louisiana Medicaid Rates. No prior authorization or notification is required for non-participating providers or hospitals. AmeriHealth Caritas Louisiana does reserve the right to request the emergency room medical records to audit the encounter if necessary.

Filing Your Claim

Submit claims to AmeriHealth Caritas Louisiana at the following address:

AmeriHealth Caritas Louisiana Claims Processing Department
P.O. Box 7322
London, KY 40742

ACLA encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or Emdeon's Provider Support Line at 877-363-3666 to arrange transmission.

You can also obtain additional claims information by visiting our website at: www.amerihealthcaritasla.com \Providers\Important Information\Claims and Billing\Billing Manual

Disputes

ACLA encourages providers to try to resolve their concerns by calling the AmeriHealth Caritas Louisiana Provider Services Line at 1-888-922-0007.

If the provider continues to be dissatisfied after attempts to resolve a complaint or dispute, please review the dispute process outlined on the website and submit your information in writing to:

Attn: Provider Complaints
AmeriHealth Caritas Louisiana
P. O. Box 7323
London, KY 40742

Please remember that you are not permitted to balance bill a member for services provided in the emergency room for any additional payment.

AmeriHealth Caritas Louisiana

AmeriHealth Caritas Louisiana Health Plan Observation Billing Guidelines

This is to clarify AmeriHealth Caritas Louisiana's billing policies with respect to observation stays. AmeriHealth Caritas Louisiana considers observation to be an outpatient service.

When a hospital requests and receives authorization for an observation stay, and bills for observation as an outpatient service, claims will be paid without delay.

When a hospital requests authorization for an inpatient stay but the plan authorizes outpatient observation, such medical necessity determinations may be disputed using standard dispute process. If the plan has authorized outpatient observation and the hospital submits a claim for the service as an inpatient service, the claim will be denied. This claim denial may also be disputed using standard dispute process.

However, if a hospital decides on further consideration that the request should be changed from inpatient to outpatient observation, the hospital may resubmit the claim as outpatient observation and the claim will be processed using standard claims payment procedures.

*Please note that the Center for Medicare and Medicaid Services (CMS) has issued Publication

100-04 Claims Processing, effective April 1, 2004, that permits a hospital to bill an outpatient service, such as observation, even if the physician ordered an inpatient service.

If a member is admitted as an inpatient following a Medical Observation Stay, notification is required to the Utilization Management Department through NaviNet, by fax to 866-397-4522 or by calling 1-888-913-0350 for authorization.

Thank you for participating in the AmeriHealth Caritas Louisiana Provider Network and for your continued commitment to our members. If you have any questions regarding this letter, our Provider Services Department is available from 7am -7pm Central Time, Monday through Friday at 888-922-0007, or you may contact your Provider Account Executive.

AmeriHealth Caritas Louisiana

PROVIDER CHANGE FORM

CURRENT PRACTICE INFORMATION

Group Practice Name/Individual Name: _____
(Please Circle One ✎)

Group Practice ID/Individual ID: AmeriHealth Caritas ID:_____ NPI #_____ PPID# _____
(Please Circle One ✎)

_____ _____ _____ _____
Contact Person Name (please print clearly) Telephone Fax E-mail address

_____ _____ _____
Authorizing Signature (physician/office manager) Today's Date Effective Date of Change
Change will not be completed without signature

PROVIDER CHANGE INFORMATION

Provide Complete Information – This Request will be processed for AmeriHealth Caritas Louisiana. If any of these changes result in a change on your W-9, you must submit a copy of your W-9 with this change form. PLEASE NOTE: Practitioners must complete AmeriHealth Caritas Louisiana Credentialing before they will be added to your practice as a participating provider. Refer to the LaCare website for Credentialing Requirements www.amerihealthcaritasla.com

Type of Change: (Please check all that apply)

- ⑤ Adding a Practice
- ⑤ Joining a Practice
- ⑤ Telephone change
- ⑤ Adding an office location
- ⑤ Changing an office location
- ⑤ Other (attach documentation)
- ⑤ Fax change
- ⑤ Name change only

PREVIOUS OFFICE INFORMATION

_____ _____
AmeriHealth Caritas Provider ID NPI

Name

Street Address

City State Zip

Telephone Fax Email address

NEW OFFICE INFORMATION

_____ _____
AmeriHealth Caritas Provider ID NPI

Name

Street Address

City State Zip

Telephone Fax Email address

ADD Practitioners (New Practitioners must complete AmeriHealth Caritas Louisiana Credentialing before they are added as a participating provider)

1._____ _____ _____
Last First M.I. Degree NPI PPID

2. _____ _____ _____
Last First M.I. Degree NPI PPID

TERMINATE Practitioners (Please give LaCare 60 days advance notice when a practitioner is leaving the group)

1._____ _____ _____
Last First M.I. Degree NPI PPID

2. _____ _____ _____
Last First M.I. Degree NPI PPID

BILLING LOCATION CHANGE ⑤

_____ _____
Street Address 1 Telephone Fax e-mail address

Street Address 2 _____
Federal Tax ID (change in Federal ID requires new W-9)

City State Zip

CHANGE OF OWNERSHIP ⑤ _____ _____
Legal Business Name of New Owner and Federal Tax ID (Requires new W-9) Effective Date of Ownership

Please mail or fax this change form and supporting documents to:
AmeriHealth Caritas Louisiana, Provider Network Management, 10000 Perkins Rowe, Block G, 4th Floor
- Fax: 1-888 972-4290 or 225-300-9126-

AmeriHealth Caritas Louisiana

PROVIDER CLAIM DISPUTE FORM

A Dispute is defined as a request from a health care provider to change a decision made by AmeriHealth Caritas Louisiana related to claim payment or denial for services already provided. A provider dispute is **not** a pre-service appeal of a denied or reduced authorization for services or an administrative complaint.

☐ First Level Dispute ☐ Second Level Dispute

Submitter / Contact Information:

Name (Last, First): _____ Phone Number: _____

Provider Information:

Name (Last, First): _____ Phone Number: _____

NPI Number: _____ Tax ID: _____

☐ I am a participating provider ☐ I am not a participating provider

Member Information:

Name (Last, First): _____ Member Date of Birth: _____

Member ID: _____

Claim Information:

Claim Number: _____ Billed Amount: $_____

Date(s) of Services: _____

To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable reason for your dispute.

☐ Inaccurate payment
☐ Post-service authorization denial
☐ Denied as a duplicate
☐ Clinical edit limitation or denial
☐ Other: _____
☐ Denied for no primary payer EOB (EOB attached)
☐ Denied for no authorization (service does not require authorization)
☐ Denied for no authorization (auth. #_____ on file)
☐ Untimely filing (proof of timely filing attached)

Additional Information:

_____

_____

Mail this form, a listing of claims (if applicable) and supporting documentation to:

AmeriHealth Caritas of Louisiana
Provider Dispute Department
P.O. Box 7323
London, KY 40742

AmeriHealth Caritas Louisiana

Provider Reference Guide

Your Network Management Representative: _____

Phone Number: _____ Fax Number: _____

Provider Services: 888-922-0007

7 a.m. to 7 p.m. CST

Member Services: 888-756-0004

24 hours a day, 7 days a week

NaviNet: www.navinet.net 888-482-8057

Access to member eligibility, claims status inquiry, Care Gap and Member Clinical

Dental Services: (Under 21) covered by DHH

Enhanced Dental Benefit: (21 and older) 800-508-6785

Vision Benefits: 800-877-7195

Administered through Vision Service Plan (www.vsp.com)

Case Management/Care Coordination: 888-643-0005

Louisiana Early Steps Program:

http://new.dhh.louisiana.gov/index.cfm/page/139/n/139

EPSDT: (formerly KidMed) 888-643-0005

Rapid Response Outreach Team: (RROT) 888-643-0005

Available from 8:00 am to 6:30 pm Monday – Friday
Call for inquiries on EPSDT, expanded services and outreach services

Tobacco Cessation Helpline: 888-643-0005 (1-800-784-8669)

http://new.dhh.louisiana.gov/index.cfm/page/608
Tobacco Smoking Cessation Hotline 800-LUNG-USA (800-586-4872)
Freedom From Smoking Clinics 800-LUNG-USA (800-586-4872)
Freedom From Smoking Online www.ffsonline.org

Injectable Pharmacy Services: 888-922-0007

All other pharmacy services are covered through the Louisiana Medicaid FFS program, more information and the formulary can be found at www.lamedicaid.com. Injectable questions and supplies: 888-922-0007

Referral Information: 888-922-0007

Referrals to Non-Participating providers always require prior authorization. Contact Utilization Management at 888-913-0350 to request authorization

Transportation: 888-913-0364

Services provided by MTM

TTY. 866-428-7588

Services requiring prior authorization include, but are not limited to the list below. The most up-to-date and detailed listing of services that require prior authorization can be found in the Provider Center at www.amerihealthcaritasla.com

Services Requiring Prior Authorization:

The following is a partial list of services requiring prior authorization review for medical necessity and/or place of service. Please refer to the AmeriHealth Caritas Louisiana Provider Handbook or contact Provider Services for a detailed list.

- In-patient services
- Home-based services
- Therapy and related services
- Transplants, including transplant evaluations
- Air Ambulance
- Durable Medical Equipment
- Billed charges $500 and over including prosthetics and orthotics
- All DME rentals
- All Enteral Nutritional Supplements and Supplies
- All Diapers/pull-up diapers for members ages 4 through 20. Not covered for members age 21 and over, or children under 3
- All Wheelchair parts
- Medications: 17P and all infusion/injectable medications listed on the Louisiana Medicaid Professional Services Fee Schedule with billed amounts of $250 or greater
- Some surgical services and surgical procedures that may be considered cosmetic
- Cochlear Implantation (covered for members under 21)
- Gastric Bypass/Vertical Band Gastroplasty
- Medical Hysterectomy Only*
- Pain Management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radiofrequency ablation and nerve blocks
- Radiology Services**
- CT Scan
- MRI
- MRA
- Nuclear Cardiac Imaging
- All unlisted and miscellaneous codes

* Providers must meet State requirements/documentation for reimbursement. Please see requirements and documentation necessary in the AmeriHealth Caritas Provider Handbook.

** Prior Authorization for, CT Scans, MRIs/MRAs and Nuclear Cardiology services are required for outpatient services only. The ordering physician is responsible for obtaining a Prior Authorization number for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call. (Outpatient studies ordered after normal business hours or on weekends should be conducted by the ordering facility as requested by the ordering physician. However, the ordering physician must contact Prior Authorization within 48 hours or the next business day to obtain proper authorization for the studies, which will be subject to medical necessity review.) Emergency room, Observation Care and inpatient imaging procedures do not require Prior Authorization.

Claims Submission, Remittance Advice, Electronic Funds Transfer:

Arrange Electronic Claims Submission through your EDI vendor or through EMDEON: 877-363-3666

Arrange Electronic Funds Transfer (EFT) through EMDEON 866-506-2830

Electronic Remittance Advice (ERA) through EMDEON: 877-363-3666

AmeriHealth Caritas EDI Technical Support Hotline: 866-428-7419

AmeriHealth Caritas Provider Services: 866-922-0007

Submit paper claims to:
AmeriHealth Caritas Louisiana
Claims Processing Department
PO Box 7322
London, KY 40742

Please indicate "Resubmitted" or "Corrected Claim" on the Claim Form (if applicable)

Member Services: 888-756-0004

1st Level Dissatisfaction NOT concerning Medical Necessity:

AmeriHealth Caritas Louisiana
PO Box 7323
London, KY 40742

Provider Disputes: (Formal)

1st Level Dissatisfaction NOT concerning Medical Necessity:

AmeriHealth Caritas Louisiana
PO Box 7323
London, KY 40742

Provider Appeals: (Formal)

Telephone: 888-913-0362

(Fax)..... 877-724-4835

Written request for the reversal of a medical denial
1st and 2nd Level Appeals:

AmeriHealth Caritas Louisiana
PO Box 7323
London, KY 40742

Please indicate "Provider Appeals" 1st or 2nd Level on the envelope

Timely Filing Limits:

When Submitting an EOB with a claim, the Dates and Dollars must all match to avoid a rejection of the claim

Initial claims: ..... 180 days

Resubmissions/Corrections: ..... 180 days

COB submissions after primary payment: ..... 180 days

Nurse Call Line: 888-632-0009

A confidential line for members to ask health-related questions 24 hours a day, 7 days a week

Other Important Contact Information:

Louisiana Enrollment Services

BAYOU HEALTH

www.bayouhealth.com

855-BAYOU-4U (855-229-6848)

TTY: 855-LAMed4Me (855-526-3346)

AmeriHealth Caritas Contact Information:

Department	Phone	Fax
Provider Services	888-922-0007	866-426-7393
Member Services	888-756-0004	866-397-4521
Prior Authorization	888-913-0350	866-397-4522
Adult Concurrent Review	888-913-0350	866-397-4522
Pediatric Concurrent Review	888-913-0350	866-397-4522
NICU Concurrent Review	888-913-0350	866-397-4522
OB Concurrent Review	888-913-0350	866-397-4522
Discharge Notification Review	888-913-0350	866-397-4522
Discharge Planning Review	888-913-0350	866-397-4522
DME Authorization	888-913-0350	866-397-4522
Bright Start®	888-913-0327	888-877-5925
Credentialing	888-913-0349	866-242-3461
Network Contracting	877-588-2248	225-300-9126

Behavioral Health Provider:

Prior to March 1, 2012contact DHH Office of Behavioral Health at (225) 342-2540 or http://new.dhh.louisiana.gov/index.cfm/subhome/10

Beginning March 1, 2012 call Merit Health/Magellan Health at 800-424-4399 or TTY 800-424-4416

Websites and Email Addresses:

AmeriHealth Caritas Louisiana - www.amerihealthcaritasla.com

Louisiana Medicaid – www.lamedicaid.com

AmeriHealth® Caritas Louisiana

PREVENTABLE SERIOUS ADVERSE EVENT SCREENING CODES

PREVENTABLE SERIOUS ADVERSE EVENT	SCREENING ICD-9 OR E CODES MUST NOT BE PRESENT AT ADMISSION BUT APPEAR AT TIME OF DISCHARGE
Events Potentially Identifiable by E Codes Only	
Wrong surgical procedure on a patient	E876.5
Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	E875.0, E875.1, E875.2, E875.8, E875.9 Claim should reflect “20” Discharge Status Code, if applicable.
Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	E874.0, E874.1, E874.2, E874.3, E874.4, E874.5, E874.8, E8749, E876.3, E876.4 Claim should reflect “20” Discharge Status Code, if applicable.
Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	E950.0, E950.1, E950.2, E950.3, E950.4, E950.5, E950.6, E950.7, E950.8, E950.9, E951.0, E951.1, E951.8, E952.0, E952.1, E952.8, E952.9, E953.0, E953.1, E953.8, E953.9, E954, E955.0, E955.1, E955.2, E955.3, E955.4, E955.5, E955.6, E955.7, E955.9, E956, E957.0, E957.1, E957.2 E957.9, E958.0, E958.1, E958.2, E958.3, E958.4, E958.5, E958.6, E958.7, E958.8, E958.9, E959 Claim should reflect “20” Discharge Status Code, if applicable.
Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)	E873.0, E873.1, E873.2, E873.3, E873.4, E873.5, E873.6, E873.8, E873.9 Claim should reflect “20” Discharge Status Code, if applicable.
Patient death associated with a fall while being cared for in a healthcare facility	E884.2, E884.3, E884.4, E884.5, E884.6, E885.9, E888.0, E888.1, E888.8, E888.9 Claim should reflect “20” Discharge Status Code, if applicable.

Unexpected Removal of Organ	E878.6
Unexpected Amputation of Limb	E878.5
Events Potentially Identifiable through ICD-9 Codes Only	
Intraoperative or immediately post-operative death in a normal healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologists patient safety initiative)	798.0, 798.1, 798.2, 798..9 Claim should reflect “20” Discharge Status Code, if applicable.
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	999.6, 999.7, 999.8, E876.0 Claim should reflect “20” Discharge Status, if applicable.
Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy while being cared for in a healthcare facility	No diagnosis code available for maternal death. Will be reported when claims group into Diagnostic Related Groups (DRG) 370 through 375. Claim should reflect “20” Discharge Status Code, if applicable.
Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility, excluding those the progress from Stage 2 to Stage 3	707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09 Note that these codes do not reflect the stage of the pressure ulcer.
Severe Allergic Reaction	977.9, 995.0, 995.2
Use of Both ICD-9 and E Codes	
Retention of a foreign object in a patient after surgery or other procedure	998.4, 998.7, E871.0, E871.1, E871.2, E871.3, E871.4, E871.5, E871.6, E871.7, E871.8, and E871.9
Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	999.6, 999.7, 999.8, E876.0 Claim should reflect “20” Discharge Status Code, if applicable.

Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9, 941.0, 941.1, 941.2, 941.3, 941.4, 941.5, 942.0, 942.1, 942.2, 942.3, 942.4, 942.5, 943.0, 943.1, 943.2, 943.3, 943.4, 943.5, 944.0, 944.1, 944.2, 944.3, 944.4, 944.5, 945.0, 945.1, 945.2, 945.3, 945.4, 945.5, 946.0, 946.1, 946.2, 946.3, 946.4, 946.5, 947.0, 947.1, 947.2, 947.3, 947.4, 947.8, 947.9, E925.0, E925.1, E925.2, E925.8, E925.9, E926.0, E926.1, E926.2, E926.3, E926.4, E926.5, E926.8, E926.9 Claim should reflect “20” Discharge Status Code, if applicable.
Medication Error (Patient death or serious disability associated with a medication error)	960, 960.0, 960.1, 960.2, 960.3, 960.4, 960.5, 960.6, 960.7, 960.8, 960.9, 961, 961.0, 961.1, 961.2, 961.3, 961.4, 961.5, 961.6, 961.7, 961.8, 961.9, 962, 962.0, 962.1, 962.2, 962.3, 962.4, 962.5, 962.6, 962.7, 962.8, 962.9, 963, 963.0, 963.1, 963.2, 963.3, 963.4, 963.5, 963.8, 963.9, 964, 964.0, 964.1, 964.2, 964.3, 964.4, 964.5, 964.6, 964.7, 964.8, 964.9 965, 965.0, 965.1, 965.4, 965.5, 965.6, 965.7, 965.8, 965.9, 966, 966.0, 966.1, 966.2, 966.3, 966.4, 967, 967.0, 967.1, 967.2, 967.3, 967.4, 967.5, 967.6, 967.8, 967.9, 968, 968.0, 968.1, 968.2, 968.3, 968.4, 968.5, 968.6, 968.7, 968.9, 969, 969.0, 969.1, 969.2, 969.3, 969.4, 969.5, 969.6, 969.7, 969.8, 969.9, 970, 970.0, 970.1,970.8, 970.9,
Medication Error (Patient death or serious disability associated with a medication error) (continued)	971 971.0, 971.1, 971.2, 971.3, 971.9, 972, 972.0, 972.1, 972.2, 972.3, 972.4, 972.5, 972.6, 972.7, 972.8, 972.9, 973, 973.0, 973.1, 973.2, 973.3, 973.4, 973.5, 973.6, 973.8, 973.9, 974, 974.0, 974.1, 974.2, 974.3, 974.4, 974.5, 974.6, 974.7, 975, 975.0, 975.1, 975.2, 975.3, 975.4, 975.5, 975.6, 975.7, 975.8, 976, 976.0, 976.1, 976.2, 976.3, 976.4, 976.5,

	976.6, 976.7, 976.8, 976.9, 977, 977.0, 977.1, 977.2, 977.3, 977.4, 977.8, 977.9, 978, 978.0, 978.1, 978.2, 978.3, 978.4, 978.5, 978.6, 978.8, 978.9, 979, 979.0, 979.1, 979.2, 979.3, 979.4, 979.5, 979.6, 979.7, 979.9, E850.0, E850.1, E850.2, E850.3, E850.4, E850.5, E850.6, E850.7, E850.8, E850.9, E851, E852.0, E852.1, E852.2, E852.3, E852.4, E852.5, E852.6, E852.8, E852.9, E853.0, E853.1, E853.2, E853.8, E853.9, E854.0, E854.1, E854.2, E854.3, E854.8, E855.0, E855.1, E855.2, E855.3, E855.4, E855.5, E855.6, E855.8, E855.9, E856, E857, E858.0, E858.1, E858.2, E858.3, E858.4, E858.5, E858.6, E858.7, E858.8, E858.9 Claim should reflect “20” Discharge Status Code, if applicable.